



INTERSECTORAL CASE STUDY

SUCCESSFUL TOBACCO LEGISLATION IN SOUTH AFRICA

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SUMMARY

In South Africa (SA), smoking results in 58% of lung cancer deaths, 37% of chronic obstructive pulmonary disease deaths, 20% of TB deaths, and 23% of cardiovascular deaths. Smoking-related TB deaths are especially prevalent in SA and Sub-Saharan Africa due to a higher vulnerability of HIV-positive individuals to TB. In SA, academic institutions and NGOs have provided country-specific data on the health burdens of tobacco and used them as effective evidence to advocate for tobacco regulation. Research, however, has not been limited solely to the health sector. The economics of tobacco played a significant role in tobacco legislation, and country-specific research and econometric models measured the costs and benefits of tobacco consumption. Public opinion polls complemented quantitative data and revealed a majority of SA citizens supported all forms of tobacco regulation. Public attitudes proved to be important in reflecting the interest of SA as a whole and not just its industries.

As a result of the multifaceted evidence and attention provided, the SA government passed the Tobacco Products Control Act in 1993. However, the tobacco dilemma could not be solved with one legislative move. Following SA's political shift to the African National Congress (ANC) at the end of apartheid, strong anti-tobacco advocacy from President Nelson Mandela and his Minister of Health, Nkosazana Zuma, allowed the SA government to pass additional amendments to strengthen the Act and address the tobacco industry's exploitations of loopholes. Whereas her predecessor had consulted with the tobacco industry before drafting the 1993 Act, Minister of Health, Zuma held fewer consultations with the industry to prevent draft regulations from being watered down. After ratifying the World Health Organization's Framework Convention on Tobacco Control (WHO FCTC) treaty in 2005, the SA government continues to pass amendments to the 1993 Act, in order to comply with the international deadlines for specific regulations.

Monitoring smoking in SA has been key in tracking the overall trend in smoking prevalence rates and showing the effectiveness of legislation, education, and taxation against the tobacco industry. Local monitoring proved that initial fears about the negative impacts on the economy from tobacco regulations were not well founded. While about a third of SA smoked in 1993, the smoking population was reduced by half to about 16.4% in 2012. Tobacco regulations in SA have had the biggest impact on Black South Africans with respect to ethnic groups and on 16–24 year olds with respect to age. The large decrease in tobacco consumption in these two groups reflects their high price sensitivity to tobacco excise tax increases. However, since these large decreases in tobacco consumption were measured by official statistics, it is possible that smoking may have a higher-than-observed consumption rate in SA due to "roll-your-own" and illicit tobacco products. The tobacco industry has had a tendency to over-exaggerate the prevalence of these illicit sales in order to lobby against high taxation rates. In addition, SA has seen a simultaneous rise in the use of smokeless tobacco products, especially among youth. Nonetheless, taxation on tobacco has proven to be the most cost-effective method at a population level.

Introduction

Tobacco regulation in South Africa was not an overnight one-step measure, but rather, an organic process over several decades. The first tobacco law, the Tobacco Products Control Act, was passed in 1993, but amendments were regularly added to strengthen loopholes/concerns and will continue to be added in the future. This report provides a roadmap of the Tobacco Products Control Act of 1993, its subsequent regulations and amendments, and the intersectoral process undertaken to address the tobacco epidemic through legislation. It also illustrates the context of tobacco's prevalence in South Africa, ranging from historical backgrounds to statistical data on smoking rates and smoking-related deaths. The report concludes with recommendations for other Low-and-Middle Income Countries (LMIC) using the South African tobacco narrative as an example.

Methodology

We conducted literature reviews using PubMed to search for articles that discussed tobacco's prevalence and effects within the South African context. Key search words for the health implications of South African tobacco included, "smoking," "South Africa," "prevalence," and "death rate." We also searched the South African Medical Journal (SAMJ) using the same key search words. We screened titles and abstracts and read full texts of relevant articles. For government documents, we accessed government archives at info.gov.za and searched under "health-public health" for a list of acts and bills concerning tobacco regulations. For international comparisons, we searched WHO files and referred to the WHO Global Tobacco Reports from various years. Dr. Yussuf Saloojee, a veteran anti-tobacco advocate and Director of the South African National Council Against Smoking, reviewed this report.

