
DOMESTICATION OF INTERNATIONAL STRATEGIES IN TOBACCO CONTROL: THE CASE OF SOUTH AFRICA

1 Introduction

With an estimated 1.2 billion smokers in the world, tobacco use is of pandemic proportions. The relationship between tobacco use, and death and disease is well established (Yach "Tobacco Control: From Concern for the Lung to Global Political Action" 2001 56 *Thorax* 247). It is not only active, but also passive or secondary smoking that is injurious to health. The morbidity and mortality from tobacco rivals that of HIV/AIDS. According to the World Health Organisation (WHO), tobacco and AIDS have become the two leading global causes of premature death (World Health Organisation *The World Health Report 1999-Making a Difference* (1999)). Smoking causes an estimated 4 million deaths per year (World Health Organisation). Unless checked, tobacco-related mortality is projected to rise phenomenally to 10 million by the year 2030, with the preponderance of the mortality (about 7 million deaths) occurring in developing countries (World Health Organisation; and Peto *et al Mortality from Smoking in the Developing Countries 1950-2000* (1994) 65).

In the last twenty years or so, there has been a reversal in smoking trends between the developed world and the developing world. In the developed world, smoking has decreased. In the developing world, smoking has increased, with women and children constituting the most vulnerable group (Satcher "Why We Need an International Agreement on Tobacco Control" 2001 91(2) *American Journal on Public Health* 191; and Saloojee *Tobacco Control in Health Systems Trust South African Health Review* (2000) 429-439). There is little doubt that the developing world has been targeted by the tobacco industry for exploitation in tobacco use, in part to make up for lost profits in the developed world (Grobbelaar "Tobacco Use in South Africa" 1993 8(3) *Nursing RSA Verpleging* 8; and Lore "Control of Tobacco: What the World Experts Recommend" 1999 3(2) *Health Line* 23). The reasons for the increase in smoking prevalence are, however, composite. In part, the increase in prevalence is an outcome of vulnerability to aggressive advertising and sponsorship by the tobacco industry. In part it is also an outcome of poor knowledge about the risks associated with smoking, poor health promotion infrastructure, absent or weak tobacco control activism, poor government funding for tobacco control, and lack of political will to control tobacco products on the part of government (Townshend and Yach

“Anti-smoking Legislation and International Perspective Applied to South Africa” 1988 73 *South African Medical Journal* 412; and Buthelezi *Tobacco Control Legislation: The Challenges of Enforcement Mechanisms* (2001)).

There is consensus among health experts that tobacco-related diseases are the single most preventable cause of death and disease, and that measures must be taken to control tobacco use (Townshend and Yach 1988 73 *South African Medical Journal* 412). Moreover, there is international consensus on the use of law and other coercive measures as instruments for controlling tobacco use (Satcher 2001 91(2) *American Journal on Public Health* 191). This article seeks to explore and evaluate the extent to which South Africa has responded to the challenge of controlling tobacco use. It is submitted that though the efficacy of the South African strategies has yet to be tangibly demonstrated in terms of translating into positive health gains, South Africa has made substantial progress in implementing international tobacco control norms. The Tobacco Products Control Act of 1999 is significant evidence in this regard.

2 Tobacco control measures: the Framework Convention on Tobacco Control

In general, the instruments for tobacco control fall into three categories: (i) legislation; (ii) information and education; (iii) and economic intervention (Townshend and Yach 1988 73 *South African Medical Journal* 412). In this article, the main focus is on legislation. It is recognised that legislation is a crucial tool in the armamentarium of tobacco control, not least on account of its coercive effect (Van Niekerk “Smoking and the Law” 1993 11(5) *CME* 981). However, it is important to appreciate that legislation is but one tool in the apparatus for tobacco control. International experience has proven that all three components, namely: legislation; information and education; and economic intervention, are interlinked and should thus form essential elements of any tobacco control strategy.

Since the 1970s, WHO has been conducting a campaign against tobacco, including urging countries to adopt anti-smoking measures (Yach 2001 56 *Thorax* 247). The approach of WHO is, *inter alia*, informed by the premise that health is a human right that should be protected and promoted, and that tobacco use severely compromises this right. Indeed, the preamble to the Constitution of WHO recognises health as a fundamental right (*Constitution of the World Health Organisation*, signed on 22 July 1946 and entered into force on 7 April 1948). The right to health is widely acknowledged in international human rights law (Toebes *The Right to Health as a Human Right in International Law* (1999)). The Universal Declaration on Human Rights recognises a right to health in article 25 (adopted and proclaimed by General Assembly resolution 217A(III) of 10 December 1948), and so does the International Covenant on Economic Social and Cultural Rights in article

12 (adopted and opened for signature, ratification and accession by General Assembly resolution 2200A(XXI) of 16 December 1966, entered into force on 3 January 1976). In respect of women and children who constitute vulnerable groups, the right to health is also echoed in article 12 of the Convention on the Elimination of All Forms of Discrimination Against Women, (adopted and opened for signature, ratification and accession by General Assembly resolution 34/180 of 18 December 1979, entered into force on 3 September 1981), and article 24 of the Convention on the Rights of the Child (adopted and opened for signature, ratification and accession by General Assembly resolution 44/25 of 20 November 1989, entered into force on 2 September 1990), respectively. At regional level, the African Charter on Peoples' and Human Rights recognises the right to health in article 16 (adopted by the 18th Assembly of the Heads of State and Government of the Organisation of African Unity (now African Union) on 17 June 1981, entered into force on 21 October 1986).

