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# Reducing the Role of the Food, Tobacco, and Alcohol Industries in Noncommunicable Disease Risk in South Africa

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## Abstract

Noncommunicable diseases (NCDs) impose a growing burden on the health, economy, and development of South Africa. According to the World Health Organization, four risk factors, tobacco use, alcohol consumption, unhealthy diets, and physical inactivity, account for a significant proportion of major NCDs. We analyze the role of tobacco, alcohol, and food corporations in promoting NCD risk and unhealthy lifestyles in South Africa and in exacerbating inequities in NCD distribution among populations. Through their business practices such as product design, marketing, retail distribution, and pricing and their business practices such as lobbying, public relations, philanthropy, and sponsored research, national and transnational corporations in South Africa shape the social and physical environments that structure opportunities for NCD risk behavior. Since the election of a democratic government in 1994, the South African government and civil society groups have used regulation, public education, health services, and community mobilization to modify corporate practices that increase NCD risk. By expanding the practice of health education to include activities that seek to modify the practices of corporations as well as individuals, South Africa can reduce the growing burden of NCDs.

## Keywords

alcohol and substance abuse, diet, health policy, social determinants, tobacco control and policy

South Africa, an upper-middle–income country, is characterized by stark inequalities in health and wealth patterned along racial, geographic (urban/rural), and socioeconomic lines (Seekings & Nattrass, 2008). After the apartheid history, in which the Black majority lived in poverty, undernutrition affecting mainly young children has persisted with high stunting rates and various micronutrient deficiencies (Muzigaba, Puoane, & Sanders, in press).

At the same time, overweight and obesity have emerged as major nutritional problems, contributing, with alcohol and tobacco use, to the rapid development of noncommunicable diseases (NCDs). While NCDs previously primarily affected the more affluent and mainly White population, these conditions now affect other population groups as well. In the coming decades, NCDs have the potential to further exacerbate wide inequalities in longevity and quality of life (Puoane et al., 2013).

In South Africa (SA), NCDs account for an estimated 37% of mortality and 16% of disability-adjusted life years (Norman et al., 2007), and 40% of NCD mortality among men and 29% among women occur before 60 years of age (World Health Organization South Africa Country Office, 2014). NCDs are also part of a quadruple burden of disease that includes infectious, maternal, and perinatal conditions; injuries including violence; and HIV/AIDS; the prevalence of which varies significantly among population groups (Bradshaw et al., 2003). For example, the prevalence of modifiable NCD risk factors is higher among urban dwellers compared with rural Black African youth (Peer, Bradshaw, Laubscher, Steyn, & Steyn, 2013), whereas older, economically disadvantaged persons are least able to manage NCDs (Phaswana-Mafuya et al., 2013). Unequal development, including poverty and health illiteracy, are strongly associated with increased NCD morbidity and mortality (United Nations General Assembly, 2011); and NCDs hence impose

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a growing cost on both the public and private health care system in South Africa (Sturm, An, Maroba, & Patel, 2013).

To improve population health and reduce health inequalities will hence require making NCD prevention a priority in SA. Four common risk factors for NCDs provide an opportunity for focused intervention: tobacco use, harmful use of alcohol, unhealthy diet and salt intake, obesity and lack of physical activity together account for a significant proportion of the NCD burden (World Health Organization, 2011a).

Despite the continuing high levels of underweight and nutritional deficiencies, overweight and obesity among adults and children are rapidly growing public health issues in SA (Armstrong, Lambert, & Lambert, 2011; S. Reddy et al., 2010). High rates of impaired glucose tolerance and obesity suggest further increases in diabetes in urban populations (Peer et al., 2012). Smoking rates are among the highest on the continent and although the prevalence of adult smoking has steadily decreased between 1995 and 2004, smoking rates remain alarmingly high among some population groups, with a prevalence of 28% among men, contributing (with high salt diets) to the near doubling of hypertension rates between 1998 and 2008 among men 35 to 44 years of age (Bradshaw, Steyn, Levitt, & Nojilana, 2011).

