WHO FRAMEWORK CONVENTION
ON TOBACCO CONTROL

# Best practices in implementation of Article 8 of the WHO FCTC
# Case study: Seychelles

NATIONAL BEST PRACTICES SERIES PAPER N/3

# BEST PRACTICES IN IMPLEMENTATION OF ARTICLE 8 OF THE WHO FCTC
# CASE STUDY: SEYCHELLES

Patricia Lambert and Kaitlin Donley
July 2013

FCTC
WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL

## I. Scientific evidence

Scientific evidence has unequivocally established that exposure to tobacco smoke causes death, disease, and disability, a fact recognized by the Parties to the World Health Organization Framework Convention on Tobacco Control ("WHO FCTC").[1] Tobacco smoke contains more than 7000 chemicals and compounds, approximately 70 of which are known or suspected human carcinogens.[2, 3, 4] There is no safe level of exposure to tobacco smoke and even brief periods of exposure to low levels of tobacco smoke are harmful.[56] As a result, only the creation of 100% smoke-free environments provides effective protection from the health risks of exposure to tobacco smoke.

Measures restricting smoking to designated smoking areas or rooms do not provide adequate protection, despite being portrayed by the tobacco industry as suitable alternatives to a smoking ban. The evidence behind the ineffectiveness of designated smoking areas or rooms is robust. An Australian study demonstrated that providing separate areas for smokers and non-smokers provided "little to no protection" from environmental tobacco smoke.[7] Restricting smoking to physically separate designated smoking "rooms" was only marginally better than restricting smoking to separate "areas" within the premises. An engineering study commissioned in 2009 by the Government of Hong Kong to test the feasibility of smoking rooms concluded that tobacco smoke inevitably leaks out of designated smoking rooms despite stringent design and ventilation standards.[8] Similarly, a 2012 study of restaurants in Pretoria, South Africa (see the South Africa case study, also available at: http://www.who.int/fctc/implementation/en/), found high levels of smoke pollution in non-smoking areas of restaurants.[9] The median air quality measurement in the non-smoking areas was "at least seven times higher than the WHO standard … set for good air quality," with the data suggesting that such smoke pollution was coming from designated smoking rooms. Under current South African law, separate designated smoking rooms must meet certain design requirements, including having separate ventilation. The results from this study of Pretoria restaurants add to the body of scientific evidence demonstrating that designated smoking rooms are ineffective. Moreover, the American Society of Heating, Refrigerating and Air-Conditioning Engineers, an association of over 50 000 business design professionals, has examined the science behind designated smoking rooms and has concluded that "[a]t present, the only means of eliminating health risks associated with indoor exposure [to second-hand smoke] is to ban all smoking activity".[10]

There is strong evidence to support the fact that smoke-free policies provide a wide range of public health benefits, including a decrease in tobacco consumption and in youth smoking initiation as well as an overall reduction in heart attacks among other physiological benefits.[11] A recent study in Uruguay showed a significant decrease in the incidence of acute heart attacks after the implementation of 100% smoke-free places.[12] Restrictions on smoking in public places can decrease consumption by between 4% and 10% and induce some smokers to quit, according to a World Bank analysis.[13] Studies have also shown a decrease in smoking in the home following implementation of a smoking ban; contrary to assertions that smoking in the home would increase.[14]

And a recent study from India confirmed that such results extend to low- and middle-income countries with growing tobacco-induced disease burdens.[15] The study found that implementation of smoke-free legislation was associated with a higher proportion of adults reporting living in smoke-free homes.

Arguments against smoke-free air are frequently inserted into the public debate by the tobacco industry, which seeks to promote tobacco consumption by ensuring that it will be easy for people to use its product in as many places as possible. It uses allies and front groups, particularly within the hospitality sector, to speak out publicly against smoke-free policies; to demand that smoking rooms or smoking areas be set up as a courtesy to smokers; and to advocate for costly and complex ventilation systems even though these have been proven to be ineffective.

