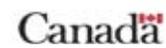




**African Population and  
Health Research Center**



International Development Research Centre  
Centre de recherches pour le développement international



# Analysis of Non-Communicable Disease Prevention Policies in South Africa





# Analysis of Non-Communicable Disease Prevention Policies in South Africa

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## Abbreviations

<b>AA</b>	Alcoholics Anonymous
<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b>ACDP</b>	African Christian Democratic Party
<b>ANC</b>	African National Congress
<b>ANPPA</b>	Analysis of non-communicable diseases prevention policies in Africa
<b>APHRC</b>	African Population & Health Research Centre
<b>APP</b>	Annual performance plan
<b>ARA</b>	Association for Responsible Alcohol Use
<b>ASGI-SA</b>	Accelerated Shared Growth Initiative—South Africa
<b>BAT</b>	British American Tobacco
<b>B-BBEE</b>	Broad-Based Black Economic Empowerment
<b>BMI</b>	Body Mass Index
<b>CANSA</b>	Cancer Association of South Africa
<b>CBO</b>	Community-based organization
<b>CDL</b>	Chronic diseases of lifestyle
<b>CHIP</b>	Community health intervention programme
<b>CSO</b>	Civil society organisation
<b>CVD</b>	Cardiovascular disease
<b>DA</b>	Democratic Alliance
<b>DAAF</b>	Department of Agriculture and Forestry
<b>DENOSA</b>	Democratic Nursing Organization of South Africa
<b>DOA</b>	Department of Agriculture
<b>DAC</b>	Department of Arts & Culture
<b>DOE</b>	Department of Education



<b>DOH</b>	Department of Health
<b>DOSD</b>	Department of Social Development
<b>DSA</b>	Diabetes South Africa
<b>DTI</b>	Department of Trade and Industry
<b>EC</b>	Eastern Cape
<b>ECLB</b>	Eastern Cape Liquor Board
<b>ECT</b>	Electro-convulsive therapy
<b>EHP</b>	Environmental health practitioners
<b>EU</b>	European Union
<b>FAS</b>	Foetal Alcohol Syndrome
<b>FBO</b>	Faith-based organisation
<b>FCTC</b>	Framework Convention on Tobacco Control
<b>FEDHASA</b>	Federation Hospitality Association of South Africa
<b>FS</b>	Free State
<b>GEAR</b>	Growth, employment and redistribution
<b>GP</b>	Gauteng Province
<b>HFCS</b>	High-fructose corn syrup
<b>HIV</b>	Human Immune Deficiency Virus
<b>HSF</b>	Heart and Stroke Foundation
<b>HSRC</b>	Human Sciences Research Council
<b>IDRC</b>	International Development and Research Centre
<b>IMC</b>	Inter-ministerial committee
<b>IMF</b>	International Monetary Fund
<b>IPAP</b>	Industrial Policy Action Plan



<b>ISA</b>	Inter-sectoral action
<b>KII</b>	Key informant interview
<b>KZN</b>	KwaZulu-Natal
<b>LP</b>	Limpopo Province
<b>MDGs</b>	Millennium Development Goals
<b>MP</b>	Mpumalanga Province
<b>MRC</b>	Medical Research Council
<b>MSA</b>	Multi-sectoral action
<b>MTEF</b>	Medium Term Expenditure Framework
<b>NC</b>	Northern Cape
<b>NCAS</b>	National Council Against Smoking
<b>NCD</b>	Non-communicable disease
<b>NDP</b>	National Development Plan
<b>NGO</b>	Non-governmental organization
<b>NGP</b>	New Growth Path
<b>NKF</b>	National Kidney Foundation
<b>NLA</b>	National Liquor Authority
<b>NLB</b>	National Liquor Board
<b>NP</b>	Nationalist Party
<b>NPC</b>	National Planning Commission
<b>NSRA</b>	National Sports and Recreation Act
<b>NWP</b>	North West Province
<b>PA</b>	Physical activity
<b>PAC</b>	Pan Africanist Congress



<b>PHANGO</b>	Patient Health Alliance Non-Governmental Organization
<b>PHC</b>	Primary healthcare
<b>RDP</b>	Reconstruction and Development Programme
<b>REC</b>	Research Ethics Committee
<b>RIP</b>	Reduced Ignition Propensity
<b>RSA</b>	Republic of South Africa
<b>SA</b>	South Africa
<b>SAB</b>	South African Breweries
<b>SABC</b>	South African Broadcasting Corporation
<b>SACCI</b>	South African Chamber of Commerce and Industry
<b>SADAG</b>	South African Drug and Anxiety Group
<b>SAHDS</b>	South African Health and Demographic Survey
<b>SAMA</b>	South African Medical Association
<b>SAMJ</b>	South African Medical Journal
<b>SANAC</b>	South African National AIDS Council
<b>SANCA</b>	South African National Council on Alcoholism and Drug Dependence
<b>SANHANES</b>	South African National Health and Nutrition Examination Survey
<b>SDG</b>	Sustainable Development Goals
<b>SRSA</b>	Sports and Recreation South Africa
<b>StatsSA</b>	Statistics South Africa
<b>SSBs</b>	Sugar-sweetened beverages
<b>STI</b>	Sexually Transmitted Infections
<b>STD</b>	Sexually transmitted diseases
<b>TAFISA</b>	The Association for International Sport for All
<b>TAG</b>	Treatment Action Group



<b>TB</b>	Tuberculosis
<b>TISA</b>	Tobacco Institute of South Africa
<b>THO</b>	Traditional Healers Organisation
<b>TUT</b>	Tshwane University of Technology
<b>UCT</b>	University of Cape Town
<b>UK</b>	United Kingdom
<b>UN</b>	United Nations
<b>UNDP</b>	United Nations Development Programme
<b>UNICEF</b>	United Nations Children's Fund
<b>USAID</b>	United States Agency for International Development
<b>WB</b>	World Bank
<b>WC</b>	Western Cape
<b>WHF</b>	World Heart Federation
<b>WHO</b>	World Health Organization



## Executive Summary and Key Messages

The Analysis of non-communicable diseases prevention policies in Africa (ANPPA) – A case study of South Africa set out to analyse non-communicable disease (NCD) policies in South Africa. Its particular aims were to: assess the state of implementation of NCD “best buy” interventions; generate evidence on the extent to which multi-sectoral action (MSA) is used in formulating and implementing policy guiding these interventions in South Africa; identify barriers to and facilitators of the formulation and implementation of NCD prevention and control policies in the country; and contribute to the literature on Multi-sectoral Action relevance in formulating and implementing NCD prevention and control policies.

The study’s methodology entailed analysing existing policies that addressed behavioural NCD risk factors such as unhealthy diets, physical inactivity, smoking and harmful alcohol consumption. The study used the Walt and Gilson (1994) policy framework analysis commonly used in health research. Each risk factor was used to frame a case study in which relevant policies were critically analysed to explicate the factors underlying the formulation of the policy, the stakeholders involved, and their roles in formulation and implementation. The policy analysis also identified existing policy gaps and how these can be dealt with to ensure NCD prevention and control.

Forty-four key informant interviews were conducted to understand how far Multi-sectoral Action was applied in formulating and implementing different NCD policies. Key themes relating to the application of MSA in formulating and implementing NCD policies were drawn through content analysis. In particular, factors both facilitating and forming barriers to MSA application in policy formulation and implementation were explored.

The literature and document review confirmed that NCDs are a growing problem at the global level, particularly in low-income countries. In South Africa, an increase in the proportion of the population living with NCD risk factors was reported. The social, economic and political context partially explains the state of NCDs. The post-apartheid government’s consistent tackling of smoking has a substantial effect in reducing tobacco use. The taxation of sugar-sweetened beverages (SSBs) is a notable adoption of best practice in the prevention and control of NCDs related to unhealthy diets in South Africa. It is expected that the impact of this taxation will be seen in coming years. A strong alcohol Bill aimed at reducing advertising and promotion of alcohol exposure was passed in 2013 and its effect will likely reduce alcohol exposure. However, policies and programmes targeting physical activity have yet to yield tangible results.

Polymaking in South Africa is constitutionally designed to be participatory and requires a wide range of stakeholders before policies can be passed. Analysis of multi-sectoral involvement in formulating NCD policies post-apartheid suggests many stakeholders were involved, although they do not consistently participate throughout the process. Participants interviewed in the current study could not provide a consistent narrative of the formulation process from start to completion of existing NCD policies (salt reduction, tobacco, alcohol abuse, and sports and recreation). Using the definition of MSA to denote the involvement of sectors outside the health system, the findings of this study suggest that participants in the drafting of NCD policies were largely drawn from the health sector, with a relatively limited number from outside (such as the food processing and retail sectors).

Application of MSA in policy implementation is also difficult to establish as departments are not bound to collaborate with different stakeholders in implementing NCD policies. What emerges,



however, is the fact that in the case the Tobacco Products Control Act and subsequent policies, the implementation of controls on smoking in public spaces led to a reduction in smoking.

### Findings and recommendations

1. The entrenchment of public participation in South African policymaking accounts for the MSA observed in the formulation of NCD policies.
2. Effective MSA in relation to NCD policy implementation needs a national coordinating and oversight structure. Such a body would have a structure similar to the South African National AIDS Council (SANAC), which has oversight of the AIDS prevention and control efforts in the country. The composition of SANAC is drawn from various sectors of society, with meetings held on a regular basis to track progress in Human Immune Deficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) prevention and control. A similar structure for NCDs is required.
3. Policymakers keen on using MSA must deliberately design stakeholder lists that represent diverse sectors.
4. Targeted beneficiaries need to participate in the formulation and implementation of policies because these groups become ambassadors and create awareness in their communities.
5. For the MSA to be effectively applied in the formulation and implementation of NCDs, resources, including budgets and human and material resources, must be made available to ensure there are no barriers to stakeholder participation.
6. While MSA use is important in both policy formulation and implementation, the specific policy always needs a champion – such as a high-profile political figure – during formulation and implementation.
7. In addition to policy champions, there must be political structures at national and sub-national level to provide implementation oversight.
8. MSA application in programme design and implementation should be used as a performance indicator by the Department of Health (DOH).
9. Just as the DOH is the custodian of NCD policies and programmes, Sports and Recreation South Africa (SRSA) is the custodian of physical activity policies and programmes critical to NCD prevention and control. SRSA policies and programmes must embody the notion of promoting physical activity for the prevention and control of NCDs.
10. The application of the MSA in NCD policy implementation should take place from grassroots to national levels for NCD prevention and control to be successfully achieved.





1.0 | Background

1.0



## Background and Context of the Study



## 1.1 Introduction

This study is the result of a call by the African Population & Health Research Centre (APHRC) for researchers in different African countries to conduct research on the analysis of non-communicable disease prevention (NCD) policies in Africa (ANPPA). The study was conducted in five African countries: Cameroun, Kenya, Malawi, Nigeria and South Africa. At the core of the study was the review of policies targeting key NCD risk factors: unhealthy diets, smoking, harmful use of alcohol and physical inactivity. These risk factors account for the major NCDs (cancer, cardiovascular diseases, diabetes and chronic respiratory disease) globally and as well as Africa. In analysing policies targeting the major NCDs, the focus was on establishing the extent to which the World Health Organisation (WHO) “best buy” interventions were included in the existing policies and implementation programmes. A major part of the study focused on the extent to which the MSA was applied in the formulation and implementation of the existing NCD policies in each of the African countries. This report presents the findings from the analysis of NCD policies in South Africa. Using the NCD risk factors as case studies, the report explores the extent to which MSA was used in the formulation and implementation of the existing NCD policies. The report discusses the “best buy” interventions included in the policies analysed, and the extent to which these interventions were implemented. The report is divided into chapters; chapter 1 outlines the study’s background, context, aim, objectives and methodology, providing definitions of key terms. Chapter 2 describes the epidemiology and burden of disease arising from NCDs, while chapter 3 explores the social, political, economic and technological context of NCDs in South Africa. Chapters 4 to 7 present findings from the analysis of various NCD policies, and chapter 8 discusses the implications of using the MSA in formulating and implementing NCD policies in South Africa. Recommendations arising from the study are also given.

## 1.2 Study background

According to Di Cesare *et al* (2013), NCDs cause about 35 million out of the 53 million deaths globally per year. Three-quarters of the NCD deaths occur in low- and middle-income countries. Di Cesare *et al* argue the key factors underlying the global burden of NCDs are mainly behavioural, dietary, environmental and metabolic. The behavioural risk factors responsible for NCDs include tobacco use and exposure to second-hand smoke; unhealthy diets (foods high in fats, salt and sugar); insufficient physical activity; and harmful consumption of alcohol (Baleta & Mitchell, 2014; Di Cesare *et al*, 2013; Igumbor, Sanders, Puoane, Tsolekile, & Schwarz, 2012; McCarthy & McCarthy, 2016; HSF (2013). While most of the behavioural risk factors are preventable and modifiable (Igumbor *et al*, 2012; Brinsden, He, Jenner, & MacGregor, 2013), access to medicines, including traditional medicine, remains critical in tackling the NCD epidemic (So, Wong, & Ko, 2015). The risk factors result in metabolic and physiological changes that increase the risk of NCDs, such as obesity, high blood pressure, hyperglycaemia (raised blood sugar) and hyperlipidaemia (increased levels of cholesterol).

Globally, there is growing concern about the increase of NCDs; the World Health Organisation (WHO) is taking the lead to ensure that governments formulate policies using multi-sectoral strategies to curb the growing NCD burden.

In assessing the interventions that address NCDs and their underlying risk factors, the WHO (2011) uses four indicators:

1. Health impact,
2. Cost-effectiveness,
3. Cost of implementation, and
4. Feasibility of scale-up in resource-constrained settings.



The term “best buys” is “used to describe interventions that have significant public health impact and are highly cost-effective, inexpensive, and feasible to implement” (WHO, 2011:1). The table detailing best buys is presented in Table 1 in the annexures. The best buys guide countries in making decisions while formulating policies for NCD prevention,

The purpose of this study was to analyse NCD prevention policies in South Africa. Its **specific objectives** were to:

1. Conduct an in-depth assessment of the development and state of implementation of the WHO NCD best buy interventions in South Africa;
2. Generate evidence on how, and the extent to which, MSA is used in policy formulation and implementation relating to these interventions in South Africa, with an emphasis on population-based measures; and
3. Identify the barriers to, and facilitators of, the application of MSA in the development of NCD prevention and control policies in South Africa.

### Definition of terms

Under apartheid, the different population groups were classified according to the colour of their skin. There were four (4) distinct classifications- African, Coloured, India/Asian and White.

African – Indigenous to the African continent

Coloured- People of mixed race

Blacks – All all non-Whites (Africans, Coloureds, Indians/Asians).

Indians/Asians - people with origins in Asia

Whites- Descendants of European settlers

The continued use of racial classification in South Africa has been for the purpose of gauging the rate of transformation particularly in view of the policies designed to redress past injustices and persistent structural inequalities (Department of Labour (DoL); 2015). This study uses the same classifications used by the Department of Labour to distinguish between different population groups.

## 1.3 Methods

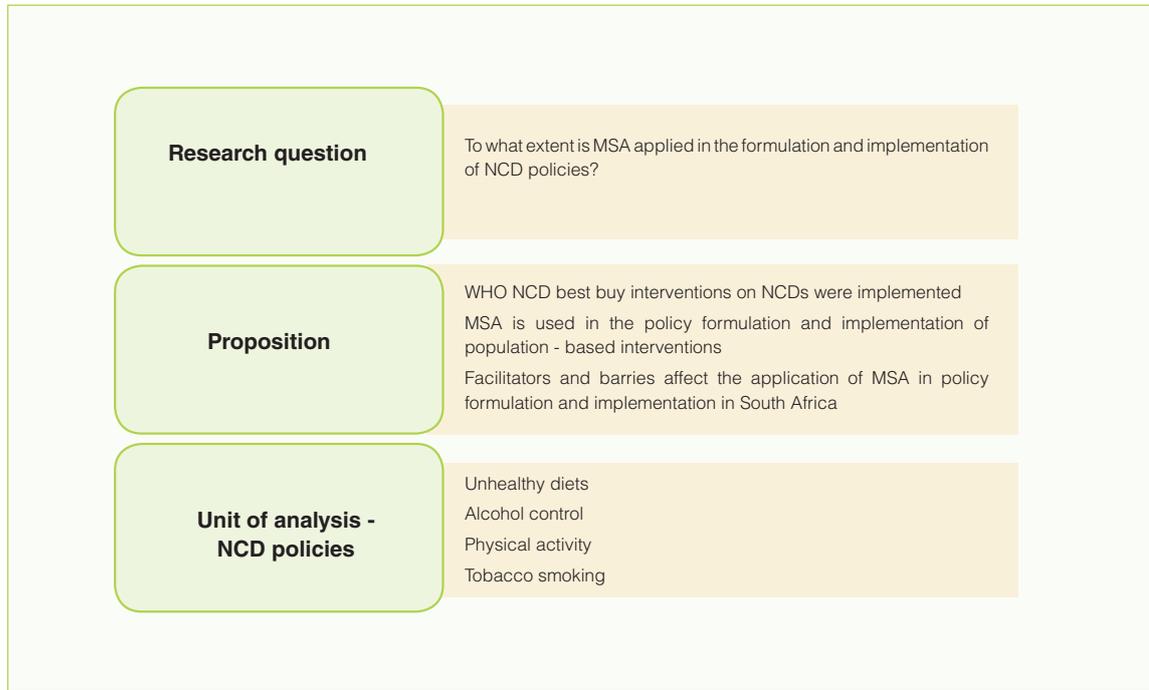
### Research design, sample and technique used in the data collection

The study used the case study approach as discussed by Yin (2009). Case studies are valuable in demonstrating patterns and contexts of specific social phenomena studied. They “provide richness of the phenomenon and the extensiveness of the real life context requires case study investigators to cope with a technically distinctive situation” (Yin, 2009:2). The context of the current study was multi-site, involving five African countries; each was taken as a case study. Within each country, NCD risk factors were selected for policy analysis and further exploration. In South Africa, the four NCD risk factors covered as case studies were unhealthy diets (with a particular focus on salt reduction), tobacco smoking, alcohol abuse and physical inactivity.

A summary of the research design elements is given is shown in Figure 1.



Figure 1: Summary of the research



In applying the case study design to this study, each risk factor was treated as a case study and within each case study a range of techniques was deployed for data collection.

### Key informant interviews

The policy analysis was complemented with 44 key informant interviews drawn from different sectors involved in formulating and implementing policies related to NCDs.

The researchers compiled a list of organisations that deal with NCDs; government departments whose work influences NCD policies or the implementation of these policies; business organisations that affect the onset and treatment of NCDs; non-governmental organisations that support people living with NCDs and who are advocates for the rights of patients; and organisations tasked with assisting individuals with NCDs at grassroots level. Purposive sampling using the initial list of stakeholders was found to be reasonably satisfactory. The key informants were selected on the basis of their experience of working with NCDs in South Africa, their participation in the formulation or implementation of NCD policies, and their representation of individuals living with NCDs. However, during the process, the research team resorted to snowball sampling by asking participants for references to other individuals and organisations involved in the formulation and implementation of NCD policies. In the process of interviewing participants, the research team learned of activities taking place in the country that were specifically focused on the control and prevention of NCDs. After attending a workshop organised by South African Non-communicable Disease Alliance, the research team was able to contact more participants for interviews. In total, 44 key informant interviews were conducted, with three of the 44 participants contributing to one interview.

The participants were drawn from a broad spectrum of society: government, non-governmental organisations, research institutions (universities and science councils); businesses; and other structures such as medical schemes and a traditional healers’ organisation. The diversity of the organisations and the interests that they represent are reflected in the data collected.



MSA was assessed by evidence of partnership involvement beyond government requirements in the prevention and control of NCDs.

### Document review

The research team captured the policy context and content, identifying existing policies and gaps through a search process. EBSCOhost web was used to access NCD policy documents focusing on four key risk factors (unhealthy diets, physical inactivity, tobacco smoking and harmful use of alcohol). When the search did not yield much, the research team refined the search to focus on policies addressing specific NCDs: cancer, cardiovascular diseases, diabetes, and chronic respiratory diseases. Both published and grey literature were reviewed; grey literature included annual and strategic departmental reports, guidelines and programme materials. Also included were unpublished dissertations and conference papers. During the interviews with key informants, the research teams also accessed policies and documents that were not in the public domain. Data extracted from the documents included identification of years in which relevant policy changes occurred and the events leading up to those decisions. Emphasis was placed on the inclusion of WHO best buy interventions in reviewing the policy documents.

### Data management and analysis

This study examined four case studies – nutrition and diet, tobacco control, alcohol control and physical inactivity – in context of the multi-country protocol on NCD prevention policy analysis in five African countries (Juma *et al* 2016). This multi-country study protocol prescribed a toolkit adapted by each of the participating countries that details the procedures for document reviews; the data collection tool and pretesting of the tool at country level; ethical considerations; the interviewing process; data management and data analysis. The approaches taken for the South Africa case are described below.

Interview recordings were transcribed verbatim and saved as separate files in a qualitative database. We used the analysis framework and the code book developed by research teams of the five countries (Kenya, Malawi, Cameroon, Nigeria and South Africa) that identified key themes to be explored in the analysis (Juma *et al* 2016). We also subjected the textual data to a variant of thematic analysis: “an approach ... which identifies and categorises themes in texts such as interview or focus group transcripts, or documents” (Searle, 2012: 599). Meanwhile, codes were categorised according to emerging dominant ideas from the textual data, and inter-rater reliability helped in comparing the identified themes. Similar themes emerged, and differences in the data analysis were accounted for by the emphasis placed on some ideas and the selection of extracts to support the dominant themes. The extracts from the key informants were reported using the name of the study (ANPPA), the data collection instrument (KII), and the pseudonym allocated to the study participant which was in the form of numbers from 1 to 44. Thus an extract from one participant is indented in the text and the reference is provided as (ANPPA\_KII\_10), (ANPPA\_KII\_20), (ANPPA\_KII\_30), etc.

### Ethical considerations

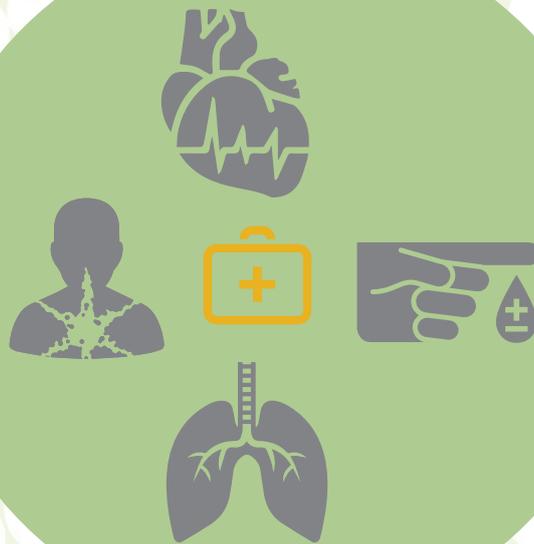
The study was granted ethical approval by the HSRC Research Ethics Committee (REC) (2/19/02/114 approval number).



2.0



2019 | Methods Current  
Status of NCD



Current Status of NCDs (Epidemiology,  
Burden of Risk Factors) and NCD Policies  
in South Africa



## 2.1 Introduction

In discussing the status of NCDs in South Africa, this chapter draws on a range of existing studies that illustrate both the magnitude of how NCDs affect specific social categories and the efforts being taken to deal with the epidemic (Statistics South Africa, 2015).

## 2.2 State of NCDs in South Africa

### Burden of NCDs

South Africa has a population of 52.9 million and 27.16 million (51%) are women (Statistics South Africa, 2014). In 2013, life expectancy at birth was estimated at 57.7 years for men and 61.4 years for women (Statistics South Africa, 2013).

Bradshaw, Steyn, Levitt, & Nojilana (2011) report that a large proportion of the working population in South Africa is affected by NCDs, with a substantial effect on national productivity. The most common types of NCDs in South Africa are cardiovascular diseases, diabetes, cancers, chronic respiratory diseases, and mental illness. For South Africans over age 40, these NCDs are a leading cause of morbidity and mortality (Schneider *et al*, 2009), with cardiovascular disease being the leading cause of mortality among both the poor\* (40%) and the rich+ (35.8%). Stroke, a major cause of morbidity among rich and poor, is often accompanied by ischaemic heart disease among the richest, and by hypertensive heart disease among the poor. Other common NCDs in South Africa are digestive disorders; diabetes; and neuro-psychiatric, genito-urinary and congenital conditions. In terms of NCDs, cancer is another major cause of mortality in South Africa, with oesophageal cancer being the leading cause of mortality among men and cervical cancer being the leading cause of mortality among African women (Bruni *et al*, 2017; Goldhaber-Fiebert *et al*, 2009; Schneider *et al*, 2009). NCDs in South Africa are not confined to the adult population; obesity and diabetes are now prevalent among children. This is becoming a critical health concern requiring urgent attention and action (Bradshaw *et al* 2011).

### NCD risk factors

The South African National Health and Nutrition Examination Survey (SANHANES), which collected data on health indicators, including NCD risk factors among adults and adolescents, points to a growing NCD risk in the country (Shisana *et al*, 2014). Among 25,000 people surveyed, prevalence of overweight and obesity was significantly higher in women (39.2% and 24.8% respectively) than men (20.1% and 10.6% respectively) (Shisana, *et al*, 2014). The survey found that 20.2% of men and 68.2% of women had a waist circumference that placed them at risk of metabolic complications. Similar results were seen for the waist-hip ratio: 6.8% for men and 47.1% for women (Shisana, *et al*, 2014). Among children, 25% of girls and 16% of boys were found to be overweight. The SANHANES findings indicate that there was an increase in the proportion of overweight adults and adolescents in the country. Based on the step-fitness test, 27.9% of men and 45.2% of women were physically unfit (Shisana, *et al*, 2014). Urban formal residents were more likely to be unfit than residents of other localities. South African men had a mean body mass index (BMI) that was significantly lower than that of women.

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\* Statistics South Africa (2009) defines the poor as people living below the poverty line. In 2009, this was defined as having an income of less than R577 per month, with 53.9% of the South African population falling into this category; 61.9% were African. (Statistics South Africa, 2009).

+ The rich largely live in urban suburbs, as shown by the high levels of inequality in urban formal settlements where the Gini-coefficient is 0.61 compared with the national Gini-coefficient of 0.64. In terms of the provinces, Western Cape has the largest concentration of the rich; in terms of race and gender, they are white and male (Statistics South Africa, 2009).



Although there appears to be a reduction in the number of obese women between 1998 and 2003, this finding is nullified by the findings of SANHANES, which shows an increase in the proportion of overweight people in South Africa. According to the SANHANES, about 5% of adults aged 15 years and older had self-reported diabetes, and 40% had hypertension (Shisana, *et al*, 2014). The proportion of individuals in South Africa living with the NCD risk factors indicates that the country needs to step up its implementation of the best buy interventions to deal with the growing crisis.

With regard to alcohol consumption, SANHANES revealed that about 6554 of the respondents consumed alcohol (Shisana, *et al*, 2014), among whom 31% were adult men, 9.3% were adult women, 2.3% were teenage boys and 0.6% were teenage girls (Shisana, *et al*, 2014). The majority of the heads of households (61.3%) did not perceive their households to have a problem, while 20.8% did not perceive alcohol misuse to be very serious (Shisana, *et al*, 2014). A significant minority, however, perceived alcohol misuse in their households as either serious (8.4%) or very serious (8.8%). The latter was mostly the case in urban informal areas (14.9%), in Mpumalanga (24.0%), and among African (9.6%) and Coloured communities (6.8%) (Shisana, *et al*, 2014).