1. General background

1.1 Trends in smoking prevalence

Smoking prevalence in South Africa (SA) has declined since the initiation of the first South African tobacco regulations in 1993. The prevalence rate is currently at 16.4% according to South African National Health and Nutrition Examination Survey (SANHANES-1) (1). Smoking prevalence, however, is not uniform in SA with respect to ethnicity, gender, age, and income. Tables 1 and 2 illustrate the differences in South African smoking prevalence across specified groups. Table 3 provides a comparison of smoking prevalence across Brazil, Russia, India and China, (BRICs) based on 2013 MPOWER findings.

Prior to 1993, the smoking prevalence in SA was more or less within a consistent range across different age groups (~25%) and income levels (~33%), respectively. Following the initial tobacco regulations in 1993, the greatest decreases in prevalence rates occurred in both the youngest age group (16–24), as well as the lowest income-level tiers (ZAR 1–1399), suggesting price sensitivity with respect to tobacco taxes.

TABLE 1: SMOKING PREVALENCE PERCENTAGES IN SOUTH AFRICA BEFORE AND AFTER INITIAL TOBACCO REGULATIONS

	1993	2003	2010
Total	32.6	23.8	20.9
Ethnicity			
Coloured	50.9	43.9	42.9
White	36.0	35.6	35.9
Indian	31.5	28.6	27.1
Black	28.4	19.5	15.6
Gender			
Male	51.8	39.0	33.3
Female	13.2	10.2	9.8
Age			
16–24	28.0	17.0	—
25–34	25.7	27.9	—
35–49	25.5	30.6	—
50+	20.8	20.7	—

Adapted from van Walbeek (2) and SAARF/AMPS (3).

TABLE 2: COMPARISON OF SMOKING PREVALENCE PERCENTAGES IN SOUTH AFRICA BY MONTHLY HOUSEHOLD INCOME

Monthly income level	Proportion of population (1993)	1993	2003
ZAR 1–499	21.0	29.4	21.2
ZAR 500–899	20.0	30.7	19.8
ZAR 900–1399	17.6	32.1	22.2
ZAR 1400–2499	14.5	33.2	24.8
ZAR 2500–3999	9.0	34.6	25.7
ZAR 4000–6999	9.2	35.6	27.4
ZAR 7000–11999	5.8	34.4	31.5
ZAR 12000+	2.9	29.2	29.1

Adapted from van Walbeek (2).

TABLE 3: MPOWER 2013 TOBACCO SMOKING PREVALENCE PERCENTAGES ACROSS BRICs COUNTRIES

	Brazil	Russia	India	China	South Africa
Prevalence:	15.0	34.0	12.0	23.0	14.0

Adapted from World Health Organization (4).

1.2 The health burden of tobacco

In 2000, smoking ranked third as a risk factor for mortality in SA behind HIV/AIDS and hypertension. Smoking caused 8% of deaths (45,000 deaths a year) and 3.7–4.3% of Disability-Adjusted Life Years (DALYs)—a measure of morbidity and mortality (5). In comparison, about 25% of deaths in the United States and the United Kingdom were related to smoking in 2000 (6). SA's smoking-related death rate appears to be relatively lower because tobacco use has only become common relatively recently (since the 1970s). The level of cigarette consumption in SA is lower than that of developed countries and SA experiences a general decreased life expectancy due to HIV/AIDS/TB.

