UUM JOURNAL OF LEGAL STUDIES
http://e-journal.uum.edu.my/index.php/uumjls

How to cite this article:
Mokhtar, K. A. (2021). The death knell of environmental tobacco smoke at public spaces: Constitutionality of smoking restrictions and smoke-free zone laws in Malaysia. *UUM Journal of Legal Studies*, *12*(2), 89-114. https://doi.org/10.32890/uumjls2021.12.2.5

THE DEATH KNELL OF ENVIRONMENTAL TOBACCO SMOKE AT PUBLIC SPACES: CONSTITUTIONALITY OF SMOKING RESTRICTIONS AND SMOKE-FREE ZONE LAWS IN MALAYSIA

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Received: 12/5/2020 Revised: 1/2/2021 Accepted: 7/3/2021 Published: 5/7/2021

ABSTRACT

Control of tobacco faces a huge obstacle because it is where important health issue has to face the powerful opposition from the wealth influence of tobacco industries (TI). Death and disease caused by tobacco use now constitute a pandemic. Unfortunately, the power and impact of tobacco's nature and commerce of its addiction make tobacco control a contentious issue of public health. The task of curbing the tobacco pandemic becomes more challenging with the use of human rights arguments and constitutional issues by smokers and the TI. This is a qualitative research on medical and legal aspects of tobacco use and smoking. This paper examines the origin of tobacco and its use as well as the development of scientific and medical

reports relating to the effect of tobacco use particularly smoking. It also demonstrates how national and global policies relating to tobacco were formulated based on the scientific findings and medical reports by giving priority to public health. This is also a legal research relating to international legal framework of tobacco control, namely the WHO Framework Convention on Tobacco Control (WHO FCTC), and the legal regulations relating to tobacco control in Malaysia as well as its enforcement strategies. The legal challenge mounted against the law and policy restricting tobacco use is also examined. The study shows the implementation of WHO FCTC is crucial in fighting tobacco pandemic. The convention also upheld the right of the people to breathe fresh and clean air by prohibiting environmental tobacco smoke (ETS) exposure in public spaces. Thus, the right must be respected by smokers and must not be infringed upon. The decision of the court is lauded because the law and policy relating to tobacco control are in line with rights guaranteed by the Federal Constitution and in tandem with WHO FCTC of which Malaysia is a party.

Keywords: Tobacco control, Framework Convention on Tobacco Control, public health.

INTRODUCTION

Smoking is not a crime and tobacco is not classified as dangerous and harmful like illegal drugs and other harmful substances. The laws in any country do not prohibit selling and using tobacco products such as cigar, cigarettes and cigarillos and others. Hence, the idea of 'the right to smoke' arises. People are free to smoke although it is harmful to their health and may damage their organs and bodies. For smokers, this is a right that must be acknowledged by the government as well as the authorities concerned. However, a wealth of research conducted worldwide by experts of medical and scientific professions from various countries, national and international agencies, and public and private institutions and organizations conclude that smoking can kill.[1] Statistics from the Ministry of Health, Malaysia reveals that the

[1] See World Health Organization. (1997). *Tobacco or Health: A Global Status Report*. Geneva: World Health Organization. Also see U.S. Department of Health and Human Services. (2020). *The Health Consequences of Smoking: A Report of the Surgeon General.* http://www.surgeongeneral.gov and World Health Organization. (2020). *Key facts on tobacco*. https://www.who.int/news-room/fact-sheets/detail/tobacco

illness in relation to smoking is a major reason of people dying in the government hospitals, accounting for 15 percent more hospitalizations and 35 percent more in-hospital deaths[2]. What most people are not aware of is that, even exposure to environmental tobacco smoke[2] may cause disease and premature death among nonsmokers. This is proven by various scientific studies including an in-depth and thorough official study by an established agency from the United States of America (U.S. Department of Health and Human Services, 2020). The study concludes that even a small exposure to smoke can cause harm to the secondhand smokers (U.S. Department of Health and Human Services, 2006). However, when the government took action and formulated a law restricting smoking in public places in Malaysia, a group of smokers were quick to challenge the validity and constitutionality of the action claiming that imposition of such a law restricts their 'rights'. Hence, the Malaysian government, the Health Ministry in particular (hereby referred as the authority), became subjected to legal challenges and court proceeding for trying to do something positive for the benefit and welfare of the people, which is, of course, part of its duty and obligation. Despite the wealth of medical and scientific studies which point to the danger of smoking, being a democratic country and government, the legal challenge brought by a team with seven members of the pro-team of *Pertahankan Hak Perokok* (Defenders of Smoker's Right) or PHP (hereby referred as the smokers) was not thrown out or dismissed terming it frivolous, vexatious or mala fide, and a mistreat used against an action of the court. Following the constitutional system that practices the doctrine of separation of powers, the court adheres to rule of law and principles of natural justice. The application by the smokers was entertained by the court which by hearing arguments and evidence tendered by them.[3] The authority was also allowed to counter whatever argument and evidence tendered by the smokers. It is quite obvious that well-intentioned law and policy, and scientifically and medically proven evidence do not automatically confer legal immunity. In this article constitutional issues relating to laws on smoking restrictions are examined. It begins with the history and use of tobacco followed by a discussion involving international human rights laws, international

[2] Environmental tobacco smoke or "ETS" refers to 'the smoke emitted from the burning end of a cigarette or from other tobacco products usually in combination with the smoke exhaled by the smoker'.

[3] *Mohd Hanizam Yunus dan lain-lain lwn Kementerian Kesihatan Malaysia* [2020] MLJU 359.

conventions and constitutional provisions. The study, which has the global interest and international dimension, will finally be focusing on the constitutional and legal positions in Malaysia.

