

The need for context-specific nutrition and health policies and interventions: The reality of disparities in socio-economic, health and nutritional status

During discussions with local health professionals pre-1994, Dr Urban Johnsson of UNICEF was told that, *unlike Malawi*, South Africa was a heterogeneous country. Interventions proposed by UNICEF needed to take into consideration differences that existed between and within regions in the country, with regard to health and socio-economic status.

The study by Kalimira *et al.*¹ published in this issue, however, appears to challenge the long-held view of Malawi as a homogeneous country! The authors highlight the differences in child undernutrition between three major agricultural development divisions in Malawi. They urge implementers of nutrition and health programmes to adjust their intervention strategies to local demands and nuances. This approach would allow for effective targeting of interventions. They further advocate that national recommendations be tempered with the need to determine *area-specific* nutrition and health actions. One wonders whether there were any differences in the prevalence of overweight between the areas.

Recently, traditional views on the differences in health and nutrition status between urban and rural populations have been questioned. The often-touted urban advantage in health can mask a huge differential between the urban poor and urban non-poor in urban areas of sub-Saharan Africa. Fotsso found that intra-urban differences in child malnutrition were much larger than overall urban-rural differences.²

The approach advocated by Kalimira *et al.* should be supported, in light of financial constraints faced by most developing countries. However, there are non-negotiable blanket health interventions that apply to all settings, irrespective of location or socioeconomic and health status, e.g. immunisation and exclusive breastfeeding for 6 months. The latter of course is the subject of much discussion against the background of the HIV epidemic in resource-poor settings, illustrating once more the importance of context.³

Besides the policy and intervention aspects of the study, there are also implications for conducting *context-specific health research*. Presenting global or aggregated routine health statistics without considering sub-groups and areas would certainly

not help to fashion and target interventions to those who need them the most. Poverty and inequity (in general and in health) are inexorably linked, and this is reflected in the not-unexpected differentials in morbidity and mortality found in South Africa.⁴

South Africa implemented blanket vitamin A supplementation (VAS) nationally in 2002 on the basis of the findings of the SAVACG study, which showed a national prevalence of low serum retinol of 33%.⁵ That such a blanket nutrition intervention policy might not be appropriate in all settings is illustrated by the findings of Van Stuijvenberg *et al.*⁶ While conducting the baseline assessment of micronutrient status among schoolchildren, the researchers found that their vitamin A levels were normal to 'high' (mean serum retinol 35.5 µg/dl). Further investigation of this unexpected result (compared with available data in South Africa) revealed that the local population ate a lot of organ meat, which was freely available and cheap. In light of the national VAS policy, the question arose whether this population (especially young children) might be at risk of receiving too much vitamin A. A study to investigate this is currently being planned by the same research team. The results may have profound implications for national nutrition policy.

Linked to the above result of higher than expected retinol levels in a specific group or region, is the finding that VAS was associated with possible harm to the HIV-positive women and infants in the ZVITAMBO study.⁷ The commentary by Dhansay⁸ refers to this study, as well as to the Cochrane Review by Wiysonge *et al.* on VAS for reducing the risk of MTCT of HIV infection.⁹ Dhansay states that the inconsistency in results from various studies of VAS in the context of prevention of MTCT of HIV infection '*... is likely to be due to differences in nutritional, social and morbidity backgrounds between and within countries and regions*'. In South Africa, with its huge burden of HIV infection, the question needs to be asked whether the national VAS policy of giving high-dose VAS to women after delivery poses a risk to them and their infants. The answer to this is certainly moot and needs to be addressed urgently.

Another example of the need to consider context is shown by the following incident during the early

1990s. The Supplementation Scheme of the Nutrition Directorate had certain eligibility criteria for pregnant women to receive food supplementation. The clientele of a certain tertiary hospital happened to be mainly of the coloured ethnic group. Based on low mid-upper arm circumference and body mass index, the majority qualified for the supplements. This caused a huge outcry among the black African women, with claims of discrimination and racism being made. In order to salvage the situation, the anthropometric criteria were scrapped, and in practice anyone who wanted the supplements could get them. The coloured women were not poorer than the black African women, but they were certainly thinner. These differences are reflected in more than one survey, e.g. the Demographic and Health Surveys of 1998.¹⁰ This incident once again emphasises the need to factor in the local context; failure to do so derailed the well-intentioned intervention programme for at-risk pregnant women.

There is therefore a plea for policy makers, health care providers and researchers to consider the context of the health and nutrition problems they wish to address, including the fact that even within the 'disadvantaged' groups there may be huge differentials. Inequality and inequity at all levels and sectors present many challenges to the goal of improving the health of nations. It is accepted that public health policies are intended to be 'generalisable' and easily 'implementable'. The reality, however, is that with scarce resources,

it is prudent to target those groups and areas that are most in need, i.e. one size does not fit all. This is the challenge facing implementers of policy, particularly in South Africa and countries with huge disparities in the social, economic and health arena. The responsibility of researchers is to ensure that the correct (and disaggregated) information is made available for decision making by policy makers.

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