Alcohol is another leading contributor to the burden of disease, accounting for an estimated 7.1% of deaths and 7% of total disability-adjusted life years lost in 2000 (Schneider, Norman, Parry, Bradshaw, & Pluddemann, 2007). The estimated prevalence rates of alcohol use disorders (5.6%) and alcohol dependence (2.4%) are much higher than the regional averages of 3.3% and 1.4%, and the estimated costs of harmful alcohol use to the economy reached 10% to 12% of the 2009 gross domestic product (Matzopoulos, Truen, Bowman, & Corrigall, 2014). Surveys have shown the widespread misuse of alcohol and its associated negative consequences, with significant variation among population groups (Parry et al., 2002; Parry et al., 2005). There is also a strong link between alcohol and NCDs, including cancer, cardiovascular disease, and various forms of liver disease (Parry, Patra, & Rehm, 2011). Physical inactivity rates, not considered here, are also high and further contribute to NCD incidence (Peer et al., 2013, Phaswana-Mufuya et al., 2013).

In SA, political commitment to combat NCDs is illustrated by the adoption of the Declaration on the Prevention and Control of NCDs in September 2011 (South African Summit on the Prevention and Control of Non-Communicable Diseases, 2011).Targets include reductions of tobacco, alcohol, and salt use and increases in prevalence of physical activity and control of diabetes, hypertension, and asthma. A 2013-2017 Strategic Plan calls for an integrated strategy and intersectoral approach to tackle the burden of NCDs to be implemented by governments, civil society, and other stakeholders (Department of Health, 2012).

Despite increased attention to NCDs, however, the focus of policy and spending has continued to be on interventions aimed at changing individual risk behavior. In SA, as elsewhere, biological, cultural, clinical, and psychological factors clearly play a role in NCD risk behavior and require interventions that reduce such risks. Growing evidence, however, shows that corporate practices also influence NCD risk and burden (Freudenberg, 2014; Igumbor et al., 2012; Moodie et al., 2013; Puoane et al., 2013) and that policy and environmental changes can make healthy choices easier options (Marteau, Hollands, & Fletcher, 2012), suggesting that expanding NCD prevention to include changing corporate as well as individual behavior warrants further exploration.

In the 21st century, transnational corporations have become the world's dominant social and economic power, supplanting governments, religion, families, and communities in their influence on behavior, beliefs, health, and environments (Best, Kahn, Nocella, & Mclaren, 2011). Any comprehensive strategy for the prevention of NCDs requires a more thorough investigation of the role of global corporations (Baum & Anaf, 2015).

In this analysis, we examine how the food, alcohol, and tobacco industries shape NCD risk in SA. Our goal is to identify opportunities for public health policies that recognize that changing social and physical environments to make healthy choices easy choices is often more effective than an exclusive focus on individual behavior (Frieden, 2010), and specifically to highlight the potential for changing corporate practices to reduce the burden of NCDs in SA. We focus our review on the food, alcohol, and tobacco industries because of the strong epidemiological evidence documenting their role in multiple NCDs, the importance of these sectors to the economy of SA and the world, and the wide population exposure to the products of these industries (Freudenberg, 2014; Moodie et al., 2013).

Using what has been called a "scoping review" (designed to "identify the nature and extent of research evidence") on a broad topic of interest (Grant & Booth, 2009), we searched peer-reviewed publications, government documents, civil society reports, mass media, and other sources for evidence on the practices of the tobacco, food and beverage, and alcohol industries related to NCD risk in SA, and on the response of public, nonprofit, and commercial institutions to these practices from 1994, the advent of the first democratic government, through 2014. To identify peer-reviewed articles, PubMed was searched using a string of keywords and MeSH terms (including "tobacco," "food," "beverages," "alcohol," "legislation," "policy," "corporate practices," "trade" and "regulations" in combination with "South Africa") and bibliographies of key articles examined for other relevant studies. Google Scholar and Google were also searched to identify sources in the grey literature, with a focus on South Africa in particular. We included only those sources with empirical evidence or analysis of the practices of the food, tobacco, or alcohol companies or the public, private, and civil society responses to those practices within South Africa. Relevant sources were retrieved, and findings were extracted according to themes we had developed (i.e., business and political

practices by industry and strategy and responses by industry and strategy). Although efforts were made to search as widely and systematically as possible, the analysis provides only a broad overview of key findings in the literature. The wide scope of the review and the heterogeneity of types of studies and outcomes assessed precluded meta-analyses or other formal analytic procedures used in other types of reviews.

## Business Practices and NCD Risk

Through the production, promotion, and sale of tobacco, alcohol, and ultraprocessed food and drinks, transnational corporations are main drivers of the global epidemics of NCDs (Moodie et al., 2013). NCDs can hence be considered corporate epidemics that emerge from the commercialization of health-damaging products (Jahiel & Babor, 2007), and corporations and their practices can be recognized as a structural determinant of health and health behavior (Wiist, 2006). By producing and promoting unhealthy products, creating psychological desires and fears, disseminating health misinformation, influencing social and physical environments, and advancing policies that favor their business goals, corporate practices have become a dominant influence on health-related lifestyles (Freudenberg, 2012). Advocating policies that modify business practices that promote unhealthy lifestyles and behaviors is hence a promising strategy for improving population health (Freudenberg, 2005).