The relatively high rate of tobacco-related TB deaths is common in LMICs. Studies in China (7) and India (8) found that smokers had higher TB-related death rates than non-smokers. Smoking-related TB death is especially prevalent in SA and other Sub-Saharan African countries. In SA, higher TB rates are exacerbated by the HIV/AIDS situation, where 10% of the population is HIV positive (5, 9). Overall, smoking results in 58% of lung cancer deaths, 37% of chronic obstructive pulmonary disease deaths, 20% of TB deaths, and 23% of cardiovascular deaths in SA (5). Although lung cancer has the highest association with smoking, tobacco-related cardiovascular diseases cause more deaths in SA (10). While approximately 5,000 died from smoking-related lung cancer in 2000, more than twice as many died from smoking-related cardiovascular complications in the same year(5).

1.3 Brief history of South African ties to tobacco

It is important to note that the initiation of South African tobacco regulations overlapped with the country's political restructuring period immediately following the apartheid era. Acknowledgement of this connection allows for further understanding of the importance of political ties to the tobacco industry. Until the mid-20th century, the white Afrikaner community was based mostly in the agricultural sector of the South African economy (2). Anton Rupert, an entrepreneur in cigarette sales, founded the Voorbrand Tobacco Company in 1940, which later grew into the giant Rembrandt conglomerate and which secured a controlling interest in Rothmans International in 1954. Rembrandt soon became the "Afrikaner symbol of economic, and specifically industrial, liberation" (2). In 1999, Rembrandt's cigarette sector merged with British American Tobacco (BAT), which currently has 86% of the market share in SA (11).

Due to its historical and cultural ties to tobacco, the ruling Afrikaner National Party of the apartheid era remained hesitant and even unwilling to address the need for tobacco regulations. In contrast, the African National Congress (ANC) party had no ties with the tobacco industry, which allowed for a strong anti-tobacco stance, confirmed by the first South African ANC president, Nelson Mandela, and his Minister of Health, Nkosazana Zuma. Following the Tobacco Products Control Act of 1993, efforts to add and strengthen tobacco regulations resumed in the post-apartheid transition under the ANC's leadership. Regulations were enacted in 1995.

2. Initiation of the policy

2.1 Early academic action

The South African research community understood the need for political, social, and economic action against tobacco from as early as 1963. A publication in the South African Medical Journal (SAMJ) not only argued for the link between cigarette smoking and lung cancer, but also urged for legislation, education, and taxation against the tobacco industry (12). Despite small and weak government interventions, SA lacked a comprehensive set of bans against the tobacco industry. As the negative health effects of tobacco products became common knowledge worldwide by the 1990s, South African academics began to focus on public opinion and the potential economic effects of tobacco regulations.

Economic evidence has been important. In 1988, the South African Medical Research Council (SA MRC) conducted a cost-benefit analysis showing that health care spending and loss of productivity outweighed the revenue gained through tobacco taxation (13). In 1992, the SA MRC showed that while the benefits of tobacco to the economy (wages and VAT/excise tax revenue) totalled ZAR 0.99 billion, the costs of tobacco (expenditure on tobacco, loss of productivity, and health care spending) was ZAR 3.64 billion (14). Not all South African academics agreed with the findings. A 1994 paper criticized the SA MRC analysis, arguing that the benefits from tobacco tax revenue exceeded government expenditures (15). In the late 1990s, additional publications argued against the link between tobacco advertisement and levels of tobacco consumption (16, 17). However, it is important to note that some

of these academics who disagreed had ties to the tobacco industry and some of the arguments were flawed because of the way they treated tobacco addiction.

Regardless of the opposition to tobacco regulation, the 1988 and 1992 SA MRC reports voiced a strong appeal for government intervention that created the impetus for political action. In 1992, 60% of the South African public was in agreement with a ban on all tobacco advertisements, 75% for a ban on tobacco sales to children, 56% for increases in tobacco taxes, and 44% for a ban on tobacco-related sport sponsorships (18).

2.2 Early government action

Twelve years after the 1963 SAMJ publication, the South African government and the tobacco industry took their first steps towards smoking reform by entering into a voluntary agreement to ban tobacco advertisements on television. Another twelve years later in 1987, the tobacco industry voluntarily enforced the printing of a small health warning on cigarette packages. In 1989, the government banned smoking on domestic flights. These actions were not sufficient, according to the tobacco control advocates, and in 1991, those in favour of regulation accused the South African government of being too protective of the tobacco industry and not its own citizens (19). In response to parliamentary questions about the 1992 SA MRC report, the newly appointed Minister of Health, Rina Venter, sought to introduce and pass the nation's first comprehensive anti-tobacco legislation.