A persistent argument against smoking bans is that they will have a negative economic impact, particularly on the hospitality industry, as smokers would patronize restaurants and bars less frequently and profits and jobs would be lost as a result. However, evidence from across the globe, including South Africa, shows that such legislation has not harmed business, and has in some cases had a positive economic impact. The WHO International Agency for Research on Cancer (IARC) reviewed 47 peer-reviewed studies that were based on survey data and found that all 47 studies concluded that "smoke-free policies have either no economic impact or a positive economic impact on the businesses affected by them".[16] Similarly, in a survey of over 1000 South African restaurants, economists concluded that, overall, the results indicated, "restaurants have not been systematically harmed by the clean indoor air legislation".[17]

## II. Article 8 of the WHO FCTC: Parties' obligations and evidence-based implementing guidelines

Article 8 of the WHO FCTC requires Parties to adopt and implement effective measures "providing for protection from exposure to tobacco smoke in indoor workplaces, public transport, indoor public places and, as appropriate, other public places".[18] The Guidelines on Protection from Exposure to Tobacco Smoke ("the Guidelines") were adopted by consensus in 2007 at the second session of the Conference of the Parties to assist Parties in meeting their obligations under Article 8.[19, 20] They are based on the best available scientific evidence and draw from Parties' experiences in implementing measures to provide protection from exposure to tobacco smoke.[21]

***Smoke-free provisions.*** The Guidelines establish that for Parties to meet their obligations under Article 8 of the WHO FCTC, they must require 100% smoke-free environments.[22] Any measures that fall short of creating 100% smoke-free environments – including measures allowing for designated smoking rooms with separate ventilation, air exchange, and other engineering features – do not provide protection against exposure to tobacco smoke.[23]

Under the Article 8 Guidelines, no exemptions to a 100% smoke-free law "are justified on the basis of health or law arguments".[24] If exemptions must be considered, Parties

have a continuing obligation under Article 8 to remove any exemption as quickly as possible and should strive to provide *universal* protection within five years of the treaty entering into force for that Party.[25]

Article 8 of the WHO FCTC requires the adoption of effective measures to protect people from exposure to tobacco smoke in four categories of places:

- indoor workplaces;
- indoor public places;
- public transport; and
- outdoor and quasi-outdoor places, where appropriate.[26,27]

In determining which outdoor or quasi-outdoor places are appropriate subjects of smoke-free legislation, Parties must consider evidence as to the possible health hazards in various places.[28]

***Definitions.*** The Guidelines define several key terms to help shape the scope of protection to be provided. These definitions make clear that protection should extend to all indoor workplaces, including motor vehicles used as places of work such as taxis and ambulances, [29] and to all parts of indoor workplaces and public places, including corridors, stairwells, lobbies, etc.[30]

***Duties and penalties.*** Effective legislation should place legal responsibilities on both affected business establishments (i.e. the owner, manager, or other person in charge of the premises) and individual smokers.[31] The Guidelines identify four duties that should be placed on the person in charge of the premises:

- a duty to post clear signs indicating that smoking is prohibited;
- a duty to remove any ashtrays from the premises;
- a duty to supervise the observance of rules; and
- a duty to take reasonable specified steps to discourage individuals from smoking in the premises.

The duty placed on the individual smoker is to comply strictly with prohibitions on smoking. For breach of these duties, the Guidelines recommend monetary penalties for business establishments and leave open to Parties whether to impose monetary penalties on individual smokers.[32] Fines must be sufficiently large to deter violations, with higher fines for businesses than for individual smokers given the resources available to each, and should increase for repeat offences.[33] The Guidelines also leave open the possibility of administrative sanctions and criminal sanctions in addition to monetary penalties, depending on what would be appropriate given each Party's general practice and legal system.[34] Administrative sanctions may include business licensure suspension or revocation and would be "sanctions of last resort".