It is thus incumbent upon the international community and individual states to take measures that are designed to promote health through, *inter alia*, the adoption of tobacco control measures. Health promotion, as was declared in the Ottawa Charter for Health Promotion of 1986, entails enabling people to increase control over and improve their health through, *inter alia*, a combination of educational as well as environmental support that influence people's actions and living conditions (First International Conference on Health Promotion *Ottawa Charter for Health Promotion* 17-21 November 1986; and Nadasen *Public health law in South Africa* (2000) 8-12).

Over the years, WHO has been intensifying its campaign to make tobacco use a truly global health problem. It has advocated strong international co-operation as a means of curbing tobacco use over and above the efforts of individual countries. In 1996, the member states of WHO resolved to begin developing a binding international instrument on tobacco control. In 2000, member states met in Geneva to negotiate the first international agreement on tobacco control – the Framework Convention on Tobacco Control (the Convention). The Convention was adopted in May 2003 (WHO Framework Convention on Tobacco Control <http://www.who.int/tobacco/fctc/text/final/en/>). The rationale for the Convention is clear from its preamble. In the main, the justifications for the Convention are that:

- parties to the Convention have a right to prioritise the protection of public health;
- tobacco consumption and exposure cause death, disease and disability;
- the spread of the tobacco epidemic is a global problem that calls for the widest possible international co-operation and the participation of all countries;

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- tobacco consumption and production has increased in developing countries in particular;
 - there is an escalation in smoking among women and children;
 - advertising, promotion and sponsorship by the tobacco industry are aimed at encouraging tobacco use;
 - illicit trade in tobacco products, including smuggling, illicit manufacturing and counterfeiting, requires co-ordinated action;
 - tobacco control is seriously underfunded in relation to the burden of tobacco-related disease and new and additional resources would make a substantial difference to the success of tobacco control;
 - long-term social and economic implications of successful tobacco demand-reduction strategies must be addressed; and
 - health is an internationally recognised human right.

The Convention is about recognising the global dimension to tobacco control. It is about the international community, led by WHO, coming together and agreeing on a common strategy for tobacco control in an environment that is inclusive and that fosters mutual support. The Convention emphasises that the responses to tobacco control must be multisectoral and that the participation of civil society is seen as essential (Preamble).

The Convention seeks to protect present and future generations from the hazards of tobacco consumption and exposure (a 3). It is a binding agreement in the sense that each party to the Convention undertakes to develop and implement comprehensive tobacco control measures, including adopting and implementing effective legislative, executive, administrative and other appropriate measures for preventing and reducing tobacco consumption and exposure to tobacco smoke (a 5). However, it is important to stress that the Convention relies on voluntary co-operation rather than coercion (a 22).

The Convention builds on all the traditional strategies for reducing demand for and supply of tobacco, and exposure to tobacco smoke. Each member state must inform every person in its jurisdiction of the harmful effects of tobacco consumption and exposure (a 4(1)). Furthermore, the state must take necessary legislative, executive, administrative or other measures to reduce consumption of tobacco and protect all persons from exposure to tobacco smoke (a 5(2)). It is incumbent upon the member state to protect themselves from commercial and other vested interests of the tobacco industry (a 5(3)). Ineffective strategies to curb tobacco use at a domestic level are often the result of governments having vested interests in the tobacco industry.

The Convention prescribes the following measures to reduce demand for tobacco:

- price and tax measures (a 6).
- non-price measures (a 7).
- protection from exposure to tobacco smoke in public places, public transport and indoor workplaces (a 31).
- regulation of contents of tobacco products (a 9).
- regulation of tobacco products disclosures (a 10).
- packaging and labelling of tobacco products (a 11).
- education, communication, training and public awareness (a 12).
- regulation of tobacco advertising, promotion and sponsorship (a 13).
- promotion of cessation of tobacco use, including diagnosis and treatment of tobacco dependence (a 14).

In respect of measures relating to reducing supply, the Convention prescribes the following:

- eliminating illicit trade in tobacco products, including smuggling, illicit, manufacturing and counterfeiting (a 15).
- prohibiting sales of tobacco products to and by minors (a 16).
- promoting of economically viable alternative activities for tobacco workers, growers and individual sellers.

