HUMAN RIGHTS QUARTERLY

The Emerging Human Right to Tobacco Control

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ABSTRACT

The economic and public health impacts of tobacco use, which kills approximately 5 million people per year and is expected to kill 10 million, mainly poor, people in 2030, are well known. Less attention has been paid to the impact of this epidemic on human rights and the potential application of a human rights perspective to tobacco control. This article examines the emerging human right to tobacco control in relation to other efforts to reduce the death and disability resulting from the activities of the tobacco industry, such as the Framework Convention on Tobacco Control, and suggests ways of implementing human rights mechanisms to address this public health disaster.

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the Right to Development. He holds academic degrees from Stanford University, the Universities of Paris, Strasbourg, Besançon and Nice, as well as the University of Damascus. His principal fields are international law, human rights, public health, international politics, international organizations, development, peace and conflict. He has held teaching positions at Columbia University, Princeton University, the University of Phnom Penh Faculty of Law; Cardozo School of Law; the New School for Social Research; Rutgers University School of Law, and City University of Hong Kong School of Law. He spent twelve years in the service of the United Nations, working for UNESCO in Paris and in various peacekeeping operations. He is the author of over sixty articles and book chapters and editor or co-editor of and contributor to *The Future of International Human Rights* (1999); *Health and Human Rights: The Educational Challenge* (2002); *Perspectives in Health and Human Rights* (2005); and *Development as a Human Rights* (2006). His latest publications relate to human reproductive cloning, universal jurisdiction, cultural rights, human rights education, human rights in development, human rights and bioethics, and the war on terrorism.

I. INTRODUCTION

The magnitude of tobacco as a major public health issue has been widely documented in official reports[1] and in the literature.[2] The application of a human rights framework is beginning to emerge in public health and legal writing.[3] The purpose of this article is to consider whether and how human rights are relevant to tobacco control as a public health strategy and to develop the elements of a human right to tobacco control. The analysis is based on several assumptions regarding health—specifically the societal and environmental dimensions—and the scope and effectiveness of the human rights regime.

Good health is a key component to a fulfilled life. Most definitions of health—including that of the World Health Organization (WHO)[4]—include not only the individual's physical and mental well-being, but also a healthy relationship with the surrounding society and environment. It is, therefore, critically important to personal good health that societal and environmental conditions be supportive of individual physical and mental well-being. It is axiomatic to public health that the health of the public or society and of the individual are inextricably linked. Healthcare workers typically focus on individual aspects of the patient's physical or mental health, yet remain very cognizant of the effects that the home, family, or socioeconomic status have on the outcome of the care prescription. Occasionally, the issues extrinsic to the individual—such as the economic, political, and cultural

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1. From the US, see U.S. Dept. Health & Human Services, The Health Consequences of Smoking: A Report of the Surgeon General (2004). From the World Bank and WGHO, see Prabhat Jha & Frank J. Chaloupka, Curbing the Epidemic: Governments and the Economics of Tobacco Control (1999); World Bank, The Economics of Tobacco Use & Tobacco Control in the Developing World (Feb. 2003) (background paper for the High Level Round Table on Tobacco Control and Development Policy), *available at* http://europa.eu.int/comm/development/body/theme/human_social/docs/health/03-03_tobacco_background_WB.pdf.
2. *See, e.g.,* Richard Doll et al., *Mortality in Relation to Smoking: 50 Years' Observations on Male British Doctors,* 328 Brit. Med. J. 1519 (June 2004); *see also* 92 Amer. J Pub. Health (June 2002) (devoted to the tobacco epidemic and efforts to control it).
3. Melissa E. Crow, *Smokescreens and State Responsibility: Using Human Rights Strategies to Promote Global Tobacco Control,* 29 Yale J. Int'l L. 209 (2005).
4. The most commonly quoted definition is that the WHO Constitution, discussed below. *See* World Health Organization (WHO) Const. pmbl., adopted by the International Health Conference, 19–22 June 1946, (Official Records of the World Health Organization, no. 2, at 100) (*signed* 22 July 1946 by the representatives of sixty-one states) (*entered into force* 7 Apr. 1948), *available at* http://www.yale.edu/lawweb/avalon/decade/decad051.htm [hereinafter WHO Constitution]. On the breadth of this definition, see Gian Luca Burci & Claude-Henri Vignes, World Health Organization 109 (2003). *See also* Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 Sept. 1978, affirming that "health, which is a state of complete physical, mental and social well being, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector."

context—become the critical components in the delivery of the care required to obtain improved health.

There is nothing remarkable about the above observations, which are widely acknowledged precepts of public health. How these factors can be considered a "human right" issue is more novel and requires an understanding of the numerous international and regional human rights texts that establish obligations not only with respect to the right to health but in relation to a wide range of concerns raised by tobacco production and consumption.[5] Our claim is that a human rights framework implies both norms and potential remedies that may reinforce tobacco control regulation.

Indeed, human rights provide the normative basis for claiming that the right to health involves overcoming socioeconomic obstacles to access healthcare; that the right to food involves establishing conditions to make food affordable, adequate, and appropriate; that the right to shelter cannot be divorced from transportation and land tenure issues; that the right to work includes safe and healthy working conditions. Thus, health, food, shelter, and work are human rights that require improvements in the underlying conditions relating to the broader physical and social environment. These underlying conditions are collective issues that are affected by societal policies and programs and the laws and regulations on which they are based. In order for an individual to have good health, the society must have good public health and this good public health results from integrating considerations of the factors that determine a society's health.

A premise of this essay is that societal policies and regulations that are the most favorable for health are based on human rights. The relevant human rights instruments and the Framework Convention on Tobacco Control have not yet had a noticeable impact on those policies. With tens of millions of lives at stake, it is worth examining whether human rights are relevant to tobacco control and, if so, how a human rights framework can be meaningfully applied to this issue. After an overview of the problem of tobacco production, marketing, and consumption from the public health perspective (Part II), we will introduce the human rights framework, including an emerging human right to tobacco control (Part III) and then examine the development perspective (Part IV). In the final section we will suggest mechanisms for the realization of the human right to tobacco control (Part V).

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5. For a collection of these texts, see Health and Human Rights: Basic International Documents (Stephen P. Marks ed., 2004).