***Inspections and enforcement.*** The Guidelines urge Parties to consider utilizing an inspections mechanism already in place, if possible, to monitor compliance with and enforce the provisions of smoke-free legislation.[35] Use of a pre-existing mechanism reduces costs associated with enforcement by eliminating the need to hire and train

large numbers of new personnel.[36] Possible pre-existing inspections mechanisms may include: business licensing inspections; health and sanitation inspections; inspections for workplace health and safety; and fire safety inspections. The Guidelines also highlight the ways in which smoke-free legislation is "self-enforcing," or enforced by the public, noting that in many jurisdictions, citizen complaints are the "primary means of ensuring compliance".[37] To facilitate enforcement by the public, the Guidelines recommend establishing a toll-free telephone number that members of the public can call to report a violation.[38]

***Protecting against industry interference.*** The Article 8 Guidelines also recognize the dangers of tobacco industry interference in smoke-free laws and policies and include important recommendations for Parties on how to counter tobacco industry tactics. These should include "monitoring and responding to tobacco industry activities that undermine the implementation and enforcement of smoke-free legislation, as specified in Article 20.4 of the WHO FCTC" (Principle 6).[39]

Reflecting Principle 6 of the Article 8 Guidelines, Recommendation 1.2 of the Guidelines for implementation of Article 5.3 urges Parties to "raise awareness about the tobacco industry's practice of using individuals, front groups and affiliated organizations to act, openly or covertly, on their behalf or to take action to further the interests of the tobacco industry".[40] There is clear evidence that the tobacco industry has worked through front groups, particularly in the hospitality sector, to dilute or delay the implementation and enforcement of smoke-free places. The industry has used front groups to influence legislation at all levels, beginning with, for example, a local restaurant association in Beverly Hills, California (USA), in 1987 and moving up to collaboration with existing international hospitality organizations at both the national and international levels, including the International Association of Hotels, Restaurants, and Cafés (HORECA) and the International Hotel Association (IHA).[41]

## III. SEYCHELLES

Seychelles was the first country in the WHO African Region to ratify the WHO FCTC, doing so in November 2003.[42] However, like in South Africa, tobacco control policies in Seychelles pre-date the WHO FCTC by many years. In Seychelles, tobacco control has been an important public health issue since the late 1980s and has been the subject of legislation and numerous national surveys of adults[43, 44] and of children[45] and community awareness programmes.[46] Smoking has been banned on public transport since colonial times (pre-1976) and in other public places such as health-care and educational facilities since the mid-1990s.[47] In 2000, the Ministry of Health established a National Committee for Tobacco Control to develop a national tobacco control plan, including drafting comprehensive tobacco control legislation. A strong omnibus tobacco control bill was unanimously adopted by the National Assembly in June 2009[48], after facing several years of opposition, principally from the hospitality industry, in large part due to the smoke-free provisions in the law.[49] Key factors underlying the processes that led to legislation have been highlighted in a case study appearing in an article in *The Lancet*.[50]

In addition to strong smoke-free provisions, the law prohibits most forms of direct and indirect tobacco advertising, promotion and sponsorship, and requires graphic health warnings on tobacco product packaging covering at least 50% of the two main sides of each pack. The regulations and the prescribed pictures and messages can be viewed on the web site of the Ministry of Health.[51]

### *A. Current smoke-free provisions*

The Tobacco Control Act, 2009 provides almost universal protection from exposure to tobacco smoke in indoor public places, indoor workplaces, and public transport. However, contrary to the call for no exemptions in the Article 8 Guidelines, the law provides an exemption for hotel guest rooms. Under this exemption, owners may choose whether to prohibit or restrict smoking in guest rooms. There is no requirement that a certain number of guest rooms be designated as smoke-free.

This provision was retained in the draft law-making process in the early 2000s because opposition to the legislation was mainly related to fears within the hospitality industry and related tourism ministry that a total ban on smoking in guest rooms could reduce the number of tourists visiting Seychelles, and tourism is a main source of revenue in Seychelles. The tourism industry felt strongly that tourists who may pay up to several thousands of US dollars per night in luxury hotels should be entitled to choose to smoke in their private rooms. In fact, the legislation was approved by the ministers' cabinet, after several failed attempts, once several countries in Western Europe, which account for the majority of tourists visiting Seychelles (primarily from France, Italy, and the United Kingdom), adopted strong smoke-free policies. It could then be expected that tourists from these main markets would be accustomed to strong no-smoking policies. However, even in these "early" times (early 2000s), and more so currently, many hotels in Seychelles belong to large hotel companies which have strong internal no-smoking policies for guest rooms, whether or not smoking in guest rooms is prohibited under national law. In practice, therefore, most hotels do not allow smoking in guest rooms. Nevertheless, under paragraph 24 of the Article 8 Guidelines, Seychelles has a continuing obligation to remove the exemption for hotel rooms as quickly as possible.[52]