It must be emphasised, however, that whilst the Convention represents an august step towards the globalisation of tobacco control, on its own, it is of little avail. Buthelezi is correct in pointing out that the crucial issue is whether the Convention will be implemented at a domestic level (Buthelezi 9). The efficacy of the Convention depends on the political will and consent of the domestic state. Unless co-operation and willingness to implement the agreed convention are forthcoming from the member state, there is little that can be done to enforce compliance. Because the Convention essentially relies on voluntary compliance rather than coercion, it is ultimately for the individual country to develop a legally enforceable framework for tobacco control. South Africa is party to the Convention. An examination of South Africa's tobacco control measures suggests that much of what is envisaged by the Convention has been implemented or is in the process of being implemented.

3 Tobacco use in South Africa

Tobacco use is prevalent, albeit declining, in South Africa. South Africa has an estimated 5 million smokers (Saloojee 432). However, there are gender,

racial, age, and socio-economic demographic characteristics to smoking trends in South Africa. Smoking is more prevalent among males than females (Saloojee 432; and Van Walbeek *Recent Trends in Smoking Prevalence in South Africa: Some Evidence from AMPS Data* (2001)). About 42% of men and 11% of women smoke cigarettes (Saloojee 432; and Van Walbeek *Recent Trends*). In 1993 an estimated 51.4% males smoked, and by 2000, the number had decreased to about 42%. Smoking prevalence among women was 12.9% in 1993, but unlike male prevalence, it has not experienced a decline. Snuff use is more prevalent among women (11%) than men (0.9%) (Saloojee 432).

In terms of race, Coloureds have the highest prevalence at about 49% (Van Walbeek *Recent Trends* 4). This is followed by Whites (37%) and Indians (28%). Africans have the lowest prevalence decreasing from 28.1% in 1993 to 22.7% in 2000. Age-wise, smoking is more prevalent among adults (Van Walbeek *Recent Trends* 4). The prevalence of young adults (aged 16-24) was 18.7% in 2000 and thus much lower than that of adults. The decrease in smoking prevalence has been more pronounced in the 25-34 age group. According to Van Walbeek, the decrease in prevalence in this group is mainly a result of the rapid rise in the price of cigarettes (Van Walbeek *Recent Trends* 4). In 1994, the excise duty on cigarettes was increased by 50% of the retail price (Van Walbeek *Recent Trends* 4). The main reason for the increase in price was not so much to raise revenue, but to reduce consumption (Van Walbeek *Recent Trends* 4).

The socio-economic characteristics of smoking show a significantly higher prevalence in urban areas (32.5%) than in small settlements and rural areas (20.2%) (Van Walbeek *Recent Trends* 4). Smoking is highest among people with primary and secondary education. This is followed by people with tertiary education. People with no education have the lowest prevalence. Among English and Afrikaans speakers smoking prevalence is 35% and 42% respectively. Among Nguni speakers it is 22% and 24% among Sotho speakers. Between 1993 and 2000, all communities experienced a significant decrease in prevalence (Van Walbeek *Recent Trends* 4).

Unlike the position in developed countries such as the United Kingdom, there is no evidence to suggest that smoking prevalence is shifting towards lower income groups. In the UK, smoking prevalence has decreased significantly in higher socio-economic groups and only marginally in the lower socio-economic groups (Van Walbeek *Recent Trends* 4; and Townsend *et al* "Cigarette Smoking by Socio-economic Group, Sex, and Age, Effects of price, income and Health publicity" 1994 309 *British Medical Journal* 412). In South Africa, the reverse seems to be true. In 2000, the level of smoking prevalence was highest among the higher income groups (Van Walbeek *Recent Trends* 4; and Townsend *et al* 1994 309 *British Medical Journal* 412).

In terms of geographical location, the Western Cape (43.0%), Northern Cape (37.2%) and Gauteng (33%) have the highest prevalence whilst Northern Province (15.1%), Eastern Cape (21.9) and KwaZulu-Natal (22%) have the lowest prevalence (Van Walbeek *Recent Trends* 4; and Townsend *et al* 1994 309 *British Medical Journal* 412).

4 Tobacco control strategies in South Africa

4.1 The Tobacco Control Amendment Act

The development and implementation of tobacco control measures are of recent origin in South Africa. Until 1993, there was no parliamentary tobacco control legislation in South Africa. Despite this deficit, some local authorities passed by-laws banning smoking in cinemas in the 1970s (Swart and Reddy *Strengthening Comprehensive Tobacco Control Policy Development in South Africa Using Political Mapping* (1998)). Also, in the late 1980s, South African Airways banned smoking on domestic air flights (Swart and Reddy). A report by the Medical Research Council in 1988 was instrumental in persuading government to consider tobacco control legislation. Moreover civil society mainly – the Tobacco Action Group, the National Council Against Smoking, the Cancer Association of South Africa, and the Heart Foundation of South Africa were also instrumental in raising media attention and public awareness about the desirability of tobacco control legislation (Swart and Reddy). The result of these early campaigns was that government was persuaded to pass the Tobacco Products Control Act (83 of 1993).