In line with this finding, 15.5% of household heads reported that violence due to alcohol abuse was a 'very serious' or 'serious' (Shisana, *et al*, 2014). A majority of heads of households (67.1%) indicated that snacking occurred while people in their households were drinking alcohol. Snacking was significantly lower among households in rural formal areas (56.2%), among black Africans (63.4%), and in Limpopo (46.8%) (Shisana, *et al*, 2014).

With regard to dietary intake, the survey revealed that two out of five participants, or 39.7%, consumed a diet low in dietary diversity, indicative of a diet of poor nutritional quality (Shisana, *et al*, 2014). Almost one out of five participants consumed a diet with a high fat score (18.3%) and high sugar score (19.7%), and one in four consumed a diet with a low fruit and vegetable score (25.6%) (Shisana, *et al*, 2014). The dietary intake of participants in the SANHANES reflects a country in nutritional transition and urbanisation. With the use of a general nutritional knowledge score sheet, nearly two-thirds of South African adult women and men (62.1% and 65.8% respectively) believed they drank and ate healthily, and that there was no need for them to make changes in their diet (Shisana, *et al*, 2014).

In terms of tobacco smoking, SANHANES showed that 20.8% of participants smoked: 16.2% smoked daily, 2% smoked less than daily, and 2.6% previously smoked (Shisana *et al*, 2014). The average mean age of smoking initiation in South Africa was 17.4 years. In terms of gender, the mean age of initiation was lower for women (16.4 years) compared with men (17.9 years) (Shisana *et al*, 2014). The average mean duration of smoking was found to be 17.9 years. Among women, the duration was 19.4 years, and 17.5 years among men (Shisana *et al*, 2014). The average number of cigarettes smoked was 8.5, with the average in terms of gender being 10 among women and 8 among men. In terms of tobacco cessation, on average, 28.8% of smokers reported that they quit. Among these, 26.1% were men and 38.7% were women (Shisana *et al*, 2014); 49.4% reported they quit due to health warnings. Of those who quit, 50.3% were men and 46.5% were women (Shisana *et al*, 2014); 48.1% of participants tried to quit (Shisana *et al*, 2014). The findings suggest that the tobacco legislation, which initially required health warnings and subsequently banned the advertising of tobacco products as a whole, is a success.

In terms of body weight, and happiness with current weight, the SANHANES reported that more men (69.2%) than women (63.3%) were happy with their current weight (Shisana *et al*, 2014). Overall, 87.9% of South Africans indicated that their ideal body image was 'fat', implying it was acceptable to them, while only 12% indicated that they had a 'normal' ideal body image and 0.1% indicated they had a 'very thin' ideal body image (Shisana *et al*, 2014). More than 96% of South Africans were able to correctly identify a 'thin' or a 'fat' body image based on body image



silhouettes. Only 9.6% and 14.2% of men and women respectively were able to correctly identify a 'normal' body weight image, with women being significantly more likely to identify normal body weight images than men (Shisana *et al*, 2014).

## 2.3 NCD Policy landscape in South Africa

South Africa has gradually put in place measures and legislation that address the growing NCD epidemic. Bradshaw *et al* (2011) noted that dealing with the South Africa's NCD challenge requires a multi-pronged approach to provide for population-wide interventions as well as primary care interventions that target individuals at risk of NCDs.

The post-apartheid state is pro-active in addressing NCD concerns; since 1994, a range of legislation and other measures were introduced that directly address smoking and alcohol consumption. The measures taken include: reducing the permitted blood alcohol level for drivers, increasing taxes on alcohol and tobacco products, and requiring warnings on the labels of alcohol and tobacco (Bradshaw *et al*, 2011). Since the formation of the Directorate for Chronic Diseases, Disability and Geriatrics in 1996, a range of national guidelines were formulated to prevent and control NCDs in South Africa (Bradshaw *et al*, 2011). The Health Act (2003) provides the national framework for tackling both communicable and NCDs. Alongside the Health Act is the Traditional Health Practitioners Act (Act 35 of 2004), which is acknowledges that much as the general population makes use of the public health system, Africans remain firmly rooted in their ways of dealing with health and illness. The Traditional Practitioners Act recognises the role of traditional health practitioners as the first point of call before most Africans make their way into the public health system. Between 2000 and 2010, about 32 documents (guidelines, regulations and legislations) were formulated (DOH, 2013) with the aim of preventing, controlling and managing the NCD crisis, which grew alongside the HIV and AIDS pandemic.

In 2012, South Africa issued its declaration on the prevention and control of NCDs, which attributed about 40% of deaths in the country to NCDs (DOH, 2012) and noted that people living with HIV and AIDS are vulnerable to conditions such as cancer, heart disease, mental disorders and diabetes. Mental healthcare policies and guidelines have existed since the 1970s. The Mental Health Policy Guidelines were drafted in 1977. The Mental Health Care Act No. 17 of 2002 (RSA, 2003) provided care guidelines in the public in the health system as well as scope for community-based care for mental health patients. The Mental Health Act (2002) was followed by the Mental Health Care Regulations (2005). The NCD declaration underscores the link between maternal and child health and the risk of NCDs, noting that malnutrition and low birth weight predispose individuals to obesity, high blood pressure, heart disease and diabetes in adult life. These risk factors affect both mothers and children.

### The National Strategic Plan for NCDs (2013-2017)

The National Strategic Plan for NCDs (2013-2017) builds on preceding legislative and policy initiatives as well as guidelines and standards developed over time as a response to NCDs (Ndinda *et al*, 2015). Legislative change to tackle NCDs has existed since 1994; one example is the establishment of the Directorate of Chronic Diseases, Disabilities, and Geriatrics. The Department of Health (DOH)'s 2004-2009 strategic plan highlighted NCDs and healthy lifestyles as major priorities, although between 1994 and 2009, NCDs were not a key priority of the government, possibly due to the HIV/AIDS pandemic (Ndinda *et al*, 2015). The National Strategic Plan for NCDs creates a framework for reducing morbidity and mortality from NCDs (DOH, 2013) by locating this effort within the context of broad health reform in South Africa, using a "whole of government" and "whole of society" approach. The strategy highlights the importance of inter-sectoral collaboration, with departments and all other key structures recognising their



role in working towards a healthy population. The departments and sectors highlighted critical for physical activity are: the departments of Sports & Recreation, Social Development, Basic Education, Human Settlement and Transport. Relevant sectors include civil society, older-persons support groups, occupational health practitioners, and local government. The strategic plan postulates that reducing mortality from NCDs is critical to increasing life expectancy, and if achieved, will contribute to the goal of “healthy life for all” as set out by government in Outcome 2 (DOH, 2010). Three critical domains for responding to NCDs are prevention and promotion; diagnosis and control of NCDs through health systems strengthening and monitoring; and surveillance and research.

Among the health goals of Vision 2030 of the National Planning Commission (NPC) (2012) is to ‘significantly reduce prevalence of NCDs’. While noting that there was a 40% reduction in self-reported smoking, the NPC reiterated that causes of NCDs are lifestyle-related, such as diet and lack of physical activity. Efforts in preventing and controlling NCDs were not only in policies but also in pronouncements made by politicians. At a church service celebrating World Diabetes Day 2012, Dr Gwen Ramakgoba, the Deputy Minister for Health, reiterated that the major causes of diabetes included unhealthy diet, lack of physical activity, smoking and overconsumption of alcohol. The policies and ministerial pronouncements all point to a concerted drive to ensure the prevention and control of NCDs. South Africa set targets to address NCD risk by 2020, as shown in table 5. Mental health is targeted for reduction by 2030. It is not clear why this target is for 2030 and not 2020; however, it is important to note that mental health is now recognised as a condition worthy of DOH focus.

South Africa aims for a 25% reduction in premature mortality (below 60 years) from NCDs by 2020, as well as reductions in tobacco use by 20%. It also targets a per capita intake of salt to less than 5 grams per day, a 10% reduction in the proportion of obese and overweight people, a 30% increase in the number of people controlled for hypertension, diabetes and asthma, as well as cervical cancer screenings for all women every five years in public health facilities and prostate cancer screenings for all men every five years through the primary healthcare re-engineering programme (DOH, 2011). The country’s NCD crisis requires collaboration from the DOH and other stakeholders if the crisis is to be tackled effectively. MSA involves different sectors of government, private sector and civil society.



3.0 | Context of NCD

3.0



# The Context of NCD Prevention Policy Development



## 3.1 Introduction

This chapter discusses the global and local contextual factors that influence NCD prevention policy development in South Africa. The global context refers to the context outside of Africa and the type of changes that took place to influence the rise of the NCD epidemic in South Africa. Since the 1990s neo-liberal economic policies have dominated in the global South. In particular, the implementation of structural adjustment policies and trade liberalisation resulted in developing countries opening up their markets highly processed food imports that affected the nutrition status of large populations. At the local level, we describe the social, economic, political and technological factors that influenced the policy.

### 3.1.1. Global context

Study participants said that by 2000, NCDs would affect low-income countries as well as advanced industrialised nations, so the United Nations (UN) World Assembly (UN, 2011) moved to tackle NCDs in developing countries as a priority. This initiative was followed by regional-level summits, where countries were presented with the NCD epidemic and urged to take action. The UN Summit on NCDs in 2011 further highlighted the challenge. The international focus compelled South Africa to pay attention to such diseases alongside the HIV and AIDS epidemic:

*“There is now a shift in burden of disease from infectious diseases now it’s moving to non-infectious diseases so now it’s a global trend of which we need to improve our intervention on those because previously there was a lot of focus and funding on infectious diseases like HIV [and] tuberculosis (TB), but now the scale is shifting towards NCDs (ANPPA\_KII\_27).”*

Rising obesity levels are a concern at the global level. Echoing research findings on obesity, a participant noted: “South Africa, we are fast becoming one of the fattest populations in the world” (APPA\_KII\_23). Although participants acknowledged that South Africa is seriously affected by communicable diseases such as HIV, AIDS and TB, they also said NCDs such as cancer are a threat to national health. However, the major focus remains on communicable diseases as the large population affected means containing these epidemics is in the public interest.

Participants argued that given the rural nature of the continent, these issues are not so much about health, but the basic necessities of life: practical concerns such as a meal to eat and a place to sleep. Some noted that NCD strategic plans proposed by the WHO target the rising proportion of overweight individuals and the problems of salt and sugar intake.

In discussing the global context of NCDs, participants pointed to costs associated with the increased burden on the health system. In particular, a participant said that such costs are “linked to the provision of care and health systems [which] impact socially on quality health outcomes” (ANPPA\_KII\_32). While recognising that NCDs pose a global health threat, participants also noted the unique position of South Africa, which has dealt with the HIV/AIDS epidemic for more than 20 years. Lessons learnt could be used to tackle the country’s NCD crisis.

The social, political, economic and technological context of NCDs cannot be fully understood without reference to South Africa’s apartheid legacy. With regard to tobacco and alcohol, the sale and distribution of these products was largely informed by apartheid policies and the economic interests of the Afrikaner-dominated Nationalist Party (NP), which rose to power in 1948.

## 3.2. Political context and events

The structural inequality of South African society became the core focus in 1994 of the democratic government led by the late Nelson Mandela. When the African National Congress (ANC) came to power in 1994, its policies on social and economic transformation were guided by the Reconstruction and Development Programme (RDP). This was “an integrated, coherent



socio-economic framework” that sought to “mobilise all our people and our country’s resources towards the final eradication of apartheid and the building of a democratic non-racial and non-sexist future” (ANC, 1994:4-5).

The RDP was essentially the government’s framework for rebuilding South Africa after centuries of racial oppression, segregation and discrimination. At the 49th ANC Conference held in Bloemfontein, the key focus was on strengthening the RDP programmes of South African society’s social and economic transformation. In particular, the party resolved to proceed with RDP implementation, a notion articulated in the idea that “branches must participate in the implementation of the RDP, especially the President’s Programmes”. Mandela was just elected president in the country’s first democratic elections. The ANC further resolved that the RDP was the only way to tackle social development, which was to be achieved from the grassroots level through local government. Local government was tasked with “establishing RDP offices and RDP standing committees in their councils” and was also required to support “the integrated campaign for socio-economic transformation” (ANC, 1994).

At the 50th ANC conference in Mafikeng (1997), the party underscored its commitment to “achieving the resolutions of the RDP” (ANC, 1997: Preamble), given the glaring structural inequalities that persisted after the transition to democracy. The ANC, while acknowledging that the inequalities were part of the apartheid legacy, also underscored the role of state intervention in tackling structural inequalities. The material conditions of the masses remained the focus of the ANC; this is evident in the resolutions that arose from the 1997 Conference and which largely spoke to key development problems of the electorate: housing, electricity, water, telecommunication and information technology, transport and public works, and the building of schools and clinics.

While prioritizing HIV and AIDS at the conference, the party also singled out NCD risk factors as focus areas. The ANC’s position on tobacco, alcohol and substance abuse implied there was political will towards tackling NCDs in post-apartheid South Africa; the battle against smoking began towards the end of the apartheid regime with the introduction of tobacco control policies.

Between 1994 and 2012, the government acknowledged the burden of disease brought about by risk factors such as smoking, alcohol and substance abuse, but the priority was the HIV/AIDS pandemic. At its 2013 conference, the ANC seriously considered the growing NCD burden posed. It recognised the “ever-increasing global burden of NCDs, which in our country adds to the already high incidence of communicable diseases and HIV and AIDS”. The party’s response to the NCD crisis was the result of its participation at the UN high level meeting in 2011, where member states dealt “decisively with the risk factors of smoking, harmful use of alcohol, poor diet and lack of exercise” as well as conditions such as “violence, injury especially on the roads, by mechanisms to control the risk factors”, according to the ANC’s agenda on healthy lifestyles, which represents the party’s first serious attempt to tackle the NCD crisis. At its 53rd conference, the party made three resolutions to deal with the crisis (Figure 2).

Although the ANC’s 2013 health resolutions went to the heart of the NCD crisis, the government’s approach to tackling NCDs remained fragmented. Although part of the health agenda, the emphasis on promoting physical activity for all was a glaringly omission in the sports and recreation resolutions, which focused on transformation in sport and the provision of recreational facilities in schools for the purpose of “sharpening of the minds of children in schools” (ANC, 2013, section 2.7.1.1). Sport was viewed from a political perspective: “Sport plays an important role in promoting community development, social cohesion” (ANC, 2013, section 2.7.1.1). The overriding political motive to use sport not only for physical activity but also to achieve political goals of social transformation, equitable access to sports and recreation facilities, and as a vehicle for breaking down social divisions based on race and building a cohesive society, is evident in the resolutions crafted at all conferences since 1994.



At its 51st ANC conference, held in Stellenbosch in 2002, the ANC's approach to health was on equitable access to services, as encapsulated in its 'Health for All' approach. Among the resolutions on health was its emphasis to "Strengthen healthcare, especially in rural areas, by ... eradicating the backlog of health services and improving the available doctors and nurses, especially in clinics". (ANC, 2002: Resolution 15a). Access to primary health care for people living with NCDs such as diabetes was important, as this was a first point of entry into the health system if they were to receive specialised care at tertiary hospitals. The closest the conference came to addressing NCDs was in its second resolution, under 'health': "Decisively attack communicable and preventable illnesses through, among others, immunization programme; strengthen measures to combat cholera [and] tuberculosis, and ensuring early treatment of chronic and NCDs" (ANC, 2002: Resolution 15c). By 2002 the ANC began to identify NCDs as requiring attention, although not in the same way as HIV/AIDS, which were allocated a whole section. It is notable that the ANC approach by then was to provide access to diagnostic services and treatment at the point of care. In the midst of the HIV/AIDS crisis, NCDs were not viewed as requiring a public health response.

The political context shows that NCDs in post-apartheid South Africa took a 'back seat' due to the HIV/AIDS pandemic. Nevertheless, the government did not lose sight of the importance of the war against smoking and drug abuse, hence its consistency in addressing these elements at each ANC conference. Since 2011, NCDs gained more prominence, not only at conferences but also in national development plans (NPC, 2012) and annual State of the Nation addresses.

### 3.3. Socio-economic context

The social determinants of health relating to social and economic factors are also associated with NCD growth, particularly in low-income countries. Rising rates of urbanisation that have not kept pace with infrastructure and other essential services contribute to the growing burden of disease among the urban poor and increase risks associated with NCDs. Neo-liberal macroeconomic policies that opened markets in developing countries led to the availability of processed foods, which are often high in salt, sugar, and trans-fatty acids, which are a lethal combination for poor urban populations. In South Africa, unhealthy foods are not only available in urban areas, but also in rural areas, where supermarkets and fast-food outlets sell the products at such affordable rates that even households dependant on social grants, such as pensions, disability, and child grants, could afford them (Ndinda *et al*, 2016). Multimedia advertising, such as television, Billboards and electronic media, is used to promote unhealthy diets. The deals are made attractive with the emphasis on 'free delivery'. Sugar-sweetened beverages are advertised as 'refreshing', with options such as 'sugar-free' or 'zero sugar'. Alcohol advertising on prime time television for such popular local dramas as *Generations*, *Isidingo* and *Muvhango* is the norm, despite captions like "only for sale to persons over the age of 18". Warnings on electronic media and product packaging do not mean much to retailers only interested in profit margins. Retailers' enforcement of product regulations such as alcohol and tobacco is often poor.

NCD risks are also aggravated by agricultural subsidies, which enable mass production of unhealthy products at affordable prices. Type 2 diabetes was previously a disease of affluence but became a disease of the poor, given that almost 70% (Arora, Chauhan, John, & Mukhopadhyay, 2011) of diabetics live in low- and middle-income countries where health care is poor and social support is limited or non-existent.

Social determinants associated with NCD risk factors include poverty, low levels of education, poor diets high in salt, sugar and trans-fatty acids, inequitable access to healthcare, and gender inequality. In most countries, poor diets, lack of fruit and vegetables, and an abundance of mass-produced processed foods all contribute to increasing NCD levels, even among the poor. While conditions such as mental health disorders are to some extent genetic, socio-economic conditions



have a role to play in the increasing levels of mental disorders, which can be a result of NCDs and communicable diseases. Harmful alcohol consumption, combined with drunk driving, results in the deaths of many in low-income countries. Health care systems, particularly in Africa, cannot cope with the NCD crisis as well as the HIV/AIDS and TB crises. In tackling NCDs, governments focus on prevention because the cost of treatment is too high for health systems unable to cope with existing public health challenges such as HIV/AIDS, TB, and malaria.

Research suggests that food choices made by parents and children are not necessarily their own, but are presented by multinational corporations through aggressive marketing strategies that target children and ensure their habituation to unhealthy diets (Matthews *et al*, 2004; Malik, *et al*, 2013; Karbasivar & Yarahmadi, 2011). Due to influence from diverse sources, children even in Africa are increasingly exposed to unhealthy diets with high sugar content, fat and salt (Torrey, 2016; Toure *et al*, 2012), resulting in increasing levels of child obesity and diabetes (Rossouw, Grant, Viljoen, 2012). As levels of childhood obesity generally increasing across the population, they are no longer the preserve of the wealthy (Rossouw *et al* 2012). In discussing the findings of a longitudinal study among 6 to 9-year-olds in North-West Province, Pienaar (2015) found that differences in overweight and obese children were race- and class-based, rather than gendered. At the start of Pienaar's study in 2010, 12.7% of the children were overweight and obese. By the end of the study in 2013, that figure rose to 16.7%, a 4% increase; white children had much higher increases. Obesity prevalence within the three-year period increased from 20.3% to 27.5% among white children. 'Overweight' and 'obese' black children increased from 10.3% to 13.3% (Pienaar, 2015). In terms of gender, the increase was higher among boys than girls: boys increased from 3.9% to 7.1%, representing a 3.2% increase (Pienaar, 2015). Among girls, the proportion of those who were overweight and obese increased from 5.2% to 7.5%, a 2.4% increase (Pienaar, 2015).

An important question among public health practitioners is what measures should be taken to have the greatest impact on preventing the onset of NCDs within the general population. In a study analysing television commercials targeting children and adults in the four South African Broadcasting (SABC) channels, Steyn *et al* (2014) found that 50% of the food advertisements appeared during family viewing time (between 17:00 to 20:00) and that the majority related to fast food, desserts, sweets, starchy foods, and sweetened beverages. More alarming was that most alcohol advertisements (67%) were aired at this time. Steyn *et al* (2014) and Mchiza *et al* (2013) suggest the government must address advertising aimed at both children and adults; in particular, Steyn *et al* (2014) recommended prohibiting adverts for foods high in salt, fat, and sugar. The analysts also recommend a restriction on advertising aimed at children. While recognising the harm it can have for both adults and children, Steyn *et al* (2014) falls short of calling for a total ban on alcohol advertising, instead recommending a restriction.

Studies examined the diverse approaches needed to deal with the growing NCD crisis in low-income countries (Airhihenbuwa, Ford, & Iwelunmor, 2013; Pratt *et al*, 2010; Tsolekile, Puone, Scheneider, Levitt, & Steyn, 2014; Arora, Chauhan, John, & Mukhopadhyay, 2011). Airhihenbuwa *et al* (2013) argue that the missing is failure to draw on the cultural repertoire. In explaining why public health interventions start off well but fail to sustain behaviour change, Airhihenbuwa *et al* (2013) argue that most of the interventions either ignore the role of culture in sustaining behaviour change, or view it as an obstacle. Drawing on earlier studies, Airhihenbuwa *et al* (2013) postulate that deploying cultural-centred approaches is critical in identifying priorities within communities: "Culture can be thought of as the building blocks that make up institutions, shared normative values, and ways of knowing and relating. Culture shapes how personal understandings of health and illness are constructed and normalised by influencing health perceptions and health seeking practices" (Airhihenbuwa, Ford, & Iwelunmor, 2013:1). In a radical departure from other approaches, they view the culture as an asset for health promotion: they argue that family and community are critical in enforcing and sustaining behaviour change, and referring to the



PEN-3 model, that every culture has positive and negative elements that should be identified in implementing public health interventions to deal with NCDs (Airhihenbuwa, Ford, & Iwelunmor, 2013:2).

Airhihenbuwa *et al* (2013) argue that obesity factors lie in social, economic and cultural contexts, and that obesity may be a product of the institutions and systems that interact to sustain these factors among individuals of a specific culture. Furthermore, the location of fast food restaurants, the use of large plates, large food portions and the scarcity and difficulty of finding healthy foods in low-income communities contribute to the prevalence of obesity. Community cultural beliefs about food, eating patterns, body size and health all determine the NCD status of individuals in a specific context.

In 2013, the Department of Health (DOH), gazetted salt reduction targets salt intake levels remain unacceptably high. This is attributed to a lack of awareness, beliefs, attitudes, and behaviour. Eksteen & Munghal-Singh (2015) note the average amount of discretionary salt intake is about 4g of salt per person per day. The analysts suggest that cultural and spiritual beliefs also account for the high intake. Common practice includes religious and spiritual beliefs as well as street vendors' use of salt to preserve meat because they do not have on-site cooling facilities. Few Eksteen & Munghal-Singh (2015) recommend healthcare professionals disseminate information on reducing salt intake, as they tend to be taken more seriously than others in society (Kesteen, 2015).

### 3.4. Economic context

In 1994, South Africa emerged from a stagnant economy caused by sanctions imposed against the apartheid state since the 1980s. Historically, the South African economy was built on excluding the majority of the population from key sectors, although they were involved as labourers, particularly in the mining industry (Ndinda, 2011).

These economic policies contributed to the growth of the black middle class in South Africa, sometimes known as Black Diamonds. Although the growth did not drastically change the pattern of asset ownership (Nieftagodien & Van der Berg, 2014), food consumption patterns changed dramatically.

The South African packaged food sector grew from R91 Billion in 2007 to R143 Billion in 2012. In terms of volume, the packaged food sector grew by 15% from 4.515k tons (2007) to 5.202k tons in 2012 (Ronquest-Ross, Vink, Sigge, 2015). The greatest per capita growth in consumption of packaged foods was in the bakery sector, where consumption of 43kg per capita per annum increased by 6.4%. This points to a growing preference of processed food over largely unprocessed traditional foodstuffs (Ronquest-Ross, Vink, Sigge, 2015).

Increases in disposable incomes among the majority of Africans contribute to lifestyle changes resulting in an increase of NCDs in the general population. The convergence of social, economic and technological advancements seems to be a lethal combination and an obstacle to reckon with in tackling the NCD crisis in South Africa. However, the same trends can be deployed in promoting healthy lifestyles and preventing NCDs. Convergence for positive use of multimedia advertising, social and technological elements is already happening, with an increase in retailer advertisements for fresh produce during prime time television. Such outlets are also being established in major shopping malls to increase access to healthy, nutritious foods. However, the cost of 'healthy, nutritious food' constrains access for the poor.



### 3.5. Technological context

Multimedia advertising of unhealthy foods and alcohol leads to NCD risk factor escalation. While evidence about the marketing of unhealthy foods in South Africa is scanty, a cursory glance at the types of foods advertised, the times when they are advertised, and the number of times that such advertisement appear during prime time television viewing, is telling. Products advertised during family time include various brands of chips (crisps), sugar-sweetened beverages, and products such as sweets and chocolates as well as milk products. Advertising glamorises products and reinforces the craving for junk food. Various alcohol brands fill commercial breaks during popular programmes. Poor nutrition and diet, as well as alcohol consumption, are reinforced through multi-media advertising. Cell phones also enable wide reach. Advertisers and marketers might argue they do not compel people to respond, but it has to be asked whether levels of junk food consumption would be at current levels if the public was not bombarded with advertisements. There is a need for a public health approach to tackle the NCD crisis, and this calls for state intervention in controlling what can be disseminated through the most accessible media channels to children and the public as a whole.

The European report on media marketing of unhealthy foods the makes strong recommendations that focus on the control of such advertising (Matthews *et al*, 2004). Countries such as Norway and Sweden recommend prohibition of marketing and advertising of unhealthy foods on cable television. Implementing measures that protect children from multimedia marketing is required (Matthews *et al*, 2004). The UK and France recommended nutrient profiling to ensure a common definition of 'unhealthy food'. So far, there is no consensus regarding the definition of 'unhealthy food' in the EU. If South Africa is to tackle the growing NCD crisis, similar policy approaches must be adopted.

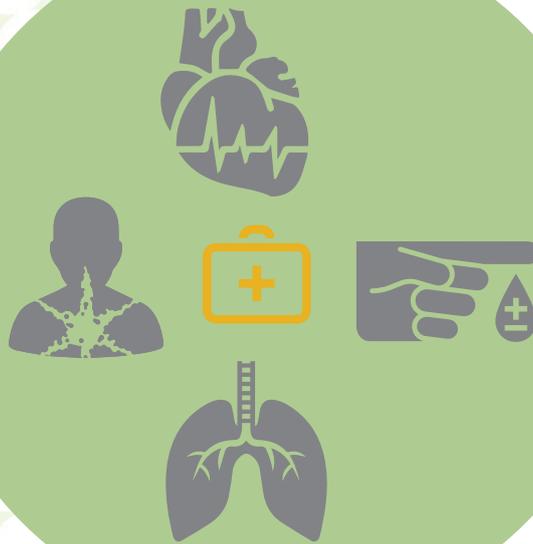
In summary, the growing number of people living with NCD risk factors are complex but can be linked to political, social, economic and technological contexts in South Africa. The DOH and research institutions are aware of the challenge, but this knowledge has yet to become mobilisation of sectors beyond health. The key message in this chapter is that the country needs MSA to deal with the fragmented ways in which NCD risk factors have been tackled so far.