II. THE PUBLIC HEALTH PERSPECTIVE ON TOBACCO CONTROL

Public health at the local, national, and global levels is significantly affected by tobacco production, marketing, and consumption. The combined effect of tobacco-related policies and regulations of a country and the underlying societal conditions can be devastating on public and individual health. This section will explore the often complex and intertwined aspects of tobacco production and consumption and the attendant morbidity and mortality from a human rights perspective. Such a rethinking of the epidemiology of tobacco suggests different and hopefully effective methods to approach tobacco control.

After some remarks on the meaning of health, we will focus on the magnitude of the tobacco problem, including secondhand consumption and staging of the tobacco epidemic. Healthcare workers are usually aware of and concerned with, the health effects of tobacco consumption but are less familiar with the devastating effects of production, especially on the health of the environment and society.

The Ottawa Charter for Health Promotion (the Ottawa Charter), adopted by the First International Conference on Health Promotion, in Ottawa, Canada, from 17 to 21 November 1986, extends the WHO definition to include health promotion as a "process of enabling people to increase control over, and to improve, their health" and continues with basic prerequisites that "[t]he fundamental conditions and resources for health are: peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice, and equity."[6] The Ottawa Charter reaffirms the basic tenant of public health that health is not just an individual issue, but that it includes the social dimensions and the impact of policies that affect the health of populations. This inclusive understanding of health encompasses, at the individual level, both the mental and physical dimensions and, at the societal level, meaningful relationships, personal security, equitable distribution of economic resources, and access to information about issues that directly affect people's health and livelihood. At the environmental level, health is dependent upon a stable ecosystem, clean air and water, and climate that can sustain human life. At all of these levels, human rights standards and implementation machinery can contribute to health, consistent with the Ottawa Charter principle that "People cannot achieve their fullest health potential unless they are able to take control of those things which determine their health."[7]

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6. *World Health Organization, Constitutions, in* Basic Documents: Including Amendments Adopted up to February 1986 (36th ed. 1986). Ottawa Charter for Health Promotion, First International Conference on Health Promotion, Ottawa, 21 Nov. 1986, WHO Doc. WHO/HPR/HEP/95.1, *available at* http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf.
7. *Id.*

In the developed world, the health effects of tobacco on the individual are well established, as are its effects on society. However, only predictions based on experience of the established tobacco consuming markets are available to warn of the impending epidemic of tobacco related death and disease that will disastrously affect individuals and society in the developing world. The problem of anticipating the scope and magnitude of the impact of tobacco in the developing world is complicated by the fact that tobacco consumption is more recent and not yet on the scale of developed countries, where it is the leading cause of preventable death and disease. In the developing countries, the economic, environmental, and public health impacts of tobacco production are likely to be greater than in more established tobacco consumption markets. As a consequence, the well-recognized individual health consequences of tobacco consumption have not yet been recognized in developing countries as a priority on a par with the current healthcare crises resulting from food insecurity or infectious diseases, such as HIV/AIDS. Part of the explanation that tobacco production and consumption are not acknowledged as an epidemic by many developing countries is that they are understandably more preoccupied by problems of security, subsistence, and survival, compared to which tobacco gives the appearance of a positive good.

In order to understand the magnitude of the tobacco epidemic, we need to consider the societal and individual aspects of health promotion in the context of both the production and consumption sides of the industry. Only by examining both aspects, in the developed and developing world, will it be meaningful to explore strategies for tobacco control that will be able to stave off the predicted death toll from tobacco.

A. The Magnitude of the Tobacco Problem for Public Health

The clearest statement of the impact of tobacco on public health was provided by the WHO World Health Report 2003:

> The consumption of cigarettes and other tobacco products and exposure to tobacco smoke are the world's leading preventable cause of death, responsible for about 5 million deaths a year, mostly in poor countries and poor populations. Latest estimates reveal that, of the nearly 4 million men and 1 million women who died, over 2 million men and 380 000 women were in developing countries.[8]

8. World Health Organization, The World Health Report 2003: Shaping the Future 91 (2003), *citing* Ezzati M. Lopez, *Estimates of Global Mortality Attributable to Smoking in 2000,* 362 Lancet 847 (2003).

The estimated number of people who will die from smoking related diseases by 2030 will approach 10 million and 70 percent of these deaths will come from the developing world, where smoking rates are relatively low, particularly among women.[9] Smoking rates are expected to continue to climb in the developing countries, with the consequent healthcare costs associated with smoking related death and disease. There are more smoking related deaths than from any other cause and more than the combined deaths from pneumonia, diarrheal diseases, tuberculosis, and complications of childbirth.[10]

It is estimated that in 1995, 29 percent of the world adult population, or 1.1 billion people smoked on a daily basis.[11] The most dangerous form of tobacco ingestion is smoked, either by hand-rolled or manufactured cigarettes, bidis (a hand-rolled tobacco wrapped in a dried leaf), or kreteks (shredded cloves buds and tobacco). Smoking has a male predominance of 81 percent, with the lowest incidence of female smoking occurring in South Asia and the Middle East/Northern Africa. Eighty-two percent of the world's smokers are from low and middle-income countries, with the largest proportion, 38 percent, from East Asia (including China), and only 18 percent of those who live in sub-Saharan Africa. Between 1990 and 2020, it is estimated that 87 percent of the increase in tobacco related deaths would occur in low-income countries.[12] Unfortunately, because low and middle-income countries have a very low prevalence of people who have quit smoking, they will not significantly lower their risk for tobacco related disease. As prevalence rates of smokers and of the number of ex-smokers best predict ability to prevent tobacco attributable disease, low and middle income countries will exhibit a predictable marked increase in deaths in the next fifteen to twenty years. These countries will experience severe constraints on their healthcare budget to care for these exponentially increasing patients with tobacco related diseases as the costs of healthcare delivery increase concurrently with economic growth.