The Minister of Law and Order was adamant that the regulations would never reach Parliament and declared that he and the then State President F.W. de Klerk—then a chain-smoker—would oppose the bill (19). However, the Minister of Health was not alone as she had the full support of the Tobacco Action Group (TAG), a consortium of anti-tobacco advocacy NGOs. TAG readily provided all the necessary facts to bolster the regulation's push through Parliament. The Minister of Health's actions resulted in SA's first tobacco control law in the form of the "Tobacco Products Control Act, 1993." Although weak and in need of substantial revision, the Act served as a necessary initial step that allowed for further regulatory action by the ANC in the late 1990s and 2000s.

3. Description of the policy

3.1. The Tobacco Products Control Act, its regulations, and amendments

Although it was SA's first tobacco law, the Tobacco Products Control Act of 1993 was criticized for being too weak compared to international standards. It failed to provide specific national regulations on which public areas would be designated as smoke-free. However, the Act did enable local governments to enforce their own restrictions on smoking in public areas. The first to adopt these were city councils in major cities, such as Johannesburg and Cape Town. National regulations against smoking in public areas were first promulgated in 1999. The tobacco industry continued to exploit many loopholes not only in the first Act, but also in the subsequent amendments passed throughout the years. This activity by industry has created the need for the South African government to constantly update its tobacco regulations, in order to keep up with the tobacco industry. Regulations have ranged from redefining terms to eliminate legal ambiguity to completely banning tobacco advertisements in all media and sponsorships.

A summary of the Tobacco Product Control Act of 1993, its regulations and amendments by year can be found in Table 4.

TABLE 4: CHANGES OVER TWO DECADES FOR TOBACCO REGULATIONS IN SOUTH AFRICA

Regulation	Description
Tobacco Products Control Act, 1993 (21)	<ul style="list-style-type: none"> • Health hazard warnings and contents on advertisements and packages • Restrictions on vending machines • Prohibition of sales to people below age 16 • Power for local authorities to regulate smoking in public places • Penalties/fines
Regulations, 1994 (22)	<ul style="list-style-type: none"> • Specifications on: <ul style="list-style-type: none"> – health warning and labelling requirements on packages
Tobacco Products Control Amendment Act, 1999 (23)	<ul style="list-style-type: none"> • Prohibition of smoking in public places except in designated areas under prescribed conditions • Bans on tobacco advertising and sponsorships • Bans on free distribution of tobacco products • Maximum content levels in cigarettes • Penalties/fines
Regulations, 2000 (24)	<ul style="list-style-type: none"> • Specifications on: <ul style="list-style-type: none"> – Smoking in public places – Tar and nicotine levels – Advertisements and sponsorships – Point of sale
Tobacco Products Control Amendment Act, 2007 (25)	<ul style="list-style-type: none"> • Amended definitions • Bans smoking in selected outdoor areas. • Product regulation of imported and exported tobacco products • Removal of misleading terms (i.e. “light” and “mild”) from advertisements and packages • Standards for manufacturing and export of tobacco products • Increase in penalties/fines
Tobacco Products Control Amendment Act, 2008 (26)	<ul style="list-style-type: none"> • Increase in age of sale from 16 to 18 • Bans on one-to-one advertising • Bans on tobacco-like toys • Bans on tobacco sales at health and educational establishments • Tighter bans on free distribution • Tighter standards on: <ul style="list-style-type: none"> – Packaging and labelling with pictorial health warnings – Point of sales and display
Regulations, 2011	<ul style="list-style-type: none"> • Reduced Ignition Propensity (RIP) cigarettes • Draft regulation on the display of tobacco products at wholesale and retail points

Adapted from the Tobacco Institute of Southern Africa (20).