4.0



4.0 | Case Study 1



## Case Study 1: Application of Multi-sectoral Action in the Formulation of the Salt Reduction Regulations



## 4.1 Introduction

This chapter discusses the policies that address unhealthy diets as a risk factor for NCDs in South Africa, with specific reference to the salt reduction regulations of 2013. The chapter examines the extent to which MSA was applied in the formulation and implementation of the salt reduction regulations. Facilitators and barriers are discussed. The terms ‘salt regulations’ and ‘policy’ are used interchangeably, as they reflect government’s position with regard to salt content in processed foods.

## 4.2 History of Policies on Unhealthy diets

Global consensus indicates that unhealthy diets are risk factors for NCDs such as cardiovascular diseases, cancer, hypertension, stroke and kidney disease (World Heart Federation (WHF), 2015; HSF (2013)). Food and nutrition policies in South Africa tend to focus on under-nutrition. The food and nutrition security policy (2013) drafted by the Department of Agriculture, Forestry and Fisheries recognises the enormous challenge that South Africa faces with regard to the inadequacy of nutritious food. The policy notes that about 13.5 million South Africans are food insecure. The policy’s framing of the food and nutrition problem leads to proposed solutions to ensure food security. As a basic human right enshrined in the Constitution of the Republic of South Africa, Act 108 of 1996, the right to food is further elaborated in the National Policy on Food and Nutrition Security, which makes proposals for fulfilling the constitutional imperative at national, provincial and local government levels. The strategic thrust of the policy “is to ensure the availability of safe and nutritious food at national and household levels” (Department of Agriculture (DOA), 2013:6).

The food policy identifies five pillars that constitute the policy’s foundation and allow for the MSA for each pillar, including literacy on nutrition and food security. South Africa took measures to prevent NCDs caused by unhealthy diets. The DOH strategy for tackling obesity employs six principles, at the core of which were “communication, education and mobilisation of all stakeholders in the fight against overweight and obesity” (DOH, 2015:15). Strategies include controlling advertising of unhealthy diets aimed at children; regulating the quality of food provided in schools; and inclusion of nutritional information on food labels. A critical element in the strategy is the recognition that “a multi-sectoral, multi-disciplinary approach with effective leadership is essential to fight obesity” (DOH, 2015:30).

Drawing on best practice in preventing and controlling NCDs related to unhealthy diets, the South African government decided to tax sugar-sweetened beverages (SSBs). According to the National Treasury (2016), “a 20% price increase of SSBs may be required to have a significant impact on purchases, consumption, and ultimately on obesity and population health” (The National Treasury, 2016:2). SSBs “contain added caloric sweeteners such as sucrose, high-fructose corn syrup (HFCS) or fruit juice concentrates which include but are not limited to (i) soft drinks, (ii) fruit drinks, (iii) sports and energy drinks, (iv) vitamin water drinks, (v) sweetened ice tea, and (vi) lemonade, among others” (The National Treasury, 2016:2).

In the discussion paper, National Treasury (2016) the proposed tax on SSB did not include “sugar that is naturally built (i.e. intrinsic sugars) into the structure of the ingredients” (National Treasury, 2016:2-3). However, during the 2017 budget speech, Pravin Gordham, the Minister for Finance, reported that beverages with added and intrinsic sugar would be subjected to increased taxation (The National Treasury 2017). In 2016, the government produced the draft policy for public comment with the aim of introducing the change in taxation from April 2017.

Measures such as implementing the strategy for the control and prevention of obesity, taxing SSBs, and the salt regulations aim at controlling and preventing NCDs arising from unhealthy



diets in South Africa. Although the issue of unhealthy diets is not explicitly tackled, it and other policies such as salt reduction were formulated to control unhealthy diets, including those with high salt, which is a risk factor for hypertension, stroke and kidney failure among other conditions. The following sections discuss the Salt Regulations (2013), part of the best buy interventions to tackle hypertension, which is a common NCD in South Africa.

### Policy objective/rationale of the salt reduction regulations

In 2013, the Minister for Health approved the amendment to the Foodstuffs, Cosmetics and Disinfectants Act 1972. The overall objective was to reduce sodium levels in the processed foodstuffs identified by the regulations. The foodstuffs are grouped into various categories: bread, noodles, potato crisps, processed meat, sausages, read-to-eat-snacks, soup powder, gravy powder, stock cubes and jelly. This reduction comes in two phases: first in 2016 and the second in 2019. For instance, salt levels in bread should be reduced to 400mg Na by 30 June 2016 and 380mg Na by 30 June 2019. These dates and sodium levels are clearly stipulated in the Act; measurable indicators make effective monitoring and evaluation possible. The policy indicates the maximum amount of sodium per 100 grams that each type of foodstuff should contain.

The reason is that illnesses such as high blood pressure, heart attacks and vascular dementia are related to high salt intake (He & Whelton, 2002). On average, about 130 people die of heart attacks each day; another 240 die of stroke (Holmes, 2013). Study participants commented that the risk of hypertension in a large proportion of the population is real because Africans have a genetic variation that makes them sensitive to salt. According to one participant:

*Well, you know that we've got the highest [incidents of hypertension] in the world ... and we've started seeing younger people getting hypertension. And large numbers of South Africans are carrying the risk factors of developing ... hypertension. ... We have very high levels of hypertension in the country. ... We see younger people being affected. ... Studies in South Africa have shown us that we're eating too much ... salt, and we know in our South African black population there is a genetic variation that makes the black population more sensitive to salt, and they develop what is called a 'salt-sensitive hypertension'. And not [only do] we have a genetic salt variation, but we also eat too much salt ... that is one of the risk factors ... driving hypertension. The other one is that we have heightened [rates] among the highest in terms of our overweight and obese rates. We're one of the fattest countries in the world, actually. (ANPPA\_KII\_2)*

Kidney disease is associated with hypertension, which is often aggravated by uncontrolled salt intake. A reduction in salt intake can help reduce the risk of people developing kidney disease. The challenge, however, is that staple and processed foods generally contain high levels of salt. These include bread and processed foods, as well as the tendency of people to add salt to their meals. South Africa is the first country in Africa to formulate a policy to reduce the amount of salt in processed foods. In other countries, salt reduction in processed foods is done on a voluntary basis.

### Principle/values stated

Read in isolation, the principles underlying the Salt Reduction Regulations are not explicit. However, when read alongside the Food and Nutrition Policy (2014), it becomes evident that the policy's motive is to ensure behaviour change that contributes to the reduction of morbidity and mortality arising from hypertension. Through such education, it may be possible to reduce salt intake in the population.



### Gaps in the salt reduction policy

The salt regulations of 2013 mainly addressed the salt content in processed foods. They did not extend their scope to the salt content in food provided by institutions such as schools, hospitals and restaurants. Among the concerns related to the implementation of the salt legislation was the fact that the people buy food from street vendors which were not mentioned for regulation by the legislation. Food processing firms were concerned that the formal, but not the informal sector, were regulated.

## 4.3 Factors that led to the development of the salt regulations

### Important international events

While the local context of hypertension might explain the attempts to control salt intake, there is also need to recognise that formulating salt reduction legislation was also driven by the fact that there was pressure from WHO on governments to tackle NCDs. The WHO (2015) set targets in terms of the milestones that governments should attain by 2018. Governments were required to set national NCD targets and develop policies to achieve the targets by 2025. Progress monitoring also includes ensuring that by 2016 governments reduce NCD risk factors, build on the WHO Global NCD Action Plan, and strengthen health systems to tackle NCDs at the primary health care level and through universal health coverage (WHO, 2015). In South Africa, hypertension, which is associated with high levels of salt intake, is more common among Africans than other population groups. Formulating the salt legislation was a low-cost measure that could affect the reduction hypertension in the largest group affected by high levels of salt intake.

### Important local events

A number of stakeholder meetings were held with the DOH as champion and convener. Although smaller meetings were convened between 2010 and 2013, when the salt reduction legislation was passed, the ones of note were the Salt Consultative Group (2010); the UN NCD meeting (September 2011), where the country was represented by Aaron Motsoaledi, Minister for Health; and the South African NCD Summit (July 2012).

## 4.4 Policy Process

### Agenda setting: Who led the process?

The key informant interviews revealed that participants attended workshops prior to drafting and finalisation of the salt legislation, although most did not attend all of them, so could only speak about the workshops they had attended. Some, mainly NGOs, said they wanted to attend and make their contributions at the workshops, but felt excluded much of the time. There seems to have been no specific criteria for inviting stakeholders to the workshops. Although specific workshops were not cited in most of the interviews, Hoffman and Lee (2013) provided a summary of workshops convened prior to the passing of the salt reduction legislation. On 18 March 2013, Aaron Motsoaledi, Minister of Health, signed into legislation the regulations for reducing salt in foodstuffs by amending section 15(1) of the Foodstuffs, Cosmetics and Disinfectants Act, 1972 (Act 54 of 1972). The regulations are divided into four sections: definitions, reduction of total sodium content of certain foodstuffs, methodology for testing of total sodium, and commencement. Definitions are provided for “bread”, “butter spread”, “fat spread”, “processed meats”, “raw-processed meat sausages”, “ready-to-eat savoury snacks”, and “total sodium”.



## Timelines

Among the meetings widely cited by the study participants was the Global Conference on NCDs, convened by the WHO in September 2011. Since then, more meetings were held, but the participants interviewed knew primarily about the 2011 conference. The outcome of the UN high-level meeting on NCDs was the “Political Declaration of the High Level Meeting of the UN General Assembly on the Prevention and Control of NCDs”. The declaration, signed by member states including South Africa, recognised the threat by NCDs to social and economic development globally and in specific contexts. The declaration also acknowledged that NCDs were not only adversely affecting countries’ economies but also were contributing to gross social inequalities due to the high costs involved in treating the different NCDs, some of which were life-long conditions like diabetes, hypertension and cardiovascular disease. The UN General Assembly held a High Level meeting in 2014 to undertake a comprehensive review and assessment of the 2011 Political Declaration on NCDs. The purpose of the meeting was to “identify and address gaps and reaffirm the political commitment in response to the challenge of NCDs” (WHO, 2014).

Most participants could not recall how many meetings were convened. This inability to recall arose from the fact that although their institutions were represented in such meetings, different people attended based on availability. Few could say that they consistently attended critical meetings/events related to the salt legislation formulation. The critical national meetings held are listed in Table 6.

## 4.5. Multi-sectoral action

Various types of sectors participated in the study in the areas of health, state departments, NGOs, regulatory institutions, universities, science councils, professional associations and other organisations. The number of participating institutions per category is shown in the Table 9. The organisations shown are those interviewed for this study and that indicated they were involved one way or another in the formulation of the sodium reduction regulations.

### 4.5.1. Application of MSA in the formulation of the salt legislation

#### Types of sectors involved in policy formulation

Different sectors were involved at different stages during formulation of the salt legislation. The involvement varied and depended on the availability of organisations to attend workshops and sessions where salt legislation was deliberated. As indicated above, the participants were drawn from the health sector, universities, research, NGOs and departments such as Sports and Recreation and Trade & Industry.

The participants identified stakeholders involved in salt reduction policy formulation, with the Department of Social Development and DOH cited as drivers of the process, as key decisions were made by these departments. Among the identified stakeholders were the Department of Environmental Affairs, Department of Trade & Industry, DOA, PHANGO, SADAG, the Patient Advocacy Group, the Health Foundation of South Africa, the Heart Foundation of South Africa, the Cancer Association of South Africa, CHALK, the Sunflower Foundation, Reach for Recovery, Living with Cancer, nutritionists and the universities of Pretoria and Cape Town.

*The public was also cited as a stakeholder in the process: “... we are led by the government ... the NGO community ... are playing a key role (ANPPA\_KII\_1).”*

*From inception, a majority of participants were not consistently involved in formulating NCD policies; but were rather more involved in the implementation of policies. With regard to stakeholder involvement or inclusion during policy formulation, two main views emerged from the findings. In*



*particular, people with disabilities felt excluded in all aspects of policymaking: “We’re not there [people with disabilities]). We were not consulted in the policy development (ANPPA\_KII\_39).”*

People who work with children, such as those from the Department of Education, and practitioners who work with people with disabilities on a daily basis, were also highlighted as important stakeholders who were not part of the policymaking process:

*“... health practitioners who are involved in the local government and national treasury and public health have been excluded in this process. They should ... form more legislation in tobacco companies. To [the] extent the department of trade and the department of education should be involved ... many government departments are involved and they always consult health crew (ANPPA\_KII\_10).”*

Study participants indicated that key stakeholders excluded from the policy formulation process included institutions affiliated with healthcare:

*“In the cancer field, we need to involve all stakeholders, so all the professional societies ... – the radiologist, the medical oncologist, the radiotherapy society, the social worker society, the oncology nursing society, all the multi-disciplinary key members – plus the NGOs should be involved in talking together and coming up with a target and guidelines for dealing with cancer in South Africa (ANPPA\_KII\_21).”*

The participants also mentioned stakeholders who should have been part of the policymaking process but were missing from the salt reduction policy. Although the DOJ was not among the stakeholders involved in the policy formulation process, it is closely involved in and responsible for legal drafting of policy proposals from other departments. DOJ inclusion would have assisted in developing the policy and made the legal translation of the policy proposals much easier.

It seems there was no deliberate attempt to exclude disabled groups. The list of stakeholders shows that most were from the health sector. Failure to include sectors outside health can be attributed to the fact there was no specific criteria for inviting stakeholders, which is indicated by individuals within the same organisation attending different drafting sessions based on their availability.

### Role of the sectors involved in policy formulation

*Participants gave information about specific policies they or their organisations were involved in: “I think the organisation was involved in things like salt content of food, and that sort of things in the past, but not a major driver of any of the programmes, but [instead] as a consultant, to give information and support on those programmes (ANPPA\_KII\_4).”*

Most participants were involved in workshops leading to legislation drafting. Stakeholders shared scientific data on salt intake and associated risks in terms of morbidity and mortality in adults. The role of institutions such as the National Kidney Foundation was to assist in drafting the regulations controlling salt content in food.

*“I was responsible [for] provid[ing] the nutritional or the dietary impact of salt and also to identify which food products should be targeted for the first regulation on reduced salt content in foodstuff. So we used all the data that we have to calculate where the salt was actually coming from, and based on that, the targets have been set and a few items are chosen for the regulation (ANPPA\_KII\_16).”*

The role of businesses such as Unilever and Nestlé was also identified as imperative in the control of nutrition elements. NGOs should advocate for the formulation and implementation of the policy guidelines, as it is NGOs that deal with NCD patients at grassroots level through patient



health organisations, counselling and providing support to the sick. The role of researchers, and the scientific community at large, was noted in their contribution of data and analysis. DOH provided funding for formulation of the salt regulations. It convened stakeholder meetings and passed the legislation whose first phase of implementation started in June 2016, with the second phase scheduled to commence in 2019.

### Level/extent of involvement

DOH organised meetings and workshops to discuss salt regulations. It took the lead in developing the salt legislation, convening and coordinating the workshops. Stakeholders came from universities, the food processing industry, and NGOs. The DOH workshops were organised during a 14-month period, from 2011 to 2013, when the salt regulations passed (Hoffman & Lee, 2013).

The Heart and Stroke Foundation (HSF) also actively participated in developing the legislation, and the awareness campaigns related to salt reduction after the legislation passed in 2013. The organisation convened one of the major national workshops before legislation finalisation. As a cardiovascular illness NGO, HSF worked closely with DOH to ensure the salt legislation passed.

*"I was part of the national NCD summit in Johannesburg, September 2011, during which this declaration was adopted. I reviewed the declaration and made recommendations, which were all actually integrated. There were different chapters and I was spearheading one of those chapters (ANPPA\_KII\_8)."*

The DOH convened the workshops for drafting the legislation and involved stakeholders from the provincial and district departments of health. Stakeholders were drawn from universities and research councils to provide data on trends related to hypertension, salt intake and kidney disease globally and locally. Independent consultants, NGOs and other government departments, such as the departments of Social Development, Sports and Recreation, and Agriculture were also invited to participate in the policy formulation.

### Actors' positions

#### Strong support

DOH drove the process of formulating the salt reduction policy. Therefore, the government supported its formulation, and was supported by a range of stakeholders. NGOs dealing with NCDs and patient rights strongly supported the formulation and passing of the salt regulations. The different tiers of health departments were also strong supporters of the initiative as they bore the brunt in dealing with the costs associated with hypertension and other conditions that result from high salt intake.

#### Strong opposition

The food processing industry's initial reaction was opposition, arguing that regulation would lead to fewer purchases of their products. In particular, bakers opposed the salt reduction, as it would affect the taste and quality of their product, resulting in poor sales. Industry players were given the option of voluntarily taking appropriate measures to reduce salt content or face regulation from the government, therefore, were left with no option but to reduce salt in their processed foods. What is interesting is that industry players were keen to ensure regulation of informal sector food processors were regulated to ensure salt reduction in street foods.



#### 4.5.2 Facilitators of the use of MSA in policy formulation

Participants who spoke about stakeholders' involvement in the policy formulation identified the strategies used to engage different societal sectors. Communication and adequate planning were identified as the main approaches through which stakeholders were brought together. Planning involved inviting multiple sectors/stakeholders across provinces and communicating with them during different phases.

*"It was planned way ahead of time and also it was populated. I think the communication was circulated to as many people as possible, and also they literally had to first gauge the list of people that had RSVP'd to come through, and only then they announced ... the date (ANPPA\_KII\_1)."*

*"The first step was to create a working group that was cross-sectoral, and it was merely a case of inviting people to come and have a discussion. The second thing we did was ... [consult] with global experts ... for example, someone from the UK, where the UK has previously successfully reduced salt levels. The third thing was open consultation with the food industry (ANPPA\_KII\_2)."*

Participants were local and global, drawn from a broad range of sectors and brought together in workshops to deliberate on salt legislation. The creation of a nucleus or core working group greatly assisted in shaping the framework of the policy and the content that went into the draft that was circulated for public comment. The working group had representatives from different sectors and this provided diverse perspectives with regard to the content of the salt reduction legislation. The inclusion of experts from outside the country was valuable as they shared their experiences of what had worked in terms of formulation and implementation of such policies.

#### Benefits of involving many actors in the policy development process

The benefits of involving a variety of actors outweighed the challenge(s) as participants indicated that the inclusive process meant that the time it took to conclude decisions was shortened as all views were shared within the same space and time.

*"The benefit of getting everybody together in one room ... certainly shortened the process. If we didn't have industry there ... to decide ... we wanted to cut levels down, then we would go back to industry (ANPPA\_KII\_2)."*

*"Everybody on board makes it easy in the end ... to get people to subscribe to it, and the changes that they can make (ANPPA\_KII\_16)."*

Additionally, participants said the policy was enriched by the diverse expertise represented by the participants, resulting in a robust policy.

*"We got [a] large number of youth involved ... so obviously those are the benefits of people who involve more input ... You can even get ... more to implement this policy and never forget these other people (ANPPA\_KII\_10)."*

Local stakeholders and international experts shared their expertise, strengthening the case for the policy before the draft was presented for public comment. One must note, however, that most of the participants indicated that the policy-making process needs to be more inclusive and spoke of the importance of involving various stakeholders.

The notion of participation underlying public policymaking in South Africa was a facilitator in the formulation of the salt legislation.

*"I think South Africa has a good principle of community participation ... and I have learnt ... over the years that people own something that they have contributed, you know, to. And even us an organisation, we had a problem in the past where things just got to be ... put on your table, so*



*implementing it was always going to be very ... difficult. So you're always eager to implement something that you have contributed to. Also, ... this multi-sectoral and multi-disciplinary ... approach literally helps a lot if only we can do more and more of it. The frustration that people have is that sometimes we try to push things too quick, even before the consultation could actually ... happen. So I think we need to guard against that, just to make sure that as hard as it is, and as difficult as it is, to organise people ... we need to ensure that those things get to happen as much as ... possible for us to get some kind of inclusive policy at the end of the day (ANPPA\_KII\_1)."*

Where communities or the public are involved in policymaking, the result is often a sense of ownership of the outcome. The reverse can be said about a failure to involve the public in policymaking. The element of participation ensures the process is accepted and that people own the outcome of their involvement and become advocates for policy implementation; in this case, the salt reduction legislation. The participation of different stakeholders is highly desirable and the MSA approach appears to be well-entrenched in South Africa's policy-making processes. A related question is whether the same notion of broad consultation and participation of diverse groups is also entrenched in the implementation of policies such as the salt reduction policy.

*"What goes well is that at least the participation [is] from all sides. It is not just the government coming up with ... policy and imposing it on ... people. ... I think [with] stakeholder participation, there is ownership of whatever document ... comes out from these gatherings ... So if there is a loophole in that policy, then you know you were part of it. So if there was something that just came after, it is not something that you can go back and blame on somebody else; it is something that you can own as well, you know you are definitely going to have ... input (ANPPA\_KII\_1)."*

*If the participation of diverse groups is a requirement in the policy-making process, the study also sought to explore the extent to which women were involved in giving their perspectives in the salt reduction policy. The participation of women in policymaking is as they are generally responsible for making food choices for households and therefore on the extent to which salt is consumed. Most of the participants indicated that gender issues were not separate from the issues discussed in the formulation of the salt reduction policy "not specifically, because other than the role that ... women play in ... the preparation of food, they are the leading group who cook and prepare the food". (ANPPA\_KII\_29) Additionally:*

*"I think when you talk about gender issues, a company like Unilever, I'm sure they realise that women are the feeders of the nation, to put it like that, and a lot of their advertisement[s] and things would be focused on how the women prepare food, and all of that. So I think there would definitely be a gender content highlighted, but was it highlighted as a separate issue. I didn't experience that on the day (ANPPA\_KII\_4)."*

Participants noted that gender issues were not specifically discussed in the drafting of the salt reduction policy. There was, however, recognition that women are key stakeholders when it comes to planning meals, food preparation, and what households consume. The acknowledgement that big business, as represented by food processing firms, targets women and should have alerted the drafting teams to the importance of involving women as key stakeholders in the salt reduction legislation. As a result, women as a demographic were left out of the drafting process despite their impact on the implementation of the salt reduction policy at household level.

*"I don't believe gender was discussed as a particularly separate issue or separate angle but most of the patients that we dealt with their cases that came forward were women (ANPPA\_KII\_3)."*

#### 4.5.3 Barriers to the use of MSA in policy formulation

Most participants spoke of difficulty in implementing the salt reduction policy. Of those interviewed, three spoke of the challenges in bringing different actors together. Managing a large number of different stakeholders was also cited as a prominent challenge.



*“I think ... the challenge ... is that people come from all parts of the country, and you know, it was merely an issue of transportation, as well as accommodation, [which] was a massive story that needed to be dealt with (ANPPA\_KII\_1).”*

Organising workshops at a time convenient to all stakeholders was certainly a barrier to using MSA. Ensuring that all interested stakeholders were invited – and that their schedules allowed them to attend the workshops – was also a challenge. Some participants felt they were not always included in critical meetings and viewed their omissions as exclusions.

## 4.6 Application of Multi-sectoral action in policy implementation

### 4.6.1 Facilitators of the use of Multi-sectoral action in policy implementation

Implementation of the salt legislation started in June 2016, with the usage to be further reduced by 2019. Although timelines were provided for policy implementation, details on stakeholder participation in ensuring implementation as designed were not addressed. NGO participation with groups affected by salt during drafting suggests the same NGOs will be advocates for adherence to the policy. They include the HSF, the Kidney Foundation, and Diabetes South Africa.

Sodium reduction in specific foodstuffs began in 2016, and there is little evidence so far to indicate the levels of compliance with the regulations. Factors likely to facilitate implementation are:

- The Minister for Health, who was a champion in its formulation and is likely to continue championing its implementation;
- The HSF, which conducts awareness campaigns targeting the general population to ensure the public is aware of high salt intake risks, and behaviour changes to reduce intake;
- The culture of reading food labels, which is growing: consumers are likely to vote with their feet if salt content is not in line with required levels; and
- MSA to drafting the salt reduction policy, which created awareness of the importance of controlling salt intake. The stakeholders involved are likely to continue being champions of salt reduction in their organisations and communities.

### 4.6.2 Barriers to the use of Multi-sectoral action in implementation

As already indicated, at the household, NGO and other levels, women make food choices and these include the use of salt and the quantities in which it is consumed. This was recognised by multi-national food processing firms who often use women in advertising processed foods. The lack of participation by women’s groups in drafting the salt reduction policy was a missed opportunity in terms of passing on the message of reduced salt intake to the household level. Sodium reduction targeted big business involved in food processing and left out key constituencies such as informal traders who have a large share of the market because the food they sell to the public is widely affordable. The inclusion of informal traders, women’s groups, learning institutions and the food and beverage industry would have ensured that the message of reduced salt content in food permeates to consumers.

Funding was cited as a key challenge in ensuring the implementation of the salt reduction policy. Participants noted that even where funding is available it is not sufficient. The funding challenge is compounded by the fact that implementing entities often do not seem to be pooling resources to implement their awareness campaigns. Implementation of the salt legislation and the required behaviour change could be hampered by the lack of funding to sustain awareness campaigns.



The fact that the policy only targets industry, and not the many other entities involved in food processing and distribution, suggests that a large proportion of the non-compliers are free to continue with 'business as usual'.

*"We could spend days talking about struggling for finances. ... I think that is just the NGO platform that you work in; it's also very difficult for us. ... One ... thing that we [are] going to discuss is support from the DOH. Our organisation does not get any funding from DOH for any ... projects that we do. And that was ongoing for over 10 years now – haven't received funding (ANNPA-KII)."*

#### 4.6.3 Funding, monitoring and evaluation

The salt reduction regulations indicate the dates that different levels of sodium reduction should occur by. Generally, industry has until 30 June 2019 to reduce sodium in specified foods to the levels specified in the Act. The first phase of reduction was effective from 30 June 2016, at which time the sodium levels were reduced from 528mg (2010) to 400mg. The mission of the Health Act is reflected in Outcome 2 (strategic document), which sets the medium to long-term targets of the DOH. These include tackling the NCD epidemic. The National Development Plan (NDP), echoing Outcome 2, also underscores the importance of preventing and controlling NCDs.

A study by Hoffman and Lee (2013) provides baseline data showing the amounts of salt in the different categories of foodstuffs and the required reductions by the specified dates (see table 5).

There was no clarity about available funding for implementation. Stakeholders were required to implement the policy in 2016 using their own resources. However, the HSF, using funding allocated by the DOH, mounted an awareness campaign in 2014 to educate the public about salt consumption.