The World Bank estimates that the rapid rise in deaths from tobacco can only be decreased in the near future by curbing the number of current smokers, that is, by encouraging smoking cessation.[13] Doll and Peto have found that approximately 50 percent of regular smokers will die from their addiction.[14] Prevention of initiation of smoking will only have an impact in

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9. Tobacco Control in Developing Countries 23 (Prabhat Jha & Frank J. Chaloupka eds., 2000)
10. Jha & Chaloupka, Curbing the Epidemic, *supra* note 1, at 22.
11. Prabhat Jha et al., *Estimates of Global and Regional Smoking Prevalence in 1995, by Age and Sex,* 92 Am. J. Pub. Health 1002 (2002).
12. *Id.*
13. Jha & Chaloupka, Curbing the Epidemic, *supra* note 1, at 10.
14. Richard Doll et al., *Mortality in Relation to Smoking: 50 Years' Observations on Male British Doctors,* 309 Brit. Med. J. 901 (Oct. 1994).

twenty to forty years from now. Thus, from the economic perspective, it is imperative for developing countries to begin now to decrease the number of current smokers in order to prevent smoking from having a disastrous impact on their healthcare systems.

Smoking causes approximately 90 percent of lung cancers and contributes to 30 percent of all cancers.[15] In addition, it is the major etiologic agent for chronic obstructive lung disease and one of the major risk factors for vascular disease, particular ischemic cardiac disease. Unfortunately, there is a long lag period, approaching twenty years, depending on the underlying genetic susceptibility, before smoking-attributable disease is diagnosed.[16] Based on data from more developed countries, it is expected that low and middle income countries, who are still in their growth phase for tobacco consumption, will see dramatic increases in tobacco attributable diagnoses and deaths in the next fifteen to twenty years.

The global burden of tobacco-related disease can be measured in "Disability Adjusted Life Years" (DALYs), measured by combining "Years of Live Lost" (YLLs) and "Years Lived with Disability" (YLDs). The 2004 World Health Report stratifies DALYs according to six different global regions and for a variety of diagnoses.[17] The DALY quantifies the amount of healthy life lost from premature mortality, morbidity, and physical or mental disability for a period of time. One DALY is a year lost of healthy life and the burden of disease measures the gap between the current population's health and an ideal of everyone enjoying a healthy life until old age.

If lung cancer is used as an indicator for tobacco related disease and compared to HIV/AIDS, a dramatic example of infectious disease, one is able to see the striking differences between regions. Table 1 shows how much greater the impact of lung cancer in Europe compared to Africa, the reverse for HIV/AIDS. Europe represents 15 percent of the world's population and 33 percent of the worldwide burden of tobacco-related diseases.[18]

Similarly, Table 2 examines the death toll from lung cancer and HIV/AIDS, disaggregated by gender and region.

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15. U.S. Dept. Health & Human Services, Women and Smoking: Report of the Surgeon General 13 (2001); P. Vineis et al., *Tobacco and Cancer: Recent Epidemiological Evidence*, 96 J. Nat'l Cancer Inst. 99 (2004). *See also* WHO, Tobacco or Health: A Global Status Report 45 (1997).
16. Tobacco Control in Developing Countries, *supra* note 9, at 24.
17. The WHO global regions are: Africa, Americas, Eastern Mediterranean, European, Southeast Asia, and Western Pacific (which includes China). The World Bank regions differ somewhat from the WHO regions. The World Bank regions are: East Asia and Pacific (which includes China), Europe and Central Asia, Latin America and Caribbean, Middle East and North Africa, South Asia, Sub-Saharan Africa, high-income OECD countries (which includes US, UK, etc.), and other high income countries.
18. World Health Organization, Regional Office for Europe, Tobacco-free Europe, *available at* http://www.euro.who.int/tobaccofree/Policy/20040614_1.

TABLE 1

Disability Adjusted Life Years (DALYs) by cause of death, estimates for 2002 (in thousands)

	Male	*Female*	*Africa*	*Americas*	*Eastern Mediterranean*	*Europe*	*SE Asia*	*West. Pacific*
Lung Cancer	7,955	3,273	183	1,879	282	3,244	1,743	3,885
HIV/AIDS	42,663	41,795	63,973	3,211	1,402	1,389	12,129	2,303

WORLD HEALTH ORGANIZATION, THE WORLD HEALTH REPORT 2004: CHANGING HISTORY 126-29 (2004), *available at* http://www.who.int/whr/2004/annex/topic/en/annex_3_en.pdf (detailing disease in DALYs by cause, sex, and mortality stratum in WHO regions, estimates for 2002).

TABLE 2

Deaths by cause, estimates for 2002 (in thousands)

	Male	*Female*	*Africa*	*Americas*	*Eastern Mediterranean*	*Europe*	*SE Asia*	*West. Pacific*
Lung Cancer	890	353	17	231	27	366	174	427
HIV/AIDS	1,447	1,330	2,095	103	44	36	436	61

WORLD HEALTH ORGANIZATION, THE WORLD HEALTH REPORT 2004: CHANGING HISTORY 122 (2004), *available at* http://www.who.int/whr/2004/annex/topic/en/annex_2_en.pdf (detailing deaths by cause, sex, and mortality stratum in WHO regions, estimates for 2002).

This comparison of DALYs and deaths demonstrates the significant variation between the dramatic effect of the HIV/AIDS epidemic and the effect of only one of the tobacco related diseases—lung cancer. Tobacco is estimated to be the major risk factor in 4,907,000 deaths or 8.8 percent of the total and 4.1 percent of total DALYs. When deaths are broken down according to gender, tobacco is the number two cause of death for men, just behind malnutrition, at 13.3 percent. Tobacco is the risk factor for death in women at only 3.8 percent of the total. Unfortunately, this simply illustrates the future problem as women increase their rates of smoking.[19]

The 2003 WHO report emphasized the impact of cardiac and vascular diseases on the health of developing countries. This report cited tobacco as the causative agent for many of the cardiovascular illnesses and thus as a major influence on health in these countries. Controlling tobacco and decreasing its impact was seen as critical to the ability of developing nations to provide healthcare to their citizens.[20]

Time will demonstrate whether the distribution of the type of diseases and deaths will be the same in developed countries as in the still developing countries. For example, the prevalence of tuberculosis is much more common in low and middle-income countries than in the higher income countries. Studies have demonstrated that smoking increases the risk of acquiring tuberculosis both for the person smoking and for children exposed to the tobacco smoke.[21] Deaths from tuberculosis are twice as likely in a smoker than in a non-smoker. It is unknown whether current smoking affects the treatment or outcome of malaria. Patients with HIV/AIDS have increased complications and more aggressive diseases than non-smokers.[22] Patients diagnosed with cancer are more likely to be in a more advanced stage of disease than if they had previously stopped smoking.[23] In addition, cancer patients may have a poorer survival if they continue to smoke through their treatment.[24] Thus,