The law extends the prohibition on smoking to some outdoor places as well, as proposed in the Guidelines.[53] The law accomplishes this by defining "public place" to include outdoor premises of health institutions, educational institutions, and children's day care centres.[54]

### *B. Duties and penalties*

The law imposes legal duties on the person in charge of the premises to post signs indicating that smoking is prohibited and to take steps to require a person to stop smoking,[55] both of which are called for by the Article 8 Guidelines.[56] However, the law fails to impose a duty to remove ashtrays. Regulations issued in 2011 require the no-smoking signs to include the no-smoking symbol and a text warning that smoking is

prohibited in one of the official languages.[57] Penalties for violation of the duties imposed include fines and/or imprisonment. As detailed in the Guidelines, the penalties increase for repeat offences (exchange rate: 1 US$ = 11 Seychelles rupees):

- Fines of between R5000 and R10000 or imprisonment for up to two years for a first offence;
- Fines of between R10000 and R15000 or imprisonment for up to three years for a second offence; and
- Fines of between R15000 and R20000 or imprisonment for up to three years for subsequent offences.[58]

Individual smokers have a duty not to smoke where prohibited and are subject to fines and, possibly, imprisonment.[59] As with the other penalties imposed and pursuant to the Guidelines, the penalties increase for repeat offences:

- Fines of between R1000 and R5000 for a first offence;
- Fines of between R5000 and R8000 for a second offence; and
- Imprisonment for up to three years for subsequent offences.[60]

The law aligns with the Guidelines in that fines for individual smokers are less than fines for persons in charge of business establishments.


**Signage requirements as prescribed in the Tobacco Control (Smoke-Free Notice) Regulations, 2011. Signs must be in one of the official languages of Seychelles – English, Seychellois Creole, or French.**

### *C. Enforcement*

The law charges the Minister of Health with responsibility for administration of the law generally, but does not impose a specific duty to inspect or enforce the law.[61] The Minister has the power to delegate this authority. In fact, the Ministry of Health has recognized the need for further regulations surrounding enforcement, specifically prescribing who has the power to inspect and how to conduct those inspections.[62]

An initial study of implementation and compliance in the period immediately following the law's enactment indicates that the smoking ban was "generally well implemented," although workers reported being reluctant to intervene when a person was smoking.[63] This reluctance may be due, in part, to the fact that only 41% of workers reported having received training on implementation of the ban. The study was also conducted during the "grace period" between the law's enactment and the imposition of penalties on offenders, which may also have affected the willingness of managers and employees to intervene. Overall, no smoking was observed in over 97% of the venues surveyed. In over 70% of the venues surveyed, patrons indicated that they had not seen smoking in those venues in past weeks. Awareness of the ban was also high – over 85% of patrons and 100% of both managers and employees were aware of the ban.

### *D. Implementation experience – public education*

Prior to the law coming into effect, the Ministry of Health conducted a multifaceted education campaign in order to educate the public about the ban.[64] Several spots about the smoking ban were broadcast on national television and radio. Leaflets were distributed and over 5000 letters were mailed to workplaces and public places. Even after the law's entry into force, the government has continued to use opportunities such as the 2011 Indian Ocean Island Games to educate the public about the ban and the benefits of a smoke-free society through television advertisements featuring sports celebrities and by providing no-smoking signs to be displayed at the Games' venues.[65]


**The 2011 Indian Ocean Island Games mascot displaying a sign to remind spectators that the Games are smoke-free.**

Health education awareness campaigns related to tobacco use are ongoing, including high profile awareness programmes organized nationally on the occasion of World No Tobacco Day each year and many programmes on national radio and TV throughout the year. These programmes reference the national tobacco control legislation and emphasize the need for enforcement of the law.

## *E. Recommendations for improvement*

Although Seychelles has very robust measures governing smoke-free places, the following improvements are recommended to strengthen its legislation and bring it into alignment with Article 8 of the WHO FCTC and its implementing Guidelines:

1. *Prohibit smoking in all indoor public places, indoor workplaces, and public transport, without exception.* The present law does not provide for 100% protection from exposure to tobacco smoke in indoor public places, indoor workplaces, and public transport because it allows an exception for hotel guest rooms. It is important to remember that hotel guest rooms are workplaces for some people. It is critical that workers in the hospitality industry, in addition to hotel guests, are protected under the law.