As public health campaigns and legislation reduce the prevalence of NCD risks such as tobacco use and soda consumption in high-income countries, transnational corporations have targeted middle-income nations such as Brazil, Russia, India, China, SA, and others as markets for restoring lost profits and market shares (AT Kearney Global Consumer Institute, 2012). As one observer noted, there are now almost two billion middle-class consumers in these emerging markets, spending a total of $6.9 trillion annually, a figure expected to rise to $20 trillion during the next decade—about twice the current consumption in the United States (Court & Narasimhan, 2010). In part as a result, these are the nations where NCDs are expected to rise most precipitously in the coming decades (Abegunde, Mathers, Adam, Ortegon, & Strong, 2007).

In SA and elsewhere, several socioeconomic and political trends have contributed to the role that transnational corporations have played in promoting NCD risk. Trade and investment liberalization have reduced trade barriers and increased importation of cheap and highly processed foods, which have increasingly been "exported" to developing settings (Schram, Labonte, & Sanders, 2013). Higher profit margins on these foods have promoted the creation of "obesogenic" environments while investment liberalization has increased corporate consolidation over global and domestic food chains (Schram et al., 2013). Urbanization has concentrated markets, making it easier for transnational corporations to develop innovative, efficient, and globalized marketing campaigns for processed food, alcohol, and tobacco (Hafez & Ling, 2005; Jernigan, 2009). Dense urban markets render unhealthy products ubiquitous. In SA and elsewhere, neoliberalism, an ideology that favors deregulation, privatization, and the supremacy of markets, has strengthened the power of corporations and weakened the role of government in public health regulation (Bond, 2014; Navarro, 2007).

## Review of Business and Political Practices, 1994 to Present

In SA, corporate practices contribute to unhealthy lifestyles and patterns by facilitating NCD risk behaviors. Business practices, activities designed to increase profits and market share, that shape the environments in which behavioral decisions are made include international trade, product design, marketing, retail, and pricing (summarized in Table 1). Political practices, activities that seek to create environments in which corporations can pursue business goals without interference, include lobbying, campaign contributions, public relations, philanthropy, and sponsored research (summarized in Table 2).

### *Tobacco*

The tobacco industry has aggressively marketed its products, including appeals to young people and women, populations with lower smoking rates than men. Despite a code of advertising practice, which has forbidden advertising to minors since the 1970s, the industry continued to use strong visual imagery, lifestyle ads, or celebrities in advertisements for tobacco-sponsored events (Saloojee & Hammond, 2002). A decade ago, the tobacco industry exploited regulatory loopholes to use radio to advertise cigarettes to young people (Malan & Leaver, 2003); now it uses new media and incentives and designs new products, as shown in Table 1. A recent study of exposure of youth aged 13 to 15 years to various forms of tobacco advertising in 20 nations found high rates of exposure for all forms in SA (Agaku, Adisa, Akinyamoju, & Agboola, 2013).

One analyst noted that the tobacco industry in SA has been "ferocious in its opposition to any tobacco control measures, including excise tax increases" (van Walbeek, 2006), seeking to block or water down any proposed legislation. The industry has also used its power to discourage unfavorable media coverage (Saloojee & Dagli, 2000). For example, R&R Tobacco, SA's largest cigarette manufacturer, withdrew its advertising from a newspaper that supported tobacco advertising regulation.

### *Alcohol*

In 1994, more than 70% of the retail alcohol outlets were unlicensed "shebeens," making alcohol easily available in Black townships and regulation difficult (Parry, 2010). However, compared with high-income nations, SA has low rates of drinking, making advertising and increased production capacity important strategies for growing market share.