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19. World Health Organization, World Health Report 2002, annex tbl.12 (2002), *available at* http://www.who.int/whr/2002/whr2002_annex12.pdf (explaining DALYs by risk factor, sex, and mortality stratum); *id.* annex tbl.11, *available at* http://www.who.int/whr/2002/whr2002_annex11.pdf (explaining mortality by risk factor, sex, and mortality stratum).
20. World Health Report 2003, *supra* note 8, ch. 6 (discussing the interplay of smoking and cardiovascular disease and cost-effectiveness of smoking cessation policies; continuing with the discussion of tobacco control's overall importance to public health).
21. C. Kolappan & P.G. Gopi, *Tobacco Smoking and Pulmonary Tuberculosis,* 57 Thorax 964, 964–66 (2002); V. Maurya et al., *Smoking and Tuberculosis: An Association Overlooked,* 6 Int'l J. Tuberculosis & Lung Disease 942 (2002).
22. Kimberly Page-Shafer et al., *Comorbidity and Survival in HIV-Infected Men in the San Francisco Men's Health Survey,* 6 Annals Epidemiolgy 420, 420 (1996).
23. Nathan L. Kobrinsky et al., *Impact of Smoking on Cancer Stage at Diagnosis,* 21 J. Clinical Oncology 907, 907–913 (2003).
24. Gregory M. M. Videtic et al., *Continued Cigarette Smoking by Patients Receiving Concurrent Chemoradiotherapy for Limited-Stage Small-Cell Lung Cancer is Associated with Decreased Survival*, 21 J. Clinical Oncology 1544 (2003); Ellen R. Gritz et al., *Smoking, The Missing Drug Interaction in Clinical Trials: Ignoring the Obvious*, 14 Cancer Epidemiology Biomarkers & Prevention 2287 (2005).

rates of death and DALYs will be influenced by the underlying prevalence of disease and rate of smoking in the societies.

Diseases caused by tobacco, like those caused by tuberculosis, malaria, and HIV/AIDS, are preventable. Tobacco-related deaths and diseases, however, are dramatically different from the consequences of infectious diseases because tobacco is only harmful if actively consumed and promoted by both the individual and the society. Multinational tobacco corporations, particularly from the United States, United Kingdom, and Japan, relying on the rules of international trade, aggressively market their cigarettes in countries that have their own tobacco industries, by utilizing trade regulations.[25] Governments institute and maintain regulations that promote tobacco production and consumption by their populations to the financial benefit of the executives and shareholders in the companies concerned, a relatively insignificant segment of the population of their countries. Vastly greater segments of the population suffer significant negative health consequences from state-supported production and consumption of tobacco. Former US Surgeon General C. Everett Koop has said:

> It is clear that the motivation of Big Tobacco is greed. I believe greed that flourishes at the expense of the destruction of millions of lives a year can only be described as evil; it cannot be reconciled with personal and corporate ethics and morality. Such greed is infectious and pervasive. . . . The public needs to know that good health and quality of life are taken away by tobacco, and are achieved through its avoidance.[26]

Tobacco production affects both individual and societal health through environmental destruction, particularly soil and water depletion, green tobacco sickness from harvesting the tobacco plant, and pesticide or fertilizer related health effects. Women and children are active in tobacco farming, and suffer from the consequences both to their personal health and to their socioeconomic status. Because the multinational tobacco corporations manipulate the costs of tobacco seed, pesticide, fertilizers, and sale prices of the product, small tobacco farmers are forced into slave-type labor with little ability to improve their economic status. These problems with tobacco production predominately affect the developing countries, which have less developed public health programs.

A second aspect of the environmental impact of tobacco results from the smoking of tobacco, particularly indoors. This "environmental tobacco smoke" (ETS) or "second-hand smoke" has been declared by the International

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25. Judith Mackay, *US Tobacco Export to Third World: Third World War*, J. Nat'l Cancer Inst. Monographs No. 12, at 25–28 (1992).
26. C. Everett Koop, *Preface* to Tobacco and Public Health: Science and Policy, at xii (Peter Boyle et al. eds., 2004).

Agency for Research on Cancer (IARC) in their recent monograph on Tobacco Smoke and Involuntary Smoking to be a Group 1 carcinogen—their highest classification.[27] The Environmental Protection Agency in the United States has found that ETS is a significant cause of disease in adults and children.[28] Other studies estimate that ETS causes approximately 3,000 lung cancer deaths per year in the US, and is implicated in several other cancers, as well as respiratory, cardiovascular, reproductive, and development disorders.[29] The tobacco industry has refuted the science and maintains there is no health concern with ETS. Fortunately, the tobacco industry has fallen into such disrepute that countries, states and provinces within countries, and localities have increasingly instituted public smoking bans based on scientific data. Most compelling is the recent countrywide ban on smoking in public places, including workplaces, restaurants, and pubs in Ireland on 29 March 2004, in Norway on 1 June 2004, and in several other countries, to protect workers' health.[30]

B. Stages of the Tobacco Epidemic

The impact of the tobacco epidemic should also be considered in its historical context, especially with the aim of designing intervention strategies. Allen D. Lopez et al., based on the historical data of smoking prevalence and resultant deaths, have proposed a chilling model of the tobacco epidemic.[31]