2. *Expand the list of outdoor and quasi-outdoor places where smoking is prohibited.* Article 8 of the WHO FCTC and the Article 8 Guidelines also require that Parties prohibit smoking in outdoor or quasi-outdoor places, where appropriate, based on evidence as to the possible health hazards.[66] The law currently prohibits smoking in outdoor areas of health institutions, educational institutions, and children's day care centres. Policy-makers should consider extending the prohibition to additional outdoor places in order to expand protection from exposure to tobacco smoke.

3. *Place a duty to remove ashtrays from smoke-free premises on the person in charge of the business establishment.* A duty to remove ashtrays helps shift the social norms around smoking and can aid in self-enforcement of the law.

4. *Consider including administrative sanctions*, such as business licensure suspension or revocation, among the possible penalties for establishments that repeatedly violate the law governing smoke-free places.

5. *Specify who has the authority to conduct inspections and outline their powers.* At the African Regional Meeting on Implementation of the WHO FCTC in October 2012, the focal point for tobacco control within the Ministry of Health recognized the need to clarify enforcement authority under the law.[67] It is also important that enforcement officers receive training on their duty to conduct inspections and the scope of their powers.

6. *Monitor compliance and strengthen enforcement.* Monitoring compliance with the law can help identify weaknesses in the enforcement system in place. Once identified, resources can be shifted and additional training can be provided to inspectors to help boost enforcement and overall compliance. A study of compliance under the law was conducted immediately following implementation; a follow-up study should be undertaken now that the law has been in place for several years.

## IV. CONCLUSION

Scientific evidence indicates overwhelmingly that smoke-free policies, and in particular the creation of 100% smoke-free environments, positively influence attitudes, behaviour and health. They assist greatly in the process of denormalizing smoking in society, of encouraging adults to quit smoking and of preventing young people from acquiring the addiction to cigarettes and other tobacco products.

South Africa and Seychelles both have a rich history of tobacco control, almost unique in the low- and middle-income countries of Africa. It is clear that both countries have exhibited the necessary political will not only to draft legislation for smoke-free environments but also to exert that will through proper implementation and enforcement of their laws. In so doing, both governments demonstrate clearly to their own citizens and to the governments and peoples of Africa, their knowledge and acceptance of the dangers associated with tobacco smoke as well as their acknowledgement that there is an increasing desire for clean air on the part of the general public. They lead by example and their example can, and should, be followed.

Not only have both countries provided smoke-free indoor public places, a general norm in tobacco control, but they have extended the prohibition on smoking to certain private places, like motor vehicles where young children are present, and to an increasing number of outdoor places as well, in line with Article 8 of the WHO FCTC and the Article 8 Guidelines. Unfortunately, however, neither country has, to date, managed to achieve the desired international and WHO FCTC standard of 100% smoke-free environments in all indoor public places, indoor workplaces, and public transport. Seychelles continues to provide an exemption for hotel rooms, and this is of particular concern as tourism is a significant part of the economy of Seychelles. South Africa's 2007 legislation mandates the Minister to create 100% smoke-free environments and regulations were gazetted in March 2012, but final regulations that would translate the policy into action have yet to be issued.

---

[1] WHO Framework Convention on Tobacco Control (hereinafter "WHO FCTC"), Article 8(1).

[2] U.S. Department of Health and Human Services. The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Coordinating Center for Health Promotion, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2006.

[3] World Health Organization. Protection from Exposure to Second-hand Tobacco Smoke: Policy Recommendations, 2007 (hereinafter "WHO Policy Recommendations (2007)"). Available at: http://whqlibdoc.who.int/publications/2007/9789241563413_eng.pdf.

[4] U.S. Department of Health and Human Services. National Toxicology Programme Report on Carcinogens (12 ed.), 2011. Available at: http://ntp.niehs.nih.gov/ntp/roc/twelfth/profiles/TobaccoRelatedExposures.pdf.