The Tobacco Products Control Act of 1993 had the following objectives:

- regulation of smoking in public places.
- prohibition of sales to minors under the age of 16 years.
- regulation of tobacco advertising.

This early attempt to regulate tobacco use had little success for a number of reasons (Swart and Reddy 3-5). In the main, it was because government had a close relationship with the tobacco industry. There was really no civil society challenge to the tobacco industry as the tobacco control movement was weak and unrepresentative. The 1993 Act was not designed to achieve a radical change in tobacco control. It was too piecemeal in that it was not a comprehensive tobacco control measure. The restrictions on advertising were diluted to exclude radio advertisements. The media and advertising agencies undermined the Act by supporting the tobacco industry. Real policy shifts only started in 1994, with the change of government.

4.2 *Tobacco Products Control Amendment Act of 1999*

In 1994, an ANC-led Government of National Unity assumed office and set about formulating and implementing policy for the social and economic reconstruction of post-apartheid South Africa. The first Minister of Health in democratic South Africa, Nkosazana Zuma, was strongly committed to introducing tobacco control measures from the standpoint of protecting and promoting health (Saloojee 430; and Van Walbeek *Effective Development Policies Require Political Will: The Example of Tobacco Control in South Africa* (2001)). The new government, unlike its predecessor, had no links with, or vested interests in, the tobacco industry. Moreover, it was committed to respecting the Constitution, which unequivocally recognises rights relating to health and the environment.

In 1998, Minister Zuma introduced the Tobacco Products Control Amendment Bill. The Bill was intended to prohibit the following activities:

- smoking in public places.
- all tobacco advertising and sponsorships.
- distribution of free cigarettes.
- sale of cigarettes to people younger than 16 years.
- sale of single cigarettes.

As can be expected, the Bill was met with considerable opposition from vested interests. In the main opposition came from the tobacco industry (tobacco growers, cigarette manufacturers), the hospitality industry and the media (Van Walbeek *Effective Development*; Anon “Global Tobacco Mafia Enlists Rushdie’s Ghost Against South Africa” 1998 <http://www.muslimmedia.com.archives/world98/tobacco.htm>; and “New Tobacco Laws Ignite Hospitality Industry” 2000 90(10) *SA Medical Journal* 1088). In essence, they argued that induced reduction of tobacco consumption and the banning of advertising would be economically detrimental not only to the tobacco industry, but also associated industries and would lead to unemployment among other economic ills. Opponents of the Bill maintained that there was no necessary link between advertising expenditure and cigarette consumption. They argued that banning smoking in public places would lead to unnecessary criminalisation. Another argument was that the advertising ban was unconstitutional to the extent that it was a restriction of the freedom of expression under the Constitution. In *Tobacco Institute of Southern Africa v Minister of Health* (1999 1 BCLR 83 (C)), in a bid to thwart the Bill, the tobacco industry launched an urgent application seeking an order to compel the Minister of Health to provide it with certain information that the industry wished to use to challenge the legality of the law that government intended to introduce. The industry was, however, unsuccessful. The court ruled that whilst the Bill contained “a severe and extensive set of restrictions” on tobacco advertising or promotion and

empowered the Minister of Health to prohibit smoking in public places and to prescribe permissible levels of tar, nicotine and other tobacco constituents, the Bill did not establish rights. It could only be challenged once it became law (*Tobacco Institute of Southern Africa v Minister of Health supra*; and Nadasen and Reddy “Public Health Legislation: Towards Health for All in South Africa – Tobacco Control Legislation” 1999 10(3) *Stellenbosch Law Review* 449).

In support of the proposed legislation, government relied on public health arguments as well as its constitutional obligation. Essentially, government’s arguments were that tobacco is a major and yet totally preventable cause of disease, disability and premature death, and that health is a human right (Van Walbeek *Effective Development* 4). Government had a constitutional obligation to respect, protect, promote and fulfil the right to health. It had a constitutional obligation to protect the environment, including the right to clean air for non-smokers. In pursuit of promoting and protecting health, and the environment, it was justifiable to limit some of the rights and freedoms of smokers, the tobacco industry and tobacco-related industry.

Government was of the view that the detrimental economic impact of tobacco control legislation was grossly exaggerated.

The Tobacco Products Control Amendment Act was passed in 1999 (12 of 1999). In September 2000, regulations pursuant to the Act were passed. The regulations came into effect on January 2001. However, on account of pleas and pressure from the hospitality industry, the regulations dealing with prohibition of smoking in public places were held in abeyance until June 2001 (Van Walbeek *Effective Development* 5).

4 2 1 Objectives of the 1999 Act

The objectives of the Tobacco Products Control Amendment Act are articulated in its preamble. In the main, the Act seeks to:

- amend the Tobacco Products Control Act of 1993.
- provide for the prohibition of advertising and promotion of tobacco products.
- provide for the prohibition of advertising and promotion of tobacco products in relation to sponsored events.
- prohibit the free distribution of tobacco products and receipt of gifts or cash prizes in contests, lotteries or games to or by the purchaser of a tobacco product in consideration of such purchase.
- to provide for prescription of maximum yields of tar, nicotine and other constituents of tobacco products.

