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diets, tobacco smoking, physical inactivity and alcohol abuse. Analyses must explore not only how these risk factors account for the four main NCDs - cancer, diabetes, cardiovascular diseases and chronic respiratory diseases [5, 6] as major causes of mortality worldwide - but also how they dovetail with a multi-sectoral approach in South Africa.

An analysis of (NCD) prevention policies in Africa (ANPPA) (2013–2016) was done in five African countries (Kenya, Malawi, Cameroon, Nigeria and South Africa). The South African case study sought to explore the extent to which multi-sectoral action is used in the formulation and implementation of policies that are related to the four NCD risk factors [7]. The study also sought to establish the extent to which the WHO "best buy" [11] interventions were included in the NCD policies and programmes. The WHO describes "best buys" as "interventions that have significant public health impact and are highly cost-effective, inexpensive, and feasible to implement" [11]. The purpose of this paper is to trace and understand the evolution of NCD policies in South Africa since 1994.

recorded, the study team took notes [7]. The interviews were conducted at mutually agreed times and at venues that were free from distractions. The interviewers explained the purpose of the study, risks and benefits of participating, the right to withdraw at any time without penalty, and confidentiality, while participants provided verbal or written documentation of consent to participate.

Recorded interviews were transcribed, edited to remove typographical and grammatical errors and real names of study participants, and were saved with identification codes on password-protected servers. In line with ethical standards and to ensure anonymity, the study participants were identified by numbers 1–44. Transcripts were uploaded into the qualitative data management software NVivo. Guided by the key research questions, thematic analysis [7, 14] was used to code both documents and transcripts, and results were

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NCD policies passed, the challenges of implementing NCD policies and the application of the multi-sectoral approach in NCD policies in South Africa.

Post-apartheid period

bridge the gap of health inequalities and inequities, and address the risk of NCDs by 2020.

The burden of NCDs

Indeed, in order to tackle premature deaths from NCDs, the government set out to reduce the mortality rate by 25% in 2020 [27]. Estimates by the DOH attributed 49% of deaths in the country to NCDs [22]. It was also established that people who lived with HIV and AIDS were vulnerable to NCDs such as cancer, heart disease, mental disorder, and diabetes, among others [4–6, 8, 9, 25]. In addition, malnutrition, low birth-weight were found to paradoxically predispose individuals to obesity, high blood pressure, heart disease and diabetes in adult life. These risk factors affected both mothers and children [4–6, 25, 27–29].

It is against this background that Dr. Motsoaledi, in his budget vote for health (2016), identified four epidemics (HIV and AIDS, maternal and child mortality, injuries and violence and NCDs), that he described as "the four highways [through which] South Africans are marching to their graves" ([21], p. 2). Recognition of the dangers of these "four colliding epidemics" ([21], p. 4) led to a national discourse on NCDs, and subsequently the adoption of a multi-sectoral approach to tackle the epidemic in line with the new path of equity.

In addition to the policies, the Strategic Plan for NCDs (2013–2017) and the WHO's 2016–2020 country strategy provided a framework for reducing morbidity and mortality from non-communicable diseases [6, 25].

NCD

Policy on alcohol and substance abuse

The growing concerns about the impact of NCDs, especially alcohol and substance abuse, informed the development of the policy on alcohol control. In the light of ANC

African Congress (PAC):

> “The industry obviously did not want the legislation at all and they opposed everything and anything the government said ... the SABC [South African Broadcasting Corporation] was worried about loss of advertising and revenues. We had ... big media houses going to parliament and saying [that] if you ban tobacco advertising...they will close down. Then ... the Freedom of Expression Institute opposed the legislation ...

In 2016, the national treasury drew up proposals for the taxation of sugar-sweetened beverages [32, 33]. The proposals for taxing sugar-sweetened beverages were not only debated by the national treasury and DOH, but stakeholders from civil society organisations, industry, research and academics also participated in the drafting and refinement of the taxation regime [7, 34].

High sugar consumption is associated with obesity and diabetes. The South African National Health and Nutrition Survey (SANHANES) that involved more than 25,000 participants reported that there were significantly more females who were overweight and obese (39.2 and 24.8%, respectively) than males (20.1 and 10.6% respectively) [35]. The situation is so serious that South Africa is now considered

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intervention in health is to ensure that the law is upheld. The underlying rationale is that actual provision and prices of healthcare should be allocated by the market.

The liberal approach to health care is based on the ideal of "equality of chances" ([42], p. 4). In this regard, state intervention is acceptable to the extent that it helps to improve the health status of the population. What sets the radical approach apart is its underlying rationale that emphasises the "equality of results" ([42], p. 4). From this perspective, state intervention is required to achieve the desired health outcomes. The radical approach in healthcare policy and implementation requires centralized planning and the allocation of resources in achieving the desired health outcomes.

Under apartheid, policies were aligned with a racist ideology that promoted racial exclusion. State intervention was for the protection of the healthcare of a privileged minority. By contrast, the post-apartheid government - a tripartite alliance of the ANC, the South African Communist Party (SACP) and Congress of Trade Unions (COSATU) – sought to redress past inequalities resulting from exclusion and redistribute resources [7]. The policy approach taken by the government since 1994 is reflective of the debates on political ideology and tensions within the tripartite alliance, resulting in a mix of liberal and radical approaches [19].

In terms of NCDs prevention and control, state intervention has tended to follow this mixed approach for the attainment of "health for all". The ideological stance of the Left (SACP, COSATU, the left-wing of the ANC and the Tobacco Action Group) inevitably influenced the formulation and implementation of tobacco control that ran counter to the anti-regulation position of tobacco multinational companies [30, 42]. However, state involvement in the implementation of other NCD policies such as salt regulation has taken a more liberal approach. The latter is similar to the Bhutan case where there is still a "need to consider policy socio-political and economic factors" [42] in the context of a radical approach.

The purpose of formulating NCD policies is to effect behavioural change and the reduction of NCDs in general. NCD policies are in place, but the prevalence of NCDs has increased except in the case of tobacco smoking. This is not unique to South Africa; rather, it is a global phenomenon particularly in low-income countries [5, 6, 9, 11]. Physical inactivity is particularly a challenge among women in low-income countries and South Africa, in particular. The lack of green spaces for walking in the sprawling urban informal settlements, as well as crime and gender-based violence in South Africa are deterrents to physical activity [43].

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CN conceptualized the paper, developed the theoretical conceptualization, analysed the data and reported on the findings. TPN analysed the data and contributed to the theoretical conceptualization of the paper. GA contributed to the methodology, literature review and discussions in the paper. PJ developed the framework for the methodology employed in the study. CK contributed to the conceptualization of the study and discussion. All the authors read and approved the final version of the paper Permission has been obtained to reproduce previously published materials (e.g. text sections, reproduced figures/tables etc.) and the original publications are correctly referenced.

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The study was approved by the Human Science Council Research Ethics Committee (REC 2/19/02/2014). The study participants involved in this study provided verbal and written consent before they were interviewed.

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Not applicable.

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The authors declare that they have no competing interests.

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