**Table 1.** Business Practices That Influence Noncommunicable Disease Risk in South Africa by Sector.

| Sector | Trade | Product design | Marketing | Retail | Pricing |
|---|---|---|---|---|---|
| Tobacco | Use international treaties to force entry into closed markets (Savell, Gilmore, & Fooks, 2014; Simpson, 2004)<br>Role in illicit trade (Bonner, 1997; LeGresley et al., 2008) | Introduction of "low-tar," "light" and "mild" tobacco products; flavoring (e.g., menthol cigarettes)<br>Promote snus (oral; Saloojee, 2008) and smokeless tobacco (Ayo-Yusuf, Swart, & Pickworth, 2004; Carpenter, Connolly, Ayo-Yusuf, & Wayne, 2009)<br>Introduction of e-cigarettes | Use "buzz" or "viral" marketing targeting youth (Freeman & Chapman, 2010); brand extension (e.g., Marlboro Classics clothing; Slade & White, 1996); stealth advertising (e.g., use of "brand amplifiers" (Rimmer, 2005), social media (Doward & Campbell, 2010; Freeman & Chapman, 2010), music events (Patel, Okechukwu, Collin, & Hughes, 2009; Stanton, Chu, Collin, & Glantz, 2011); sampling and value incentives (Gedye, 2006); product placement (e.g., use in soap operas, movies) | Diversification of tobacco distribution (e.g., through kiosks and street vendors; Euromonitor International, 2015)<br>Sale of single cigarettes (Savell & Gilmore, in press) | Introduction of cheaper variants in response to increased pricing (Euromonitor International, 2015) |
| Food and beverages | Trade/economic liberalization in SADC countries (e.g., 1996 SADC trade agreement; 1997-2003: SA signs 22 bilateral investment agreements; 2008 SADC Free Trade Area; Thow et al., 2015) | Packaging designed to appeal to health-conscious consumers (Igumbor et al., 2012) | Product placement/social and traditional media (e.g., TV (Igumbor et al., 2012; McHiza, Temple, Steyn, Abrahams, & Clayford, 2013); food and beverage marketing to children (Cassim, 2010) | Expansion of formal food retail sector (Emongor & Kirsten, 2009)<br>Expansion in the informal retail sector (Igumbor et al., 2012)<br>Rapid growth of supermarkets (Igumbor et al., 2012) | Lower prices of processed food products in supermarket chains due to improved supply chains (Emongor & Kirsten, 2009) |
| Alcohol | Trade agreements facilitate import and export of alcohol products (e.g., EU Free Trade Agreement) | Introduction of ready to drink fruit wine and spirit coolers (U.S. Department of Agriculture, 2014) | Sport sponsorship (e.g., SA cricket; Springbok Rugby team)<br>Increased advertising of wine and spirit fruit drinks | Large distribution of retail outlets outside the regulated market (including unlicensed "shebeens") | |

In 2007, Diageo and Heineken, two alcohol multinational corporations, opened a U.S. $473 million brewery near Johannesburg. These companies rely heavily on advertising not only to wrest customers away from other brands but also to win new recruits from nondrinkers, including young people and women (Jernigan, 2013).

While beer is the preferred drink in SA, accounting for 80% of alcohol consumption, in recent years, major alcohol producers have introduced and marketed wine and spirit-based fruit coolers to young people and women. Between 2010 and 20013, consumption of these products increased by 20% (Esterhuizen, 2014).

The alcohol industry seeks to influence SA government policies by, for example, sponsoring trips for parliamentarians, cofunding educational workshops, and partnering with the Department of Trade and Industry to sponsor an underage drinking initiative (London, Matzopoulos, Corrigall, Myers, Maker, & Parry, 2012). Increasing concentration of the alcohol industry, a global phenomenon also occurring in SA, especially in the spirits and beer sectors, gives the largest transnational alcohol corporations a more powerful voice in influencing policy (Jernigan, 2009).

## *Food and Beverages*

In recent years, the SA food and beverage industry has become increasingly concentrated and tied to global food companies. Its priorities have been to make the highly processed food it produces, distributes, and sells more available, affordable, and acceptable (Igumbor et al., 2012). Between 1995 and 2010, trade and investment in processed snack foods and soft drinks have increased substantially in the nations of the Southern African Development Community (SADC; Thow et al., 2015). SA acts as a regional trade hub, importing food and exporting