3.2 Taxes on tobacco

Increases in excise taxes on tobacco products have resulted in significant increases in the retail prices of the most popular brands from ZAR 2.55 in 1993 (ZAR 9.60 in 2013 ZAR values) to ZAR 28.50 in 2013 per pack of twenty cigarettes (2, 27). Rising retail prices have effectively resulted in a decrease in cigarette consumption. Econometric studies show that in middle-income countries such as SA, increasing tobacco taxes by 10% decreases cigarette consumption by 8% (28). Table 5 shows that taxation measures against tobacco are considered a particularly cost-effective population intervention.

TABLE 5: COST-EFFECTIVE PREVENTION FOR LMICS IN TOBACCO CONTROL (IN USD)

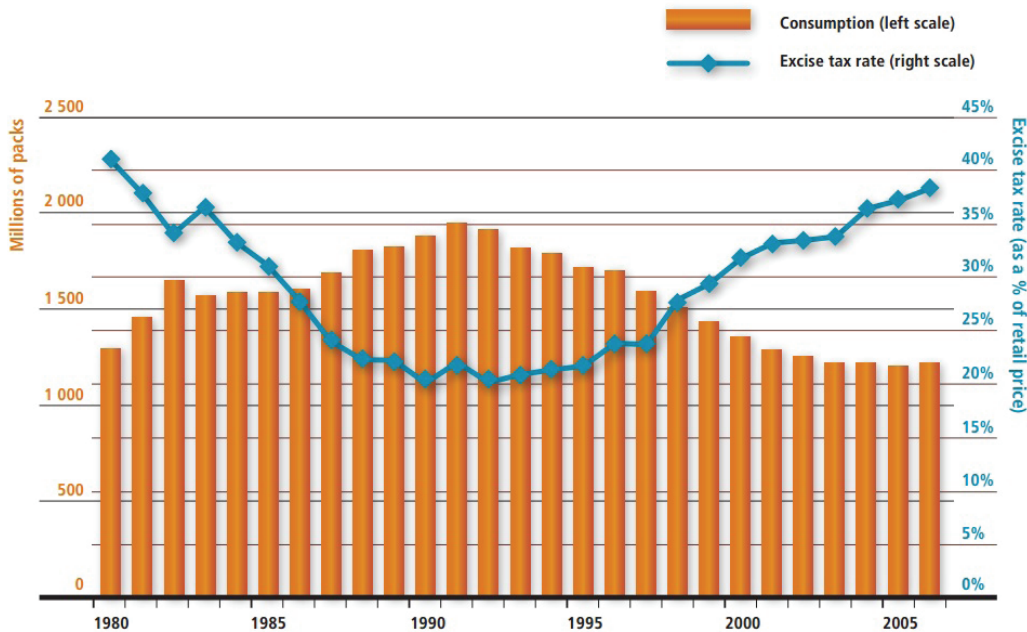
Methods used to decrease smoking	Cost-effectiveness
Nicotine replacement therapy	\$396/DALY
Regulating tobacco advertising and promotion	\$353/DALY
Increasing excise taxes on tobacco products	\$3–\$43/DALY

Adapted from Disease Control Priorities Project (29).

Since 2004, the total tax on cigarettes in SA has remained at 52% of the retail price (30). This is well below the 75% level recommended by the WHO (30). In addition, although taxation on tobacco products produced a decrease in consumption, economic forecasts show that this declining trend will not be

sustained if current tax levels are not increased. Figure 1 demonstrates the initial steep drop in cigarette consumption over two and a half decades. It also shows that the number plateaued by the mid-2000s and has increased marginally since 2005. Tax on tobacco must factor in rates of inflation and increase in earnings or else cigarettes will become relatively more affordable (30).

FIGURE 1: TRENDS IN CIGARETTE CONSUMPTION OVER TIME IN RELATION TO EXCISE TAX RATES IN SOUTH AFRICA



Retrieved from the World Health Organization (31).