*"Funding is never sufficient. As an organisation, we, like many other organisations in the NGO sector, ... are struggling to survive. We don't have any government funding for ... our programmes at the moment, so ... we have [to] pay for ourselves. Fundraising, as one of our things that we do, is becoming more difficult by the day ... funding is always the problem. Government has very limited resources – I mean the DOH itself, which is the custodian of ... preventative policies. With the limited resources ... it's very difficult to ... create policy and even more difficult to implement it, but I think that's also why it's so important to involve all the role players, because your funding might come from your other role players ... so that's why it is important to involve them in the process as well ... As an organisation, we [are] trying our best, but ... [the resources are] very limited (ANNPA\_KII\_04)."*

NGOs have limited funding despite being ideally placed to educate the public and create awareness of the risk factors for high sodium consumption. The Department of Social Development (DOSD), which distributes funding to NGOs, provides assistance but the available resources are minimal and barely help the organisations to survive. The DOH can assist but it is constrained by limited funding for distribution to NGOs. Therefore, NGOs must fundraise for their activities, and this limits the amount of resources and time that can be committed to educating the public and creating awareness of the risks involved in high sodium consumption.

### 4.7 Gaps in the MSA approach

Formal, organised institutions were involved in deliberations leading to passing the legislation. The MSA employed in the drafting of the sodium reduction regulations seems to be intersectoral rather than multisectoral. The DOH invited stakeholders from the health sector and related government sectors such as DOSD. Some critical stakeholders were not part of the process.



A key gap in MSA application was the fact there were no inclusion/exclusion criteria for the invitation of stakeholders. There was also little representation of the informal sector and private and public sector institutions involved in preparing meals for the public.

Application of MSA in policymaking is costly and time-consuming. Considerable resources have to be used to engage participants on policymaking. While MSA is a useful model for policymaking, the omission of stakeholders can result in the process being labelled 'not inclusive'. For the MSA to work, there must be a need to ensure stakeholders bring useful input to discussion. One way of ensuring constructive input is to create templates and circulate these for inputs before workshops.

5.0



5.0 | Case Study 2



## Case Study 2 – Application of MSA in Tobacco Control Policies

## 5.1 Introduction

The previous chapter discussed salt reduction as one policy intervention the South African government has taken to deal with NCDs. This chapter deals with another risk factor, tobacco smoking, which is responsible for a range of NCDs such as cancer and chronic respiratory disease, among others. The chapter begins with the history of tobacco control in South Africa, then identifies the factors that influenced policy formulation; the process of drafting tobacco control legislation, monitoring and implementation; and finally the application of the MSA, as well as barriers and facilitators for using MSA in policy formulation and implementation.

## 5.2 History of tobacco control legislation

Tobacco control has long been a concern of the global community and international organisations. International literature on tobacco control explores trends in smoking, the dynamics of passing tobacco control legislation, as well as the economics of tobacco control (Abreu-Villaça *et al*, 2013). Existing global literature generally examines the magnitude of tobacco smoking across regions (Unwin, Alberti, & Sanders, 2006; Baleta & Mitchell, 2014; Horton, 2013). Some studies discuss the costs and economics of smoking (Chaloupka, Jha, de Beyer, & Heller, 2004) while others focus on global strategies for the control of tobacco with a view to protect the general public from tobacco smoke, which is harmful to both the smoker and non-smokers (WHO, 2011; WHO, n.d.; Efroymson *et al*, n.d.). Analysts also explored the extent to which global agreements such as Framework Convention on Tobacco Control (FCTC) were implemented (Tumwine, 2011; Efroymson, Alam, & Jones, n.d.)

A range of scholars attempted to shed light on the magnitude of tobacco smoking in South Africa. The unique context of tobacco control in South Africa, which is characterised by politics is a major focus of policy analyses of tobacco control (Malan & Leaver, 2003; Saloojee, 2000; Saloojee, 2005). A critical review of the policies, when the policies were passed, and the dynamics of policy formulation, gives credence to the notion of politics strongly influencing the content and process of tobacco control policies (RSA, 1993; 1999; 2007; 2008). The implementation of tobacco control policies (RSA, 1994; 2000; 2011) was largely successful due to NGO advocacy (Mungal-Singh, 2012), such as the National Council Against Smoking (NCAS) (NCAS; 2012; NCAS, 2015; NCAS, 2016a; NCAS, 2016b; NCAS, 2016c). To understand more clearly the processes and content of tobacco control policies in South Africa, it is imperative to understand the political context during and after apartheid, from 1994 onwards.

From 1948 to 1994, the tobacco industry and the apartheid government had such a close relationship that it was difficult for the government to take any measures to control tobacco smoking. In 1948, the Afrikaaner-dominated party, the Nationalist Party (NP), using their rallying call 'apartheid' won the elections (Whites only). The win of the NP marked the institutionalisation of racial discrimination and segregation in every aspect of South African life. The term 'apartheid', is an Afrikaaner term that denotes 'separateness' (UNESCO, 1973:44). The NP began initiating measures for the economic empowerment of Whites, Afrikaners (Boers), particularly through their strong network known as the Broerderbond (brotherhood). Anton Rupert was among the crop of Afrikaners that utilised Afrikaaner political power to build his vast tobacco empire. The influence of Rupert, leader of the Rembrandt group extended to other industries such as the legal and media sectors. The Afrikaaner-owned Corporation, Rembrandt, controlled 87% of the tobacco manufacturing and distribution market. When Rembrandt merged with Rothman's, the corporation literally controlled 95 per cent of the market share. In the British American Tobacco (BAT) which controlled the remaining 5 per cent of the market, Rupert also had influence through his two firms which owned 30 per cent of the shares in BAT. The relationship between Rembrandt and the apartheid government was so close that the corporation funded the annual outings for NP Cabinet ministers. The same Corporation (Rembrandt) also financed the repair of one



of De Klerk's homes in the early 1990s. In return, the NP "demonstrated a favourable attitude toward the industry through the low excise taxes, virtually unrestrained advertising, and an absence of restrictions on smoking in public places" (Lever & Malan, 2003:123). So close was the relationship between the NP and the tobacco industry that during apartheid, "the tobacco industry [Rembrandt] was the Ministry of Finance's prime adviser on cigarette excise matters" (ibid:123). It is therefore unsurprising that the apartheid government's failure to enact tobacco control measures was considered a "crime of apartheid" (ibid:122). Despite the failure of the apartheid government to design and implement policies, various groups kept up the pressure for tobacco control.

In 1963, the *South African Medical Journal* called for tobacco control, suggesting that banning advertisement of tobacco products, restrictions on smoking in public areas, and increased taxation on tobacco products, would improve the health of the general public. This call was ignored, but in 1975, the tobacco industry "volunteered not to advertise cigarettes on television. However, it took another 12 years for it to agree to print on cigarette packs a warning ["Smoking is a health risk"]" (ibid: 122). However, the print of the warning was so small and poorly done that it basically defeated the purpose.

*The first tobacco legislation was passed in 1993 after decades of hurdles. Throughout apartheid it was almost impossible to put any controls on tobacco regardless of the evidence of tobacco smoking on health. As a key participant noted, "since 1976, the department [of health asked] for measures to reduce the tobacco use ... nothing had happened in parliament before because the apartheid government was protective of Afrikaner businesses ... who were the sole manufacturers of tobacco at the time" (ANPPA\_KII\_42). Despite resistance to the formulation and implementation of tobacco control policies, advocates kept up the pressure, amassing evidence. They drew arguments from the international context, where such policies were introduced and proven successful. According to the key informant interviews, many countries started to introduce "what should have been the legislation. Internationally they ... had already published data about what to do to reduce tobacco use and other resolutions, calling on government to act against tobacco. And then in the late 1980s ... the United States, Canada, Australia, New Zealand, France ... all passed legislation banning tobacco advertising, putting information on cigarette packages, and banning smoking in public places. So all of that was the background for South African government when it was looking at legislation" (ANPPA\_KII\_42).*

In 1993, the South African government passed the Tobacco Products Control Act. The promulgation of the Act protected children and adolescents from the glamorisation of smoking. The Act also protected the rights of non-smokers by ensuring smoke-free public environments. Government attempts to control smoking were also evident in the annual tax increases on tobacco products and this has not only discouraged potential smoker from starting the habit but also may have encouraged existing smokers to quit. Smoking is among the attributes included in the South African death notification form, which helps to monitor the causes of death related to smoking.

As the first major law, the 1993 Act prohibited the sale of tobacco products to children under the age of 16, mandated the labelling of tobacco products and advertisements with written warnings and provided for the control of smoking in public areas. Worth noting is the fact that it was after the ANC policy conference in Mafikeng that the Amendment Act of the Tobacco Products Control (1999) was passed. The thrust of the policy was to ensure a smoke-free environment by banning smoking in public buildings and tobacco advertising.

An amendment to the Tobacco Products Control Act 83 was passed in March 1999 and came into effect on 1 October 2000. Its objectives were to reduce the pressure of addiction on 15-year-olds, protect the constitutional right of non-smokers to a smoke-free environment, and reduce the harmful effects of cigarettes on tobacco addicts. This was achieved through banning tobacco advertising and promotions as well as tobacco's association with sporting, educational or cultural events.



As a response to the globalisation of tobacco prevalence, the World Health Assembly developed the WHO FCTC, which was adopted in May of 2003 and came into effect in February 2005. In July 2011, the Assembly indicated that the FCTC had 168 signatories and 174 parties. Of the 46 WHO countries in Africa, 41 are parties to the FCTC (Tumwine, 2011). The FCTC treaty objectives are: “packaging and health warning labels on tobacco products, regulation of tobacco advertising, promotion or sponsorship, measures to protect [non-smokers] from tobacco smoke, tobacco tax and price increases, regulation of the contents in tobacco products, regulation of tobacco product disclosure, support for economically viable alternatives, measures to curb illicit trade in tobacco products, liability provisions and other” (Tumwine, 2011, p. 4313).

### Policy objectives/rationale

The objectives of the Tobacco Products Amendment Act 83 of 1993 are:

- enforce health hazard warnings and content on adverts and packaging;
- restrict sale of cigarettes from vending machines;
- prohibit cigarettes sales to young people under 16;
- empower local authorities to regulate smoking in public spaces within their jurisdiction; and
- impose penalties and fines.

The Tobacco Products Control Amendment Act 63 of 2008 gave its objectives as follows: “To amend the Tobacco Products Control Act 1993, so as to define certain expressions and to amend certain definitions; to provide anew for the advertising, sponsorship, promotion, distribution, and information required in respect of the packaging and labelling of tobacco products; to make the standards that apply to manufacturers of tobacco products applicable to importers of tobacco products; to prohibit the sale of tobacco products to and by persons under the age of 18 years; to extend the provision in respect of free distribution of tobacco products; to provide anew for tobacco sales by means of vending machines; to extend the Minister’s powers to make regulations; and to adjust the provisions in respect of offences and penalties; and to provide for matters connected herewith” (RSA, 2008:2).

### Principle/values stated

In the preamble of the act, the use of tobacco is acknowledged as harmful to the health of both smokers and non-smokers, and that it is highly addictive and therefore restrictive legislation is important. Through advertising campaigns, smoking was previously associated with success; therefore advertising encouraged people, and especially the youth, to use tobacco products.

Key focus areas of the 1993 Tobacco Control Act were the visible placement of health warnings on cigarette packs and the prevention of tobacco product sales to teenagers and young adults. Subsequent legislation (1997; 1999) aimed to prevent tobacco advertising in public (Billboards, television, sporting events, etc.) and to bring in penalties for subjecting the public to secondary smoke. This legislation was accompanied by an increase in taxes on tobacco products and the total banning of tobacco product advertising by 1999. Business operators are required to ensure their premises are smoke-free and that specific spaces in public buildings are designated for smokers to protect the public from the harmful effects of secondary smoke inhalation.

The best buys interventions recommended by the WHO with regards to tobacco use are:

- raise tax on tobacco;
- protect people from tobacco smoke;



- warn about the dangers of tobacco; and
- enforce bans on tobacco advertising

All these measures were in place in South Africa by 1999 and Dr Nkosazana Dlamini-Zuma, the Minister of Health, received commendation from Gro Harlem Brundtland, WHO Director General, for her work in banning tobacco smoking in public spaces, raising taxes, and banning the advertising of tobacco products.

The 1993 Tobacco Products Act was amended twice (1999; 2008) and the WHO recommendations were legislated. Excise taxes make up 52% of the total retail price of cigarettes; advertising and sponsorship of cigarettes was banned along with smoking in public areas (unless clearly demarcated). It also became illegal to sell cigarettes to people under 18, and cigarette packaging must contain prescribed health warnings (Reddy & Sewpaul, 2014; Malan & Leaver 2014).

## 5.3 Factors that led to the drafting of the tobacco legislation in South Africa

### Important international events/meetings

The International Union for Tobacco Control published information on what resolutions government and NGOs should employ to act against tobacco. In the late 1980s, the United States, Canada, Australia, New Zealand and France all passed legislation on tobacco control by banning tobacco advertising, reducing harmful content in cigarettes, and banning smoking in public areas, which provided a foundation for South Africa to introduce tobacco legislation. The legislation protects the rights of non-smokers to clean air, makes sure that young people do not start smoking, and encourages smokers to stop.

### Important critical national events/meetings

Attempts to control smoking in South Africa started in Cape Town when, in 1989, the city, under leadership of its chief medical officer Dr Michael Pookiss, announced plans to “restrict cigarette advertising and smoking in public places” (Malan & Lever, 1999; 123). However, due to the influence of the Rembrandt tobacco company, the bylaw planned for Cape Town was not passed. The proposed law would have banned cigarette smoking and advertising in all public buildings. The new law in Cape Town was also opposed by the restaurant industry through the Cape Restaurateurs Association, who argued that the law infringed on their right to conduct business and threatened court action if it was not withdrawn in 12 days. Opposition also came from the Federated Association of South Africa (FEDHASA), which organised a petition that garnered 307 signatures from restaurants, and argued that the Cape Town law banning cigarette smoking and advertising “infringed on their right to decide how best to run their businesses...” (ibid:125). The Chamber of Commerce in Cape Town added its opposition to the anti-smoking bylaw, arguing that “business in South Africa was already overregulated” (ibid: 125).

## 5.4 Policy process

### Agenda setting: Who led the process

*The tobacco control discussion gained momentum with the appointment of Dr Rina Venter, the first women minister in the apartheid government. She worked together with Treatment Action Group (TAG), an influential anti-tobacco alliance comprised of the Heart Foundation of Southern Africa (now HSF), the Cancer Association of South Africa (CANSA), and the NCAS. They helped the minister to lobby for the policy and to discredit industry’s claims regarding the implications*



*of the policy. These advocacy groups lobbied, released media statements and went to NGOs working in communities to share information about the harmful effects of tobacco. Such efforts won the support of the public by creating awareness about the rights of non-smokers (ANPPA\_KII\_40).*

Besides industry, another hurdle was the government itself, which had strong ties to the tobacco industry and did not support the control Bill. From 1963 to 1993, when the Tobacco Control Act was passed, the industry was controlled by Afrikaner businesses. The NP was determined to ensure its survival. During apartheid, there was no interest from the government to control tobacco smoking, even though former South African leader P. W. Botha (1978-1989) could not stand smoking and banned it in his Cabinet meetings.

*“We worked very closely with the DOH, we made recommendations to reduce tobacco consumption in South Africa and we worked fairly closely with the government. We’d give media interviews to create public awareness and lobbied for the legislation; we talked to parliament, talked to different ministries, the in-government (ANPPA\_KII\_40).”*

When ANC came to power in 1994, the new Minister of Health, Dr Nkosazana Dlamini-Zuma, was determined to protect the public against tobacco. The industry changed its strategy from trying to overthrow the Bill to weakening it. The first tobacco control policy, enacted in 1993, was considered too weak to make any dent on smoking in South Africa, therefore the 1993 Tobacco Products Control Act was subjected to various amendments:

*“Under the leadership of Nkosazana Dlamini-Zuma as the health minister in the new government, the Tobacco Control Act was amended a couple of times to address the shortcomings of the initial policy, which was weak in comparison to international standards (ANPPA\_KII\_40).”*

*A combination of factors led Dr Dlamini-Zuma to consider the scientific evidence in South Africa and initiate changes that resulted in the tobacco control legislation. “The work on tobacco control goes back to 1991. The issues that led to the drafting on the Act in South Africa date back to the 1980s, when the Medical Research Council published a report on economic and health impacts of tobacco use in South Africa. Internationally, there was a drive to push for smoke-free legislation and the protection of non-smokers (ANPPA\_KII\_40).”*

## Timelines

The first tobacco legislation was passed in 1993. The first Tobacco Control Act was criticised for being weak compared with international standards, but the leniency is explained by the then-apartheid government, which had strong ties with the tobacco industry. In 1994, the ANC government, with no links to the tobacco industry, could make decisions without any concerns about ties. Another important element was that the new government had health champions, such as President Mandela and Dr Dlamini-Zuma, who showed serious commitment to public health.

The formulation of tobacco control policies involved a range of stakeholders with diverse interests. Government departments included the departments of Health, Agriculture, Treasury, and Trade & Industry. The DOH was concerned about the public health impact of smoking but the other departments (Agriculture, Trade & Industry and Treasury) were concerned about the loss in revenue that would occur if controls were placed on tobacco smoking in South Africa.

## 5.5 Multi-sectoral action

In the formulation of the tobacco control legislation, the main sectors involved were health-related: Department of Health, Trade & Industry and Agriculture, Schools of Medicine, the Medical Research Council, the *South African Medical Journal* and diverse NGOs such as the HSF, NCAS, and the Cancer Association among others.



*"I haven't mentioned several groups of the Medical Association of South Africa. They all contributed to some extent, but there were lots of people who contributed to it. I think the most important group of people was the public: we had to show the public [that] support was what we stood for, but there's no group I can think of that might have influenced more. But nothing in my head says that there was a group that we didn't get ... we talked to all the political parties. We didn't just talk to the ANC, which is in power, but we talked to PAC, to the ACDP, we talked to the DA or whatever they were at that time, so we talked to all the political parties. We didn't just talk to the government (ANPPA\_KII\_40)."*

However, the vested interests of the tobacco industry and the media resulted in a policymaking process that was multi-sectoral. The state led the process of legislating the tobacco control policies.

## Types of sectors involved

### *Actors' positions: Strong supportive actors*

The formulation of the tobacco control policies was multi-sectoral and involved diverse sectors. Civil society was particularly interested in passing tobacco control legislation and lobbied members across the sectors:

*"We had a group [TAG] was a coalition of the three organisations – Heart Foundation, CANSA and NCAS – and we worked with the DOH. Obviously there were problems from other people. I didn't know the tobacco industry (ANPPA\_KII\_40)."*

- DOH and regional departments: City Health Departments (City of Cape Town, Port Elizabeth and Johannesburg); Medical Research Council (MRC); HSF

Strong actors in the policy formulation process included the following:

- Universities: Professor Harry Seftal, Witwatersrand Medical School;
- MRC: Dr Derek Yach and Krisela Steyn compiled evidence on harm caused by tobacco, used the *South African Medical Journal* to provide evidence of the harmful effects of tobacco smoking;
- ANC: Came to Power in 1994. Dr Nkosazana Dlamini-Zuma became MOH and championed further tobacco smoking control;
- City of Johannesburg: banned smoking in takeaways;
- Anti-tobacco alliances: TAG; CANSA; Heart & Stroke Foundation; NCAS;
- University of Cape Town; and
- *South African Medical Journal*.

The supportive actors were motivated by public health interests given the abundance of scientific evidence that showed the negative impact of smoking on the public. Furthermore, the overwhelming scientific evidence that linked tobacco smoking to risks such chronic respiratory disease and cancer could simply not be ignored.

## Strong oppositional actors: industry

Actors in the process opposed the policies. They argued that the economy would be adversely affected by the tobacco control measures and banning of tobacco product advertising. Strong opposition actors included:



- Federation of Hotel Liquor and Catering Associations; Cape Restaurateurs Association;
- Cape Town Chamber of Commerce and Johannesburg Chamber of Commerce;
- Tobacco industry;
- Media: SABC; Nasinale Pers, who owned almost all Afrikaans newspapers; and
- Treasury; Department of Trade & Industry; DOA.

### The roles of the sectors involved in the formulation of the policies

In 1982, researchers from the Medical School of the University of Witwatersrand and the Medical Research Council (MRC) compiled evidence on the harmful effects of tobacco smoking on health costs and the impact on the economy. In 1988 the *South African Medical Journal* published a special issue on tobacco smoking to coincide with the 'World No-Tobacco Day'.

The MRC, the Schools of Medicine at the Universities of Cape Town and Witwatersrand and the *South African Medical Journal* provided scientific evidence of the harmful effects of smoking; this was done through a special issue of the *South African Medical Journal*. In 1991, when the tobacco industry brought in experts to block the Tobacco Control Bill, South African scientists provided the then Minister, Dr Rina Venter with evidence that smoking was harmful to health and the economy. Despite the opposition to passing the bylaw in Cape Town, proponents of the anti-smoking bylaw made compelling arguments for the ban and got public support for it. However, provincial administrator Kobus Meiring vetoed the proposed law.

On World No-Tobacco Day in 1993, Nelson Mandela called on the apartheid government under F. W. de Klerk to pass the tobacco control legislation. In 1994, when Mandela became president of a democratic South Africa, he appointed Dr Nkosazana Dlamini-Zuma as Minister of Health, who immediately called for smoke-free Cabinet meetings. She warned that she would introduce anti-smoking legislation if companies did not take measures to introduce anti-smoking policies.

In 1996, Dr Dlamini-Zuma referenced the fact that tobacco companies failed to display health warnings clearly on cigarette packs. In 1997, Trevor Manuel, Minister of Finance, introduced a 50% tax on the retail price of cigarettes, therefore marking a departure from the apartheid government that consistently ensured that taxes on tobacco products remained low.

*"They've increased it, but not as much as we would like them to do. So they've increased taxes in line with inflation, which is a policy decision taken back in 1997 and they have not changed that decision since 1997. So in the last 10 to 19 years, the level of cigarettes ... the rate at which cigarettes are taxed remained the same ... The taxes have gone up because inflation goes up, but if we said 52% in 1993, 52% of the cost, and it's remained ... so the 50% in 1997 went up to 52% in 2004 and it remained steady ... The WHO shows that it should be 75% and the council supports that. But ours are at 52%. We are way, way, way below what the WHO recommends (ANPPA\_KII\_40)."*

In January 1998, Dr Dlamini-Zuma announced in parliament that a Tobacco Amendment Bill would be introduced; she referenced a complete ban on advertising and raising the legal age for cigarette purchases to 18 years. Within six months, the Tobacco Products Control Amendment Bill was approved by Cabinet. The Bill accomplished three things: it outlawed smoking in public buildings, banned tobacco advertising in all forms, and made it illegal to sell cigarettes without health warnings on the pack.

When the tobacco industry protested against the way the Bill was bulldozed through parliament, arguing it was excluded from the process, Mandela asked the Minister, Dr Nkosazana Dlamini-



Zuma to consult more widely before proceeding to enact the legislation. The Minister (Dr Nkosazana Dlamini-Zuma) “called them together on short notice one late night” (Malan & Leaver, 2003:147). MRC representatives were also present at this meeting to allay advertising industry fears. An unexpected outcome of the meeting was that Caxton, a major publisher of medical journals, immediately stopped advertising tobacco products.

Within two weeks of approval, the Tobacco Products Control Amendment Bill was published for public comment. Within 12 days, the tobacco industry applied for an urgent interdict to stop the legislation, citing lack of consultation and demanding that the Minister, Dr Nkosazana Dlamini-Zuma reveal all the information used in drafting the Bill. Within eight days, the application heard at the Cape High Court was dismissed based on the fact that the information demanded was public knowledge.

The Tobacco Products Control Amendment Bill was passed at dizzying speed. Within two months, more than 80 groups applied to give evidence in Parliament for two days. “Three days later after the hearings, the parliamentary health committee approved the Bill, to the dismay of the cigarette companies. Yet again, the tobacco industry threatened to go to court, but as in the past, the threat failed to materialize ... after a day’s heated debate, the National Assembly approved the proposed legislation, with 213 votes all from the ANC and the African Christian Democratic Party, in favour and 106 against (ibid:148).” Civil society groups lobbied all the political parties to support the amendments to the Tobacco Products Control legislation, but the outcomes were varied:

*“We didn’t just talk to the ANC ... we talked to PAC, to the ACDP, we talked to the DA ... Some people said they would support us, but when [we] went to parliament, they turned around and didn’t support us, including the DA and the PAC ... but both those parties did not support the legislation. The one party that did was the ACDP, who very strongly supported this legislation (ANPPA\_KII\_40).”*

In March 1999, the National Assembly and the National Council of Provinces voted for the Amendment Legislation with only the provinces of Western Cape and Kwazulu-Natal voting against it. By April 1999, the Tobacco Products Control Amendment Bill was gazetted.

### Tobacco industry influence

The tobacco industry was determined to ensure the Bill was not passed, and it took between 1991 and 1993 to finally pass a watered-down version of the Tobacco Products Control Act 1993. This became the subject of amendments under the ANC government in 1999 and again in 2007. For all the tobacco control legislation, the industry had a strong lobby defending the status quo that allowed cigarettes and smoking in public.

*“The industry obviously did not want the legislation at all and they opposed everything and anything the government said. But more interestingly, we had, as I said, the SABC was worried about loss of advertising and revenues. We had ... big media houses going to parliament and saying if you ban tobacco advertising ... they will close down. And then you had groups who ... opposed the legislation because ... the courts found that the ban on advertising was constitutional. So there was widespread opposition from the advertising agencies, from radio stations, from the media and from the tobacco industry, to the 1999 legislation (ANPPA\_KII\_40).”*

Opposition to tobacco control not only came from the tobacco industry itself but also from related sectors such as the media and advertising agencies, who argued against the ban of tobacco advertising. The claims were dramatic, but in the face of public health concerns, these arguments were not going to dissuade the government to pass legislation that was for the greater public good.



Industry in the 1980s strongly opposed legislation and always found ways to delay the action as the apartheid government showed no interest in tobacco control.

*“The 1993 legislation was in the works and kind of gentler ... and opening up the door. The difference was that the first time, remember the country [has] existed since 1976, the department had been asking for measures to reduce the tobacco use and nothing had happened in parliament before, because the apartheid government was protective of the Afrikaner businesses ... who were the sole manufacturers of tobacco at the time (ANPPA\_KII\_40).”*

It was not until towards the end of apartheid that the NP drafted the policy, which was the result of pressure from all sectors of South African society. There were many tobacco-related deaths that could have been otherwise prevented. Industry always found and exploited loopholes in the policy; this created the need for government to constantly amend the Act so as to eliminate these opportunities.

### Who else should have been involved in formulating the policies?

Domestic workers, a large section of society, should have been involved in the discussions but were not. They are confined to private homes, and when exposed to the secondary effects of smoke, have no recourse. An NGO representing domestic workers' interests should have been present to ensure their interests were included.

#### 5.5.1 Facilitators of using MSA in policy formulation

In the formulation of tobacco control policies, many stakeholders were involved for a range of reasons. The use of the MSA demonstrated by the inclusion of diverse groupings of academics, local government, NGOs, government departments, the advertising industry and the tobacco industry was critical in passing the initial tobacco control policy in 1993. The stakeholders brought their own contribution to the policy formulation process. The Medical Schools (University of Cape Town, Witwatersrand University), the MRC and the *South African Medical Journal* all brought scientific evidence to support the passing of the tobacco control policy.