[5] WHO Policy Recommendations (2007).

[6] Bonetti PO, Lardi E, Geissmann C, Kuhn MU, Brüesch H, Reinhart WH. 2011. Effect of brief secondhand smoke exposure on endothelial function and circulating markers of inflammation. *Atherosclerosis*. 2011 Mar; 215(1):218-22.

[7] Cains T, Cannata S, Poulos R, Ferson M J, Stewart B W. 2004. Designated "no smoking" areas provide from partial to no protection from environmental tobacco smoke. Tob Control 2004; 13:17–22.
[8] (Hong Kong) Legislative Council Panel on Health Services. Findings of Technical Feasibility Study on Smoking Rooms. LC Paper No. CB(2)1876/08-09(01). 20 April 2009.
[9] There was a positive correlation between the level of indoor smoking pollution and the "active smoking density," which is the average number of burning cigarettes in the smoking section per 100 $m^3$ of non-smoking area. Ayo-Ysuf OA. Research Letter: Tobacco smoke pollution in the 'non-smoking' sections of selected popular restaurants in Pretoria, South Africa. *Tob Control* doi: 10.1136/tobaccocontrol-2012-050738. Published online first: 11 December 2012.
[10] Samet J et al. ASHRAE position document on environmental tobacco smoke. American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE). Atlanta, GA: 2005. Available at: http://www.ashrae.org/File%20Library/docLib/About%20Us/PositionDocuments/ASHRAE_PD_Environmental_Tobacco_Smoke_2010.pdf.
[11] Sargent R et al., Reduced incidence of admissions for myocardial infarction associated with public smoking ban: before and after study. *British Medical Journal.* 2004; 328(7446):977-80.
[12] Sebrie E M et al. Hospital admissions for acute myocardial infarction before and after implementation of a comprehensive smoke-free policy in Uruguay. Tob Control. doi:10.1136/tobaccocontrol-2011-050134.
[13] Prabhat Jha & Chaloupka F J. Curbing the epidemic: governments and the economics of tobacco control, 51-53. The World Bank. 1999.
[14] Mons U et al. 2011. Impact of national smoke-free legislation on home smoking bans: findings from the International Tobacco Control Policy Evaluation Project Europe Surveys. *Tob Control* doi:10.1136/tobaccocontrol-2011-050131.
[15] Lee JT et al., Association between smoke-free workplace and second-hand smoke exposure at home in India,
[16] International Agency for Research on Cancer (IARC), "Evaluating the effectiveness of smoke-free policies: IARC Handbooks of Cancer Prevention, Tobacco Control, volume 13," World Health Organization (WHO), IARC, 2009, http://www.iarc.fr/en/publications/pdfs-online/prev/handbook13/handbook13.pdf. Accessed April 2013.
[17] van Walbeek C et al., Effects of the Tobacco Products Control Amendment Act of 1999 on restaurant revenues in South Africa – a survey approach, *South African Medical Journal* 2007; 97(3):208-11. Available at: www.samj.org.za/index.php/samj/article/download/780/250. Accessed April 2013.
[18] WHO FCTC Article 8(2), http://whqlibdoc.who.int/publications/2003/9241591013.pdf.
[19] Decision A/FCTC/COP/2/7, http://apps.who.int/gb/fctc/PDF/cop2/FCTC_COP2_7-en.pdf.
[20] Guidelines for Implementation of Article 8 of the WHO FCTC: Protection from Exposure to Tobacco Smoke (hereinafter, Article 8 Guidelines), para. 1, http://www.who.int/fctc/cop/art%208%20guidelines_english.pdf.
[21] Article 8 Guidelines, para. 1.
[22] Article 8 Guidelines, para. 6.
[23] Article 8 Guidelines, para. 25.
[24] Article 8 Guidelines, para. 24.
[25] Article 8 Guidelines, para. 24.
[26] WHO FCTC Article 8(2).
[27] Article 8 Guidelines, paras. 23-27.
[28] Article 8 Guidelines, para. 27.
[29] Article 8 Guidelines, para. 26.
[30] Article 8 Guidelines, para. 20.
[31] Article 8 Guidelines, para. 31.
[32] Article 8 Guidelines, paras. 31, 32.
[33] Article 8 Guidelines, para. 32.
[34] Article 8 Guidelines, paras. 33, 34.
[35] Article 8 Guidelines, para. 36.
[36] Article 8 Guidelines, para. 38.
[37] Article 8 Guidelines, paras. 39, 45.
[38] Article 8 Guidelines, para. 45.