SOCIAL, SCIENTIFIC AND MEDICAL ASPECTS OF TOBACCO AND SMOKING

History of Tobacco and Smoking

Smoking is defined as an action of breathing in and exhaling smoke of the burning material (US Legal, 2020). This is an action of burning a substance when the smoke is breathed, absorbed and tasted into the stream of blood of the human being (Wikipedia, 2020). The material which is usually used to produce the fumes is a plant material. There are a variety of plant materials that can be used for smoking such as marijuana and hashish, but the most commonly used is tobacco. Tobacco is the common name of the plant *Nicotiana tabacum* which is under the same branch of *nicotiana* genus (Wipfli, 2015). *Nicotiana tabacum* is an annual plant belonging to the eggplant family. *Nicotiana Tabacum* or cultivated tobacco was developed from the wild original tobacco or *Nicotiana Rustica*.[4] The dried leaves of the tobacco plant are used in cigarettes[5], cigars[6], or pipes[7] which are tobacco products used for smoking. The most popular way of smoking is cigarette. Historians established using radiocarbon methodology that the remains of sophisticated and fierce use of tobacco had existed in New Mexico circa 1400 – 1000 BC, and believed that cultivation of tobacco could be traced in Central Mexico since 5000 BC along with the development of agriculture (SWEDISH, 2020). When Christopher Columbus first set foot on the new continent, he was warmly welcomed by the tribes of native American and was presented gifts various fruits including dried up leaves of the tobacco plants by them. This is how Christopher Columbus became the first European to discover tobacco. The native Americans have been smoking the leaves for over 2 millennia for

[4] Tobacco was named after Tobago, the island in the West Indies from where the major part of the tobacco used in Europe was imported. Hajdu, S. I., & Vadmal. M. S. (2010) 'A Note from History: The Use of Tobacco'. *Annals of Clinical & Laboratory Science, 40(2),* 178. http://www.annclinlabsci.org/content/40/2/178.full.pdf+html

[5] Tobacco which have been rolled into a small square of rice paper to create a small, round cylinder.

[6] Tobacco wrapped in a tobacco leaf or paper made from tobacco pulp.

[7] Loose-leaf tobacco smoked in a pipe.

various purposes, including medicinal and religious. They used to chew and smoke the leaves during their ceremonies and cultural events (The Cancer Council New South Wales, 2020). Subsequently, cigarette smoking started in the 15th century when tobacco was imported by Columbus to Europe (Zalewska et al., 2009). The Portuguese sailors planted nearly all their trading outposts in the 15th century. In the middle of that century, tobacco started growing widely in Brazil and was traded in Europe and America because it became a sought-after commodity (The Tobacco-Free Life Organization, 2020). In 1531 tobacco was cultivated for the first time by the Europeans on the island of Santo Domingo (Keoke & Porterfield, 2002). Tobacco was first taken to Europe by Hernandez de Toledo, who introduced it in Spain and Portugal from Santo Domingo in 1559 (United States Census Office, 1902). Popular use of tobacco can be attributed to Jaen Nicot Villeman, the French representative to Portugal, who in 1560 presented tobacco to the French court.[8] In 1773, the consignment of tobacco to the UK was brought back by Sir Francis Drake (Clarke, 1812). Tobacco was introduced as a plant and its benefits was unfurled to the people of every single country in Europe before the end of the 16th century (The Tobacco-Free Life Organization, 2020). It then continued for centuries because it also became a symbol of monetary standard (The Cancer Council New South Wales, 2020). During the Revolutionary War, tobacco products gained its position in the US. This is evidenced when the revolutionaries used it to secure loans from France (The Tobacco-Free Life Organization, 2020).

By the 1700s the practice of smoking become more public (The Cancer Council New South Wales, 2020). Until the 19th century, chewing tobacco was the most prevalent method of consumption, but cigarettes were gradually gaining ground.[9] Cigars were commercially

[8] The name of nicotine, the addiction-causing component of tobacco, originate from his surname. Hajdu, S. I., & Vadmal. M. S. (2010) A note from history: The use of tobacco. *Annals of Clinical & Laboratory Science*, *40*(2), 178. http://www.annclinlabsci.org/content/40/2/178.full.pdf+html. Wipfli, H. M., & Samet, J. M. (2016). One hundred years in the making: The global tobacco epidemic. *Annual Review of Public Health*, *37*(1), 150. Doi: 10.1146/annurev-publhealth-032315-021850 and Zalewska, M., Jagielska, I., Kazdepka-Ziemińska. A., Ludwikowski. G. & Szymański. W. (2009). History of cigarette smoking. The effect of tobacco smoking on women's health, *Przegl Lek*., *66*(10), 885. https://www.ncbi.nlm.nih.gov/pubmed/20301962.

[9] R. J. Reynolds Tobacco Company was founded in 1875 and produced chewing tobacco, exclusively. The Tobacco-Free Life Organization. (2020). *History of Tobacco*. Retrieved from https://tobaccofreelife.org/tobacco/tobacco-history/.

produced by Pierre Lorillard in 1760.[10] The cigarettes that are ready-rolled were first mass-produced after the American Civil War by Duke of North Carolina in the US (History Extra, 2020). During the mid-1800s in the UK, partially machine and hand-made cigarettes were first developed.[11] Philip Morris established and started selling Turkish hand-rolled cigarettes in the UK in the year 1847. It was followed in the United States by J.E. Liggett and Brother (The Tobacco-Free Life Organization, 2020). Cigarettes became popular after the invention of machines that can make cigarettes and it could produce 120,000 cigarettes a day in 1881.[12] Mass production and advertising of cigarettes allowed company related to tobacco to expand their markets during this period (The Cancer Council New South Wales, 2020). The cigarette was everywhere in the trenches of the First World War as it was an essential item for the soldiers' rations.[13] This was repeated during the Second World War as cigarettes continued to be included in soldiers' rations (The Cancer Council New South Wales, 2020).