The preamble to the Act is explicit in acknowledging that tobacco use is “extremely injurious to the health of smokers and warrants, in the public interest, a restrictive legislation”. It also takes cognisance that advertisements and sponsorship by the tobacco industry may encourage children and young people to take up smoking. Equally significant, the Act is intended to align the health system with the democratic values of the Constitution and to enhance the fundamental rights of citizens. In this connection it is worthy of note that the Constitution recognises that everyone has a right to life (s 11 of the Constitution), a right to an environment that is not harmful to one’s health or wellbeing (s 27 of the Constitution), and a right to health care services (s 24 of the Constitution) and the state is enjoined to take reasonable and other measures to realise these rights for everyone. No doubt, tobacco use and tobacco exposure severely compromise the realisation of these rights.

4 2 2 Advertising, sponsorship and promotion

The Act bans tobacco advertising, sponsorship and promotions completely. It provides that no person shall advertise (including the use of tobacco trade marks, logos, brand names or company names used on tobacco products), or use tobacco marks, logos, brand names or company names for the purposes of advertising any organisation, service, activity or event (s 1 of the Act). The Act employs a very wide definition of advertisement in order to close any loopholes. (The Act defines advertisement in relation to a tobacco product as “any drawn, still or moving picture, sign, symbol, other visual image, or message or audible message aimed at the public and designed to promote or publicise a tobacco product or to promote smoking behaviour and includes the use in any advertisement or promotion aimed at the public of a tobacco product manufacturer’s company’s name where the name or any part of the name is used as or is included in a tobacco product trade mark and ‘advertise’ has a corresponding meaning”.) Both direct and indirect advertisements are within the ambit of prohibited conduct.

The Act is equally robust about banning tobacco sponsorship and promotion. A manufacturer, importer, distributor or retailer of tobacco products is prohibited from organising, promoting or making a financial contribution towards any organised activity in South Africa (s 2 of the Act). The Act employs a wide definition of organised activity. (According to the Act, organised activity means “any activity or event which the public attend or participate in, which is organised for the purpose of entertainment, sport, recreation or for educational or cultural purposes, and where a tobacco product, or brand name, trade mark, logo or company name is used in the name of or portrayal of the activity or event”. However, organised activity excludes “any private activity arranged by a manufacturer, distributor or retailer of a tobacco product where its shareholders or its employees or their spouses attend”.)

However, it is important to note that the Act makes a limited concession to retailers insofar as permitting them to indicate by signs at the point of sale, the availability of tobacco products and their price, providing there is compliance with the Regulations Relating to the Point of Sale of Tobacco Products. (R976 RG 6895 in GG 21610 of 2000-09-29. This regulation requires that the sign must not exceed one square metre in size, and must be placed within one metre of the point of sale. The sign must also indicate that the retailer cannot by law sell tobacco products to anyone under the age of 16 years and also contain a health message.)

There is little doubt that advertisements glamourise smoking and may lure the young especially to smoking. The complete ban on advertising, sponsorship and promotion closes the loophole in the 1993 Tobacco Control Products Act. Although the 1993 Act required health warnings, sponsorship messages were not required to carry health warnings. The tobacco industry was able to bypass the ban on television advertising through sponsorship messages (Saloojee 433). In 1997 alone, the tobacco industry spent R477-million on advertising and sponsorship (Saloojee 433).

4 2 3 Warning information required in respect of tobacco packages

In line with international trends, the Act requires tobacco products to be sold in a packaged form accompanied by a health warning (s 4 of the Act). The package in which the tobacco product is sold must bear a warning concerning the health hazards incidental to the smoking of tobacco. The quantities of the constituents present in the tobacco product must also be stated on the package.

4 2 4 Maximum yields of tar and other constituents in a tobacco product

The Act empowers the Minister of Health to prescribe the maximum permissible levels of tar, nicotine and other constituents which tobacco products may contain as well as the maximum yield of any such substance that may be obtained from a tobacco product. The Minister of Health has issued regulations in this regard (Notice Relating to the Maximum Permissible Yield of Tar, Nicotine, and Other Constituents in Tobacco Products. R974 RG 6895 in GG 21610 of 2000-09-29). The regulations require the tar yield of cigarettes marketed in South Africa not to exceed 15 mg per cigarette and the nicotine yield not to exceed 1,5 mg per cigarette as from 1 December 2001. As from 1 June 2006, the yields will be reduced to a maximum of 12 mg of tar and 1,2 mg of nicotine per cigarette.

Whilst the reduction in tar and nicotine yields is to be welcomed, it must be appreciated that such reduction does not necessarily translate into harm-free

tobacco products. The benefits of low tar and low nicotine cigarettes can easily be nullified by increasing the number of cigarettes smoked or inhaling more deeply (Saloojee 435).