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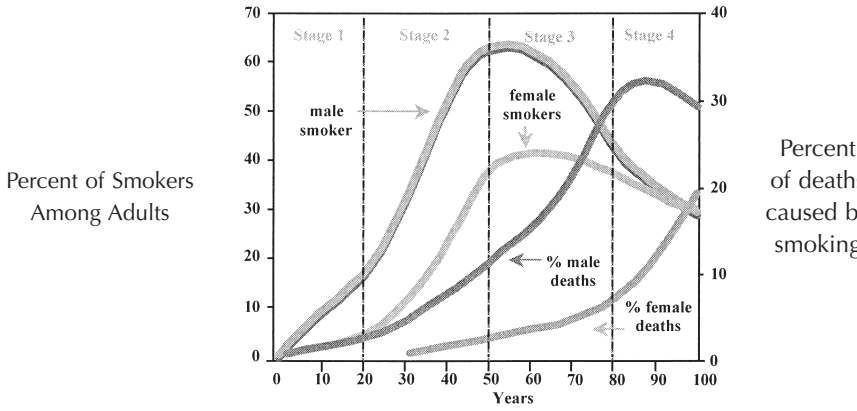
27. International Agency for Research on Cancer (IARC), Tobacco Smoking and Involuntary Smoking 1413 (IARC Monographs vol. 83, 2004).
28. State of California Air Resources Board, Proposed Identification of Environmental Tobacco Smoke as a Toxic Air Contaminant, at ES10–ES18 (2005), *available at* http://www.arb.ca.gov/toxics/ets/finalreport/finalreport.htm [hereinafter California ETS Report]. *See also* National Cancer Institute (NCI), Health Effects of Exposure to Environmental Tobacco Smoke: The Report of the California Environmental Protection Agency (Smoking and Tobacco Control Monograph no. 10., 1999).
29. A. Judson Wells, *An Estimate of Adult Mortality in the US from Passive Smoking,* 14 Env't Int'l 249, 249 (1988).
30. Public Health (Tobacco) (Amendment) Act, 2004 (Act No. 6/2004) (Ir.), *available at* http://www.oireachtas.ie/documents/bills28/acts/2004/A0604.pdf; Norway Ministry of Health, Act No. 14 of 9 March 1973 Relating to Prevention fo the Harmful Effects of Tobacco, *available at* http://odin.dep.no/hod/engelsk/regelverk/p20042245/042041-990030/index-dok000-b-n-a.html; Tobacco (Smoking Control) Act, ch. 315, *available at* http://www.ba-malta.org/legislation/CHAPT315.pdf (Malta legislation passed in Oct. 2004); New Zealand Ministry of Health, Smokefree Law in New Zealand, *available at* http://www.moh.govt.nz/smokefreelaw (describing Dec. 2003 legislation in New Zealand); Governo Italiano, *Tutela della salute dei non fumatori, available at* http://www.governo.it/GovernoInforma/Dossier/fumo_divieto/art_51.html (describing Jan. 2005 legislation in Italy); *Rokfria Serveringsmiljoer, available at* http://www.regeringen.se/sb/d/108/a/3307 (describing June 2005 legislation in Sweden).
31. Alan D. Lopez et al., *A Descriptive Model of the Cigarette Epidemic in Developed Countries*, 3 Tobacco Control 242 (1994).

The model is developed from the more than 100 year history of smoking, particularly in the developed world. It has been observed that three to four decades after the peak in smoking prevalence, a country experiences a peak in smoking-related deaths. This model is even more powerful when gender is one of the variables. When comparing gender-related prevalence and rate of deaths, the tobacco epidemic may be divided into four stages. Stage I is one of quite low male and female prevalence of smoking and few smoking-related deaths. Many low-income countries, such as in sub-Saharan Africa, are in this stage. Stage II consists of a rapid rise in the number of male smokers to its peak, a start in the rise in female smokers, an upswing in the number of male deaths, but still few deaths among females. In Stage III, the prevalence of male smoking begins to decline, female smoking continues to increase, and the rate of smoking attributed male deaths is at its peak (around 30 percent of all deaths), while the rates for females begins to sharply increase. In Stage IV, female smoking peaks and then declines as male smoking continues to decline and smoking-attributable death for men and women decreases. Countries such as the United States and United Kingdom are characteristic of Stage IV, where the rates of female smoking attributable deaths are just reaching their peaks, while the males rates have already started their decline.



Alan D. Lopez et al., A Descriptive Model of the Cigarette Epidemic in Developed Countries, 3 TOBACCO CONTROL 242, 246 (1994).

Unfortunately, at present smoking tobacco is estimated to be the cause of death in one of two long-term smokers. If interventions could be instituted in early stages, particularly in Stage II or III, which applies to most of the world, especially the low and middle-income countries, significant numbers of deaths could be prevented. Tobacco control efforts, particularly in the

form of information and education, could alter the predictions of this model and shift the movement of countries more quickly through the stages. Peaks of smoking prevalence and smoking-attributable deaths could be lower and occur earlier. The model can be used by public health planners to avoid the predicted millions of deaths.

Public health planners have not regarded human rights as of much use to tobacco control efforts. We will now examine whether there is much to be gained by reconsidering tobacco control strategies in light of a human rights framework.

III. HUMAN RIGHTS FRAMEWORK

In many other areas human rights and the public health have increasingly been linked because of their synergistic ability to draw attention to the causality and possible methods for resolution for the major health problems facing the world, particularly in the developing world. As globalization proceeds, the public health and human rights regimes offer a counterweight to the international trade regime,[32] increasingly influenced by multinational corporations, including Big Tobacco.

The linkage between human rights and public health has gained acceptance as the world struggles with the AIDS crisis. The health of the individual and of the community is significantly affected by the extent to which the rights and dignity of the individual are respected. This respect of the dignity of the individual is defined at the local, state, national, or international level by the norms of human rights. In the World Health Report 2003, WHO acknowledged,

> Although some people may have become wary of expressions such as "adopting a human rights approach to HIV/AIDS," highly pragmatic steps can be taken to do just that, and these interventions will have a salutary effect on AIDS prevention and care. Social and economic rights, including the right to health care, are central to a future in which HIV will play a less destructive role in people's lives. Governments should take the lead in promoting a human rights model of AIDS prevention and care.[33]

In its 2004 report, WHO discussed "the power of a human rights approach."[34]

The "power" or utility of a human rights approach for tobacco control as a public health concern is related to some key principles and methods of

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32. Laurence R. Helfer, *Regime Shifting: The TRIPs Agreement and New Dynamics of International Intellectual Property Lawmaking*, 29 Yale J. Int'l L. 1 (2004).
33. World Health Report 2003, *supra* note 8, at 50–51.
34. WHO, The World Health Report 2004: Changing History 47–49 (2004).

public health. Public health focuses on the health needs of the community, which must be assessed on the basis of evidence and attention to vulnerable groups. Interventions are designed to address the most pressing needs of the community particularly the most disadvantaged, without discrimination, and with the highest probability of providing an effective remedy for the public health issue. Interventions thus must meet the triple requirements of being evidence-based, of reaching the most vulnerable, and of effectively reducing mortality or morbidity. There are human rights implications of meeting these three requirements. For example, evidence-collection requires protection of privacy of personal information in surveys of HIV infection or syphilis demographics. Special human rights standards have been adopted for the particular conditions of vulnerable populations, including children, the disabled, minorities, and indigenous peoples. Limitations on certain human rights are authorized by human rights treaties in the interest of public health, thus promoting effectiveness of public health interventions. These three dimensions of the intersection of public health and human rights are also relevant to tobacco control.