Scientific Research and Medical Studies on the Effect of Tobacco and Smoking

Native Americans used tobacco in their religious ceremonies as well as for medical purposes. Tobacco was used as a medicine for wound dressing for its benefit in lessening pain and toothaches. It gained instant popularity when Christopher Columbus brought it to Europe in the late 15th century. One of the main factors was the belief that tobacco had a magical healing power (SWEDISH, 2020). Doctors used to believe in the end of the 16th-century that tobacco had medicinal properties, and they advised patients to snuff or smoke tobacco according to their preference (The Tobacco-Free Life

[10] Today, 200 years later, P. Lorillard is the oldest tobacco company in U.S. history. History of Tobacco Use in America. (2020). *Where Does Tobacco Come From?* Retrieved from https://www.swedish.org/classes-and-resources/smoking-cessation/history-of-tobacco-use-in-america

[11] Walker., R. (1984) *Under Fire. A History of Tobacco Smoking in Australia.* Melbourne: Melbourne University Press

[12] The ATC survives today as a part of British American Tobacco, a global company with reported revenues of 13, 104 billion in 2015. The Tobacco-Free Life Organization. (2020). *History of Tobacco*. Retrieved from https://tobaccofreelife.org/tobacco/tobacco-history/ and History Extra. (2020). *A Brief History of Smoking. Retrieved from* https://www.historyextra.com/period/modern/a-brief-history-of-smoking/.

[13] Walker R., (1984) *Under fire. A history of tobacco smoking in Australia*. Melbourne: Melbourne University Press. and History Extra, *A Brief History of Smoking*. Retrieved from https://www.historyextra.com/period/modern/a-brief-history-of-smoking/.

Organization, 2020). Nicolas Monardes wrote a book which discusses about 36 topics of tobacco efficiency on the medical field which included toothache, worms, halitosis and cancer (1571).

However, one of the earliest write-ups that linked smoking to ill health was written anonymously by an English author who published an essay titled 'Work of Chimney Sweepers' in 1602 telling that tobacco might have the same effect as soot which could be seen in chimneys (The Cancer Council New South Wales, 2020). In the early 17th century, a Chinese philosopher named Fang Yizhi stated that smoking caused 'scorched lungs', indicating the symptom of a deadly disease called lung cancer (The Cancer Council New South Wales, 2020). Sir Francis Bacon realized that tobacco is very addictive. During that time people did not know that nicotine was addictive. In fact, it was unknown that nicotine was a part of tobacco.[14] The state of Massachusetts in 1632 passed a law which made smoking in public illegal (SWEDISH, 2020). In Great Britain the dangers of nose cancer was warned to the snuff users as early as 1761. While in1795, a medical doctor from Maine named Sammuel Thomas von Soemmering issued a warning to pipe smokers in Germany about the risk of developing lip cancer. Two years later, a writing by Benjamin Rush, a US physician, was published about the medical hazards of tobacco. In the 1920s, medical findings linking smoking to lung cancer made headlines. However, since the tobacco companies rely on the media to advertise their products, a number of newspaper editors did not want to displease tobacco industry. In the 1930s, American doctors first identified the connection between tobacco use and lung cancer. A number of medical studies from the 1950s and 1960s reported tobacco use was the cause of serious disease (Procto, 2004). This can be observed, for instance, from a report by Royal College of Physicians of the United Kingdom (The Royal College of Physicians, 1962). It was followed by a similar report released by the US Surgeon General (1964). These studies provide conclusive scientific and medical evidence relating to cigarettes that have had a negative effect on health. Numerous research conducted over time support this epidemiology (World Health Organization, 1997).

[14] 'History of Life and Death,' transl., Spedding, V, p. 265 (Montagu, III, p. 491-492) as in Waldman. C.G., (2018). *Francis Bacon's Hidden Hand in Shakespeare's The Merchant of Venice: A Study of Law, Rhetoric, and Authorship* (pp.241). New York: Algora Publishing.

GLOBAL INITIATIVES AND INTERNATIONAL LEGAL FRAMEWORK ON TOBACCO CONTROL

Report of the Royal College of Physicians (1962) and the US Surgeon General's Smoking and Health Report (1964) provided the basis for the respective governments to begin controlling the products and sales of cigarettes in their countries. The harmful effect of tobacco use, however, was regarded as a problem only by certain countries. According to World Health Organization (WHO), the top public health fiasco in the 20th century was the use of tobacco (Taylor & Bettcher, 2000). According to many studies, cigarette smoking was the leading cause of mortality worldwide. It was also determined to be the main risk factor of premature death in the industrialized countries (Murray & Lopez, 1996). Based on WHO's report of global tobacco epidemic in 2017, the use of tobacco caused a number exceeding 7 million deaths per year (WHO, 2017). If no effort was taken to curb the use of tobacco, an estimated 8 million people will die each year from tobacco-related causes worldwide by 2030, WHO noted (WHO, 2011). Even though the harmful effect of tobacco is of global concern, only a handful of countries initially took necessary actions to minimize tobacco use (WHO, 2011). A global initiative was introduced in 1970 at the 23rd World Health Assembly, which is the authoritative body of the World Health Organization that makes up 191 Member States. It was formally recognized in the resolution that smoking significantly impacted on the pulmonary development and cardiac disease which includes the cancer of bronchopulmonary, chronic bronchitis, emphysema and ischaemic heart disease. Furthermore, the resolution demanded all 'health agencies needs to show demonstration of concern to reduce the main reason of smoking disease'.[15] This was followed by several other resolutions by the body which provided proof of the damage to health as well on the economic effect relating to tobacco (Yach & Wipfli, 2006) including introduction of World No Tobacco Day and the World Conference on Tobacco or Health (WHO, 2020). Concrete steps by the international community, however, took some time to materialize. Before the 1990s international communication regarding tobacco control was largely limited among the countries in Western Europe and the United States. Despite WHO's effort to encourage its member states to adopt national