4 2 5 Free distribution and reward

The Act prohibits a manufacturer, distributor, importer or retailer of a tobacco product from distributing or supplying tobacco products free or at a reduced price, other than a normal discount price (s 4A of the Act). It further prohibits any person from offering any gift, cash rebate or right to participate in a contest, lottery or game, to any person in consideration of the purchase of a tobacco product or the furnishing of evidence of such a purchase.

4 2 6 Prohibition on sale to children

Children are particularly vulnerable to smoking (Guthrie *et al Children and Tobacco in South Africa* (2000)). The sale of tobacco products to children under 16 years of age is prohibited (s 4 of the Act). It is irrelevant that the tobacco is not for the child's personal use. If a retailer puts up a sign indicating the availability of tobacco products, there is an obligation, *inter alia*, to include in the sign a message to the effect "WE CANNOT, BY LAW, SELL TOBACCO PRODUCTS TO ANYONE UNDER THE AGE OF 16 YEARS". The protection of children is extended to vending machines. The sale of tobacco products from vending machines is restricted to places in which purchases from such machines are inaccessible to persons under 16 years of age (s 5 of the Act).

4 2 7 Prohibition of smoking in public places

Worldwide, on account of both aesthetic and health grounds, there is a clear preference by the public to prohibit or restrict smoking in public places such as restaurants, bars and shopping malls (Boland *et al* "Staff Member's Acceptance of the Introduction of Workplace Smoking Bans in the Australian Public Service" 1989 151 *Medical Journal of Australia* 525; La Vecchia *et al* "Attitudes Towards Smoking Regulation in Italy" 2001 358 *Lancet* 245; Chapman "Smoking in Public Places" 1996 312 *British Medical Journal* 1051; and Anon "Public Attitudes Regarding Limits on Public Smoking and Regulations of Tobacco Sales and Advertising – 10 US Communities" 1989 40(21) *MMR* 344). The well-established evidence on the dangers of passive smoking especially has tilted public opinion overwhelmingly against unrestricted smoking in public places (Townshend and Yach 1988 73 *South African Medical Journal* 414). In South Africa the public unequivocally supports restrictions on smoking in public places. Over 70% of both smokers and nonsmokers are in favour of restrictions (Saloojee 435). South Africa has followed the international trend in adopting

legislation banning smoking in public places (Townshend and Yach 1988 73 *South African Medical Journal* 416).

According to section 2(1)(a) of the Act, smoking of tobacco in public places is prohibited. According to section 1, public place means “any indoor or enclosed area which is open to the public or any part of the public and includes a workplace and a public conveyance”. The Minister is empowered by the Act to declare by notice permissible smoking places subject to any conditions that may be specified in the notice (s 2(1)(b) of the Act). Indeed, the Minister has issued regulations – Notice Relating to Smoking of Tobacco Products in Public Places – declaring permissible smoking areas subject to certain conditions (R975 RG 6895 in GG 21610 of 2000-09-29).

It would be impossible for any legislation to list all places that constitute a public place as this would only encourage opponents of the legislation to seek loopholes. What is clear is that the definition of public place is very wide. It excludes a private dwelling which is defined in section 1 of the Act as any room or apartment of a building or structure which is occupied as a residence or any building or structure or outdoor living area which is accessory to, and wholly or principally used for, residential purposes. It means, of course, that where part of a dwelling is used for a purpose other than residence then it may cease to be a private dwelling for the purposes of the Act. Examples in this regard would be a residence that is in part used for child care activities or pre-schooling (Buthelezi 23-24). Such a residence may be deemed to be a public place and thus subject to the conditions that bind public places (described below), including designating a portion of the residence as a smoking area.

The meaning of public place has been considerably clarified by the regulations. The regulations list “smoking areas” where smoking is permitted but subject to certain conditions. The following are smoking areas under the regulations:

- (a) smoking establishments which means a place where the primary business is to sell tobacco to the public for consumption on or off the premises.
- (b) bars, taverns or any other public place where the primary business is the sale of alcohol beverages, subject to clause 3.
- (c) night clubs, casinos, or any other public place where the primary business is the provision of entertainment, subject to clause 3.
- (d) restaurants, subject to clause 3.
- (e) hotels, guest houses, bed and breakfast places, game lodges and other places where accommodation is offered for sale, subject to clause 3.
- (f) passenger ships registered in the Republic, subject to clause 4.
- (g) passenger trains operating in the Republic, subject to clause 5.

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- (h) workplaces, subject to clauses 3, 6, 7 and 8.
 - (i) airports, subject to clause 3.