*“Well clearly there's several benefits. One, we were able to reach all provinces of the country because the bigger organisations had offices in many parts of the country, so we were able to get down to local communities all over the country. We were able to pull our limited financial resources and then of course we were able to make meaningful policy direction (ANPPA\_KII\_40).”*

The South African government introduced the tobacco control policies in phases. The initial legislation, introduced in 1993, required health warnings on tobacco products, sales bans to under-16s and increased taxation. According to key informants, this was considered a gentle policy, as it did not get into the core of smoking and because the effect on sales was minimal. However, the legislation was credited for a number of successes:

*“It did three things: it allowed for health warnings on the cigarette packets, it banned the sales of cigarettes to young people under the age of 16, and it allowed local authorities to regulate smoking in public places. The products legislation in 93, we had Johannesburg city council deciding that it was going to make public places smoke free, and it also passed it as legislation. So there were bylaws by local government restricting smoking in public places, and the national legislation took the draft to all local governments to strictly regulate smoking in public places (ANPPA\_KII\_40).”*

*“The National Research Council, cancer association, and HSF countered smoking and all worked to promote the legislation. We obviously made recommendations to government about the content of the legislation, and made sure that there would be support for the legislation. We provided research evidence to support the legislation in the case of the MRC (ANPPA\_KII\_40).”*



The apartheid MOH by then took the evidence provided by scientists seriously and forged on with the drafting of the 1993 policy. In the meantime, the public was interested in the Bill as it touched on an industry that had strong links with the apartheid government – its demise was seen as part of the demise of apartheid. Smaller NGOs publishing media releases and giving radio talks resulted in awareness at grassroots level: people got to know about their rights to a smoke-free environment and their ability to demand it.

Diverse perspectives were presented by different stakeholders. Towards the end of apartheid, the Minister for Health broke ranks with the apartheid government, and in 1993, the first tobacco control policy was passed by the apartheid government. However it was a very weak Bill, which made little dent on the industry or smoking in general.

When the ANC came into power, the Dr Dlamini-Zuma took the lead in ensuring that more measures were taken to ensure that tobacco smoking and advertising was banned. The minister, with all the evidence available, and support from anti-tobacco smoking lobbies, drafted a Bill for public comment within six months. The industry was called to provide their perspectives but this did not change the position of the minister. The importance of involving all stakeholders was that disgruntled ones such as the tobacco industry could then not say they were not consulted. The Bill, once approved by the Cabinet, was available for public comment, resulting in more than 80 groups making submissions in Parliament before final Cabinet approval.

### 5.5.2 Barriers to the use of MSA in formulating the tobacco control policy

The barriers to the application of MSA in formulating the tobacco control policies in South Africa are:

1. Influence of the tobacco industry on government meant that enactment of legislation against tobacco smoking was next to impossible;
2. The power of the tobacco industry meant that any stakeholder associated with supporting tobacco control measures in anyway was dealt with by the industry and isolated;
3. The power of tobacco industry that extended to the media meant that it was risky to report on anything negative about the tobacco industry. Stakeholders were afraid to be identified as supporting tobacco control measures; and
4. The financial stakes involved in tobacco control were high. The advertising industry including the public broadcaster argued that banning cigarette advertising would result in the loss of revenue and the closure of radio stations that depended on advertising revenue.

### 5.5.3 Facilitators of MSA in the implementation of the tobacco control policies

Passing tobacco control policies was viewed as important because of the health benefits of living and working in smoke-free environments, therefore diverse groups were united in pressing for the passing of the tobacco policies from 1991 to 2008.

MSA was facilitated by the common goal of ensuring that the damage wrought by the tobacco industry since 1948 was corrected. Diverse groups were keen to bring down an industry that supported their oppression under apartheid. Alongside such sentiments was the ample scientific evidence that convinced the stakeholders of the urgency of passing tobacco control policies.

Media releases by urban-based NGOs were useful in rallying groups and rural NGOs to support the legislation. The history of the country, and the association of the tobacco industry with an oppressive regime, meant that diverse groups coalesced around the same goal of ensuring control of tobacco sales and advertising. The abundance of evidence supporting anti-smoking legislation helped create public awareness about the harmful effects of smoking.



In 1991, municipal administrations such as the City of Johannesburg banned smoking in fast food outlets and required that 60% of seats in such restaurants be reserved for non-smokers. Port Elizabeth banned smoking in public buildings during the same period. Although the City of Cape Town again attempted to ban smoking in public, the proposal faced strong opposition from the city's pro-tobacco. The appointment of Dr Rina Venter in 1991 as Minister of Health was important as her sympathies were with non-smokers and she was ready to enact tobacco control legislation in the face of stiff opposition.

The greatest facilitator to anti-tobacco legislation implementation was the ANC's rise to power in 1994. In its Reconstruction and Development Programme (RDP), the party identified tobacco control as one of its top priorities. When Dr Dlamini-Zuma was appointed Minister in 1994, she pushed for more tobacco control measures by enacting legislation that banned tobacco advertising and smoking in public buildings. Some ANC members who worked at the MRC also became strong advocates for the ban.

Before the enactment of the legislation in 1989, the University of Cape Town already banned smoking in public at its medical school and banned the sale of cigarettes in bars and cafeterias. In Johannesburg:

*"we had Johannesburg city council deciding that it was going to make public places smoke-free, and it also passed it as legislation. So there were bylaws by local government restricting smoking in public places and the national legislation took the draft to all local governments to strictly regulate smoking in public places (ANPPA\_KII\_40)".*

Private firms also took action to ban smoking in their boardrooms, cafeterias and buildings; some sponsored their executives for programmes to help them quit.

*"Clearly the legislation created err rights. So the non-smokers can demand their rights. But previously, if you went into a place and somebody smoked ... the smokers and non-smokers liked to think that there was a conflict of the law. In some places, the general belief is that you [are] not allowed to smoke unless there's a demarcated area. So that was clarity in the Act, and then the other thing was the Environmental Health Practitioners initially were informed of the law so they had responsibility to enforce it (ANPPA\_KII\_40)."*

Banning smoking in public buildings helped create awareness among the public regarding their rights. The public, being aware of their right to a smoke-free environment and the knowledge that such rights were protected by the constitution, were eager to make submissions in support of the control and banning of the advertising of tobacco products.

### Since 1994, there was political will to implement tobacco control legislation.

*"We had a new Health Minister, Dr Nkosazana Dlamini-Zuma, and Dr Dlamini-Zuma was prepared to do things that were international best practice. The 1999 legislation banned the advertising of tobacco products, restrict[ing] smoking in indoor public places by creating demarcated smoking and non-smoking areas (ANPPA\_KII\_40)."*

Government continued to tighten tobacco control and prevention, and this now yields results with fewer teenagers reported as smoking. Greater public awareness regarding the right to clean air made a difference in that people are now able to demand that smokers abide by the regulations.

#### 5.5.4 Barriers to the use of MSA in implementing tobacco control policies

The legislation implementation began immediately after it was passed. Between 1993 and 1999, health warnings on cigarettes appeared. When the amendment banning tobacco advertising was enacted, all forms of advertising had to stop. Restaurants were given six months to designate



smoking zones in their premises. However, advertising in stores where cigarettes were sold remained and monitoring was difficult.

*“Well partly because of the perceptions. Many of them think that they’ll lose businesses if they stop people from smoking, especially when people [say] that when you go to bars, you’ll drink and smoke and that’s not true. It’s not true. The evidence by City of Cape Town shows that restaurants did not lose sales, but there’s a misconception that if you ban smoking, they’ll lose business. ... I think that’s part of the explanation. The other explanation is that the fine was very small, it was R200. So if you fine restaurants R200, they didn’t care. They can just pay the R200. So I think it’s that perception that they’ll lose business and the fine was little so they ignored the law ... now the fine has one up to R10,000. But unfortunately it was between 1999 and 2007, so there [were] 10 years in which the fine was R200 and after the fine went up – there wasn’t strict enforcement with city council putting out and issuing fines against restaurants, because by then, 10 years had already passed (ANPPA\_KII\_40).”*

Implementing the anti-tobacco legislation was challenging. When advertising in schools and public places was banned, the tobacco industry sponsored youth parties where cigarettes were available. Monitoring industry strategies is difficult. In some restaurants, smoke-free zones are not completely sealed, and this too was a challenge to monitor and achieve. Another is the fact that cigarette taxes in South Africa are pegged to the rate of inflation.

*“Treasury is obviously involved because one of the laws to increase the pricing of cigarettes by increasing taxes, so ... in the last few years we’ve had problems with Treasury. They have not increased taxes on cigarettes as much as they should have done, because they believe the tobacco industry propaganda that higher taxes lead to smuggling. It’s not true; the cigarettes taxes [increased] in many countries other than South Africa (ANPPA\_KII\_40).”*

As a result, tax makes up only 52% of the total retail price of cigarettes, far below the recommended 75%. The fact that environmental health practitioners (EHPs) cannot be everywhere at once means that some restaurants and clubs allow smoking on their premises.

Ensuring that everyone works in a smoke-free environment was complicated by the fact that smoke-free zones do not include private homes, where a large proportion of women work as domestic workers and are therefore exposed to secondary smoke. It is difficult to monitor smoking in private homes.

## 5.6 Implementation, monitoring and funding

Implementation of the tobacco control measures was immediate. In 1993, clear health warnings appeared on cigarette packs. By 1999, tobacco advertising in South Africa was banned, and public businesses such as restaurants were given six months to designate smoking spaces. By 2000, smoking in public buildings, public transport and in private vehicles carrying children under 12 years was banned. Although a fine was imposed on business premises that did not comply with the requirement for a tobacco free environment, the R200 fine was too small to deter offenders. In 2008, a new fine of R10,000 was imposed on business owners who did not comply with the regulations. All forms of tobacco advertising, including sports sponsorship, were banned. Penalties introduced to ensure tobacco control measures remain in place.

The impact was immediate. Smoking in South Africa reduced by 26% in the period between 1993 and 2000 (Malan & Lever, 2003). The proportion of adults who smoked decreased from 33% to 27% during the same period. The greatest impact of tobacco control measures was among youth 16-24: smoking declined from 24% to 19% between 1993 and 2000 (Malan & Leverage, 2003). Monitoring of the policies is done in terms of legal compliance, where non-compliance is an offence that can result in a fine. The fine amounts range between R500 and R1,000,000.



*“There are EHPs appointed to monitor compliance with cigarette regulations. These EHPs are required to enforce the law related to the control of cigarette smoking (ANPPA\_KII\_40).”*

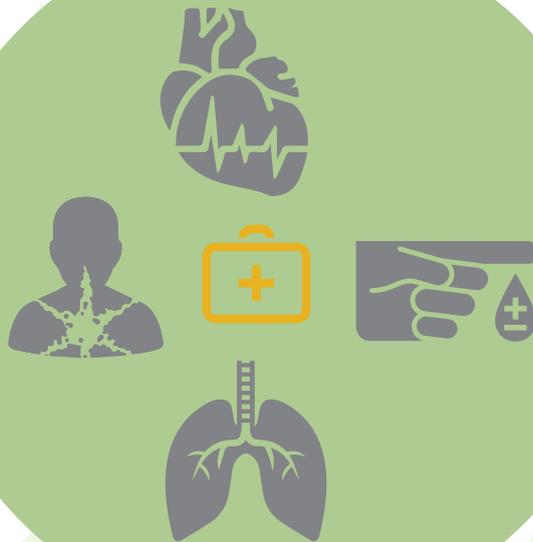
There is a national quit line funded by the DOH and managed by the NCAS is a helpline that is open 24 hours a day. Other activities are funded by businesses that support anti-smoking measures, but this is limited, so there is little funding for NGOs involved in tobacco smoking control.

In terms of the tobacco control legislation, more work is required to ensure that taxes on tobacco products are brought into line with the WHO recommendation of taxing such products at 70% of their retail price.



6.0 | Case Study 3

6.0



## Case Study 3 – Application of MSA in Alcohol Control Policies



## 6.1 Introduction

Harmful use of alcohol is a risk factor for NCDs. This chapter reviews policies designed to tackle the harmful use of alcohol in South Africa. The analysis of alcohol control policies discusses the history, content and best buy interventions contained in the policies, and critically assesses the extent to which the best buy interventions were implemented. Most critically, the chapter explores the application of the MSA in the formulation and implementation of alcohol control policies in South Africa, as well as the facilitators and barriers involved in using MSA in policy formulation and implementation.

## 6.2 History of alcohol control legislation

Various studies globally and locally not only discussed the impact of alcohol as a risk factor for NCDs such as liver disease, but was also a major cause of traffic accidents and gender-based violence, among others (Marais & Fourie, 2014; WHO, 2009; Abreu-Villaça *et al*, 2013; Healey, Rahman, Faizal, & Kinderman, 2014; World Health Organization, 2011; Unwin, Alberti, & Sanders, 2006).

Some studies advocate a ban on alcohol advertising, arguing that the promotion of alcoholic beverages is a risk to public health (Huang, Tao, Bogg, & Tang, 2012; Smith, Tang, & Nutbeam, 2006; Fukuda-Parr & Yamin, 2013; Matzopoulos, Truen, Bowman, & Corrigall, 2014; Ajuebor *et al*, 2015). Some studies also advocate control of alcohol consumption, with global organisations such as the UN, WHO, and South African government at the forefront of efforts to control alcohol consumption (WHO, 2009; WHO, 2010; UN, 2011). To understand the approach taken to control alcohol abuse in South Africa, the discussion has to be set against the backdrop of apartheid liquor policies.

As a participant noted with regard to the control of alcohol consumption: “So what we found is ... for example, under apartheid, people could not buy [alcohol] in bars in towns or in suburbs, so we had a proliferation of *shebeens* (informal drinking places) in townships. And what has happened since 1994 is that that regulation completely failed so what we’re having is a lot of unregulated spaces where people can go and access alcohol. And we need to begin to implement what is called zoning- so normalise the manner in which sheebens actually grow (KII\_42).” Although the sale and distribution of alcohol was tightly regulated after 1994, apartheid-type controls were disregarded, giving way to the unregulated sale and distribution of alcohol to the extent that in practice, there are currently no clear demarcations on where beer should and should not be produced, distributed and consumed, although existing laws and policies clearly define the scope of such operations.

*Besides the apartheid legacy, the global and local contexts have influenced government’s approach to liquor control policies. From the global perspective, key informants noted that since the 1950s, alcohol increasingly became “almost a celebrated drug and marketed enthusiastically, [resulting] in particularly the use of alcohol by young people ... and lately we are seeing a specific kind of alcohol being marketed to women” (KII\_42).* The departments of Health and Social Development tend to approach alcohol use and abuse from a disease-burden perspective, suggesting that “alcohol is a significant contributor to ... [harming] others, which means that people ... may not necessarily be drinking alcohol to harmful levels, but live with people who drink alcohol to harmful levels, so there’s domestic violence, there’s abuse. ... The disabilities and death caused by road accidents, in effect, where a person under the influence of alcohol was driving. And we also found that other social contact crimes have been significant drivers [of] those using alcohol to harmful levels” (KII\_42). Essentially, the rationale for advocating stronger controls on alcohol, including advertising, is attributed to the harm caused to both the users and to those who live around them – in effect, everyone. The harmful effects of alcohol on society,



whether individuals do or do not consume alcohol, are strong motivations for governments to control the marketing and distribution of alcohol and related products.

Before the amendment of the Liquor Act in 1962, liquor distribution and consumption was done along racial lines, meaning Africans were excluded from all legal activities of liquor distribution and consumption. In terms of the Liquor Act of 1927, Africans were excluded from serving liquor, driving liquor vehicles, or entering licensed liquor premises. This prevented them from employment, even by legitimate license holders. According to this Act, Africans were not allowed to legally buy alcohol, which led to the increase in the creation of illegal outlets such as *shebeens*. The amendment of this Act in 15 August 1962 lifted the restrictions on Africans buying liquor from legal outlets. There are two national Liquor Acts currently in force: the Liquor Act 27 of 1989 and the Liquor Act 59 of 2003. There is also the Liquor Products Act 60 of 1989, which aims to control the quality and safety of all alcoholic beverages. Both acts put restrictions in place to allow a safe drinking environment, which led to the restriction of trading hours, age limits, and public drinking. There were also restrictions on liquor advertising, as alcohol advertisements are not allowed to carry misleading information nor target minors.

In 1980, the apartheid government drafted a policy to address the growth of alcohol abuse. The National Plan to Combat Alcohol Abuse, formulated in March 1980, was not effective due to its narrow scope: it did not address the risks of drinking. The plan was improved in 1988 under a new name, the Plan to Prevent and Combat Alcohol and Drug Abuse in South Africa. The policy did not achieve its intended results because it lacked funding.

In 2003 South Africa passed the Liquor Act (59 of 2003), which aimed to control alcohol abuse and its associated socio-economic effects. The Liquor Act (RSA, 2003) encourages a responsible and sustainable liquor industry through promoting a culture of social responsibility and preventing liquor advertising to children. Annual tax increases are meant to discourage alcohol consumption, but whether this objective is being achieved is subject to debate, as the increases for branded alcoholic beverages do not stop consumption. Instead, consumers seek cheaper – and often more dangerous – alternatives. Other measures taken include: reducing the amounts allowed in the blood alcohol levels of drivers; increasing taxes; and requiring warnings on alcohol labels (Bradshaw, Steyn, Levitt, & Noliwana, 2011). The government's seriousness in dealing with alcohol-related mortality is evident in the fact that not only is there a national Liquor Act (2004) but also provinces such as the Eastern Cape, Gauteng, and the Western Cape have liquor legislation that regulates how they deal with alcohol-related issues in-province (Western Cape Province, 2008; Gauteng Province, 2013; Eastern Cape province, 2003). Provinces such as the Eastern Cape have liquor regulation boards which ensure compliance with the laws, legislations and regulations related to alcohol.

Like most of countries, alcohol was a part of South Africa's lifestyle, culture and economy for centuries. Economically, alcohol contributes to 1.7% of total government revenues each year. According to WHO (2014), South Africa's per capita consumption was 11 litres of pure alcohol from 2008-2011. This drinking habit is particularly harmful to youth and there are many problems caused by alcohol consumption and abuse. It plays a significant role in risky sexual behaviours, which include unwanted, unprotected, unintended sexual activities, and also multiple sexual partners. The consequence of the behaviour may result to unwanted unplanned pregnancy as well as contracting sexually transmitted diseases (STDs).

Liquor control policies have mainly fallen under the Department of Trade & Industry (DTI), who controls sale and distribution of alcohol. On the one hand, DTI's approach to liquor control ensures liquor distribution outlets are licensed, and manufacturers and distributors comply with regulations. On the other hand, the departments of Social Development (DOSD) and Health approach liquor control from a public health perspective. DTI, DOSD and DOH take opposing sides when formulating and implementing liquor control policies. A recent case regarding a



proposed alcohol advertising ban had the DTI calling for a partial ban, whereas DOSD and DOH advocated a complete ban.

In 2004, the Liquor Act of 2003 resulted in a shift of regulation responsibilities: all value chain categories of the liquor industry, previously regulated by the Provincial Liquor Authorities, became a national responsibility. According to the 2003 Act, regulation of micro manufacturing and liquor retailing remained a provincial responsibility (National Liquor Act 2003) (RSA, 2003).

### Policy objectives/rationale

The objectives of the alcohol advertising ban are to:

- reduce government expenditure, particularly the DOH, on the alcohol-related burden of preventable diseases that continue to place a serious financial burden on the public health system, such as: foetal alcohol syndrome (FAS); social problems such as physical and emotional abuse; drunk driving with resultant road deaths; and other severe medical conditions; and
- prevent introduction of consumers to alcoholic beverages, mainly youth who can be easily persuaded by alcohol advertisements.

According to Anderson (2009), a well-designed, US-based longitudinal study indicated that exposure to advertisements and media increases the likelihood of young people starting to drink.

In terms of Section 4(1) of the Liquor Act 59 of 2003, the manufacture and distribution of liquor was prohibited, except by those with permits from the Liquor Authority and the Provincial Liquor Authority in compliance with terms for micro-distributors and manufacturers. The 2003 Liquor Act prohibits liquor distribution to unauthorised retailers and requires all liquor retailers be registered. Manufacturers and retailers are prohibited from advertising liquor or methylated spirits in a manner that persuades minors to use alcohol. The Act also prohibits the advertising of anything as liquor when it actually is not.

The National Liquor Act also prohibits liquor sales to minors, who the Act defines as those under age 18. The Act requires reasonable measures to determine the age of those suspected to be minors.

Section 11 (1) of the Liquor Act allows any qualified person to apply to the Minister, in a prescribed manner and form, to be registered as manufacturer, distributor, or both. This does not apply to any minor at the time of submitting the application.

## 6.3 Factors that led to the drafting of the alcohol legislation in South Africa

In 2010, an inter-ministerial committee (IMC) was appointed to look into alcohol advertising bans due to its harmful effects and the associated costs of abuse. In 2013, the Minister for Social Development, Bathabile Dlamini, announced that the Control of Marketing of Alcohol Beverages Bill was approved by the Cabinet. In discussing the Bill with the media, Ms. Bathabile Dlamini, Minister for Social Development, said “the intention of the Bill is to reduce exposure to the advertising and promotion of alcohol” (*Mail & Guardian*, 2013). The Minister noted that the harmful effects were too obvious to be ignored: they ranged from road fatalities and deaths caused by alcohol abuse; crime; violence; risky sexual behaviour; rape; family disintegration due to alcoholism; disruption of communities and the economic impact from loss of life; and burdens on the health system due to injuries associated with alcohol abuse. The Minister estimated that alcohol abuse cost the country R38 Billion per year; research estimates the losses at R240 Billion. The Minister also noted that “alcohol is the third-leading risk factor for death and disability in the country and was responsible for around 130 deaths every day” (*Mail & Guardian*, 2013).



According to a MRC study on health-related harm caused by alcohol, 40% is due to violence, 18% is caused by mental health problems resulting from alcohol abuse and dependency disorder, and 12% is caused by road deaths (Parry, 2012). Crime statistics from 2010 indicate that alcohol played a significant role in violent social contact crimes such as murder, attempted murder, rape, and assault. A ban, or highly restricted, alcohol advertising would reduce these risks and the number of new consumers.

In 2003, the advertising and liquor industries, as well as other departments within government, could not support more restrictions on advertising, even if it yielded positive results in Australia, Kenya, and Zambia. The industry argued that there was no correlation between advertising and abuse at any age; instead, it argued that what advertising did was provide consumers with options of different alcohol brands. South Africa is one of the few countries with no legal restrictions relating to advertising liquor products.

Dr Aaron Motswaledi, the current Minister of Health, raised the need for a ban of alcohol advertising, but the proposed Bill did not get far – it was opposed before being presented for public comment (Parry, 2012). In April 2012, the draft of the Control of Marketing of Alcohol Beverages Bill leaked to the press (Parry, 2012). It showed the government was determined to ban the explicit alcohol advertising outside premises in which it was sold. It sought total prohibition of alcohol advertising and only permitted notices limited to the description of price, brand name, type, the source of origin and composition of the product. The proposed Bill required these descriptions be displayed inside licensed and registered premises, and the notices be accompanied by health warnings. In particular, the Bill required that the warnings be visible from the outside; delivery vehicles do not display names or logos of any alcoholic beverages; and sports sponsorship should not be linked to any alcoholic brand names. The promotion of alcoholic donations and discounts at events were also banned (Parry, 2012).

Once the Bill leaked, the merits and problems of banning alcohol advertising were openly debated in the media by the advocates, opponents and the general public as well as academics. Despite government's intention, opponents of the ban used every avenue and opportunity to argue, focusing mainly on the perceived negative economic impact and particularly on jobs. Employment is a serious challenge in South Africa and any policy likely to lead to job losses is considered very carefully; that seems to be what happened to the Bill. Due to strong opposition during drafting and the public outcry about job losses, it was put aside. Little was done to revive it. Given the slump in economic growth and mounting job losses, it would not be politically expedient for government to act on a Bill that is perceived to lead to further job losses.

## 6.4 Policy process

There were three phases in the process of formulating alcohol control policies in South Africa. The first relates to the formulation of the 2003 Liquor Control Act, the second to the Control of Marketing Alcohol Beverages Bill (2013) and the third to the Review of Liquor Policy (2015) by the Department of Trade & Industry. There is little information about the policy process in formulating the 2003 Liquor Act but more on the Control of Marketing of Alcohol Beverages Bill (2013). This report focuses on the policy-making process involved in the proposed ban on alcohol advertising Bill.

### Important events

There was public dialogue between government, academic, civil society organisations and the alcohol and advertising industries on the proposed ban of alcohol advertising in South Africa. According to Romsóomar (2015), health researchers, practitioners and organisations such as Soul City supported the Bill and provided credible, consistent evidence demonstrating that exposure



to alcohol advertising, particularly to adolescents, encouraged entry into alcohol consumption that could lead to abuse. Medical and health researchers also demonstrated that exposure to alcohol advertising promoted underage drinking. An article in the *South African Medical Journal* by Parry and colleagues (2012) argued that a ban on alcohol advertising and all sport and art sponsorship by alcohol producers would reduce exposure to alcohol, and the likelihood of early alcohol use and related harm. However, given the opposition to the ban, drafting was not finalised by the time this study concluded.

## 6.5 Implementation, monitoring and funding alcohol control policies

Given that the Control of Marketing of Alcohol Beverages Bill (2013) is still with an inter-ministerial Committee (IMC) and was not released for public comment, this section deals with existing liquor policies that have been in effect for some time. The Liquor Act (2003) is implemented by the Department of Trade & Industry (DTI) through the National Liquor Authority (NLA). The NLA was established in terms of the Liquor Act 59 of 2003; its mandate is to monitor compliance with the Act. The functions of the NLA are to:

1. regulate alcohol through registration of liquor manufacturers and distributors;
2. educate the Act's internal and external stakeholders;
3. avail information on how to register with the NLA and create awareness regarding the harmful effects of alcohol;
4. inspect and assess compliance with the Act;
5. deal with complaints related to alcohol manufacturing and distribution, brought to the NLA;
6. monitor and enforce compliance with the Act;
7. conduct regular inspections to ensure that stakeholders have the requisite documents for manufacturing and trading as per the Act; and
8. seize liquor manufactured contrary to the Act.

Given the mandate and functions of the NLA, it is evident that the institution's role leans more towards ensuring that alcohol is obtained through correct procedures. Of all NLA objectives, increasing awareness of alcohol's harmful effects is not a major function, as it is subsumed under the general objective of educating stakeholders on how to register as liquor manufacturers or traders.

Some restriction on alcohol advertising was implemented in 2003 that prevented advertisements from carrying false or misleading information about alcohol products. The 2003 Liquor Act prohibits advertising designed to appeal to minors. However, the Act falls short in limiting alcohol advertising to certain times of the day in both private and public broadcasting.

DTI implements the Liquor Act and controls alcohol manufacture and distribution. DTI focuses on ensuring that manufacture and distribution stakeholders comply with existing regulations, and on revenue generation from the production and distribution of liquor, rather than public health concerns. The police are responsible for ensuring responsible drinking among motorists and they monitor this by conducting alcohol tests, particularly at the end of the month.

A key barrier to implementing the Liquor Act (2003) is that most alcohol retail outlets in townships are unlicensed and therefore illegal. Controlling consumption and abuse in these outlets is difficult because alcohol is available to all ages and operating/trading hours are not regulated.



In 2010, the South African government tasked an IMC with identifying ways of reducing alcohol-related harm (Ramsoomar, 2015), resulting in the draft policy. However, it was leaked to the media before approval for public comment, and the debates took their own course in the media. The Bill was withdrawn.