[15] It was held from 5 to 22 May 1970. WHA23.32 Health Consequences of Smoking. Retrieved from https://www.who.int/tobacco/framework/wha_eb/wha23_32/en/.

laws and regulations for tobacco control[16], the concerns relating to the harmful effect of tobacco during the period were confined among high-income countries and developed nation (Wipfli, 2015). However, not many countries provided a positive response and took concrete actions especially low-income and underdeveloped nations. The paradigm shift began when the World Health Assembly instructed the Director-General of the WHO "to report on the feasibility of creating an international instrument such as guidelines, a declaration or an international convention on tobacco control". In 1996 the Director-General began to develop a framework (World Health Assembly, 1995). The proposal of framework convention contemplated to use the international law and its legal rulings in dealing with the problems of public health that occur globally. After the adoption of WHO 1996 resolution, the body began to conduct negotiation and diplomatic processes to come up with an agreed framework convention. The process took several stages, initially involving a Working Group and later an Intergovernmental Negotiating Body (INB). The outcome was Framework Convention on Tobacco Control (FCTC) which was adopted in February 2003. It was the first public health agreement by the World Health Organization. The convention signifies the main area of global public health in developing international law. For the first time in its history, WHO practiced their responsibilities in getting used to the agreement under Article 19 of its Constitution.[17]

The WHO FCTC commenced in 2005 which is one of the most accepted United Nations (UN) treaties, with 181 parties as of May 2018. WHO FCTC is built to reinforce national and international coordination in fighting the epidemic of tobacco and to provide a comprehensive plan for the parties involved in the fight (Roemer, 2005). The treaty incorporates various measures for the state parties to use in curbing the growth of tobacco production and use. It allows the state parties to have restricted advertisement, sponsorship, and

16 See, e.g., Roemer. R. (1982). *Legislative Action to Combat the World Smoking Epidemic*. Geneva: World Health Organization. Roemer. R. (1987). *Legislative Strategies for a Smoke-Free Europe.* Copenhagen: WHO Regional Office for Europe. and Roemer. R. (1993). *Legislative Action to Combat the World Tobacco Epidemic, 2nd ed*. Geneva: World Health Organization.

17 Article 19 states 'The Health Assembly shall have authority to adopt conventions or agreements with respect to any matter within the competence of the Organization. A two-thirds vote of the Health Assembly shall be required for the adoption of such conventions or agreements, which shall come into force for each Member when accepted by it in accordance with its constitutional processes.'

promotion activities and to impose strict standards for packaging and labelling. The agreement also urges the governments to initiate clean indoor air regulations, adopt legislation to overcome tobacco smuggling, enact and enforce tobacco products tax and price policies aimed at reducing tobacco consumption. In addition, the FCTC also reports on the testing, evaluation and regulation of tobacco products. Manufacturers and importers are expected to open up the contents and emissions of tobacco and the authorities are obliged to provide true proof of the toxic component of the goods. The objective and provisions of WHO FCTC relating to the restriction of smoking and smoke-free area or zone are articles 3, 4 and 8. Article 3 states the aim of FCTC which is 'to take care of future and present generations from a disastrous health, social, environment and economic impact on consumption of tobacco and the exposure of tobacco smoke.' Article 4 provides the guidelines to reach the aim of FCTC and in implementing it. The article requires the governments to inform 'every person who has health difficulties and any threats that is present because of the tobacco consumption or smoke exposure from tobacco. They should be protected and the government needs to revise on the legislation, administrative and executive levels regarding the usage of tobacco.' Furthermore, there must be a solid political reason in commitment to develop and keeping up measures to take care of people from the smoke tobacco exposure. The responsibility to guard against tobacco smoke exposure is laid down in article 8(2):

> Each Party shall adopt and implement in areas of existing national jurisdiction as determined by national law and actively promote at other jurisdictional levels the adoption and implementation of effective legislative, executive, administrative and/or other measures, providing for protection from exposure to tobacco smoke in indoor workplaces, public transport, indoor public places and, as appropriate, other public places.

Various areas are covered under the provision including in workplaces, public transport and public places that are indoor. The Conference of the Parties (COP) adopted guidelines for implementation of Article 8 at its second session in 2007.[18] The instructions are supposed to help the state parties in undergoing their responsibilities with specific

[18] Decision FCTC/COP2(7).

provisions of the Convention. It reflects the combined perspectives of state parties on many ways of execution, experiences, achievements and challenges. The guide also seeks to facilitate the best practices and the extent at which governments will benefit from the application of the treaty mechanism. In meeting their obligations under Article 8 state parties have to ensure that it is done in a constant manner based on scientific evidence relating to the second-hand tobacco smoke exposure. The guidelines also help the parties in taking note that the main element of legislation is needed to efficiently help in protecting people from the tobacco smoke.