**Table 2.** Political Practices That Influence Noncommunicable Disease Risk in South Africa by Sector.

| Sector | Lobbying | Public relations | Philanthropy | Sponsored research |
|---|---|---|---|---|
| Tobacco | Influence political processes related to concerns about illicit trade markets, job creation, and tax revenues (Malan & Leaver, 2003; Van Walbeek, 2004)<br>Use preemptive legislation and legislative countermeasures (e.g., opposition to the Tobacco Products Control Act)<br>Adopting voluntary codes of practice to create appearance of responsibility (Saloojee & Hammond, 2002) | Restoration of social acceptability of smoking (engineering consent; Saloojee & Dagli, 2000)<br>Adopting a pseudolibertarian position concerning freedom of speech and choice (as opposed to the nanny state principle)<br>Corporate social responsibility (Burton, 2001) | Corporate philanthropy (buy social respectability from arts, sports, and cultural groups; Fooks & Gilmore, 2013) | Reversal of scientific facts about impact of second-hand smoke (create controversy; Malan & Leaver, 2003)<br>Establishment of the Tobacco Institute to compete with antitobacco groups and public health professionals; Sport Science Institute funded by Rembrandt (Saloojee, 1996) |
| Food and beverages | Voluntary regulations relating to marketing and advertising to children (e.g., ASA Food & Beverage Code to Protect Children 2008, South African Pledge on Marketing to Children; Cassim, 2010; Hawkes & Lobstein, 2011) | Active corporate social responsibility programs (Igumbor et al., 2012); e.g., Coca-Cola one of the most "socially responsible brands in SA" (Rudd, 2011); Woolworths Healthy Tuck Shop Guide | Sponsoring local sports teams and tournaments; e.g., McDonald's (BBC News Health, 2010) | |
| Alcohol | Voluntary marketing codes and self-regulation (1989; e.g., 2000 ASA Code of Practice; Grant & O'Connor, 2005)<br>Lobby against proposals to reduce the availability of alcohol, increase its pricing, and place restrictions on advertising (Matzopoulos et al., 2012; Parry, 2014; Parry, London, & Myers, 2014)<br>Establishment of the Freedom of Commercial Speech Trust (1997) | Relationship with government and public health agencies, e.g., SA Miller (Matzopoulos et al., 2012); relationship with civil society (e.g., Brandhouse/Lovelife) | Corporate citizenship, incl. campaigns targeting underage and drunk driving (e.g., Brandhouse's Drive Dry campaign); education and community-based projects (e.g., ARA's social investment programs) | Establishment of the Industry Association for Responsible Alcohol Use (ARA; 1989; e.g., research undertaken by the Institute for Health Training & Development; support of the Foundation for Alcohol Related Research [FARR]; e.g., research on Fetal Alcohol Syndrome; Grant & O'Connor, 2005) |

capital to invest in food processing, food retail, and "fast food" outlets in the region. Studies have documented increased consumption of processed snack foods and sugary beverages in all SADC countries since the mid-1990s, along with decreased consumption of healthier traditional foods (Abrahams, McHiza, & Steyn, 2011; Hamada et al., 2010). In addition, food retail sectors have expanded regionally, increasing accessibility and affordability of processed foods and beverages (Emongor & Kirsten, 2009; Igumbor et al., 2012). Although a voluntary Pledge on Marketing to Children has been signed by the Consumer Goods Council of SA in 2009, the pledge contains many exclusions related to packaging and labeling, and so far none of the 24 signatories have made any commitments (Hawkes & Harris, 2011).

These changes in SA food industry's business practices have contributed to a steady increase in per capita food supply of fat, protein, and total calories, and salt intake in excess of WHO recommended levels. These changes appear to be associated with unhealthful changes in dietary patterns and increases in sales of most categories of packaged foods (Igumbor et al., 2012). In addition, lower per calorie prices for nutritionally inferior diets encourage low-income populations to consume less healthy food (Temple & Steyn, 2009). To illustrate these changes, in 2010, South Africans consumed 254 Coca-Cola products per person per year, an increase from 130 in 1992 and almost 3 times the 2010 global average of 89 Coca-Cola products per person per year (Igumbor et al., 2012).