*“It basically was withdrawn because of pressures from the industry [which said] that the studies by social development and health were focusing on narrow issues – on public health and not the economy. We had to actually do another impact study [that] looked at the economy, which came out with the same kinds of answers. We are a little puzzled by where we are now, and so that’s why we are asking for another discussion at the IMC level: so that we can actually look at if there are any good evidence-based reasons as to why the DTI wants to go the route they want to go (ANPPA\_KII\_42).”*

The proposals and outcomes of the National Drug Master Plan (2013-2017) that addresses substance abuse, including alcohol, are under implementation. The plan (DOSD, 2013) aims to achieve outcomes on a national level (DOSD, 2013:4-7), which among other objectives, relate to alcohol abuse as follows:

1. reduction of the bio-, psycho-, social and economic impacts of substance abuse and related illnesses on the South African population;
2. ability of all people in South Africa to deal with problems related to substance abuse within communities;
3. recreational facilities and diversion programmes to prevent vulnerable populations from becoming substance abusers/dependents;
4. reduced availability of dependence-forming substances or drugs, including alcoholic beverages; and
5. harmonisation and enforcement of laws and policies facilitating effective governance of the supply chain with regard to alcohol and other drugs.

It is no surprise that the drafting of the Control of Marketing of Alcohol policy was done by the departments of Health and Social Development, and that they remain key champions for passing the policy. The department deals with the social consequences of substance abuse, including alcohol, which was described as a ‘legal drug’ with serious consequences. DOSD (2016 online) indicated that about 6000 lives are lost annually due to alcohol abuse. South Africa has the highest incidence of the foetal alcohol syndrome, which is 30 to 50 times more common than Down’s Syndrome.

## 6.6 Multi-sectoral action

### Agenda-setting

The IMC to draft the Control of Marketing Alcohol Beverages Bill was appointed under the direction of the departments of Social Development and Health, as these were the two ministries dealing with the effects of alcohol in society.

As indicated in earlier sections, we underscore that the DTI and National Treasury were against banning alcohol advertising. Their key arguments related to the amount of revenue generated from alcohol sales and advertising. The South African Chamber of Commerce and Industry (SACCI) opposed the alcohol advertising ban, arguing the move would lead to job losses and affect the broader economy (Smith, 2013). Since the 1950s, South African Breweries (SAB) sponsored the football Premier League, the Springboks rugby team, and contributed



to local economic development by providing opportunities for businesses in townships. SAB argued the alcohol advertising ban would affect other sectors such as media, advertising, retail, and hospitality.

Stakeholders who deal with the effects of alcohol consumption and abuse are mainly government departments (Social Development, Health, police); NGOs such as Soul City, who deal with teenage issues such as sexual behaviour, substance and alcohol abuse, and HIV/AIDS; and academics. Given the opposition to the Bill, it was withdrawn. It is currently under revision and the same groups that opposed it (DTI and Treasury) would still like it withdrawn or substantially watered down. DOH and DOSD want to see the Bill enacted into legislation, as these departments bear the brunt of alcohol abuse.

### 6.6.1 MSA application in policy formulation and implementation

#### Actors' positions

Previous policies were drafted by the DTI with the aim of regulating alcohol manufacture, sales and distribution. In the case of the Control of Marketing of Alcohol Beverages Bill (2013), the departments of Social Development and Health took the lead in drafting the Bill and invited others to contribute via IMC. However, before the proposed Bill could be presented to Parliament for public comment, there was already public debate about it. It was eventually withdrawn to allow for further evidence as requested by the alcohol industry. From the media debates, alignments based on the support and oppositions could be identified as shown below:

#### Strong supportive actors

- Government departments: DOSD; DOH
- Universities
- MRC
- NGO

#### Strong oppositional actors

- Alcohol industry (alcohol manufacturing and distributing companies)
- Media: advertising industry; SABC
- Government departments: National Treasury; DTI

As indicated in earlier sections, the drafting of the Control of Marketing of Alcohol Beverages Bill was done by the IMC championed by the departments of Social Development and Health. Within the IMC, the DTI championed interests that aligned closely with those of the alcohol industry.

*“There has been [a] lot of inputs by what you call public health interest NGOs and communities. But evidence-based input shape[s] the way the policy goes, because we don’t want to be seen as operating under the guidance of particular interests groups. And the fact that we say that once we make the Bill public, then people can make comments to the extent to which it [is] far, not too far or not far enough (ANPPA\_KII\_42).”*

The Bill (2013) was still in the drafting process so the diverse interest groups had not formally had the opportunity to comment on it. The alcohol manufacturing industry made objections to the Bill before it was officially presented for public comment and as a result the IMC was forced to withdraw the Bill and conduct further research to provide evidence to enable the Bill to pass.



### 6.6.2 Role of the sectors involved in the formulation of the policies

The MRC, DOH, Soul City Institute for Health and Development Communication, and universities provided scientific evidence on the negative effects of alcohol advertising on use and abuse. They also provided empirical evidence of the cost to the government of South Africa; in contrast, the negative effects of alcohol cost the South African government double that contributed by the alcohol industry to the country's GDP. Bathabile Dlamini, the Minister of Social Development, argued that although a law against liquor advertising may cost jobs, alcohol consumption cost South Africa 130 lives a day. This was informed by the research conducted by the MRC (Roos, 2013):

*"The ANC had a National General Council in 2010, and most of the discussions in the social transformation committee came from communities that had massive problems with alcohol-related harm in the communities ... [The] Minister of Social Development ... chaired the committee, which then became an IMC. The research that we did was then done jointly by the [departments of] Health and Social Development... But we asked [the] Minister of Health to champion it through Cabinet because they have the experience in managing a similar Bill to ban the advertising of tobacco. So that was the agreed decision. So Health, then presenting together with social development, did both with Cabinet and the IMC (ANPPA\_KII\_42)."*

So controversial was the Control of Marketing Alcohol Beverages Bill (2013) that even government departments took opposing views. On one side were the departments of Health and Social Development supporting the Bill, and on the other were the DTI and National Treasury in opposition:

*"We were a bit concerned that DTI is trying to have a much lesser version of [the Bill] managed by the DTI, because currently, alcohol advertising and marketing is part of the National Liquor Act, which is administered by the DTI. In our initial discussions, we agreed that they (DTI) can't do it because they never had any restrictions, they only have self-regulation, which was not working. But it seems like they have decided to go back to their group ... The DTI is looking at industry, and the industry must operate, grow, and be more effective. The issue of harm associated with the industry is not necessarily one that is well-placed within [it] (ANPPA\_KII\_42)."*

Stakeholders opposed to the advertising ban brought their own evidence, which showed that 12,000 jobs would be lost.

### Benefits of involving many actors in the policy development process

Drafting the Control of Marketing of Alcohol Beverages Bill (2013) was an internal process of government through the IMC, championed by the departments of Social Development and Health, as well as involving other government departments. Stakeholders not involved in the initial drafting of the Bill still needed approval from Cabinet before it could be presented for public comment. The initial process of drafting the Bill can be said to be inter-sectoral in that it involved different government departments.

That the Bill drew a lot of interest from a range of stakeholders was beneficial as it resulted in serious and robust debate regarding its merits. The Departments of Health, Social Development and Police had compelling arguments about why alcohol advertising should be banned.

The departments of Trade & Industry and National Treasury had compelling reasons related to the loss of revenue; hence their opposition to the Bill. The claim by the advertising industry, liquor industry and sporting fraternity that the ban on alcohol advertising would result in massive job losses meant that the trade unions too opposed the Bill. The result was a deadlock and since 2013 the proposed Bill has not been discussed.



*“We thought that it would be ready ... for public discussions, and now a new approach has emerged that was not discussed with the IMC, ... the partial ban ... We must be convinced that the DTI is coming up with a new approach to alcohol regulation and advertising, and must present it to the IMC before they actually present it to the Cabinet ... that’s why it’s been delayed (ANPPA\_KII\_42).”*

The inclusion of community-based organisations and other NGOs helped to boost awareness programmes during the policy formulation process, as they were familiar with what was happening in the communities. The community base and NGOs could educate and encourage people to participate in the formulation and implementation processes.

The other benefit is that the involvement of many stakeholders would help in the implementation of the policy where all sectors involved will know their part in implementation. When all stakeholders are involved, even those opposing the Bill would not say they had not been informed about the Bill. Moreover, common ground could be reached on issues that may be unfair to the opposition, especially the alcohol industry, the DTI and with the national treasury.

### 6.6.3 Barriers to the use of MSA in alcohol control policy formulation

The control of alcohol advertising Bill was debated in the public before it could be released for comment. Government departments were divided regarding the value of banning alcohol advertising. The Departments of Health and Social Development championed the Bill based on public health concerns. On the other hand, DTI and Treasury argued not from a public health perspective, but rather from a financial one, claiming that controlling alcohol advertising would lead to a decline in revenue. During the latest phase of drafting, and just before the IMC could submit the Bill for Cabinet approval in June 2016 for public comment, the DTI brought in a watered-down version, which called for a partial ban on alcohol advertising. This alteration delayed the process:

*“We are a little puzzled by where we are now, ... so that’s why we [asked] for another discussion at the IMC level, so that we can actually look at if there are any good evidence-based reasons as to why the DTI wants to go the route they want to go (ANPPA\_KII\_42).”*

Industry, the media, the sporting fraternity and the advertising industry all strongly argued that enactment of the Bill would result in about 12,000 job losses and would cost R7.4 billion. Debates on the Bill were conducted in the media and opponents were vocal regarding the harm it would cause. The general public was also involved in commenting on the Bill by calling into talk shows and writing to newspapers. There was a wide range of opinion among opponents and stakeholders. Therefore the challenge was the agreement to pass the legislation. Since approval of the Bill in 2013, it was not discussed further and the process seems to have stalled.

The firms argued that alcohol advertising only targeted consumers, and it provided them with product choice. SABC also argued the ban would result in loss of revenue for the public broadcaster. Thus, debates on the proposed Bill resulted in the postponing of the advertising ban policy.

### 6.6.4 Facilitators of the use of MSA in implementing alcohol control policies

*According to study participants, Dr Motswaledi, the Minister for Health, is a strong champion of NCD reduction and is at the forefront of advocating an alcohol advertising ban. He and Ms. Bathabile Dlamini, the Minister for Social Development, formed a formidable team and gave public support to the proposed Bill on marketing and advertising of alcoholic beverages. Soon after his appointment in 2009, Dr Motswaledi advocated for measures to reduce harm caused by alcohol abuse, given the enormous cost to livelihoods and the health system. Another facilitator was the production of scientific evidence by universities and research councils showing the*



*harmful effects of alcohol consumption. NGO advocacy work called for the regulation of exposure to alcohol, suggesting that similar NGOs are likely to support the Bill on banning advertising. So much as there is strong opposition to the liquor advertising ban, there is also a strong lobby for enactment of the Bill. Evidence on the harmful effects of alcohol is mounting (ANPPA\_KII\_42).*

### 6.6.5 Barriers to implementing alcohol control policies

A large proportion of alcohol consumption and abuse occurs in unlicensed outlets such as *shebeens*. Informal retailers must be regulated to address the social harm associated with alcohol consumption and abuse. Non-compliance with the 2003 Act, which prohibits the sale of alcohol in unlicensed outlets and to minors, is common. In unlicensed outlets and sheebens, liquor is sold to all consumers without checking they are eligible to purchase alcohol, which results in the widespread availability of alcohol in townships.

#### Disagreement within the government itself

While the departments of Social Development, Health and Police are concerned about the damage caused by alcohol abuse; the departments of Finance and Trade & Industry are concerned about the loss of revenue from taxing alcohol consumers as well as job losses. So far there was no consensus between the different state departments. Strong opposition from media and sport seems to have 'killed' the Control of Marketing of Alcohol Beverages before it was presented to the public for comment.

#### Enforcement problem

There are laws in South Africa, such as the Liquor Act of 2003 and the National Drug Master Plan, which focuses on alcohol abuse and covers aspects such as the production, distribution and consumption of alcohol. However, enforcement of these laws is weak in that homebrew alcoholic beverages are unrecorded, uncontrolled and sold in unregistered outlets. The sale of liquor in illegal outlets, as well as to minors, is common. Enforcement of these laws requires more resources and more law enforcement agents to manage the problem.

### 6.6.6 Monitoring and evaluation

According to the Liquor Act (2003), the Minister of Trade & Industry may appoint any person as an inspector with general and specific authority to exercise power in terms of this Act. The appointed inspector must then be issued with a certificate in a prescribed form to indicate that the person is designed as an inspector. The inspector may investigate complaints submitted to him/her and may monitor and enforce complaints or conduct an inspection under the Liquor Act (2003).



7.0 | Case Study 4

7.0



## Case Study 4: Application of MSA in Physical Activity Policies



## 7.1 Introduction

This chapter analyses physical activity policy formulation and implementation in South Africa and explores how MSA was used in this process. The chapter begins with a description of existing policies before proceeding to a detailed analysis of MSA use. Physical activity policies and programmes are largely but not exclusively the domain of the Department of Sports and Recreation South Africa (SRSA).

## 7.2 Policy content and history

Physical inactivity is internationally recognised as a key risk factor in NCDs such as cardiovascular conditions, cancer and diabetes (Cecchini *et al*, 2010; Sparling *et al*, 2000; Rütten *et al*, 2013). Existing studies focus on risk factors such as hypertension (Lachat *et al*, 2013; Pratt *et al*, 2010; Fallis, 2013; Kruger *et al*, 2005). Physical inactivity was identified as a key driver of most, if not all, NCDs (Unwin *et al*, 2006; Baleta & Mitchell, 2014; Horton, 2013; Bauman *et al*, 2006) and the challenge for governments is to promote physical activity for well-being of the general population. The existing literature also underscores the importance of physical activity in tackling NCDs such as cardiovascular disease, hypertension, diabetes and cancer.

While some analysts (Rütten *et al*, 2013) view physical inactivity as an issue that affects a large proportion of the general population, some studies (Pienaar, 2015; Cezar, 2008) point to the growing challenge of overweight and obesity among children, and other studies highlight the importance of physical activity in improving the quality of life among the elderly (SRSA, 2011). Physical inactivity in low- and middle-income countries is attributed to inequality and health inequity (Di Cesare *et al*, 2013). Analysts such as Sparling *et al* (2000), Pratt *et al* (2010), and Fallis (2013) advocate the promotion of physical activity as a means of NCD prevention and control. This report argues that physical activity is an important no- to low-cost intervention, which if effectively implemented, helps control and prevent NCDs in the general population. To be effective, NCD physical activities policies and programmes must apply MSA in the design and implementation of the policies, programmes and strategies. Although PA policies, strategies, and programmes exist in South Africa, their development context is critical in understanding the extent to which multi-sectoralism is an integral part of their design and implementation.

When the South African sports policy was formulated in 1998, the focus was on transformation of sport and racial representation in competitive sport. South Africa emerged from decades of apartheid, in which racial discrimination and segregation in sports was the norm. The country was banned from international competitions due to its racist sports policies. Under apartheid, competitive sports such as rugby and cricket were predominantly white, while football was predominantly an African (indigenous people) sport. Given such a history steeped in racist and segregationist policies, programmes and practice, it was imperative for the post-apartheid government to desegregate sport and ensure inclusivity in every sense. The underlying rationale of the 1998 sports policy was ensure that teams represented the demographic profile of the country. The National Sports and Recreation Act (NSRA, 1998) was amended in 2007 (NSRA, 2007). The terminology and definitions in the policy were revised to ensure clarity of meaning, but the core content and main intent of the policy remained unchanged.

To understand South Africa's vision for physical activity, it is important to critically review other documents dealing with transformation in sport. The Sports Transformation Charter (2012), hereafter referred to as the 'Sports Charter', articulates the meaning of 'transformation' with regard to sports in general and physical activity in particular. The transformation strategy "has to be multi-dimension[al] and focused on changing demographic profiles on and off the field of play; ensure equitable access and resource availability; skill and capability development on and off the field of play; extensive community involvement with a view to provide participation opportunities and to identify potential talent; and building and shaping relationships with its future



leaders and decision-makers on the basis of broad-based community engagement” (SRSA, 2012:5). Central to the notion of transformation is community participation, equitable access, and resource availability, all of which are relevant in ensuring physical active general population.

To fully comprehend the Sports and Recreation policy, it is critical to examine the vision, mission, and strategic objectives of the SRSA. The vision is stated as achieving “an active and winning nation” (SRSA, 2016) to underscore the broad vision of a country that is physically active; the goal of a physically active nation for NCD prevention is not explicitly stated. More evident is the idea of creating a highly competitive nation that wins at sporting tournaments. Using sport to meet national and global priorities is one strategic objective. Whether these priorities include using sport as a means to tackle the NCD crisis is not clear, but such an assumption would not be incorrect given that the NDP (2012) identifies NCD prevention and control as a Vision 2030 goal. Another strategic NCD objective of the SRSA is ensuring citizen access to sport and recreation facilities, which is critical to promoting physical activity and ultimately results in reducing NCDs. The notion of increased access can be understood from the apartheid past where residential areas were segregated and black areas had few, poorly maintained recreational facilities. These strategic objectives implicitly address the growing NCD burden; the remaining objectives address transformation in South African sport, improving the success of athletes, and creating an environment that promotes sport and recreation. Subsequent strategic documents and programmes increasingly focused on sports development and recreation for the promotion of physical activity, and ultimately, a healthy nation.

The policy and strategic documents focus on ensuring that youth can participate in competitive sport. Sport is promoted with a view to keeping youth away from drugs and crime. The department increasingly designs programmes to address the lack of physical inactivity in communities and schools.

DOH and SRSA have different objectives: DOH's rationale in programme design is based on global recognition of physical inactivity's importance in combating an increasingly overweight population. The SRSA promoted sport first to improve competitiveness of the country in global tournaments and second to ensure specific social categories, such as the elderly, are physically active, as this ensures that they interact with others, are not isolated in their homes, and their quality of life improves.

### School Sport Act (SA Schools Act, 1996, Act No. 84 of 1996)

The Act intends to facilitate the introduction and the implementation of school sport in a fair and an equitable manner in all schools across South Africa. The policy maintains that every school should introduce physical education, therefore, relevant games and activities promoting play and recreation should be identified, prioritised, and implemented. They, should also enable all learners to participate in an ongoing basis.

The network of policies and strategic plans related to sports and recreation illustrates how sport and recreation are viewed in the South African context. Although the initial approach emphasised equity and race representation in competitive sport, subsequent strategic approaches diversified to include sport for recreation and healthy living. The policy framework depicts South Africa's approach to tackling physical inactivity as an NCD risk factor (see Table 14).

### The Promotion of physical activity in older persons – November 2011

The DOH Directorate of Chronic Diseases, Disabilities and Geriatric compiled physical activity promotion guidelines to address the burden of disabilities associated with old age. The aim is to provide older people with endurance, strength, balance and flexibility in order for them to age comfortably. Potential programme outcomes are: a decrease in premature deaths; a decrease



in disabilities associated with chronic diseases; a decrease in the costs related to medical and treatment care; an increase in people enjoying a good quality of life; and an increase in the elderly participating actively social, cultural, economic and political as they age.

According to the Directorate, the programme can be implemented both formally and informally. Formal activities are implemented and facilitated by a health worker at a designated facility. Informal activities form part of a daily routine, such as walking, gardening, and housecleaning. Subsequent to the policy, various programmes such as the Golden Games were designed to promote physical activity among the elderly.

### The National Sport and Recreation Plan, 2012-2016

A critical document in understanding South Africa's policies and programmes on physical activity is the National Sport and Recreation Plan (2012-2016) (NSRP). Its vision statement crystallizes the intended long-term outcome to build an active and winning nation. Recreation, school sport, and participation promotion campaigns were identified as three programmes that reach the objective of an active nation. A strategic objective under 'recreation' is to improve the health and well-being of the nation by providing mass participation opportunities through active recreation. For example, the school sport programme aims to maximise access to sport, recreation and physical education in every school in South Africa (NSRP, 2012).

The National Sports and Recreation Act No 110, 1998 focuses more on competitive sport and its transformation to be more representative of national demographics. The National Sport and Recreation Strategic Plan (SRSA, 2012) lists objectives appropriate to tackling physical inactivity in the general population, aiming for a 10% increase the prevalence of physical activity by 2020. In practical terms, physical activity is defined as 150 minutes of moderate-intensity physical activity per week.

The most important aspect of the strategic plan for physical activity is its target of increasing habitual levels of physical activity. Towards this goal, the government aims to:

- create knowledge and awareness concerning the importance of regular physical activity for health, well-being and disease prevention;
- increase and promote inter-sectoral collaboration to increase physical activity opportunities;
- implement physical activity programmes and related interventions to promote physical activity; and
- disseminate examples of evidence-based interventions, programmes and policies to promote physical activity.

### The initiatives for the promotion of physical activity under the NSRP (2012-2016) are as follows:

- raising public awareness about physical activity benefits to prevent NCDs
- increasing population-wide physical activity participation in all domains (leisure time, transport, work) and settings (school, community, home, work), promotion of healthy behaviours and lifestyles, and addressing health-related issues through sport and physical activity, such as no tobacco use, healthy diet, reduction of violence, stress, and social isolation;
- re-positioning indigenous games as family festivals; development of indigenous games federations to establish a league system that encourages broad participation;
- the 'Golden Games', which help the elderly significantly improve their quality of life by staying physically active and fully engaged;



- the 'Big Walk', to encourage participation in physical activity; and
- develop an inter-departmental league within the public sector to be formally established in August 2013 (Department of Sport and Recreation, 2013).

The Strategic Plan 2012-2016 outlines steps on how NSRP implementation should be carried out, indicating that by 2016, citizenry should have access to sport and recreational activities; sports should be transformed; and athletes should be positioned to achieve international success. It also details the budget and implementation bodies to ensure success of the plan.

### Principle/values stated

The preamble of the Sport and Recreation Act 110, 1998 states the principles and values that underlie the policy, which are stated as "to redress the inequalities in sport and recreation by optimizing the participation, involvement and ownership of previously disadvantaged communities in the participation, administration, management and support of sport and recreation in the Republic" (Sports Act 198: Preamble). The intention of the White Paper on sports and recreation is to achieve equity and transformation in competitive sport.

The purpose of the Sports Charter is given as "the establishment of a system focused on the principles of human capital development; equitable resource distribution; elimination of all inequalities and increased access to participation opportunities; skill and capability development at all levels and in all areas of activity; greater community involvement through new sport infrastructure development; empowerment; mutual respect; fair and just behaviour, competitive innovation; sustainable, internationally competitive performance; and good governance" (SRSA, 2012:12). The purpose of the Charter is to make opportunities for the general public to participate in PA for recreational purposes, increasing PA in communities through provision of sporting infrastructure where it does not currently exist and removing barriers to accessing existing infrastructure and opportunities.

With transformation as the guiding principle, the Sports Charter identifies six objective areas in which to track change; these areas are used in defining indicators for measuring transformation. Relevant indicators are access, skill and capability development, and demographic profile. Without access to recreational and sporting facilities, as well as streets safe from crime, widespread PA becomes almost impossible. The equitable distribution of sporting facilities, opening access, and ensuring security contribute to changing the demographic profile of those involved in recreational and competitive sport. The Sports Transformation Charter therefore goes beyond examination of professional sports team composition to include PA needs of the general public. A critique of the Charter is, however, the generic language used, which is devoid of specificity as a critical element in preventing and controlling NCDs in the country.

### Risk factors addressed

Although the policies on sport and recreation redressing persistent inequalities resulting from apartheid discrimination and exclusion, they also address PA as a risk factor. The interventions for addressing physical inactivity focus on ensuring people move and are engaged in PA to reduce NCDs aggravated by physical inactivity. PA is key to tackling NCDs and population-based interventions help reduce morbidity and mortality arising from NCDs.

## 7.3 Factors that led to policy development

The sports policy design suggests an intention to deracialise competitive sport, making it more inclusive in terms team composition, sports management, and sporting facilities access. The initial sports policy formulation (1998) involved competitive sport stakeholders. However,



subsequent approaches to sports policy and programme formulation were more inclusive and reached out to stakeholders beyond the competitive sporting fraternity. Stakeholders include the health sector, NGOs, and business. All have varying motives, but the common denominator is the recognition that PA is important not only for competition but for healthy living while also being useful in achieving philanthropic objectives such as fundraising for charities involved in the prevention and treatment of NCDs such as cancer.

## 7.4 Policy process

As indicated at the start of this chapter, PA policies were formulated in 1998; hence the lack of comprehensive data on the actual policymaking process. Available data relates to the process of designing PA programmes, which were mainly the function of the SRSA in conjunction with other government departments, the private sector, and the targeted population groups. The programme design seems less conflictual than the policy design, as programmes mainly seek to implement the strategic objectives of an existing policy. This is particularly the case with the design of programmes for ensuring PA. The main stakeholders are government departments, provinces, local government, international organisations and indigenous communities involved in implementing PA. The role of the private sector was minimal in PA programme design of the SRSA, but the sector was actively involved in implementation. Public PA programmes are also designed by the private sector, but the process is an internal affair of the concerned organisations. Stakeholders of PA private sector programmes are often NGOs that benefit from fun walks and runs.

In terms of designing the Golden Games, the main stakeholders were the departments of Social Development (DOSD) and the SRSA. DOSD conceptualised the programme and SRSA implemented it. As previously indicated, the purpose of the Golden Games is to provide senior citizens with the opportunity to connect with fellow citizens to improve their health and overall quality of life. The DOSD conceived the idea and assisted with the resources and personnel to implement the programme. SRSA used the concept to design the Golden Games programme to align with its annual performance plans. The DOSD oversees PA to ensure it is aligned with the SRSA's mandate of using sport for transformation and social cohesion as well as achieving an active and winning nation. The rationale used by the SRSA in implementing the Golden Games resulted in them being planned as a competition. This was not well received by DOSD, which insisted the purpose of the games was for senior citizens' recreational enjoyment rather than for competition. The DOSD argument was underscored by notions of senior citizens' health and well-being and the recognition that framing these games in 'competition' terms would exclude potential participants and result in participants over-stretching themselves to win medals, which would compromise enjoyment. The displeased DOSD leadership used its partnership to insist the Golden Games revert to being recreational rather than competitive. The Golden Games would be difficult to implement without DOSD support. SRSA agreed with DOSD and implemented the games as a recreational activity. The DRSA rotates the games across the different provinces. SRSA led the indigenous games programme design and drew communities together to discuss the principles and rules of indigenous games commonly played across all ethnic groups in South Africa.

The design process was characterised by intense, detailed discussion about the terms used for common games, with differences emerging about how the games were identified for comparative purposes, specifically, how the common games were adapted to varying contexts; the differences relating to finer details; and nuances rather than general principles. The contribution of indigenous groups, such as the Zulu, Tsonga, Tswana, Ndebele, Xhosa and others, helped in drafting general codes for indigenous games, and these are used in assessing the performance of different provinces or clubs during competition. Different SRSA units were involved in determining the codes for indigenous games. The community sports unit was involved



in mobilising communities to provide inputs during workshops on indigenous games, so there was more consensus than conflict in the programme design. The development was taken further, and now the Tshwane University of Technology is involved in research and development of codes for various indigenous games.