3.3 Further regulation considerations

On 16 June 2003, the South African government signed the WHO Framework Convention on Tobacco Control (FCTC), an attempt at an international standardization of tobacco regulation. In October 2003, Health Minister Manto Tshabalala-Msimang disclosed plans for further amendments to SA’s tobacco regulations in order to align the country with the FCTC. The National Department of Health continues to update the tobacco regulations and currently publishes a regular report card to inform the WHO of the country’s progress (28).

In order to comply with the FCTC, the South African government is currently considering implementing graphic/pictorial health warnings on all cigarette packages. These graphic warnings are projected to be more effective than text-based warnings as they are more likely to affect people with lower levels of education (32). Draft regulations, published for public comment, also propose completely banning smoking in indoor public places. The current regulations allow for a maximum of 25% of an indoor public area to be allocated for smokers, as long as it is separate, physically isolated, equipped with its own ventilation and with prescribed signage.

4. Process of intersectoral action

4.1 Passing the tobacco products control act of 1993

Following the Minister of Health’s announcements to draft a comprehensive set of tobacco regulations in 1991, the tobacco industry was determined to kill the proposed bill before it reached Parliament. However, the regulation’s endorsement from the soon-to-be president, Nelson Mandela, forced the tobacco industry to adopt different strategies, so as to minimize the bill rather than directly eliminate it altogether (2). A meeting was convened by Health Minister Dr Venter, with the industry, including its international scientific consultants and tobacco control groups, like the SA MRC, and Tobacco Action

Group. Despite the tobacco industry's attempts to use overseas experts to dilute the Bill, the tobacco control advocates succeeded by using SA context-specific research and data showing the negative effects of tobacco on the country.

Some compromises were made with the South African Parliament, in order for the initial Bill to be passed. Its final version no longer had specific regulations against smoking in public places and exempted radio advertisements from broadcasting mandatory health warnings (2). In addition, loopholes in the wording of the 1993 regulations allowed the tobacco industry to carry out "indirect" advertising without any health warnings. An increase in advertising through sponsored events soon followed (2).

4.2 Strengthening tobacco regulations under a new government

Mandela's firm stance against tobacco was mirrored by his Minister of Health, Nkosazana Zuma. Aware of her predecessor's experiences in 1993 and the loopholes in the current Act, the new Minister of Health sought a new approach to curb the tobacco industry's influence on stricter regulations. She held fewer consultations with the tobacco industry and relied on anti-tobacco experts to help her table a bill in 1998 to amend the current Act. Once the Bill was published for comments, the tobacco industry attempted to halt it by claiming a "lack of consultation" (2). However, the high court dismissed the industry's claims and the Tobacco Products Control Amendment Act of 1999 was passed.

4.3 Economic responses from the tobacco industry

Not only has the tobacco industry taken advantage of the loopholes in the Act and its amendments, it has also taken advantage of the tax measures issued against tobacco products. A study on the economies of tobacco shows that for every 10-cent increase in tobacco tax, the tobacco industry responds with an 18 cent increase in retail price (2). In other words, the industry has been riding the wave of price increases, using media publicity to blame the total increase in cigarette prices on government taxes alone.

4.4 Responses from the hospitality industry

In 1999, the hospitality industry noted serious concerns that tobacco regulations would result in loss of revenue as a result of restricting smoking in public places. A 2007 survey of restaurants showed that these concerns were unfounded; on average the restaurant sector had no change in revenue (33). In detail, 59% of restaurants reported no change in revenue, 22% reported an increase, and 19% reported a decrease in revenue following the 1999 regulations (33). According to the survey, half of the restaurants reported that no additional expenses were required to alter their establishment to comply with the regulations (33).