[39] Article 8 Guidelines, para. 11.
[40] Guidelines for Implementation of Article 5.3 of the WHO Framework Convention on Tobacco Control (hereinafter, Article 5.3 Guidelines), Recommendation 1.2.
[41] JV Dearlove, SA Bialous, SA Glantz. Tobacco industry manipulation of the hospitality industry to maintain smoking in public places. Tob Control 2002;11:94-104. Available at: http://tobaccocontrol.bmj.com/content/11/2/94.full#xref-ref-44-1. Accessed July 2013.
[42] Parties to the Framework Convention on Tobacco Control, http://www.who.int/fctc/signatories_parties/en/index.html. Accessed April 2013.
[43] Bovet P et al. High prevalence of cardiovascular risk factors in the Seychelles (Indian Ocean). *Arteriosclerosis, Thrombosis and Vascular Biology* 1991;11:1730-36.
[44] Bovet P et al. Divergent fifteen-year trends in traditional and cardiometabolic risk factors of cardiovascular diseases in the Seychelles. *Cardiovascular Diabetology* 2009;8:34.
[45] Faeh D et al. Clustering of smoking, alcohol drinking and cannabis use in adolescents in a rapidly developing country. *BMC Public Health* 2006;6:169(e).
[46] Bovet P et al. Addressing non-communicable diseases in the Seychelles: towards a comprehensive plan of action. *Global Health Promotion* 2010;Supp(2):37-40.
[47] Viswanathan B et al., Linking Global Youth Tobacco Survey (GYTS) data to the WHO Framework Convention on Tobacco Control: the case for the Seychelles. *Preventative Medicine* 47(2008):S33-S37. Available at: http://www.iumsp.ch/Publications/pdf/GYTS_linking_policy_Sey.pdf. Accessed April 2013.
[48] Tobacco Control Laws – Legislation – Seychelles. Tobacco Products Control Act, 2009, Section 4(2). http://www.tobaccocontrollaws.org/files/live/Seychelles/Seychelles - Tobacco Control Act - national.pdf.
[49] Viswanathan B et al., Impact of a smoking ban in public places: a rapid assessment in the Seychelles. *Tob Control* 2011; 20:427-430.
[50] Bonita R, Magnusson R, Bovet P et al. Country actions to meet UN commitments on non-communicable diseases: a stepwise approach. *The Lancet* 2013;381:575-84.
[51] Ministry of Health, Republic of Seychelles, http://www.health.gov.sc/ (menu for downloading materials appears on the home page).
[52] Article 8 Guidelines, para. 24.
[53] Article 8 Guidelines, para. 27.
[54] Tobacco Products Control Act, 2009, Section 2.
[55] Tobacco Products Control Act, 2009, Sections 5, 6.
[56] Article 8 Guidelines, para. 31.
[57] Tobacco Control (Smoke-Free Notice) Regulations, 2011, Section 4.
[58] Tobacco Products Control Act, 2009, Section 25(2).
[59] Tobacco Products Control Act, 2009, Section 4(1).
[60] Tobacco Products Control Act, 2009, Section 25(1).
[61] Tobacco Products Control Act, 2009, Section 3(1).
[62] Bharathi Viswanathan, "Implementation of FCTC Article 8 in Seychelles," Presentation at the African Regional Meeting on Implementation of the WHO Framework Convention on Tobacco Control, Dakar, Senegal, 9-12 October 2012 (hereinafter "Seychelles Article 8 Presentation").
[63] Viswanathan (2011), at 428-29.
[64] Seychelles Article 8 Presentation.
[65] ProCor News Release, Seychelles: Promoting smoke free Indian Ocean Island Games, August 4, 2011, http://www.procor.org/news/news_show.htm?doc_id=1616701. Accessed April 2013.
[66] Article 8 Guidelines, para. 27.
[67] Seychelles Article 8 Presentation.