The Move for Health programme, designed by WHO, was provided to DOH, who introduced it to the SRSA for implementation. Discussions regarding the programme were about its implementation rather than content. The programme was adopted and included in the Annual Performance Plans of the SRSA, and in its annual calendar of events. While DOH's intention was to see Move for Health implemented in order to address the challenge of physical inactivity, SRSA viewed the programme as an achieved performance target. Like the DOH, the SRSA is responsible for policy rather than implementation; however, expectations of both departments were not clearly stated. After the initial implementation, DOH partnered with the Western Cape Province. In the absence of collaboration from national DOH, SRSA collaborated with Gauteng province to ensure further implementation of the programme. The inclusion of the province brought in private sector stakeholders, who funded the programme, as well as local government, which provided venues for the event.

*The process of designing the Big Walk event was done in collaboration with The Association for International Sport for All (TAFISA), an international organisation headquartered in Frankfurt, Germany. The organisation, originally formed in the 1960s as the Trim and Fitness International Sport for All, but it changed its name to The Association for International Sport for All in 1991. In 2005, TAFISA became a fully fledged organisation, operating under a president with full-time employees. Since 2009, the name of the organisation changed and has globally promoted the concept of sport for all. "TAFISA is an association of structures that focus on physical activity, so as a national department of Sport and Recreation, we commemorate that every year (ANPPA\_KII\_44)."*

TAFISA promotes walking as a daily PA and every October holds World Walking Day. This is the walk that South Africa has adopted as the Big Walk and which was included in the calendar of the SRSA. To achieve increased PA, TAFISA encourages communities to take back their streets and public spaces to make them safe for walking. TAFISA's Big Walk provided a manual on how to plan and organise the walk. The DRSA used the information, adapted it for South Africa, and included it in the annual calendar of events.

## 7.5 Implementation/actions plans stated

SRSA PA project implementation is aimed at meeting the department's strategic objectives. In doing so, it promotes PA, particularly through Active Nation Programme and School Sport, ultimately resulting in tackling PA-associated NCDs. However, the partnerships that the SRSA forged with the DOH and DOSD resulted in a greater focus on PA with a view to preventing and controlling NCDs among the general public. This is particularly evident in the following:

*"For the past ...three years ... our department was approached by the office of the deputy Minister for Health. She approached her counterpart within the Department of Sport and Recreation she asked him to send officials to an organised event, which they had as the Department of Health ... in Mpumalanga [which was] was multifaceted. It had physical activity because it started the day with a ... 5km walk, and now the activity itself falls under our call as the Department of Sports and Recreation. ... Thereafter there [were] consultation sessions with the organisations that fall under the Department of Health. That was the beginning of the partnership between the two departments because the following year we implemented a programme (ANPPA\_KII\_44)."*

This extract refers to the collaboration between the SRSA and the DOH. The DOH approached the SRSA to partner in implementing the Big Walk, a global initiative. Thereafter, the Big Walk



initiative was taken up by the SRSA and has become an annual event that has attracted more partners.

*"[In] 2014 and 2015, when we anticipated that partnership with [DOH would] continue but realized that they had not approached us ... they approached the Western Cape Province ... because we had already included the programme in our Annual Performance Plan and we included the programme as the Move for Health ... it was a decision taken at WHO, which physical activities can be used to address NCDs. So in our 2014-2015 APP ... we included it as 'Move for Health', which falls under activity recreation, and ... that the anticipated partnership was between Sport and Recreation and DOH. But when we that realised they moved [on] without us, as it was in our APP, we decided to be creative so that [w]as an opportunity for widening our net. Because in reality we are national department which should be focusing on policies (ANPPA\_KII\_44)."*

The collaboration between national departments in the implementation of PA programmes is evident. Although introduced by the DOH as part of meeting international obligations as articulated by the WHO, the Move for Health project was adopted by the SRSA which included it in their APP and implemented it under recreation which is also a mandate of the department. A project that specifically targets the elderly is the Golden Games:

*"We were the drivers of Golden Games. ... Why do I have to emphasise [the] recreational approach? ... They participate in football, athletic running, and there are others which are purely recreational, like passing the ball over your head, and stuff like that. There was an element of competition and we realised that the participants in some provinces do not change. Now the Golden Games, with us, when we were the core drivers, we ... solely focus[ed] on the physical part, but the Department of Social Development took over and ... claimed ownership of the programme, which is true. Just like Move for Health, it emanated from them (ANPPA\_KII\_44)."*

In line with the initial objectives of the DOSD, the purpose of the Golden Games remains to enable senior citizens' participation in PA, and this has multiple benefits. Another project implemented in conjunction with the DOH is Move for Health, a WHO project introduced by the DOH.

*"We included the [Move for Health programme], which one can call ... a policy. From written material it was a decision taken at WHO, which physical activities can be used to address NCDs. So in our 2014-15 APP ... we included it as Move for Health, which falls under activity recreation, and then in that the anticipated partnership was between Sport and Recreation and [DOH] (ANPPA\_KII\_44)."*

The fact that the SRSA now organises the Move for Health programme suggests that the DOH owns and embraces it as part of their programmes and annual activities. The SRSA approach promotes PA for recreation, but the spin-offs include improved health.

In line with the Sports Policy (1998), implementation of sports programmes is done through the DRSA's APPs (ANPPA\_KII\_44). It uses four strategic programmes to implement PA projects: Winning Nation, Active Nation, Sport Support, and Sport Infrastructure (SRSA, 2015). According to the 2015-16 APP, the Active Nation programme set the target of increasing the number of participants in the programme from 9150 in the 2014-15 financial year to 150,000 in 2017-18. The School Sport programme was marked for improvement and SRSA rolled the programme out to 10,000 schools nationwide. Also marked for improvement was the community sport programme, which focuses on promoting PA among marginalised groups such as the elderly, the physically disabled, and in rural communities and townships.

As part of the sports policy, the SRSA implements PA projects such as the National School Sport Championships; the National Sports Awards; the Indigenous Games Festival; National Recreation Day; the Big Walk; the Andrew Mlangeni Golf Day; Andrew Mlangeni Green Jackets; the Trail Blazer Movement and Youth Championships; Boxing is Back; the Basketball National



League; and Sport in the Struggle. The purpose of these sports programmes is to achieve SRSA's strategic objectives. Although not explicitly stated, PA promotion through school sport and the Active Nation programme ultimately helps tackle NCDs arising from the lack of PA. This is particularly the case when PA projects are targeted at the elderly, the physically disabled, and schoolchildren.

Despite the formulation of policy on school sport in 1998, it was only in 2011 that a memorandum of understanding on the rollout for school sport signed between the Department of Sports and Recreation and the National Department of Basic Education. Available data on school sport suggests the programme was in operation, but it is not clear for how long. What is evident is that since 2012 the Department of Sports and Recreation requires schools to register in the school sports league and holds annual school sporting awards. Despite the implementation of school sport, the impact on overweight and obesity is not clear, as current data points to an increase in the population of overweight individuals in the country.

*"We commemorate it every year and we also ensure that provinces ... plan ... [to] commemorate [the] Big Walk. Also it's ... a recreational approach, not a competitive one.... Our approach is that it should be a family event. They register ... and we go out mobilising for people in the streets. And it's an activity/programme that fall under Sports and Recreation (ANPPA\_KII\_44)."*

DRSA activities are not only national events but are also increasingly decentralised to the provinces to ensure greater participation in the different annual PA programmes and projects. The underlying message is that the Big Walk and other PA projects promoted by the SRSA are not for competition but to encourage communities to become more physically active. These events are organised for families so that all members can participate. The walking also takes place in the streets and this ensures that people can join in as it suits them.

Indigenous games, also implemented by the SRSA, promote PA in cultural ways understood by the African majority:

*"Informal research was made so that we were able to come with common rules. You ... realise that anything ... indigenous is across Africa, just like communication. You may tell me something, but when I pass to him, it starts changing ... The core cuts across the whole continent, but the rules keep on changing (ANPPA\_KII\_44)."*

Beyond PA is the drive towards recognising indigenous sports which are commonly played across different ethnic groups using different terms. The common factor among these games is that the underlying principles and rules are the same. The promotion of indigenous sport by the SRSA is part of recognising and reclaiming African and pan-Africanist identity and ensuring its recognition by the global community. It simultaneously increases PA and tackles NCDs in communities.

*"The objective ... is that with time, the indigenous game must be competitive like other sports. So for it to be competitive, ... we must not only form structures but [also be] capacitating them. Now ... we have started with the formalization of structures because sport in our country is run by volunteers. We can't run away from that, but by formalizing the structures, we are saying [that] before you can be the national coordinator, you must belong to a club, and a club must belong to an association. The association must grow to a federation, which is what is prevailing in the competitive sport (ANPPA\_KII\_44)."*

Although designed for recreation, indigenous games are also promoted in South Africa with a view of taking them to international competitions where Africans can compete on their own terms. The promotion of indigenous games is for recreational purposes as well as for competition. Communities and key stakeholders are now required to organise into clubs, associations and federations. An example of an indigenous game across different ethnic groups is *Morabaraba* [in the Tswana language], whose name changes across the different languages.



*“Every year, we have [an] indigenous games festival in September, during the heritage month. So this year [2016] it's going to take place from the 24th of September until the 28th, and it will be held in Limpopo at Seshego Township. So that's whe[n] all the provinces come with their different participants ... and compete ... It's a festival ... family comes together, sharing ... cultural diversity. And on the Thursday ... we have a street carnival, all th[ese] different groups from all different provinces will [showcase] things they do in their provinces (ANPPA\_KII\_44).”*

Indigenous games are promoted on an annual basis to promote PA and culture with a view to understanding the diversity among the people of the country. Indigenous games are held in September, being Culture Month. Implementation takes a week and the set-up ensures families can participate in different ways. Different provinces compete for various groups of medals.

The SRSA recommended a national recreation day to promote PA among citizens. The rationale is that physical activities are currently fragmented, and it would make sense to include such activities under a national day:

*“Then there is National Recreation Day, which belongs to South Africa only, for now. Department of Sports and Recreation South Africa wrote to Cabinet requesting [approval for] ... an annual ... National Recreation Day. Now people would argue about the difference between National Recreation Day and Big Walk, and the answer is that Big Walk is an activity within recreation. The fact that it has its own day recognised for the commemoration, it's just because it was acknowledged by an international organisation, TAFISA (ANPPA\_KII\_44).”*

There is PA implementation classified as recreation, but there is not yet a 'national recreation day' that would cover a variety of PA under the leadership of the SRSA and its partners.

### Youth fitness and wellness charter

The Charter came about as a result of organisations, institutions, government agencies and individuals around South Africa, committing themselves to promote PA as an imperative in addressing inactivity and wellness issues among young people. Acknowledging that youth is the future of the country, the Charter addresses health as a development agenda. It aims to enhance general well-being and improve the quality of life and health of all young South Africans. The charter holds that all South African children and youth have the right to be physically active (University of Cape Town (UCT), *n.d.*). It also calls for opportunities and facilities to participate in PA to be equally accessible and available for all. The promotion of PA should place emphasis on “variety, enjoyment, fair play, positive attitudes and the need to accommodate and accept individual differences and abilities” (UCT *n.d.*- Youth Charter (ND) Article 3 Section 3.3). The Charter also states that:

1. the successful promotion is achieved through partnerships among parents; sporting organisations; provincial, local and national government; non-government and non-profit organisations; higher education institutions; clubs; schools; faith-based organisations; the youth sector; the private sector; and other key role players;
2. formal movement education, PA, sport programmes and play should be assigned a prominent and meaningful place in the school curriculum and should be given sufficient time in the weekly timetable; and
3. qualified professionals and trained volunteers undertaking instruction of formal movement education, PA, and sport programmes for children and youth should be suitably trained and fully understand and appreciate child growth and development, as well as all issues related to all aspects of diversity, including religion, gender and disability (UCT, *n.d.*).

*“The campaign does not aim to introduce new interventions and programmes, but rather serves to educate schools about PA, nutrition and wellness, facilitate those interventions that are*



*already in place, and to provide a support base for improving and enhancing school intervention programmes and those of private service providers” (Lambert and Kolbe-Alexander, 2005: 30).*

The DOH reported some progress regarding PA programmes. Collaboration with schools and the private sector was a key strategy. For example, one major company assisted in developing an employee wellness programme to promote healthy lifestyles at work.

About 1500 primary schools across the country were identified as ‘health-promoting schools’. The media were also enlisted to promote healthy lifestyles with an emphasis on nutrition. Physical education is included in school curricula (Department of Sport and Recreation, 2013). While it is not possible to evaluate the outcomes of policies simply by studying the policies themselves, the details of the department’s APP 2013-14 shows there is slow movement in terms of mass participation programme rollout. The national sport volunteer corps programme was launched in 2012, and it was expected that volunteer deployment would take place in 2014. This is an indication that the mass participation programme is off to a slow start and does not provide much hope of success.

Inter-sectoral contributions are gaining momentum as evidenced by municipalities building recreational parks (Lambert, no date). The scope and breadth is still to be determined through empirical data collection. Other multi-sectoral programmes of note were from the NGO and private sectors and included the Community Health Intervention Programme (CHIP) started by the Sports Science Institute of South Africa in 1997 as a response to the NCD burden. The programmes are ‘Healthnutz’ for children; ‘Optifit Outreach’ for adults; ‘Fit for Work’, a workplace-based exercise intervention; ‘Live It Up’ for older adults; and ‘Wakey’, a group-based health awareness programme. The programmes aim to promote health through regular PA. The private sector’s contribution was demonstrated in the Woolworths Health Promotion Programme ‘Making the Difference through Nutrition’, which teaches learners the importance of PA and fun ways to become physically active. Programme partners include the Department of Education, the Sports Science Institute of South Africa, as well as Woolworths. Using a DVD, children, caregivers, parents and teachers are taught how to make PA an integral part of children’s lives. It also includes practical advice on how to improve children’s PA levels at home and at school. According to Skille (2009), voluntary organisations as social policy implementers, do not necessarily have the same interest as the state, so the state should maintain responsibility of its programmes and not yield them to private institutions implementation.

## 7.6 Application of MSA in the implementation of the sports policy

The design of the National Sports Policy (1998) indicates that its key stakeholders were the Ministry of Sport and Recreation and competitive sports clubs. This is shown by the emphasis placed on the need to deracialise sports teams, management and administration, and the requirement for quotas in national sports teams involved in international tournaments and competitions. While the design points to the sports sector as the main participant in policy formulation, sport implementation, as shown in the Strategic Plan, points to a broader MSA. The sports sector, health sector, NGOs, and businesses were all involved in ensuring PA among a diverse range of groups such as school children, youth and the elderly. Business involvement in convening sports events to raise funds for charity, the promotion of indigenous sports, and the creation of the public sector sports league also points to MSA moving beyond the sports sector for philanthropic purposes.

### 7.6.1 Implementation facilitators

Socio-political factors are critical in the successful implementation of a policy and the implication is that for programmes to be supported actors must possess the necessary influence in the



decision-making and must have power and proper social relationships. There is a clear synergy between the DOH and the SRSA in the National Sports and Recreation Plan. In practice, the two departments partnered to promote PA.

The draft of the Schools Sport Act was presented by both departments. There are no potential contradictions between the two, as the sports policy mutually reinforces both departments. This is possibly assisted by the fact that sport promotion is a low-priority issue within the two departments and has few ramifications except for resources. Therefore a high level of cooperation is expected, although the exclusion of DOH is clear. This aspect is important in deciding the fundamental goal of the two policies: whether health or other considerations are primary focal areas of the policies.

The Strategic Plan on NCDs identified a number of departments as relevant inter-sectoral stakeholders for its successful implementation. Under PA, it cited SRSA and the departments of Human Settlements, Basic Education, Transport and Social Development. No specific PA objectives are outlined for these departments is a lost opportunity. It is important that the DOH takes a leading role in charting the course and in the creation of partnerships with key sectors. This is important for the alignment of programmes that improve PA as well as for ensuring all NCD-targeted projects flow from the DOH-sanctioned programme. As is evident in the Sports and Recreation South Africa Strategic Plan, NCDs received due attention in its content. Therefore with policies and programmes outside the health sector making promises, the DOH will need to address itself mainly to the question of coordination. The attempt to ensure that health is addressed in other sectors is particularly evident in the partnership with SRSA which has also extended its partnership to organisations at the forefront of tackling health challenges affecting the youth, such as Love Life:

*“We approached the provincial Department of Sports and Recreation [in] Gauteng and requested the partnership. It was warmly welcomed. ...[Our] target ... was 400 participants across all board; that is, elderly people, youth, boys and girls. It took place in Hammanskral. ... Within [the] year, the Department of Health ... requested us as a core department for [PA-related] programmes ... to train their community health workers ... so that they are ... empowered to ... assist communities ... We then wrote in one of our agents [Love Life]. We are one of the departments that transfers huge amounts of funds to Love Life” (ANPPA\_KII\_44).*

The government's agenda of 'health-in-all' policies is an excellent approach towards MSA on NCDs., but it might have unintended consequences, such as wide compliance with the requirement to develop health-oriented policy, yet little commitment towards implementation of policy goals. Beyond the departments' arrangements and collaborations, the champions of the Youth Charter seek to contribute by educating schools about PA, nutrition and wellness; facilitating interventions already in place; and providing a support base for improving and enhancing school intervention programmes and those of private service providers. This is an important contribution and an example of multi-sectoralism, particularly as the campaign does not introduce interventions and programmes, but instead supports existing ones. Inter-sectoral action, in which two departments collaborate in implementing a programme, often leads to MSA. The DOH-SRSA collaboration resulted in participation of the private sector, provincial government, and local government, in implementing the Move for Health programme.

MSA is facilitated when departments take ownership of programmes they did not conceptualise. The Move for Health programme was introduced by DOH, and SRSA, after initial implementation, adopted it and incorporated it into its APPs. The programme's ownership meant the SRSA had to find stakeholders in both the private and public sector to annually implement it.

A major facilitator of MSA in PA programmes was the participation of external agencies such as TAFISA and WHO. TAFISA introduced the concept of the Big Walk, emphasising the event could be implemented as part of reclaiming the streets and making them safer for PA. The underlying rationale of the Big Walk on its own was sufficient as it meant that on the day of the



walk interested stakeholders could move into the streets and take part even if they were far from the main event.

Another facilitator of MSA in PA policy implementation relates to the framing of the programmes. A typical example is the indigenous games, which represent an attempt to reclaim culture while simultaneously encouraging PA. The notion of indigeneity alone has encouraged participation in the indigenous games event which not only includes PA but also music and other art forms. Therefore how programmes are framed is critical to facilitating multi-sectoralism.

### 7.6.2 Barriers to the application of the MSA in the implementation of sports policy

When the sports policy was formulated in 1998, South Africa was only four years into its democracy. Until 1994, South Africa was banned from international sport because of its racist apartheid policies, which meant that sport was segregated. Sports such as rugby and cricket were dominated by white players while football had predominantly black athletes. The foremost mission of the post-apartheid sports policy was to desegregate sport and ensure its inclusivity, from team composition to sports management and administration.

The NCD Strategic Plan (2012) identifies PA as critical to the health and well-being of the general population including the elderly. The Strategic Plan for Sports and Recreation (2012) goes into detail about programmes for promoting sport and recreation among the general population. The design of these strategic plans underscores the importance of PA for recreation, health, and well-being. However, the National Sports Policy (1998), with its emphasis on competitive sport and achievement of broad social economic and political objectives, was too narrowly focused on professional sport, therefore excluding the general public, which requires PA to achieve social and health objectives.

*There was collaboration between SRSA and other departments, but it has not always been sustained. This appears to be the result of departments operating in isolation: "In our 2014-15 APP, ... we included it as Move for Health, which falls under physical activity and recreation, ... in that [we] anticipated [the] partnership was between Sport and Recreation and [the Department of Health], but when we realized, they moved without us. As it was in our APP, we decided to be creative [and use] that as an opportunity for widening our net" (ANPPA\_KII\_44).*

While the strategic plans for NCDs and Sports and Recreation point to the involvement of a wide range of stakeholders in sports, health, NGOs and education, important stakeholders such as city planning departments appear to be excluded. The emphasis on achieving PA for different groups has limited the extent to which it can be achieved by the general population. Limiting PA to a few sectors resulted in their active involvement in implementing the programmes in such a restrictive environment. In promoting PA, there is a need to move beyond activities to include identification of PA barriers, and involve the stakeholders who may help in resolving these barriers. Such stakeholders include city planning divisions and the departments of Transport and Environmental Affairs.

## 7.7 Funding and monitoring

Financing for PA in South Africa is largely a function of the SRSA. Although addressing NCDs is not explicitly stated as the key intent of the SRSA, we argue the promotion of school sport and community mass participation in sport results in reaping the benefits of increased PA. Targeted groups, such as the elderly, school children, and people with physical disabilities, might not be involved in PA without state or other forms of intervention. The SRSA directorate of community sport and recreation is responsible for the transfer of the mass participation grant to the provinces. The grant is to encourage mass participation in community sport and also to



promote school sport. In 2010, the directorate of community sport, in partnership with German Technical Cooperation and Deutsche Gesellschaft für Technische Zusammenarbeit, was involved in projects that supported the FIFA World Cup in South Africa. The medium-term expenditure budget (2010-2013) prioritised the promotion of South African recreational activities.

National competitive sport is funded by government and businesses, who use sports tournaments to market products such as insurance and alcohol. PA among young people is funded by government and parents through curriculum inclusion. Medical aid schemes also encourage PA through policy holder discounts, given registered and active participants. Big businesses such as Pick n Pay, through organising PA events such as fun runs, walks, competitive sport, marathons and triathlons, indirectly fund PA policy implementation.

Monitoring PA in South Africa ensures transformation in competitive sport. The sports policies do not contain explicit monitoring and evaluation mechanisms for tracking and ensuring PA among the general population except through essentially voluntary programmes. The private sector, through medical aid schemes, is able to track the level of PA, as members who attend physical activities through gym registration are known to the medical schemes, and members who consume healthy diets are awarded points. An example is Discovery Medical Aid, which awards 'Vitality points' to members who purchase healthy foods.

Monitoring and evaluation of sports policy presents as achieving equity targets in competitive sport. The policy is silent about monitoring PA in the general population. Subsequent policies and programmes suggest that PA is part of the school curriculum and this addresses the PA needs of young people enrolled in schools. However, learners (pupils and students) and the general population outside the learning environment remain unaddressed.

PA policy and programme design suggests that South Africa put in place legislation and regulatory frameworks to promote PA. This study argues that NCD policies and programmes were developed, but that the challenge lies in deploying a MSA in the implementation. A further challenge is that the various programmes and activities competing for similar and limited funding and lack of proper coordination and uniform messaging could jeopardise the success of the PA or the NCD agendas.

Concerns abound regarding programme sustainability. Detailed studies are required to establish the programmes' effectiveness and impact, and whether they possess potential for sustainable replication. This is important because with policies driven by global organisations like WHO, symbolic compliance is possible. As a signatory to the WHO, the government could ratify policies or adopt programmes, but stumble during implementation, with misplaced emphasis on political correctness rather than genuine commitment to dealing with the problem. PA with its 'low politics' status could mean that less attention is paid to it while resources and interest are directed towards issues high on the political agenda. Therefore monitoring and evaluation of PA policies and programmes becomes necessary to guard against the phenomenon of policy not translating into action or tangible results.

Multi-sectoralism is important and the requirements for PA promotion prove that its objectives can be attained with collaboration. PA is important because of its effect on health and development in general. Different departments and sectors have their primary responsibilities, but collaboration with the DOH during strategic planning can influence the inclusion of NCD prevention and other health objectives while remaining within their remit. The Big Walk, Move for Health and the Golden Games are examples of how departments, via inter-sectoral and multi-sectoral collaboration, can contribute to NCD prevention and control.

Another important factor is that sports and recreation policies will not necessarily translate into NCD prevention or control action as envisaged in the NCD strategic plan (2012-2016). The

policies are enablers, but not necessarily drivers, of action. This means more lobbying of the departments of Sport and Recreation and Education is necessary to implement the PA policy provision. In the interim, the SRSA must ensure urgent development of PA programmes as well as mass targeting and participation.



8.0



8.0 | Discussion



Discussion



## 8.1. Introduction

This chapter discusses the issues emerging from the NCD policy analyses with a particular focus on the facilitators and barriers to the application of MSA in the formulation and implementation of NCD control and prevention policies in South Africa.

## 8.2. Gaps in NCD policy development in South Africa

Policies targeted at NCD prevention and control generally employ population-wide measures to ensure reduction. South Africa has developed tobacco control legislation, and put measures in place such as taxation, a ban on smoking in public spaces, written warnings on cigarette packaging and a ban on cigarette advertising. However, there is a glaring silence with regard to smoking in spaces where non-unionised workers, such as domestic workers and gardeners, operate. The failure to protect workers in private homes can be attributed to the limited participation of stakeholders affected by smoking and an overemphasis on public buildings and vehicles.

Where taxes are imposed on products that promote NCD risk factors, it is not clear whether these taxes are used to prevent and control these risk factors.

The focus of the salt reduction policy was largely based on formal establishments involved in food processing. Firms involved must use content information to show how much sodium their products contain in order for consumers to make informed decisions. A gap in the salt reduction legislation relates to omission of the informal sector, such as street vendors, from the requirement to comply with the salt reduction guidelines. This omission overlooks the fact that the informal sector is a key player in processing and distributing salty foods. Emphasis on regulating the food processing industry, not the distributors at the end of the value chain, leaves a gap in the policy. Also, institutions that train workers in hotel management and hospitality need to be targeted for messaging on salt reduction.

Similarly, the Liquor Act (2003) overlooks the fact that most alcohol retail outlets in townships are unlicensed and illegal, therefore controlling consumption and abuse of alcohol is difficult, as liquor in these outlets is available to all ages and operating/trading hours are not regulated.

The omission of health from the PA policies is another issue that can be attributed to the political nature of sports and recreation, as well as the need to deracialise sport and recreational facilities to ensure equity in representation in tournaments and equal access to facilities. The goal of promotion PA and recreation should ideally be to ensure a physically fit nation with reduced NCDs related to the lack of PA.

## 8.3. The Application of MSA in policy formulation

### Significant facilitators of the application of MSA in NCD policy development

The significance of MSA in NCD prevention and control is underscored by the fact that “public health problems are complex, and in many cases, a single health issue may be influenced by interrelated social, environmental, and economic factors that can best be addressed with a holistic, MSA” (USAID, 2014:1). In this study, MSA is applied with reference to actions taken by health, and more than two sectors outside of health, to achieve NCD targets. While the United Nations underscores the importance of MSA in NCD policy design and implementation, the United States Agency for International Development (USAID) poses the challenge of how action by different stakeholders can be co-ordinated to achieve optimal results and outcomes. Multi-sectoral co-ordination that “refers to deliberate collaboration among various stakeholder groups (e.g. health, environment, economy) to jointly achieve a policy outcome” (USAID, 2014:1) is



critical for implementation of NCD control and prevention programmes. Effective implementation requires an office or agency that co-ordinates MSA for NCD prevention.

The main facilitator in ensuring MSA use in NCD policy formulation was public participation in policymaking, which is a constitutional requirement in South Africa. This means that all policies formulated post-apartheid have to demonstrate broad stakeholder participation. The Constitution requires that public policymaking involve a broad spectrum of stakeholders.

Post-apartheid NCD-related policies include the salt reduction policy, sports and recreation policies and programmes, and alcohol and tobacco control policies. Deliberate measures must be in place to ensure MSA is part of NCD policymaking. Such measures include a coordinating committee that convenes important stakeholder consultation workshops and documents the process of policy formation to ensure that inputs to and critiques of the proposed policy are well articulated before submission to Cabinet for approval as well as ensuring that public comments are integrated into draft Bills.