MALAYSIA AND THE WORLD HEALTH ORGANIZATION'S FRAMEWORK ON TOBACCO CONTROL

Laws Relating to Tobacco Control and Smoke-Free Zone in Malaysia

Malaysia is a party to the WHO FCTC. In September 2003 Malaysia signed the FCTC and ratified it in 2005, two years later. Since the ratification, Malaysia has made significant development in building stronger, extensive tobacco control plan which is aided by the national anti-tobacco campaigns. The Malaysian government has worked on the policies of tobacco control according to the requirements of the FCTC such as including protection from the exposure of tobacco smoke as required by article 8. On 15 December 2005, the country became a party officially to the convention. On the same date Malaysia's national FCTC Secretariat was formed and approved by the cabinet. A new unit then began to start up in 2006. It was called the Tobacco Control & FCTC Unit which was put under the Non-Communicable Disease (NCD) Section of the Disease Control Division, Ministry of Health. This unit aims to curb the consequences of tobacco use so that it does not become the leading factor of a public health problem by slowing down the smoking uptake among youth and to protect the public from danger of second-hand smoke. It also helps in ensuring that the WHO FCTC is implemented in the proper way. The unit is the focal point for WHO FCTC and everything relating to the control of tobacco. It is also responsible for reporting to the FCTC Secretariat on a regular basis. The unit on FCTC enforcement also provides feedback on Malaysia's tobacco control stakeholders. Until now, the involvement

of Malaysia in the process of FCTC has remained active. Malaysian representatives have attended the Conference of Parties (COP) as well as the Intergovernmental Negotiating Body (INB) on control of illicit tobacco trade. It also became a partner country in various working groups relating to the convention. At least four interagency meetings have so far been held by FCTC Malaysia to discuss the status of the implementation at the national level.

Food Act of 1983 is currently a relevant law relating to tobacco control in Malaysia. The Control of Tobacco Products Regulations (CTPR) 1993[19] were passed under the Food Act in 1993, and it is the main law to regulate tobacco use and product. The Minister of Health is authorized to execute the law and regulations under the Food Act 1983 and the CTPR 1993. The CTPR 1993 does not allow any indoor smoking in healthcare institutions, public spaces including public lifts or toilets, theatres, and air-conditioned eating venues, as well as public transportation designated as 'no smoking zone'. All direct advertisements and sponsorships are prohibited. It also includes clear health warnings and a fixed maximum amount of tar (20 mg) and nicotine (1.5 mg). Children are also prohibited for any tobacco sales, possession, and smoking.[20] When the CTPR 1993 Regulations were replaced in 2004 by the CTPR 2004, the law was improved and strengthened with the goal of making it more stringent by banning tobacco advertisements and sponsorship, restricting smoking in additional specified areas, prohibiting the selling of tobacco products to minors, and limiting the labelling, packaging and sale of tobacco products. Therefore, CTPR 2004, which is quite similar to the CTPR 1993 Regulations, began to govern the tobacco control issues. On 23.9.2004, the Prohibition of Smoking Areas under Regulation 11 of the CTPR 2004 came into force. The CTPR 2004 adopted bans on smoking in places that are public. Only one-third of designated smoking areas such as eating places that is air-conditioned, non-airconditioned public transport terminals, and open-air stadiums could be occupied. It was still permitted to smoke in pubs, discotheques, night clubs, and casinos.[21] The CTPR 2004 has been amended several

[19] P.U.(A) 383/93.
[20] The Control of Tobacco Products Regulations 1993.
[21] The Control of Tobacco Product Regulations 2004.

times.[22] It was amended in 2008 to ban smoking in National Service Training Centers.[23] Further amendment to the CTPR 2004 was made in 2011 whereby smoking was banned in all workplaces that are air-conditioned.[24] However, designated smoking areas were only permitted by the legislation where written permission was issued by the Minister of Health. The Minister never overruled the law even such rules existed. Proprietors were required to put up 'No Smoking' signs in places where smoking was not permitted. During the period, enforcement in the Control of Tobacco Products Regulations was implemented across the country with more than 2,000 enforcement officers placed in the states and at districts levels.[25]

Sub-national (state) jurisdiction/state law is allowed to adopt laws on smoking restriction. The states are allowed to be more strict than national law. However, the states have relied on the federal government's law, namely regulation 22 of the CTPR 2004, which allows the Health Minister 'to declare or gazette certain areas as Non-Smoking Area (NSA)'. The Minister can designate any location that can be accessible by the public as a "no smoking" place, regardless of building or grounds, and may make certain regulations that he deems necessary on the location. For example, the Tobacco Control & FCTC Unit had successfully enacted provisions for smoke-free areas in support of the Smoke-Free Melaka Initiative (MBAR) commenced by the Melaka State Government. This project was a collaborative effort between an alliance of non-government organizations with a financial commitment from the Malaysian Health Promotion Board (MySihat) and the Government through its numerous agencies. In April 2010, the Melaka State Government which is known as one of the UNESCO World Heritage Site in Malaysia, officiated Melaka as a Smoke-

22 The amendments are Control of Tobacco Product (Amendment) Regulations 2008; Control of Tobacco Product (Amendment) (No. 2) Regulations 2009; Control of Tobacco Product (Amendment) Regulations 2010; Control of Tobacco Product (Amendment) Regulations 2011; Control of Tobacco Product (Amendment) Regulations 2012; Control of Tobacco Product (Amendment) Regulations 2013; Control of Tobacco Product (Amendment) Regulations 2014; Control of Tobacco Product (Amendment) Regulations 2015; Control of Tobacco Product (Amendment) (No. 2) Regulations 2015; Control of Tobacco Product (Amendment) Regulations 2017, and Control of Tobacco Product (Amendment) Regulations 2018.

23 Control of Tobacco Product (Amendment) Regulations 2008.

24 Control of Tobacco Product (Amendment) Regulations 2011.

25 In 2010, a total of 6,033 compounds were issued and in 2011, 8,042 compounds. For 2012 (Jan-Mac), a total of 2,813 compounds had been issued. Ministry of Health. (2020). *Maklum Balas: Get Tough On Smokers*. Retrieved from http://www.moh.gov.my/index.php/pages/view/582.