**Table 3.** Major Responses to Corporate Practices That Influence Noncommunicable Disease Risk by Sector.

| Sector | Regulation | Public education | Health care | Community mobilization |
|---|---|---|---|---|
| Tobacco | Tobacco Products Control Act 1993 (requirements for health warnings and statement of tar and nicotine contents; phased annual increases in excise tax); 1999 Amendment (complete ban on tobacco advertising & sponsorship; limits on tar and nicotine contents; restrictions on sales to minors and of smoking in all public and workplaces); 2003 Amendment (pictorial health warnings; further restrictions on sales to minors; ban descriptors like "mild," "light" and "low tar"; ban the sale of duty-free tobacco products and smoking in some outdoor public places); 2007/8 Amendment Acts (regulations for tighter tobacco control policies; Langa, 2009)<br>2005 Signing of WHO Framework Convention on Tobacco Control<br>Plain cigarette packaging (2015; Roelf, 2014) | Introduction of antismoking campaigns (1990; counteradvertising)<br>Comprehensive health education (e.g., part of Life Skills curriculum) | Treatment of tobacco dependence (e.g., helplines, counseling); access to medication (i.e., smoking cessation aids; World Health Organization, 2013) | Antitobacco lobby (i.e., Tobacco Action Group, especially the National Council Against Smoking) which works actively with the SA DOH (Malan & Leaver, 2003) |
| Food and beverages | Foodstuffs, Cosmetics and Disinfectants (FCD) Act 54 (1972) amendments:<br>• Regulations relating to the labelling and advertising of foodstuffs (2007; FCD, 2010a)<br>• Regulations relating to the reduction of sodium (2013; (Bertram, Steyn, Wentzel-Viljoen, Tollman, & Hofman, 2012; FCD, 2013) and trans-fat in certain foodstuffs (2010; FCD, 2010b)<br>• Proposed regulations restricting food advertising to children (2007) | 2001 South African Food-Based Dietary Guidelines (Vorster, 2001)<br>2013 Revised South African Food-Based Dietary Guidelines (Vorster, 2013)<br>South African Food Guide | Community-based prevention, treatment and care (Department of Health, 2012)<br>Health-promoting settings (e.g., health-promoting schools and hospitals; Delobelle, Onya, Langa, Mashamba, & Depoorter, 2012; Swart & Reddy, 1999) | Public programs (e.g., National School Nutrition Programme, Salt Watch education and awareness campaign); NGO programs (e.g., Healthkick, Healthy Tuck Shop Guide; Draper et al., 2010; Marraccini, Meltzer, Bourne, & Draper, 2012)<br>Establishment of a health promotion and development foundation (Perez et al., 2013) |
| Alcohol | Restrictions on alcohol advertising (e.g., 1997 mandatory warning labels about the health effects of alcohol; 2007 regulations relating to health messages on containers of alcoholic beverages; Parry, 2010)<br>Liquor Act 59 (2003; regulates large-scale manufacture and distribution of liquor and prohibitions on the sale of liquor to persons younger than 18 years; Parry, 2010)<br>Draft Control of Marketing of Alcoholic Beverages Bill (2012; Parry, 2010)<br>Discussion document relating to increased alcohol taxation (Republic of South Africa, 2014) | Campaigns against drinking and driving; counteradvertising | Treatment of alcohol-related problems (incl. brief interventions; specialist treatment services; rehabilitation) | Establishment of the Southern Africa Alcohol Policy Alliance (address the challenge of harmonizing and accelerating alcohol policy development in the region; 2012) |

## Responses to Corporate Influences on NCD Risk

In response to practices of the tobacco, alcohol, and food corporations that contribute to NCD risk, government, civil society, and private-sector organizations have taken action to reduce these risks as shown in Table 3. Analyzing these responses can help identify opportunities for promoting organizational responses that reduce risk and challenging those that are ineffective or promote risk.

### *Tobacco*

The government elected in 1994 enacted strong tobacco control policies that allowed SA to rapidly catch up with and overtake tobacco control policies implemented in many other developed countries (Van Walbeek, 2004). As a result, tobacco consumption decreased dramatically in the ensuing decade, while increasing government revenue. The tobacco industry opposed this increase in excise duty on cigarettes alleging unfair discrimination against a legitimate industry and warning of an increase in illicit trade. Similarly, the tobacco industry tried to stall a 1998 tobacco control bill and opposed banning of tobacco advertising and sponsorships on the grounds that advertising was aimed primarily at increasing and maintaining a brand's market share and that empirical evidence on the effect of advertising on consumption was lacking. These and other arguments were refuted by proponents of the legislation and the Bill was eventually approved and signed into law in 1999 (Van Walbeek, 2004). Subsequent

analyses found that increased taxes led to reduced consumption (Groenewald et al., 2007; van Walbeeck, 2002). More recently, efforts have focused on accelerating reductions in youth smoking, which declined among learners in Grades 8 to 10 from 23% in 1999 to 16.9% in 2009 (P. Reddy et al., 2013). To achieve this goal, the government proposed restrictions on the display of tobacco products in shops, a proposal the industry opposed (Saloojee, 2013).