In the case of the salt reduction policy, knowledge that the government will impose stiff penalties for noncompliance ensured industry's participation in the policy formulation process to the extent that industry also recommended the control of salt content in food processed by informal traders.

Unity of purpose ensured that MSA was strong in policy formulation. The policy draft to ban tobacco products meant there was interest in the Bill from diverse groups who were keen to make their submissions in Parliament. In the case of the Tobacco Control Amendment Act (1999), more than 80 groups made submissions to Parliament in support of the legislation, which sought to ban tobacco smoking in public.

Evidence of NCD risk factor impact ensured that various stakeholders supported legislation aimed at the control and prevention. The academic community, represented by universities and the MRC, provided scientific evidence on the dangers of smoking and the public health benefits of controlling tobacco. Organisations involved in the care and treatment of NCDs related to tobacco smoking mobilised at grassroots level to create awareness about the hazards of tobacco and the need for the control, and eventual ban, of public smoking. In the same vein, those who stood to lose under the legislation gathered their own contrary evidence on the value of controlling tobacco.

Champions for NCD prevention and control, such as the Ministers of Health, were a key factor in MSA during policy formulation. Dr Nkosazana Dlamini-Zuma was at the helm of championing the Bill leading to the Tobacco Amendment Act (1999), which banned tobacco advertising and smoking in public. Despite industrial opposition and delaying tactics, Dr Dlamini-Zuma ensured that all the processes of public participation were complied with. Similarly, in the formulation of the salt reduction legislation, the main champion was the Minister for Health, Dr Aaron Motsoaledi, who consistently disseminated information about the legislation and spoke to the media throughout the drafting process, which ensured the public was aware of the legislation's purpose. In terms of the Control of Marketing Alcohol Beverages Bill, the ministers of Social Development and Health were champions of the legislation that is yet to be passed.

### Significant barriers to the application of MSA in NCD policy development

Although the MSA to policy formulation is entrenched in South Africa's policymaking process, there are barriers to applying it in its entirety. The approach is often applied in an inter-sectoral sense, meaning stakeholders who participate in policymaking are generally within the health sector or performing health-related work. Few stakeholders are drawn from outside health. The use of an inter-sectoral approach limits participation in policymaking, therefore inputs into policy, as well as the implementation of NCD prevention policies, are limited.



This was also observed in the salt legislation, where attendance of policy-drafting workshops was mainly from the health sector. The inclusion of industry and health was viewed as sufficiently participatory, although it was not. Lack of understanding remains a key barrier to ensuring a MSA to policy formulation.

Industry opposition emerged as a key theme in the formulation of policies targeting NCD risk factors. The focus on profit by business was an obstacle to MSA application. This was evident in the formulation of the tobacco control, alcohol advertising and salt reduction policies. In the case of tobacco control, policy opposition was sustained until final approval by the President. In terms of alcohol advertising, opposition was so strong that the proposed policy was leaked to the media before it could be approved by Cabinet for public comment. So serious was the opposition from industry that the alcohol advertising control Bill was withdrawn. Business also opposed the salt reduction policy, but opposition faded when the private sector realised it was not strong enough, so the strategy focused on the lack of control in the informal sector.

Contested/insufficient evidence to support policy was also a barrier to enacting NCD legislation. In the case of tobacco control policies, evidence was presented by tobacco industry stakeholders to prevent the policy from being passed. However, local and global evidence was so robust that the industry's claims could not withstand scientific rigour. In the case of alcohol advertising, the available evidence was international; local evidence presented was deemed insufficient. The industry and the DTI had strong evidence in support of their argument about the potential loss of revenue and employment resulting from an alcohol advertising ban. To ensure there was sufficient evidence, the DOSD and DOH sought more time-present evidence, therefore the Bill stalled.

When departments implement policies with a narrow vision, the notion of multi-sectoralism is challenged. A key barrier to MSA in banning alcohol advertising was the lack of a united government voice. While DOSD and DOH understood the impact, the narrow focus of DTI and Treasury meant these departments became obstacles to formulating the Control of Marketing Alcohol Beverages Bill. The divisions gave the alcohol and advertising industries strength to oppose the policy. As a result, the DOSD and DOH sought more time to present further evidence.

Co-coordinating workshop attendance by different stakeholders was also cited as a challenge. Participants reported that agreeing commonly accepted dates among all relevant participants was an issue. That meant organisations invited to policymaking workshops sent whoever was available. This created challenges when interviewing, as study participants who attended initial drafting workshops did not necessarily attend subsequent workshops and could not comment comprehensively on the process. This was the case with all legislation examined in the study.

The lack of funding to attend workshops was cited as a challenge to NGOs' participation in the process. Funding issues included the cost of travel and where the workshops were held in different provinces. The cost of accommodation was also considered to be quite high; participation was therefore limited to stakeholders who could afford the costs.

A critical barrier to the enactment of NCD prevention policies and MSA relates to the power of industry and how it is able to manipulate political power for its own benefits; for example, the close links of the NP with the tobacco industry. Political parties who take industry contributions are open to manipulation during formulation of policies that could affect profits while protecting the general public from harm. Often the stakes are so high that political parties, particularly those in power, sacrifice public interest to political expediency. A case in point is the relationship between the NP and the tobacco industry, which ensured that throughout apartheid, no tobacco control policies were passed. This close relationship ensured that MSA was not possible, as the industry had a free hand to deal with challenges from the grassroots level to the national executive.



## Limitations of the study

This study was designed to analyse NCD policies in South Africa in terms of MSA application during policy formulation and implementation. The limitations of this study are:

1. Study participants did not have sufficient information on a number of levels. Participants knew about existing NCD policies, but few could discuss the policy formulation process in detail due to recall bias. Such participants tended to discuss MSA application during implementation of existing NCD policies. Most participants interviewed were able to discuss their involvement in the salt reduction legislation, which is the most recent NCD policy in South Africa. However, most could not provide details as they were not consistently involved. To understand the contribution of an organisation to the policy-making process, therefore, requires a group discussion comprising all the representatives who attended workshops on policy formulation.
2. Policy implementation did not yield results as implementation of the first phase of salt reduction for various foodstuffs started at the end of June 2016, with the second phase of compliance set to start in June 2018.
3. Participants were able to comment on MSA application in NCD policy implementation since the 1990s. However, the majority had difficulty in commenting about MSA use during policy formulation. An understanding of the extent to which the MSA was applied in NCD policies older than five years can be gleaned from existing literature, but only if the process was documented. If documentation does not exist, this presents a gap in terms of knowledge of the policy formulation process. All targeted participants were interviewed.

## 8.4. Conclusion

This study set out to review policies relating to NCD risk factors and specifically focused on unhealthy diets, tobacco smoking, harmful use of alcohol, and physical inactivity in order to establish the extent to which MSA is applied in the formulation and implementation of NCD prevention and control policies. The study established that broad stakeholder participation is a requirement in policymaking in post-apartheid South Africa and that NCD policies formulated in this period have to comply with the requirement. However, the notion of wide stakeholder participation seems to be conceptualised as being the responsibility of the DOH and stakeholders from the broader health sector and industry. In the literature, such conceptualisation is termed inter-sectoral. In theory, MSA is entrenched in South Africa's policymaking, but practice suggests that inter-sectoral action is more common. There is a need to reconcile the MSA envisioned in South Africa's policy-making process with actual practice.

Although useful, MSA does not provide a structured way of engaging participants and ensuring that their inputs are fed into the policy-making process. Policy makers must devise their own criteria in identifying stakeholders for inclusion to ensure they are indeed multi-sectoral. Deployment of MSA does not guarantee stakeholder participation or inclusion, as participation is not compulsory.

While it might be possible to achieve MSA in policy formulation, its utility in policy implementation remains limited because of the fragmented way in which different sectors operate. For example, while DOH programmes were designed to encourage PA for NCD prevention, SRSA's initial policies use sport to achieve social, political, sporting and economic objectives but are silent on its use to tackle NCDs. Subsequent documents, such as the Sports and Recreation Strategic Plan (2012-2016), refer explicitly to the importance of sport in promoting healthy lifestyles and tackling health conditions such as diabetes, obesity and cardiovascular diseases.

There were clear efforts to involve a range of stakeholders, and this can be construed as attempts to employ MSA. However, MSA application in policy implementation seems to occur by



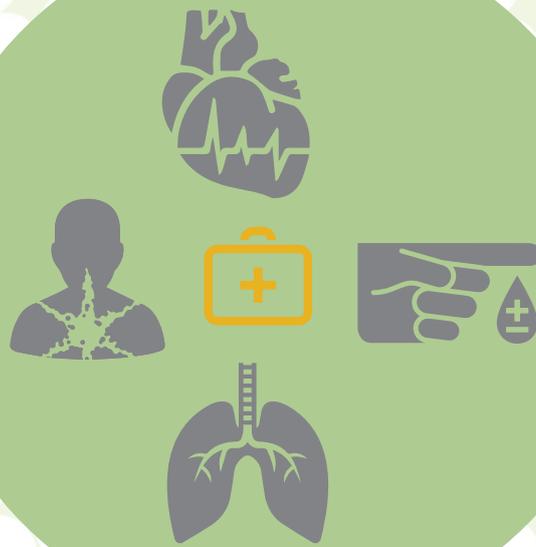
chance. This is particularly the case with the implementation of the tobacco and sports policies. In the case of tobacco, the public responded to the call for the public smoking ban. In terms of sport, a range of stakeholders promoted sport for varied reasons. MSA in the implementation of PA programmes is not by design, but by default. Policies to reduce alcohol abuse also led to MSA in the policy-making process. The application of MSA in the implementation of the salt reduction policy remains subject to debate. What is required is to create awareness regarding the benefits of reduced salt intake so that the public can begin to demand their rights when making purchases of processed foods in retail outlets or restaurants, with monitoring of food processors to ensure compliance. In terms of legislation related to alcohol use, implementation of the policies is by two departments: the DTI and traffic police.

MSA is applied during policy implementation and monitoring is not clear. The salt radium regulations provide clear guidelines in terms of limits that should not be exceeded in certain foods (from 2016; the ultimate reductions are set for monitoring and evaluation by 2019). Although MSA use is ideal in policy formulation, the approach does not guarantee inclusion and participation of all critical stakeholders, as participation is voluntary and without incentives.

9.0



9.0 | Recommendations



Recommendations



The recommendations arising from this study are:

- Effective MSA in relation to NCD policy implementation needs national coordination and oversight structure. Such a body would have a structure similar to the South African National AIDS Council (SANAC), which has oversight of national AIDS prevention and control efforts. SANAC composition is drawn from various sectors of society, with meetings held on a regular basis to track progress in HIV/AIDS prevention and control. A similar structure for NCDs is required.
- Policymakers keen on using MSA must deliberately design lists of stakeholders to ensure they represent diverse sectors.
- Targeted beneficiaries must participate in formulation and implementation of policies, as such groups become ambassadors and create awareness in their communities.
- For the MSA be effectively applied in NCD formulation and implementation, resources – including budgets and human and material resources – must be available to ensure there are no barriers to stakeholder participation.
- While the use of the MSA is important in both policy formulation and implementation, there is always need for a champion for the specific policy during formulation and implementation. In formulating NCD policies, there is a need to have a high-profile individual, such as the Minister of Health, championing the specific issue targeted by policy.
- In addition to policy champions, there must be political resources and structures at national and sub-national level to provide implementation oversight.
- There is a need to improve understanding of MSA and emphasise it over inter-sectoral action in NCD policy formulation and implementation in South Africa.
- There is also need to develop multi-sectoral plans for the implementation of NCD prevention and control policies.
- MSA application in programme design and implementation must be used a performance indicator by the DOH.
- The application of MSA in NCD prevention and control requires risk factors beyond the health sector be addressed and NCD prevention be integrated into various national policies: for example, transport, urban design and planning, environmental and economic policies.
- The use of MSA must extend to the DTI and the National Treasury to increase taxes on the retail price of products known to contribute to NCDs. South Africa already took this route with regard to the proposed tax on sugar-sweetened beverages. The proceeds from the taxes should be used to fund NCD control and prevention.
- Just as the DOH is the custodian of NCD policies and programmes, the SRSA is the custodian of PA policies and programmes critical to the prevention and control of NCDs. SRSA policies and programmes need to embody the notion of promoting PA for the prevention and control of NCDs.
- Application of MSA in NCD policy implementation must take place from the grassroots to the national level if NCD prevention and control is to be successfully achieved.
- Where MSA is applied in both formulating and implementing NCD policies, there is a need to assess its impact in order to identify gaps and rectify identified challenges.



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## Annexures

**Table 1: Recommended best buys**

Risk factor for disease	Best buy interventions
Tobacco use	Raise taxes on tobacco
	Protect people from tobacco smoke
	Warn about the dangers of tobacco
	Enforce bans on tobacco advertising
Harmful use of alcohol	Raise taxes on alcohol
	Restrict access to retailed alcohol
	Enforce bans on alcohol advertising
Unhealthy diet and physical inactivity	Reduce salt intake in food
	Replace trans fats with polyunsaturated fats
	Promote public awareness about diet and physical activity via mass media
Cardiovascular disease (CVD)	Provide counselling and multi-drug therapy, including blood sugar control for diabetes mellitus for people with medium-high risk for developing heart attacks and strokes (including those who have established CVD)
	Treat heart attacks (myocardial infarction) with aspirin
Cancer	Hepatitis B immunisation beginning at birth to prevent liver cancer
	Screening and treatment of pre-cancerous lesions to prevent cervical cancer

Source: WHO, 2011. *Prevention and Control of NCDs: Priorities for investment*

**Table 2: Link between study propositions, data and types of interpretation**

	Type of data	Data analysis
To conduct an in-depth assessment in South Africa about the development and state of implementation of WHO NCD best buy interventions	Policies addressing NCD risk factors: unhealthy diets, tobacco control, alcohol abuse and physical inactivity	Policy analysis Secondary analysis of the state of NCDs: SANHANES data
To generate evidence on how, and the extent to which, MSA is used in policy formulation and implementation of these interventions in South Africa, with an emphasis on population-based measures	Policies addressing NCD risk factors: unhealthy diets, tobacco control, alcohol abuse and physical inactivity	Policy analysis Content analysis of Key informant interviews (KIIs)
To identify the barriers to, and facilitators of, the application of MSA in the development of NCD prevention and control policies in South Africa	Key informant interviews	Policy analysis Content analysis of KIIs

Source: Authors' interpretation of case study research design based on Yin, R. K. 2009



**Table 3: Total number of participants interviewed for the study**

Respondent type	Totals
Government sectors	15
Health (5)	
Education (1)	
Sports and recreation (1)	
Arts and culture (1)	
DTI (1)	
DOSD (1)	
Regulatory bodies (5)	18
Private & /not-for-profit –(NGOs/CSOs/FBOs/CBOs) (16)	
Private/for-profit (6)	6
Research/academic institutions	1
International organisations	0
Bilateral organisations	0
Universities/research organisations	4
Donors	0
<b>Total</b>	<b>44</b>

Source: Summary of organisations interviewed for this study

**\*Table 4: South African NCD policies**

Year	Act
1999	National Guidelines on Primary Prevention and Prophylaxis of Rheumatic Fever (F) and Rheumatic Heart Disease for health professionals at primary level
1999	National guideline on prevention of falls of older persons
1999	Guideline for the promotion of active aging in older adults at primary level
1999	National Cancer control programme – Baseline Document
2000	National Guideline: Cervical Cancer Screening Programme
2000	National guideline on foot health at primary level
2001	National guidelines on Long-Term Domiciliary Oxygen
2001	National Guideline on Osteoporosis
2001	National Guideline: Management of Asthma in Adults at primary level
2002	Information on Female Breast Cancer for Primary Level Health Care Providers
2002	National Guideline on Stroke and Transient Ischaemic Attack Management
2003	National guideline on testing for prostate cancer at Primary hospital level
2003	National Guideline: Palliative care for adults – A guide for health professionals in South Africa



Year	Act
2004	National guideline: Early detection of and management of Arthritis in Adults at primary level
2005	Child and Adolescent Mental Health Policy Guideline
2005	National Guideline: A guide for Health Care Personnel in Paediatric Palliative Care
2005	Guidelines for the management of epilepsy in adults
2006	National Guideline: Non-Communicable Diseases – A Strategic Vision
2006	National Guideline: Updated Management of Hypertension in Adults at Primary Care Level
2007	Mental Health Review Board Orientation Guidelines and Manual
2008	Guidelines for the management of epilepsy and seizures in children at hospital level
2009	Long-term care model implementation framework
2011	Promotion of Physical Activity in Older Persons
2011	Management of Foot Health at Primary Level

Source: DOH (2013). *Strategic Plan for the Prevention and Control of NCDs, 2013-2017*. Pretoria: DOH

**Table 5: Targeted implementation status of best-buy interventions**

Condition	Reduction in percentage (%) by 2020	Programmes/interventions
Reduce the relative premature mortality (under 60 years of age) from NCDs	25%	
Reduce tobacco use	20%	Enforce existing legislation; strengthen compliance with legislation Finalise regulations on smoke-free public spaces; display of tobacco products at point of sale and pictorial messages and warnings on packages Intensify education and support for cessation
Reduce relative per capita consumption of alcohol	20%	Reduce harmful effects of alcohol Collate and change legislation (Bill banning alcohol advertising) Reduce accessibility and availability of alcohol Improve care and treatment including palliative care Health education and promotion
Reduce mean population intake of salt to <5 grams per day		Reduce salt in common foods Implement measures to reduce obesity Implement and monitor regulations on trans-fats Implement population prevention strategies on childhood obesity
Reduce proportion of people who are obese or overweight	10%	Sports and Recreation South Africa (SRSA) in its draft White Paper (2010)
Reduce prevalence of people with raised blood pressure	20%	Vuka (Move for Your Health); Department of Sports and Recreation (SRSA) in its draft White Paper (2010)
Screen all women at least every five years for cervical cancer	All	Screen for cervical cancer in public health facilities
Screen all men over 40 years of age for prostate cancer	All	Primary healthcare re-engineering programme: extended package of services for PHC
Increase the percentage of people controlled for hypertension, diabetes and asthma	30%	Vuka (Move for Your Health); SRSA in its draft White Paper (2010); Part of essential services package provided by DOH
Increase the number of people screened and treated for mental health by 2030	30%	Work-place interventions for stress management

Source: DOH, 2012. *South African NCD Declaration*. Pretoria: DOH



**Table 6: Processes leading up to the sodium legislation**

Date	Action
March 2010 to May 2011	Inception and meetings with industry
July 2012	Draft regulations gazetted
December 2012	All comments to draft regulations reviewed
March 2013	Regulations

Source: Hoffman, K, & Lee, R. (2013). *Intersectoral Case Study: Success Sodium Regulation in South Africa*. Geneva: WHO (pg 8)

**Table 7: Monitoring and evaluation**

Policy	Best buy addressed	Year of development	Reference
Policy guidelines on primary prevention of chronic diseases of lifestyle (CDL) (1999)	Lifestyle diseases	1999	DOH
National Health Act	All diseases including NCDs	2003	DOH
Outcome 2	All NCDs	2010	DOH
National Development Plan	NCDs	2012	The Presidency
Strategic plan for the prevention and control of NCDs in South Africa	All NCDs including hypertension, stroke etc.	2013	DOH
Food and Nutrition Security policy	Food insecurity	2013	Department of Agriculture
Salt reduction regulations	Unhealthy diet and hypertension	2013	41 interviews; Legislation; National Strategic Plan for NCDs, 2012-2016

Source: Authors' summary based on review of policies relevant to NCDs

**Table 8: Maximum limits of sodium content in targeted food products**

Foodstuff category	Baseline 2010	30 June 2016	30 June 2019
Bread	528mg	400mg	380mg
Breakfast cereals and porridge	638mg	500mg	400mg
Butter and spreads such as margarine	867mg	550mg	450mg
Savoury snacks (excluding salt and vinegar flavour)	1000mg	800mg	700mg
Flavoured potato crisps (excluding salt and vinegar flavour)	1067mg	650mg	550mg
Salt and vinegar-flavoured savoury snacks and potato crisps	1730mg	1000mg	850mg
Cured process meat	1596mg	950mg	850mg
Raw processed meat sausages and similar products	1061mg	800mg	600mg

Source: Hoffman, K, & Lee, R. (2013). *Intersectoral Case Study: Success Sodium Regulation in South Africa*. Geneva: WHO



**Table 9: Multi-sectoral involvement in drafting salt regulations**

Sector	Institutions	Total
Health departments	National Department of Health Provincial departments of health: Tshwane, Western Cape District department of health: Ekurhuleni City department of health: City of Tshwane	5
Government departments	Department of Arts and Culture; DTI; Departments of Sports and Recreation South Africa; Department of Basic Education; Public Health Department of Agriculture and Forestry (DAAF); Department of Social Development	6
NGOs	HSF South Africa; National Kidney Foundation South Africa; Diabetes South Africa; South African Depression and Anxiety Group; South African National Council on Alcoholism and Drug Dependence; CANSA; Cancer Buddies; NCD Alliance/PHANGO; Campaign for Cancer; Soul City; Alcoholics Anonymous; National Council Against Smoking	12
Regulatory bodies	South African Council Against Smoking; the Tobacco Institute of South Africa	2
Big business	Nestle; South African of Chamber of Mines; UFF; Agri Asset Management	3
Health insurance	SA Council for Medical Aid Schemes	1
Universities	North West University; UCT; University of Witwatersrand; Tshwane University of Technology	4
Science councils	Medical Research Council	1
Professional associations	DENOSA; South African Medical Association; Traditional Healers Organisation	3
Other organisations	Kedibone Health Systems Consultant	1
<b>Total</b>		<b>35</b>

Source: Summary of organisations sampled for the study

**Table 10: Tobacco control policies in South Africa**

Regulation	Description
Tobacco Products Control Act 83, 1993	Health hazards warnings and contents on advertisement and packaging Restrictions on vending machines Prohibition of sales to people under age 16 Power for local authorities to regulate smoking in public spaces Penalties/fines
Regulations, 1994	Specifications on: health warning labelling requirements on packages
Tobacco Products Control Amendment Act 83, 1999	Prohibition of smoking in public places except in designated areas under prescribed conditions Bans on tobacco advertising and sponsorships Bans on free distribution of tobacco products Maximum content level on cigarettes Penalties/fines
Regulations, 2000	Specifications on: smoking in public places nicotine and tar levels advertisement and sponsorship point of sale



Tobacco Products Control Amendment Act 83, 2007	Amend definitions Bans smoking in selected outdoor areas Product regulation of imported and exported tobacco products Removal of misleading terms like (i.e. light and mild) from advertisement and packages Standards for manufacturing and export of tobacco products Increase in penalties/fines
Tobacco Products Control Amendment Act 83, 2008	Increase in sale from ages 16-18 Bans on one-to-one advertising Bans on tobacco-like toys Bans on tobacco sales at health and educational establishments Tighter bans on free distribution  Tighter standards on: packaging and labelling with pictorial health warnings Point-of-sale and display
Regulations, 2011	Reduced Ignition Propensity (RIP) cigarettes Draft regulation on the display of tobacco products at wholesale and retail points

Source: Summary of organisations sampled for the study

**Table 11: Stakeholders in regulations to ban the advertising of alcohol**

Organisations	Total
DOH	5
DOSD	
National Treasury	
DTI	
<b>Law enforcement</b>	1
Police department	
Universities	1
The Medical Research Council	1
NGOs (Soul City Institute), Association for Responsible Alcohol Use (ARA)	2
Alcohol industry: Brewers and distributors South African Chamber of Commerce & Industry (SACCI)	3
Media (SABC and advertisers)	2
<b>Total</b>	<b>15</b>

Source:

**Table 12: Alcohol-related regulations in South Africa**

Policies	Intended effects
2003 Eastern Cape Liquor Act, No 10	Regulation of liquor distribution in the Eastern Cape Province
National Liquor Act 59 of 2003	Licensing of distribution and manufacturing of liquor Prohibition of sale to people below age 18 Power for provincial authority to regulate the manufacturing and distribution of micro-manufacturers and distributors of liquor in provinces Regulating the manufacturing and distribution of liquor by macro manufactures and distributors



Policies	Intended effects
Liquor Product Act 60 of 1989	Control the quality and safety of all alcoholic beverages.
National Drug Master Plan 2013-2017	Reduction of the bio-/psycho-/social and economic impact of substance abuse and related illnesses on the South African population Reduced availability of dependence-forming substances/drugs, including alcoholic beverages
Prevention of and Treatment for Substance Abuse Act 70 of 2008	Ability of all people in South Africa to deal with problems related to substance abuse within communities Recreational facilities and diversion programmes that prevent vulnerable populations from becoming substance abusers/dependents
2008 National Guideline: Management of Substance Abuse and Misuse among older adults	Management and control of substance abuse among adults
Control of Marketing Alcohol Beverages Bill (2013)	Reduce the exposure of minors to alcohol advertisements Prevent advertisements with misleading information

Source: Summary of various NCD policies by research team

**Table 13: Monitoring and evaluation**

Year	Policy	Risk factor addressed
1998	National Programme for control and management of hypertension at primary level	Hypertension
1998	National Programme for control and management of diabetes type 2 at primary level	Diet
1999	Policy guidelines on primary prevention of CDL	NCDs
1999	Policy guidelines on primary prevention of CDL (1999)	Lifestyle diseases
2004	National Health Act	All diseases, including NCDs
2003	National guideline: Prevention and management of overweight and obesity in South Africa	All NCDs
2005	National guidelines: Management of diabetes Type 1 and Type 2 in adults at hospital level	Unhealthy diet
2009	Diabetes declaration implementation strategy	Diabetes in the general population
2008	Guidelines for the management of Type 1 diabetes in children	Diabetes in children
2010	Outcome 2	All NCDs
2011	Regulations relating to transfats in foodstuffs	Unhealthy diets
2012	National Development Plan	NCDs
2013	Strategic plan for the prevention and Control of NCDs in South Africa	All NCDs including hypertension, stroke
2013	Food and Nutrition Security policy	Food insecurity
2013	Salt reduction regulations	Unhealthy diet and hypertension

Source: Authors' summary of diet-related policies from various DOH documents



**Table 14: Physical activity policy development timelines**

Regulation	Objective	Responsible Department
Schools Act No 84, 1996	Inclusion of sport as part of the specialised activities provided in public schools	Department of Education
The National Sports and Recreation Act, 1998	Addressing equity, representativity and redress in international sporting activities Promoting good governance in sport and recreation organisations Addressing inequality in South African sport Dealing with inequity and representativeness in sports administration	Department of Sports and Recreation
Promotion of Physical Activity in Older Persons, 2011	Promotion of physical activities in older persons for physical, mental and social well-being Promotion of physical activity programmes for older persons Delineating the roles of healthcare workers Ensuring the safety concerns of older persons during physical activities	Department of Sports and Recreation; Department of Social Development
The National Strategic Plan for NCDs, 2012-2016	Focus on ensuring that citizens access sport and recreation activities Access to sport and recreation in every public school Integration of the 16 sporting codes and indigenous games into physical education Community mass participation in sport with specific reference to previously disadvantaged communities to improve health and wellbeing	DOH

Source: Authors' summary of physical activity policies