Free City. MBAR then became an important model project for other Heritage Sites within the ASEAN Region. The State Government, in June 2011, stated that there are five areas in the states to be smoke-free. A similar move was also taken by states of Johor and Penang. The Melaka and Penang governments have been recognized by the WHO and South-east Asian Tobacco Control Alliances for their initiatives to curb smoking in public.[26]

Apart from the above, there are other laws related to tobacco control and other agencies involve in their implementation and enforcement namely the Custom Act 1967 which comes under the authority of Royal Malaysian Customs; the Excise Act 1976 and Excise Regulations 1977 which come under the responsibility of Royal Malaysian Customs; the Sales Tax Act 1972 which comes with responsibility of the Royal Malaysian Customs; Industrial Co-ordination Act 1975 which comes under the responsibility Ministry of International Trade and Industry (MITI) and Malaysian Investment Development Authority (MIDA); the Local Government Act 1976 which comes under the responsibility local governments of each state; Trade Descriptions Act 2011 which comes under the responsibility Ministry of Domestic Trade and Consumer Affairs, and National Kenaf and Tobacco Board Act 2009 which comes under the responsibility National Kenaf and Tobacco Board.

The Control Tobacco Product Regulations 2004 (Amendment 2018) and Its Enforcement

Effective from 1.1.2019, no-smoking areas are extended to all dining areas under Regulation 11, CTPR 2004 (Amendment 2018). Prior to 2018 amendments, smoking was banned at places with air-conditioner eating places under CTPR 2004. However, amendments were made in 2017 that designated the smoking areas.[27] As a result of the 2018 amendments, any eatery is considered as a non-smoking area. Under the amended regulation smoking is banned in any "eating place," which is explained as

26 'Penang conferred SEATCA, WHO award for smoke-free campaign.' (2018). *The Star*. Retrieved from https://www.nst.com.my/news/nation/2018/11/433026/penang-conferred-seatca-who-award-smoke-free-campaign

27 Control of Tobacco Products Regulations 2004, regs. 11 & 21; Control of Tobacco Products (Amendment) Regulations 2017, reg. 5, P.U. (A) 32.

> any premises whether inside or outside building, where food is prepared, served or sold and includes —
> (a) any room or area on a ship or train where food is prepared, served or sold;
> (b) any area on a vehicle where food is prepared, served or sold, and any surrounding area within a radius of three meters from the vehicle; and
> (c) any area within a radius of three meters from any table or chair which is placed for the purposes of preparing, serving or selling food[.][28]

As stated above the "area" which is mentioned does take count the surroundings of the place including borders, a space of 3 meters from a fixed roof connecting to the main building. Under the regulation "smoking" is stated as "inhaling and expelling the smoke or vapour of any tobacco product and includes the holding of or control over any ignited heated or vaporized tobacco product." [29] The regulations are enforced by the people who has the power or known as "authorized officers" in the Food Act 1983 who are described as:

> "any medical officer of health or any assistant environmental health officer of the Ministry of Health or of any local authority, or any suitably qualified person, appointed by the Minister to be an authorized officer…"

According to the Deputy Health Minister, 5,008 health officers and assistant health officers from the Ministry would be responsible for overseeing the eateries.[30] Under the CTPR 2004, a fine of up to RM10,000 and up to two years' imprisonment is levied on anybody who is found smoking in a non-smoking location.[31] Owners and residents who do not display a no-smoking sign can be fined up to RM3,000 and sentenced to up to six months in jail. If their customers at the premises smoke in their no-smoking section, a fine of up to RM5,000 or up to one year of imprisonment can be imposed on them,

[28] Amendment) Regulations 2018, reg. 2, P.U. (A) 329, Federal Government Gazette (Dec. 24, 2018).

[29] Control of Tobacco Products (Amendment) (No. 2) Regulations 2015, reg. 2, P.U. (A) 304.

[30] 'Over 5,000 officers ready to enforce smoking ban, says health ministry' (2018). FMT News. Retrieved from https://www.freemalaysiatoday.com/category/nation/2018/12/25/over-5000-officers-ready-to-enforce-smoking-ban-says-health-ministry/

[31] Control of Tobacco Products Regulations 2004, reg. 11, P.U. (A) 324.

under the same law.[32] The Deputy Health Minister stated that the changes are being made in order to comply with the law and the rules for enforcing article 8 of the WHO FCTC, and this announcement was made in light of plans for the ban extension.[33] Thus, on January 1, 2019, Malaysia started to ban smoking at all kinds of eateries including open air stalls.

The government, however, initially adopted a soft approach to enforce in order to provide opportunities for all walks of life to change their smoking habits as required by law. The Ministry of Health stated that it "will give a time of six months to follow with the ban, during which it would teach a lesson and alert restaurant owners and smokers."[34] The smoking ban training period was later extended for another six months to give cigarette smokers more time to think about the hazards of their habits and areas they were not permitted to smoke and to raise public visibility and awareness of the matter. It was noticed that the smoking ban was adhered to by most eateries in urban areas, but not by those in rural areas. The phased implementation of the ban demonstrates that it was not intended to penalise smokers, but to provide an incentive for them to quit the habit.[35] The educational enforcement period later gave way to full implementation of the ban starting on Jan 1, 2020 through which any individual found to be smoking in banned locations, including all restaurants, may face a fine of RM250. However, the compounds were reduced to RM150 for those who committed the offense for the first time if the payment was made at any District Health Office within one month from the date on which the compound was registered. A full payment of RM250 must be paid for the second offense and no reduction can be made. Those who did the offense for the third time would be charged with a compound of RM350 and so on. Under Regulation 12 of the CTPR 2004, owners of the premises must ensure that their premises are smoke-free. Providing items for smokers to take a puff which includes

[32] Control of Tobacco Products Regulations 2004, reg. 12 (as amended).

[33] 'Ban on smoking in Malaysian eateries takes effect' (2020). *The Straits Times*. Retrieved from https://www.straitstimes.com/asia/se-asia/ban-on-smoking-in-malaysian-eateries-takes-effect.