### *Alcohol*

In 1997, officials in the National Department of Trade and Industry proposed a comprehensive policy to restructure the liquor trade. Their proposal, ultimately defeated, sought to bring more Black entrants into the industry at all levels, while also trying to reduce the social costs of alcohol and address the problem of unlicensed outlets. In 2001, provincial governments were given the option to assume responsibility for alcohol regulation but only three of the nine provinces took this option. As a result, different policies are in place in the provinces, and overall policy has not addressed comprehensively the problem that the majority of liquor outlets are unlicensed and operate outside the law (Parry, 2010; Parry et al., 2014). More recently, the national government proposed a ban on alcohol advertising, but the industry continues to oppose this measure (Parry, Burnhams, & London, 2012; Parry, London, & Meyers, 2014).

The alcohol industry in SA has also taken action to address alcohol risks. In 1989, the Industry Association for Responsible Alcohol Use set up a self-regulatory code that regulates advertising, packaging, and promotional activity. The code has been amended three times and adopted by the Advertising Standards Authority of South Africa as its own, thereby making the Association for Responsible Alcohol Use code applicable to nonmembers as well (Grant & O'Connor, 2005). In 2000 and again in 2003, a more stringent code of practice was developed and applied specifically to practices in the licensed trade, including the need to avoid sales to minors and to discourage excessive or irresponsible consumption.

New international evidence that shows that taxation and policies regulating the environment are effective in reducing alcohol-related consumption and harm (Anderson, Chisholm, & Fuhr, 2009; Ataguba, 2012) contributed to SA's policy maker reviews of alcohol taxation and marketing. The Minister of Health has drafted legislation that would ban all advertising and sponsorships, realizing that combating alcohol-related harm requires a range of measures rather than a single "silver bullet" (World Health Organization, 2014).

### *Food and Beverages*

The rapidly changing food environment throughout the region suggests the need for regional policy action to stem the flood of high-calorie and nutrient-poor processed products, and thus contribute to reducing obesity and diet-related NCDs (Thow et al., 2015). Given the importance of SA as a regional trade hub, its policies will influence the food supply for much of sub-Saharan Africa. These changes have led to the call for regional labeling and fiscal policy measures to address the availability, acceptability, and affordability of healthy versus less healthy foods, and for improvements in the implementation of regulations for the marketing of foods and beverages to children (Igumbor et al., 2012).

Reduction of salt intake was recommended through a population-wide strategy to reduce sodium content in prepackaged food, which is predicted to prevent 7,400 cardiovascular deaths per year through its effect on population blood pressure (Bertram, Steyn, Wentzel-Viljoen, Tollman, & Hofman, 2012). Voluntary measures have already been discussed with the appropriate consumer and industry groups, and a comprehensive salt reduction plan including legislative measures recommended using multiple targets over a number of years. The Department of Health has approved regulations which will come into effect in 2016 (Foodstuffs, Cosmetics and Disinfectants Act, 2013). Similarly, regulations relating to trans-fats in food came into effect in 2010 (Foodstuffs, Cosmetics and Disinfectants Act, 2010a). At the U.N. High Level Meeting on NCDs, the Minister of Health urged the food industry to reduce production of harmful food and promote healthy eating habits worldwide, advocating for a "whole of government" approach (South African Government New Agency, 2011). In addition, a new advocacy group was established and an educational campaign launched by the Heart and Stroke Foundation to raise awareness about the dangers of high salt consumption.

## Discussion and Recommendations

In SA, government, business and civil society sectors have responded to growing concerns about corporate practices that contribute to NCD risk. These include public-sector responses such as taxes on tobacco and alcohol, new regulations including restrictions on marketing, and mandated reformulation of products (e.g., lower salt and elimination of trans-fats). Tobacco, alcohol, and food companies have generally opposed these measures and argued instead for three different strategies: self-regulation, public–private partnerships, and consumer education. To date, however, there is limited evidence that these strategies are effective in reducing NCD risk behavior (Moodie et al., 2013). South African civil society groups, which have played a strong role in catalyzing action on tobacco (Van Walbeek, 2004) and HIV prevention and management (Simelela & Venter, 2014), have begun to mobilize around NCD risk with some attention to the role of corporate practices.

The high prevalence of NCDs among adults and NCD risk behavior among young adults, especially the majority and growing population of Black and colored young adults (Peer et al., 2013) suggests that more action is needed to prevent further increases in prevalence and inequitable distribution of

NCDs. What role can health educators and other public health professionals play in creating such a response? Based on the evidence from within SA as well as NCD prevention experiences in other nations, we suggest five strategies.