The biggest question, however, was how well the hospitality sector would enforce and monitor the public smoking regulations. Surprisingly, 92% of restaurants believe that they are in compliance with the regulations, because the new public smoking policies have been accepted well by both smokers and non-smokers.³³

4.5 Monitoring smoking in South Africa

The South African government and the academic sector continue to monitor smoking prevalence amongst the population by using different surveys and data collection methods. In 1998, a new question was added to the South African death registration certificate, asking whether or not the deceased was a smoker five years prior to death (10). This new addition to the death registration form has allowed researchers to find statistical correlations between smoking and the immediate causes of death. Other methods of research include the All Media and Product Survey (AMPS), South African Demographic and Health Survey (SADHS), Global Youth Tobacco Survey (GYTS), and other general household surveys.

5. Conclusion:

5.1 Progress made among the South African youth

Overall, per capita cigarette consumption decreased by 50% between 1991 and 2005, and most importantly, the youth smoking prevalence has also decreased (2). Compared to a rate of 17.6% in 1999, the youth smoking prevalence dropped to 13.6% in 2008, a decrease of about 25% (28). In addition, fewer children are exposed to smoke in their homes, dropping from 43.6% in 1999 to 32.1% in 2008 (28). Such change in youth consumption patterns is key to decreasing cigarette consumption over time. Despite the decline in smoking prevalence, however, students have now increasingly turned to other tobacco products as a substitute to cigarettes. Use of these products, such as chewing tobacco and hookah pipes, has increased from 11.8% in 1999 to 14.6% in 2008 and continues to rise (28). One possible explanation in the shift to alternate tobacco products could be a sense that non-smoking tobacco products are safer than cigarettes.

TABLE 6: COMPARISON OF SMOKING STATISTICS IN PERCENTAGES AMONGST SOUTH AFRICAN STUDENTS

	1999	2008
Smoke cigarettes	17.6	13.6
Boys	20.0	17.9
Girls	15.3	10.6
Use other tobacco products	11.8	14.6
Boys	15.7	16.9
Girls	9.4	12.8
Desire to quit smoking	69.1	77.0
Receive help to quit smoking	57.8	70.3
Learn in school about dangers of smoking	38.7	49.2

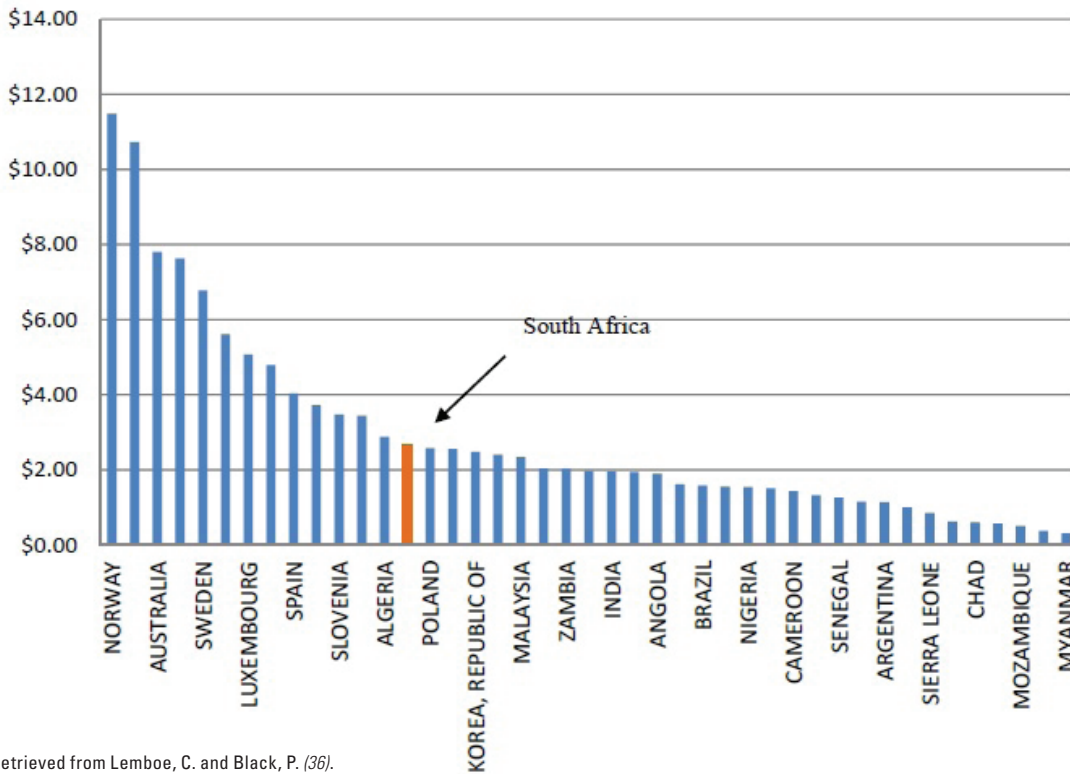
Adapted from SA: Report Card on the WHO Framework Convention on Tobacco Control (28).