In order to assess the negative health impacts of tobacco production and consumption from a human rights perspective, we will first review the human rights instruments applicable to tobacco control, particularly in the developing world and then the problems and prospects for human rights claims to be made at the individual, society, or state levels to claim these rights against the behavior of states and transnational corporations.

A. APPLICABLE INTERNATIONAL HUMAN RIGHTS STANDARDS

There are at least three clusters of human rights norms relevant to this inquiry, namely, the right to health, including safe and healthy working conditions; children's rights, including child labor; and women's rights.

1. The Right to Health

The constitution of the World Health Organization affirms that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, and political belief, economic or social condition."[35] This right was reaffirmed in Article 25 of the 1948 Universal Declaration of Human Rights as "the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services."[36]

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35. WHO Constitution, *supra* note 4.
36. Universal Declaration of Human Rights, *adopted* 10 Dec. 1948, G.A. Res. 217A (III), U.N. GAOR, 3d Sess. (Resolutions, pt. 1), at 71, art. 25(1), U.N. Doc. A/810 (1948), *reprinted in* 43 Am. J. Int'l L. 127 (Supp. 1949).

In 1966, the UN General Assembly adopted the International Covenant on Economic, Social and Cultural Rights (ICESCR), further defining, this time in the form of legally binding obligations on states parties, the right to health and related rights.[37] The ICESCR defines the right to health as follows:

> 1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
> 2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
> (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
> (b) The improvement of all aspects of environmental and industrial hygiene;
> (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
> (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.[38]

The Committee on Economic, Social and Cultural Rights comprehensively interpreted Article 12 of the ICESCR in 2000, in its General Comment 14 (GC 14).[39] GC 14 addresses such issues as access of safe and potable water, safe and healthy working conditions, a healthy environment, and access to health-related education and information, as well as the "prevention and reduction of the population's exposure to harmful substances such as . . . harmful chemicals or other detrimental environmental conditions that directly or indirectly impact upon human health."[40]

In addition, GC 14 notes that "industrial hygiene" as used in Article 12, "refers to the minimization, so far as is reasonably practicable, of the causes of health hazards inherent in the working environment."[41] The Committee considered that Article 12.2(b) "discourages . . . the use of tobacco."[42] Tobacco farming, particularly in developing countries involves precisely the hazards to which this article refers. Furthermore, workplace smoking also constitutes a significant health hazard[43] and should be discouraged under the same interpretation.

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37. International Covenant on Economic, Social and Cultural Rights, *adopted* 16 Dec. 1966, G.A. Res. 2200 (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3 (*entered into force* 3 Jan. 1976).
38. *Id.* art. 12.
39. *The Right to the Highest Attainable Standard of Health,* General Comment No. 14, U.N. ESCOR, Comm. on Econ., Soc. & Cult. Rts., 22d Sess., ¶ 15, U.N. Doc. E/C.12/2000/4 (2000), *available at* http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En?Open Document [hereinafter GC 14].
40. *Id.*
41. *Id.*
42. *Id.*
43. The health risk caused by environmental tobacco smoke is extensively covered in the California ETS Report, *supra* note 28; IARC, *supra* note 27, also thoroughly reviews the carcinogenicity of secondhand smoke. Both of these references exhaustively review the health effects of secondhand smoke, which occurs where one obtains the exposure, whether at work, home, outside, etc.

Article 12.2 (c) is particularly pertinent to both the production and consumption of tobacco. According to GC 14, it "requires the establishment of prevention and education programmes for behaviour-related health concerns," which certainly applies to the health risks of growing or using tobacco. The most significant educational message is that cigarettes are the only legal product that, when used as intended, kills. This information is readily available in developed countries, but prevention and education programs with this message are rarely accessible in developing countries. According to a 1996 prevalence survey in China, 69 percent of the Chinese smokers thought that smoking had negligible risk with little knowledge about specific disease risks such as cardiovascular disease.[44] Education of the health risks of both production and consumption of tobacco is an obligation of states parties to the ICESCR according to this interpretation of Article 12.2(c). It is critical, especially for countries that have severe resource constraints, that "the vulnerable members of society must be protected by the adoption of relatively low-cost targeted programmes."[45] Whether the poor states themselves are solely responsible for this dissemination of information and programs will be addressed later.

As discussed above, ETS has been documented to be the cause of significant health impairment and should be eliminated for the safety of the people around the smokers. Ireland has led the way in enacting smokefree legislation and several others countries have followed suit[46] or will as they consider similar legislation. Legislation in Bhutan, India, several states within the United States and Australia, and several provinces within Canada demonstrate that the concept of the right to a healthy work environment is acceptable and enforceable.[47] Exposure to ETS is a human rights issue that very directly relates to ICESCR Article 12(b), which requires "The improvement of all aspects of environmental and industrial hygiene." Despite the tobacco industry's ongoing refutation of well accepted scientific data, ETS is detrimental to the health of all exposed, as a known carcinogen[48] and necessarily must be eliminated. By utilizing a human rights and health framework that is intended to support the health of the exposed woman, man, or child, imposition of indoor smoking restrictions on an individual is justified.