4 2 8 *Clause 3*

Clause 3 of the Regulations is crucial to the efficacy of protecting non-smokers from passive smoking and smoke-related irritation. Clause 3 permits an employer, owner, licensee, lessee or person in control of a public places (in this case bars, pubs, taverns and any other places where the primary business is the sale of alcohol beverages; night clubs, casinos or any other public place where the primary business is the provision of entertainment; restaurants; hotels, guest houses, bed and breakfast places, game lodges and other places where accommodation is offered for sale; workplaces; and airports) to designate a smoking area providing the following conditions are met:

- (a) the designated smoking area does not exceed 25% of the total floor area of the public place.
- (b) the designated smoking area is separated from the rest of the public place by a solid partition and an entrance door on which the sign "SMOKING AREA" is displayed, written in black letters, at least 2cm in height and 1.5cm in breadth, on a white background.
- (c) the ventilation of the designated smoking area is such that air from the smoking area is directly exhausted to the outside and is not re-circulated to any other area within the public place.
- (d) the message: "SMOKING OF TOBACCO PRODUCTS IS HARMFUL TO YOUR HEALTH AND TO THE HEALTH OF CHILDREN, PREGNANT OR BREASTFEEDING WOMEN AND NON-SMOKERS. FOR HELP TO QUIT PHONE (011) 720 3145" is displayed at the entrance to the designated smoking area, written in black letters, at least 2cm in height and 1,5cm in breadth, on a white background.
- (e) notices and signs indicating areas where smoking is permitted and where it is not permitted must be permanently displayed and a sign indicating that smoking is not permitted must carry the warning: "ANY PERSON WHO FAILS TO COMPLY WITH THIS NOTICE SHALL BE PROSECUTED AND MAY BE LIABLE TO A FINE".

4 2 9 *Clause 4 and 5: passenger ships and passenger trains*

Clause 4 of the Regulations applies to passenger ships only. It permits the operator of such a ship to allocate not more than 25% of the total accommodation as designated smoking areas. Clause 5 permits an operator of a passenger train with a total number of carriages exceeding 10 to

designate not more than 25% of the entire train as a designated smoking area. Incidentally, the regulations do not apply to forms of transport other than passenger ships and trains. The inference to draw from this omission is that in respect of public transport such as buses and taxis, smoking is completely prohibited. This would seem to be a tenable interpretation given the impracticalities of designating a smoking area in conveyances with very small surface areas.

4 2 10 Clauses 7, 8 and 9: the workplace

Employers have special obligations that are designed to protect non-smokers. Clause 7 requires an employer to ensure that employees who do not wish to be exposed to tobacco smoke are protected. The clause requires the employer to respect the rights of those who object to tobacco smoke and not to subject them to any victimisation. According to Clause 8, the employer must have a written policy on smoking which must be applied three months from the coming into operation of the Act. It is open to the employer to totally prohibit smoking in the workplace (clause 9).

4 2 11 Structural changes

At the time of its passage, the Act was alive to the fact that structural changes might be necessary for public places to comply with the statutory obligations. Clause 11 accords a grace period for compliance. It provides that where structural changes are necessary in order to comply with the obligations imposed by the regulations, a written application must be made requesting exemption for periods of up to six months. The application must state the nature and extent of the proposed structural changes and give an indication of the exact time envisaged to make the structural changes.

5 An appraisal of the Tobacco Control Products Act

There is little doubt that the new Act is a positive and major contribution to tobacco control in South Africa. It constitutes South Africa's best effort yet to reduce tobacco consumption and to protect the non-smoking public from the dangers of passive smoking. At a political level, the Act demonstrates strong commitment to tobacco control by post-apartheid governments that have had no links with the tobacco industry. The Minister of Health of the Government of National Unity in 1994 made it clear that tobacco control would be one of her Ministry's priorities (Van Walbeek *Effective Development* 2). This commitment was complemented by the Minister of Finance who simultaneously announced a large increase in the excise rate on cigarettes (Van Walbeek *Effective Development* 2-3). The Act demonstrates that severing ties with the tobacco industry is a necessary element of the development of an effective tobacco control strategy. The previous

government failed to introduce strong tobacco control measures largely because they had strong and lasting ties with the dominant cigarette manufacturer – Rembrandt (Van Walbeek *Effective Development* 2). The new government's commitment has survived strong opposition from the tobacco industry, the hospitality industry and the media. The more substantial consideration though is whether in practice the Act has been effective.

If it is accepted that tobacco advertisements, sponsorship and promotion encourage consumption, then the Act has been a great success. All advertisements – in the print media, newspapers, television, and billboards – have come to a complete stop. Young people in particular can no longer be enticed into smoking through glamorous advertisements. In this connection, the ban on selling cigarettes to children under 16 years is a complement to the advertising ban. Equally, sponsorship of events, including sporting events, has come to a halt.

From the standpoint of health promotion, the requirement to label cigarette packages with explicit health warnings about the dangers of tobacco consumption is an important success. Tobacco consumption in developing countries, in particular, is partly the result of ignorance about tobacco-related risks. Health warnings can counter this ignorance. However, in a country where large sections of the population are functionally illiterate, the efficacy of health warnings on cigarette packs is questionable, more so when the warnings are frequently in English which is not the first language of many South Africans.