5.2 Remaining challenges for South Africa

The increase in smokeless tobacco use is not restricted to the youth. A rising prevalence is noticeable among South African women, rural residents, the elderly, the poor, and the less educated, as they are unaware of the health hazards of these products (2). Roll-your-own tobacco and illicit cigarettes have also become growing alternatives to manufactured cigarettes, and they must be addressed in order to retain the country's declining smoking rate. Both alternatives are significantly cheaper to the presently high-priced cigarettes and have thus found popularity amongst the poorer population (34). The tobacco industry has especially raised concern about illicit cigarettes, which it claims are smuggled into the country by international traders and sold by street vendors. In order to address the illicit trade, the tobacco industry suggests that taxation be lowered on tobacco products. However, the tobacco industry has exaggerated the amount of taxation revenue the government loses through illicit trading. For instance, in contrast to the tobacco industry's claims that 20% of all cigarette sales are illicit, the academic sector has found the value of illicit sales to be closer to 10% (35).

South African government should, instead, keep raising its tobacco tax levels but also enforce stricter regulations and monitoring of illicit cigarette sales. The current 52% tax level on tobacco products remains short of the 75% level recommended by the WHO. Using international comparisons, cigarette prices in SA are above those in other developing countries but remain far below those in high-income countries.

FIGURE 2: COMPARISON OF CIGARETTE PRICES AROUND THE WORLD (ONE PACKAGE OF 20, IN USD)



Retrieved from Lemboe, C. and Black, P. (36).

5.3 Policy recommendations for other low-and-middle income countries

Success in tobacco legislation lies in a synchronization of domestic and international efforts. On the domestic front, country-specific data is needed to analyse the benefits of tobacco taxation revenue against the backdrop of costs in government health expenditures and lives lost. The South African example has shown the significance of persistent anti-tobacco advocacy by both academics and NGOs (2). Policy-makers must collaborate with local academic institutions and NGOs in order to obtain data to form evidence-based decisions. Research, however, should not be limited solely to the health sector. The economics of tobacco plays a significant role in tobacco legislation, and country-specific research and econometric models can help find optimal taxation rates. Taxation measures have been found to be greatly effective against tobacco consumption, and the WHO recommends tax levels of up to 75%.

Standardization is key to addressing tobacco legislation on an international level. The WHO Framework Convention on Tobacco Control (FCTC) reflects an effort to reduce tobacco consumption at a gradual yet global pace. There are currently 177 parties to the FCTC, nations which have agreed to pass required tobacco regulations in accordance to an agreed timeline. On the African continent, however, Ethiopia, Morocco, and Mozambique have not ratified the FCTC; Eritrea, Malawi, Somalia, South Sudan, and Zimbabwe have not signed the FCTC. Tobacco regulations in these countries fall below international standards, and pose serious concern as sources of cheaper, smuggled tobacco products on the continent.

Tobacco legislation has huge potential across the African continent for population health. The South African tobacco narrative is unique due to its past economic cultures and its present political situation. Current South African tobacco regulations would not have been possible without endorsements from leading public figures, such as Nelson Mandela, and socio-political reforms following the apartheid era. Tobacco regulations, in a sense, rode the waves of change, and in many international cases, political change is necessary to bring tobacco legislation to attention.

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