By utilizing this right to a healthy environment, India has passed national legislation establishing smokefree public places. In 1999, the High Court of Kerala banned smoking in public places. The Court declared "public smoking

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44. Gonghuan Yang et al., *Smoking Cessation in China: Findings from the 1996 National Prevalence Survey*, 10 Tobacco Control 170 (2001).
45. GC 14, *supra* note 39, ¶ 18.
46. *See* Lopez, *supra* note 31.
47. *See* Action on Smoking and Health (ASH) Scotland, Smoke-free Legislation Around the World, *available at* http://www.ashscotland.org.uk/ash/ash_display.jsp?p_applic=CCC&p_service=Content.show&pContentID=4264& (providing a webpage to monitor the legislative activity of countries as they move toward smokefree initiatives).
48. IARC, Tobacco Smoking and Involuntary Smoking, *supra* note 27, at 1413.

as illegal, unconstitutional and violative of Article 21 of the Constitution." It further held that smoking in public "falls within the mischief of the penal provisions relating to public nuisance as contained in the Indian Penal Code and also the definition of air pollution as contained in the statutes dealing with the protection and preservation of the environment, in particular, the Air (Prevention and Control of Pollution) Act 1981."[49] In 2001, the Supreme Court banned smoking in all public places and public transports.[50] The national Anti-Smoking Act banning public smoking went into effect 1 May 2004 with provisions for penalties.

Many countries have national and international endorsements of the right to health and the right to a healthy environment, including workplaces, which would enable them to follow India's lead based on a "rights argument." Due to the weight of evidence supporting the health effects from secondhand smoke, other states will need to accept the concept of protecting the health of non-smokers, including employees in public or in their workplaces, and ban smoking in all public places (including restaurants and pubs).

Indoor and outdoor smoking restrictions are sometimes used as a red herring to invoke smokers' rights in ways that are misleading. Some have warned of "the potential for human rights rhetoric to be co-opted by public health's opponents," citing tobacco interests as an example.[51] It has been argued that smokers have rights, especially that their personal choice to use a legal substance and to enjoy their private property should not be interfered with by government for public health purposes.[52] R. J. Reynolds maintains a website called "My Smokers Rights"[53] and a New York-based organization called C.L.A.S.H. (Citizens Lobbying Against Smoker Harassment) provides links to smokers rights groups.[54] The vague references to "freedoms" and "civil rights" tend to articulate general concerns with property and choice. One group at a "World Smokers' Day" web site[55] has published a "Smokers' Rights Declaration," based on the Universal Declaration, which explains, "Although the United Nations no longer seems to believe in, or abide by, their own Declaration of Human Rights, smokers are here to remind them that at least one segment of global society still take their Articles seriously."[56] Among the

49. Murlia S. Deora v. Union of India, WP 316/1999 (2001), *available at* http://www.elaw.org/resources/text.asp?id=796 (the case for smokefree places in India).
50. *Countrywide Ban on Smoking in Public Places,* Times of India, 3 Nov. 2001, *available at* http://w3.whosea.org/hin/pdf/01/country.pdf.
51. Peter D. Jacobson & Soheil Soliman, *Co-Opting the Health and Human Rights Movement*, 30 J.L. Med. & Ethics 705, 713 (2002).
52. *See, e.g.,* Jacob Sullum, For Your Own Good: The Anti-Smoking Crusade and the Tyranny of Public Health (1998).
53. RJ Reynolds, My Smoker's Rights, *available at* https://mysmokersrights.rjrt.com/SGRHome.jsp.
54. *See* New York City C.L.A.S.H., *available at* http://www.nycclash.com/SmokerGroups.html.
55. *See* World Smokers' Day 2005, *available at* http://www.worldsmokersday.org/.
56. *See* World Smokers' Day, Smokers' Rights Declaration, *available at* http://www.worldsmokersday.org/srd.html.

many organizations behind the World Smokers Day is Forces International (Forces, Inc.), which describes itself as "a non-profit educational corporation organized under the laws of the Commonwealth of Virginia."[57] The Declaration begins with a preamble that proclaims, for example, "Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world, Whereas smokers are considered human beings as well, Whereas it is essential for smokers to rebel against tyranny and oppression." Nevertheless, it is an extreme version of the confusion around the concept of "smokers' rights." The "rights" of smokers, like those of gun users, are not "human rights" but rather legally protected interests, which may compete with social welfare as a matter of legislative policy. Human rights are a higher order of legally protected interests that have been acknowledged by a legal system (national or international) to take precedence over other rights. Thus, the human rights to life and to health trump the (non-human) rights to consume a toxic but legal substance. To call the legally protected right of a smoker to purchase and consume tobacco products a human right is a misuse of the term. The public authorities may restrict such "rights" for reasons of public health through a democratic process and, to the extent that they acknowledge a human right to tobacco control as a derivative right of the right to health, they are well founded to impose restrictions on smoking in public places where ETS threatens the right to health of others, to ban advertising or require warnings, and to tax heavily tobacco products, all of which constitute legitimate public health-based limitations on smokers' rights to privacy, expression, and property.

2. Rights of Children

The special issues of children and adolescents are also addressed in paragraph 23 of GC14, specifically the obligation of states to "provide a safe and supportive environment for adolescents, that ensures the opportunity to participate in decisions affecting their health, to build life-skills, to acquire appropriate information, to receive counselling and to negotiate the health-behaviour choices they make."[58] The Convention on the Rights of the Child (CRC)[59] elaborates further the right to health issues discussed in GC14.

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57. *See* Forces International, *available at* http://www.forces.org/. There is no evidence to date that this organization is supported by tobacco industry funding; however, many of its members are members of other organizations that have received substantial tobacco industry support.
58. GC 14, *supra* note 39, ¶ 23.
59. Convention on the Rights of the Child, *adopted* 20 Nov. 1989, G.A. Res. 44/25, U.N. GAOR, 44th Sess., Supp. No. 49, U.N. Doc. A/44/49 (1989) (*entered into force* 2 Sept. 1990), *reprinted in* 28 I.L.M. 1448 (1989).

a. Tobacco Consumption by Children

Particularly pertinent for the consumption of tobacco is the decrease in the age of initiation of smoking from the twenties down into the early teens, as countries become increasingly developed. Much of this uptake of smoking of increasingly younger children is driven by the advertising and marketing of the tobacco industry. It is estimated that 82,000 to 99,000 young people start smoking every day, with 68,000 to 84,000 of these teenagers occurring in low to middle income countries.[60] The tobacco industry aggressively pursues this market share, with the result that it is estimated that 250 million children alive today will be killed by tobacco.[61]