The reduction of tar and nicotine levels is also a welcome development. The reduction of tar and nicotine will conceivably retard the onset and progress of disease. However, as alluded to earlier, such reduction may be nullified by increasing the quantity of cigarettes smoked or inhaling deeper.

Much as there are successes, there are also areas where problems have arisen. The problems are mostly confined to the ban on smoking in public places. There have been media reports that the hospitality industry has not been complying with the law (Makoni "Over 100 SA Eateries Defy Smoking Laws" 2001 wysiwyg://10/http://iafrica.com/news/sa/809676.htm). It has been reported that many restaurants and taverns have not complied with the requirements in the regulations to: designate smoking areas, display prominently a sign for the smoking area and health warning signs, and provide ventilation (Buthelezi 49-52).

Some problems are related to perceived ambiguities in the Act. It has been argued by detractors of the Act, especially, that "private clubs" do not constitute public places and are, thus, outside the purview of the Act (Makoni "Smoking in Private Clubs in a Tangle" 2001 wysiwyg://22http://

iafrica.com/news/sa/713243.htm). However, this argument flies in the face of the definition of public place under the Act which is “any indoor area which is open to the public or any part of the public and includes the workplace and a public conveyance”. As the National Council Against Smoking has pointed out, there is no club where a member of the public or part of the public does not at some stage enter for the purposes of recreation or work (“National Council Against Smoking ‘Private’ Clubs is a Myth” 21 August 2001 *Media Release*). The fact that membership of a club is open to the public brings it within the ambit of the Act. In any event, someone, whether a member of the club or an employee, will need, at some stage, to enter the premises where such a club convenes. That would render the venue of the private club a public place or a workplace and thus within the ambit of the Act.

Another argument relating to the perceived ambiguities of the Act is that it is unclear whether it makes it an offence to smoke in a public place. In August 2001, for example, the police in the Western Cape received legal advice to the effect that though the Act forbade smoking in a public place, it did not specifically declare it to be an offence (Anon “Young Men Jailed for Public Smoking” 2001 wysiwyg://36/http://iafrica.com/news/sa/561748.htm). In 2001, the Western Cape Police Commissioner advised all stations that smoking in a public place was prohibited but did not constitute an offence. This view was also adopted by the Western Cape Director of Public Prosecutions who said that “With regard to whether the legislation makes it an offence to smoke in a public place, I am of the opinion that it does not”. However, this is an incorrect view that has been robustly refuted by the Department of Health (Makoni “Health Department in a Puff Over Smoking Law” 2001 wysiwyg://16/http://iafrica.com/news/sa/711130.htm; and Meyer “No Loopholes for Public Puffers” 2001 wysiwyg://16/http://iafrica.com/news/sa/746925.htm). The preamble to the Act is explicit in its intention to make smoking in public places an offence. The very fact that in section 2(1) the Act prohibits smoking in a public place is an indication of the intention to make such conduct an offence. Even more conclusive, is the fact that in section 7(1), the Act prescribes a penalty for non-compliance with the prohibition against smoking in public places. In short, the Act complies with the principle of legality which requires that a person can only be punished if a crime has been defined by law, and if proved to have committed the offence.

Perhaps an even more fundamental problem with the Act has been enforcement. The deterrent element in legislation prohibiting smoking in public places lies in the possibility of the offender being ultimately prosecuted. The efficacy of such legislation also depends on complaints being made by members of the public to an appropriate authority. A problem has, however, arisen from the negative attitude of the police. The National Commissioner of Police, Jackie Selebi, is reported to have said that the

police do not have the resources to police the prohibition against smoking in public places. Furthermore the National Commissioner of Police has expressed the opinion that such laws were never meant to be policable, but subject to peer pressure only (Makoni "Selebi Fumes Over Smoking Laws" 2001 wysiwyg://16/http://iafrica.com/news/sa/716483.htm). A spokesman for the South African Police Services also echoed the view that the police do not have the resources to enforce the ban on smoking and that such law will be given low priority (Buthelezi 50). Such views are, however, at variance with the Department of Health which receives complaints daily from the public about breaches of the law. Indeed there has been a successful prosecution relating to a breach of the ban on smoking in a public place (Anon "Young Men Jailed for Public Smoking" 2001 wysiwyg://36/http://iafrica.com/news/sa/561748.htm). But given the general apathy of the police, what is needed at a practical level is perhaps to accord environmental officers the special responsibility of policing the law (Buthelezi 57). Environmental officers can, with the voluntary assistance of interest groups such as the National Council Against Smoking, develop and implement effective enforcement of the law.

6 Conclusion

Though South Africa's Tobacco Products Control Amendment Act preceded the Framework Convention on Tobacco Control, it was nonetheless influenced by global developments and thinking on tobacco control. It is for this reason that the provisions of the Act are consonant with the spirit and objectives of the Convention. The major challenge facing South Africa is the enforcement of the Act so that tobacco control measures are translated into positive health gains. It is crucial that the Act is monitored and enforced and that all relevant enforcement agencies, including the police, facilitate rather than impede its enforcement.

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