### Educate the Public About the Role of Big Business

In the case of tobacco, several decades of legislation, litigation, and educational campaigns convinced the public in many nations that the tobacco industry was not a credible partner in setting tobacco policy—thus freeing public health professionals to take more effective action to reduce tobacco use. Compelling evidence suggests that the alcohol and food industries in SA use similar business practices to target children and young people, obfuscate the harm of their products, and undermine public health protection (Parry, 2014; Temple, Steyn, & Nadomane, 2008). By learning from the successes of tobacco control (Brownell & Warner, 2009; Viacava et al., 2015), public health professionals can contribute to social marketing and counteradvertising campaigns to educate South Africans to resist and restrict the appeals of industries that seek to profit at the expense of public health.

### Strengthen Civil Society Capacity to Take Action on NCDs

In both health and other public services, civil society groups in SA have played a key role in mobilizing people and pressuring government to take action (McLennan & Munslow, 2009). A proposal by several health nongovernmental organizations (NGOs) in SA to create an independent Health Promotion and Development Foundation financed by a surcharge on tobacco, alcohol, and possibly food and beverage industries could help integrate health promotion and social development into all government and civil society programs (Perez et al., 2013). On priority issues, such a foundation could mobilize resources, allocate funding, develop capacity, and monitor and evaluate health promotion and development work. To be effective in taking on social determinants of NCD risk, such an organization would need to be independent from its funding industries.

### Support Public-Sector Action

An obstacle to stronger public health protection has been industry insistence that voluntary approaches are best and public–private partnerships the most effective vehicle for change. Guided by neoliberal ideology, this belief system insists that governments are the problem and markets the solution (Harvey, 2005). In this view, public-sector involvement always invokes the threat of the nanny state, intent on depriving citizens of rights to consume as they choose. Some business leaders, media, and libertarians in SA warn that efforts to restrict marketing of tobacco, alcohol, and food constitute an unwarranted intrusion into the private lives of citizens (Channel FMF, 2013). In wealthy nations, this argument has been effective in undermining elite and popular support for public health protection. With its postapartheid history and ideology of government action to promote the well-being of all sectors of the population, SA has an opportunity to demonstrate that governments can overcome corporate opposition to public health measures. Public health professionals can play a key role in a national dialogue on the appropriate balance between markets and government and on the suitable use of policy measures such as increased taxation, subsidies for healthy products, and limits on promotion of unhealthy lifestyles.

### Create Health Education and Countermarketing Campaigns That Enable People to Resist Appeals to Unhealthy Consumption

While education alone will not reverse SA's alarming NCD trends, any comprehensive plan must reduce demand as well as supply of unhealthy products. This will require educating people about the appeal of tobacco, alcohol, and unhealthy food; the strategies that corporations use to market and distribute these products; and the alternatives to harmful consumption (Hawkes, 2013). Since people often use these products to alleviate the stresses of poverty, racism, inequality, and work, a comprehensive approach also requires reducing these sources of stress and offering healthier alternatives (Myer, Stein, Grimsrud, Seedat, & Williams, 2008).

In a multicultural society, different groups think differently about their consumption of tobacco, alcohol, and food. The industries that market these products have shown great ingenuity in targeting their appeals to distinct segments of their potential markets (Cassim, 2010; Grier & Kumanyika, 2010). To compete effectively, public health professionals will need to develop more sophisticated educational and communications campaigns, learn to listen more carefully, use appeals to emotion more frequently, and tailor messages more precisely.

### Look to Other Nations for Best and Promising Practices

Around the world, governments, civil society organizations, and businesses are testing new ways to prevent NCDs by changing corporate practices. The Framework Convention on Tobacco Control provides a global forum where NGOs can pressure governments to act more forcefully to restrict tobacco marketing (Collin, 2010). In Brazil, new national food standards encourage consumption of unprocessed local food and discourage consumption of the ultraprocessed products that multinational food companies produce (Ministry of Health of Brazil, 2014). World Health Organization "Best Buys" offer best practices in several domains (World Health Organization, 2011b). The Global

Alcohol Policy Alliance is a developing network of NGOs and public health professionals who share information on alcohol issues and advocate evidence-based alcohol policies (Global Alcohol Policy Alliance, n.d.). These and dozens of other initiatives and organizations around the world constitute a foundation for an expanded public health practice to prevent NCDs by changing corporate practices that promote NCD risk and inequalities in NCD burdens. With its high burden of NCDs, its historical commitment to health and equity and a mobilized civil society, SA has an opportunity to develop this path to more effective prevention of NCDs and their disproportionate burden on SA's majority population.

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