[34] 'Six-month grace period for smoking ban' (2018). *The Star*. Retrieved from https://www.thestar.com.my/news/nation/2018/12/18/sixmonth-grace-period-for-smoking-ban-then-we-will-do-periodic-enforcement-says-ministry/

[35] 'Educational enforcement period on smoking ban extended with focus on rural areas' (2019). *New Straits Times*. Retrieved from https://www.nst.com.my/news/nation/2019/04/483787/educational-enforcement-period-smoking-ban-extended-focus-rural-areas

ashtrays or shisha services is also not allowed. Proprietors also need to have the "no smoking" sign fixed and placed clearly to the sight of people[36]

On Dec 31, 2018, seven smokers challenged the laws on smoking ban in all eateries. However, their request to suspend the ban until the full hearing of the lawsuit was dismissed by the judge saying that, the"court did not have any intention to interfere in the operation of the law". However, the High Court granted *ex-parte* application for a judicial review to challenge the ban.[37] Accordingly, they filed their application at the High Court Registrar in Kuala Lumpur. In response to the legal challenge against the enforcement of the new no-smoking ruling at eateries, the Minister of Health stated that the official banning on smoking in restaurants were enforced according to the legal fundamental of the CTPR 2004. He added that, the government thus was ready to fight the application in court to safeguard public health. The legal action was perceived by the authority as an ordinary process in a democracy, where any people can voice out their objection towards the government. Malaysia is a democratic country which means smokers may resort to court and legal channel to seek justice.[38]

The Legal Challenge on Constitutionality of Restriction on Smoking and the Smoke-Free Zone Laws

In their application, the smokers stated they act for themselves and other smokers who support the pro-tem *Pertahankan Hak Perokok* (Defenders of Smokers Right) or PHP. They named the Health Ministry as the sole respondent. The smokers claimed that the smoking ban (hereby referred to as the ban) contradicted the Federal Constitution because it is not a criminal act to smoke, and it is not forbidden in the country by any law. They also claimed that, since the activity is guaranteed by the Constitution and legally accepted, smokers and non-smokers has the same right in being a customer at

[36] 'Smoking ban at all eateries comes into force on Wednesday' (2019). *The New Straits Times*. Retrieved from https://www.nst.com.my/news/nation/2019/12/551849/smoking-ban-all-eateries-comes-force-wednesday.

[37] 'Seven smokers granted leave to challenge smoking ban at eateries' (2019). *The Star*. Retrieved from https://www.thestar.com.my/news/nation/2019/01/29/seven-smokers-granted-leave-to-challenge-smoking-ban-at-eateries.

[38] 'See you in court', Health Ministry tells Smokers Right Club' (2019). *The New Straits Times*. Retrieved from https://www.nst.com.my/news/nation/2019/01/445918/see-you-court-health-ministry-tells-smokers-right-club.

the eateries where they are allowed to spend time and money as long as they wanted. Smokers had the equal right as non-smokers to visit and patronize eateries, but they would be prevented from visiting the eateries, they added to their claim arguing that the smokers are being discriminated in being in eateries which, according to them, was illegal and unconstitutional. They also argued that it was wrong in procedure as the respondent did not consult with smokers or any other stakeholders prior to the enforcement of the ban. They also pleaded that the government must provide a different smoking area, or give discretion to food operators to implement the ban and provide a separate smoking area. With the above appeal, the smokers sought a court order prohibiting against the authority or any of its agents to work on the implementation of the ban along with the rules to strike out the authority's choice in enforcing the banning in eateries. They also sought a proclamation that the CTPR (Amendment) 2018 P.U (A) 329 and paragraph 5 CTPR (Amendment) 2017 P.U(A) 32 are null and void because the provisions conflict with article 5 and 8 of the Federal Constitution.[39]

However, the application of the smokers group for a certiorari order to revoke the option of the Minister to enforce a ban on smoking was rejected by the court. In addition, their application to declare the decision to enforces the prohibition as an action contrary to the Federal Constitution was also rejected declaring that the Minister had the power to make any restrictions on smoking and smoking-related matters pursuant to the powers provided by section 36(2) (d) the Food Act 1983 and the CTPR 2004. Moreover, since the power and decision of the Minister are based on laws that do not violate the Federal Constitution, the court held that the decision and action made by the authority are legally valid and constitutional. On the above ground, the smokers' contention that the decision of the authority to impose the ban and the anti-smoking rules as violation of their smoking rights were held by the court to be irrational and unreasonable. The court, in its decision, quoted the statement below:

> [In] Provincial Picture Houses Ltd v Wednesbury Corporation [1948] 1 K.B 223 Lord Green at page 233 in his judgment stated;

39 *Mohd Hanizam Yunus dan lain-lain lwn Kementerian Kesihatan Malaysia* [2020] MLJU 359.

> "… That the task of the court is not to decide what it thinks reasonable, but to decide whether what is prima facie within the power of the local authority is a condition which no reasonable authority, acting within the four corners of their jurisdiction, could have decided to impose".

Furthermore, the court added that the requirement that smokers be at least 3 meters or 10 feet away from every table or chair in any eatery was not unfair and disproportionate because all factors of public interest were considered by the authority in setting the distance. The same law allows the smokers to enjoy food on the premises and if they maintained the prescribed distance.

As mentioned earlier, the smokers claimed that the authority took the decision arbitrarily without taking views of the smokers, they considered the decision improper and unlawful. The court, however, disagreed and concluded that there was no arbitrary action by the Respondent to render the decision invalid pointing out that there was no legal obligation on the authority to hold public consultation with an agency or parties. However, the court noted that although the authority was not obliged under the law to hold a public consultation before making the decision and creating the rules, a series of discussion with relevant parties and stakeholders was done by the authority regarding the efforts to implement the prohibition of smoking from 2004 to 2019. The public were also invited to send their opinions regarding the implementation or enforcement of the ban until 18.5.2018 through the authority's website. None of the smokers expressed their feedback or objections since 2015. In fact, the implementation of the prohibition in 2015 was delayed due to a request from a group which was not a party to the legal proceeding. Furthermore, it was impractical for the authority to seek the views of all the smokers at an early age when no institution or association was representing them to discuss with the Respondents, the court observed. It may be noted that, the smokers established the Smoking Awareness Association and PHP after the authority adopted the anti-smoking laws.

In response to the smokers' contention that the decision by the authority and the relevant provisions of the CTPR should be null and void for contravening Article 5 and Article 8 of the Federal Constitution, the court concluded that the ban did not conflict with Article 5 and Article 8 of the Federal Constitution. In relation to article 5 concerning the

right to 'personal liberty', the court decided that the phrase 'personal liberty' meant liberty relating to the persons or body of the individual. It is the very antithesis of physical restraint or coercion. Based on the interpretation of 'personal liberty' in earlier court decisions the court concluded that the right to smoke is not a fundamental right guaranteed under Article 5 of the Federal Constitution. Despite the prohibition in smoking, the smokers have their life and personal liberty rights guaranteed under the Federal Constitution. Personal liberty rights cannot be equated with the right to smoke. The right to smoke was interpreted by the court as a person's right of choice. One can choose to smoke or not to smoke. People can still smoke as they want to smoke provided that they follow the rules set by the government. There is no law prohibiting anybody from smoking at all. However, smokers are not allowed to smoke anywhere as they wish because they are subject to areas that are advertised as non-smoking areas. The court also decided that even there is no area of smoking on the premises it does not mean freedom to smoke is restricted. A person can still smoke outside 3 meters (10 feet) of the dining area and it is the responsibility of the smoker to ensure the cigarette butts are removed in a proper place. Therefore, the applicants' claim that their rights have been eroded and denied by the prohibition of smoking at the premises is not justified, according to the court. The court maintained that, articles 5 to 13 of the Federal Constitution on "fundamental liberties" do not cover the right to smoking. As regards to article 8 which deals with the right to equality, the court held the contention made by the applicant 'that if the Smoking ban were implemented, eating-place areas across Malaysia would be an exclusive area for non-smokers Malaysians and that smokers would be excluded or discriminated against visiting and enjoying the food at the restaurant or dining spot' as 'baseless statement and is not supported by any evidence and was a speculation beyond the reach of the mind.' Discrimination did not arise because all the Malaysians are free to visit every restaurant evenif they wished to smoke. The judge also reminded the smokers that they must respect the rights of other Malaysians by not smoking within 3 meters of the restaurant or dining premises

CONCLUSION

The right to equality requires everybody must be treated equally by the law and the right to be protected by the law. It means non-smokers and smokers have the right to be protected by the law. The right to

breathe unpolluted air are also on both smokers and non-smokers. Smoke fumes caused by smoker pollute the air, which deny the right of non-smokers to breathe fresh unpolluted air. Furthermore, the smoke of tobacco spreads harmful effects especially in enclosed spaces because it is breathed by everyone, smokers or nonsmokers alike. A number of 250 tobacco smoke are known to be dangerous and the remaining of 40000 are cancerous. Coronary heart disease and lung cancer are also included in the ETS which brings an effect of serious cardiovascular and disease of respiratory. Ventilation, filtration or a combination of the two, cannot curb the exposure of tobacco smoke indoors to levels that are considered acceptable. The only effective protection is 100 percent smoke-free environment (WHO, 2020). Non-smokers have the right to fresh air that must be respected by the smokers, as correctly stated by the presiding judge Dato' Seri Mariana Yahaya in the judgment. Victims of secondary smoke are usually not in a position to defend their rights to clean air. Thus, this is a proper judgement passed by the judiciary towards the appropriate direction and policy set by the authority. Together with other nations, Malaysia has supported the 2030 Agenda for Sustainable Development at the United Nations General Assembly in 2015. Many of the 17 Goals of SDG have a direct or indirect relation to tobacco control. A key target for Goal 3 of SDG is "Strengthen, as appropriate, implementation in all countries of the WHO FCTC". The WHO FCTC is a legal binding on Malaysia. The ban strengthens Malaysia's commitment as a member of the FCTC and adherence to its Article 8 (Protection from exposure to tobacco smoke). The country is also committed in achieving the goal of the WHO Global Non-Communicable Diseases, which is to achieve a smoking prevalence of 15 percent or less by 2025. Creation of smoke-free zone has a number of benefits for the citizens which include a better health and wellbeing of the people, reduction of the number of cigarette butts and packets littered, citizens becoming role models in following a healthier lifestyle to each other mostly among younger generation, increased awareness of smoking which does not bring a better lifestyle and health, reduction of fire risks and many more. The harm and expenditure caused by tobacco are greater than the money that it brings to the country. The government spends more on the expense of treating patients with smoking-related illnesses than the tobacco industry's income. The amount of money generated from tobacco industries ranges from RM4 billion to RM5 billion, but the cost per year for treating smoking-related diseases is more than

RM16 billion (https://www.nst.com.my/news/nation/2019/04/483787/educational-enforcement-period-smoking-ban-extended-focus-rural-areas, 2019). Scientific and medical evidence together with social and economic findings are resolute in concluding that smoking brings gravely negative reaction towards the body of an individual as well as prejudicial towards public health. The court and the legislators then should work in tandem with the authority in protecting the public's health which is one of the most essential functions of government.

ACKNOWLEDGMENT

The writer would like to express his gratitude to FCTC and Tobacco Control Unit, Disease Control Division, Ministry of Health Malaysia for their kind cooperation and invaluable insight and expertise that greatly assisted the research.

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