In addition to primary smoking, children are at particular risk of environmental exposure to tobacco smoking within their home. The WHO estimated that approximately 700 million children are exposed to tobacco smoke, including in their homes.[62] Because the children have no ability to control this exposure, education must be provided to their caretakers to improve their home environment. Exposure to secondhand smoke has been clearly demonstrated to increase children's incidence of middle ear infections, respiratory infections, severity of asthma attacks, and sudden infant death syndrome.[63] Children who grow up in a household where the parents smoke are more likely to initiate smoking themselves[64] and parental smoking, especially by the mother, is the most important determinant of exposure in children aged five to seven.[65] Thus, smoking cessation is both beneficial to the caretakers and to the children who would otherwise be exposed to secondhand smoke.

b. Advertising Targeting Children

Consistent with the obligations of Article 17 of the CRC regarding the child's right to information aimed at the promotion of his or her social, physical, and mental health, the Committee on the Rights of the Child has stressed the obligation of states parties to promote "cost-effective measures, including through laws, policies and programmes, with regard to . . . the abuse

60. Jha & Chaloupka, Curbing the Epidemic, *supra* note 1, at 19.
61. WHO, Tobacco & The Rights of the Child 5 (2001), WHO Doc. WHO/NMH/TFI/01.3 Rev. 1, *available at* http://www5.who.int/tobacco/repository/stp53/CRCreport.pdf.
62. WHO, Report on Tobacco Smoke and Child Health (1999), *available at* http://ash.org/who-ets-rpt.html.
63. NCI, Health Effects of Exposure to Environmental Tobacco Smoke, *supra* note 28, at ES5.
64. Jennifer O'Loughlin et al., *One-Year Predictors of Smoking Initiation and of Continued Smoking among Elementary Schoolchildren in Multiethnic, Low-Income, Inner-City Neighbourhoods,* 7 Tobacco Control 268, 272 (1998).
65. Derek G. Cook et al., *Passive Exposure to Tobacco Smoke in Children Aged 5–7 Years: Individual, Family, and Community Factors,* 308 Brit. Med. J. 384 (1994).

of alcohol, tobacco and other harmful substances."[66] Accordingly, the state should provide education concerning the ill effects of air pollution relative to indoor or passive smoking and to the health risks to which they expose their children.

States are required under Articles 24 and 27 of the CRC to assist in the promotion of the child's health to the best of their financial ability. These articles would require the states to provide education on the health risks of the child to both primary and secondary smoke. Whether the states have the right to legislate smoking within the home will be an issue to discuss in the future. At the present however, sufficient information concerning the risks of passive tobacco smoke is available to pursue legislation requiring a smoke-free environment in any public, work, or school situation where children might be present. At a minimum, states are required by the Convention to institute such legislation.

Additionally, when one or more of the parents smoke, there may be reduced resources for food, clothing, and shelter for the entire household.[67] This of course is of particular importance in developing countries where poverty is so prevalent and is usually accompanied by under-nourishment or malnutrition. When a household is deprived of income that could support the basic necessities, the rights to health, survival, and economic improvement necessarily suffer. Parental mortality and morbidity due to smoking results in decreased household incomes.

States parties accept responsibility in Article 27 of the CRC for "the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development." This article requires parents, with the assistance of the state, "to secure, within their abilities and financial capacities, the conditions of living necessary for the child's development." To meet this requirement, policies must be implemented that will contribute to decreased smoking by the child's caretakers both to protect the child's physical development and to ensure that the family does not spend on tobacco addiction at a level inconsistent with the duty to provide for an adequate standard of living for their children. Besides protecting the child from secondhand smoke and the risks of income constraints harmful to the child's standard of living, the absence of smoking in the household also leads to lower levels of smoking initiation by the child.[68]

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66. *Adolescent Health and Development in the Context of the Convention on the Rights of the Child,* General Comment No. 4, U.N. Comm. on the Rights of the Child, 33d Sess., ¶ 10, U.N. Doc. CRC/GC/2003/4 (2003), *available at* http://www.unhchr.ch/tbs/doc.nsf/(symbol)/CRC.GC.2003.4.En?OpenDocument [hereinafter CRC, GC 4].
67. Y.L. Gong et al., *Cigarette Smoking in China: Prevalence, Characteristics, and Attitudes in Minhang District,* 274 J. Am. Med. Assn. 1232 (1995).
68. Among the articles on the effect of smoking restrictions in the home on teenage initiation of smoking, see Melanie A. Wakefield et al., *Effect of Restrictions on Smoking at Home,*

The children and teenagers should be provided information that allows them to decide whether they want to risk the health dangers by starting smoking. Children and adolescents often do not acknowledge the addictiveness of cigarette smoking until it is too late. Many teenagers who have been smoking for a few years want to stop smoking or believe that they will stop smoking soon, for instance, within the next five years. Unfortunately, the addictiveness of the product makes it almost impossible to live up to this expectation because few established adolescent smokers successfully quit. Therefore both education and counseling are required to prevent the initiation of smoking by children and teenagers; further, there must be regulations in place to eliminate the marketing of the products to children and to prevent ongoing use. The tobacco industry has, in the recent past, specifically targeted children in the developed world; however, restrictions are progressively tightened to prevent them from doing so. This prohibition is critical in the developing world if the predicted public health epidemic is to be controlled. It is equally important for similar restrictions to be placed on advertising to children and teenagers in the developing world where restrictions have not yet been imposed on the tobacco industry.

A critical dimension of states parties' obligation to provide a safe environment for adolescents and children is to control the marketing and advertising directed to them. Advertising particularly influences teenagers, even more than peer or family pressure.[69] This advertising and marketing occurs in a variety of ways, including direct and indirect methods, such as promotional items in the form of garment or trinket giveaways, and sponsorship of sporting events, particularly car races and rock concerts. Smoking is portrayed as attractive, adult, sexy, and indicative of independence—in myriad ways that would entice teenagers to emulate the characteristic of the people portrayed in the ad. The duty of the state to eliminate this enticement of youth to initiate tobacco use must be weighed against the freedom of commercial expression. States with the political will and constitutional authority can significantly restrict the increasingly wily marketing maneuvers of the tobacco industry. As tobacco advertising bans have been more widely adopted and increasingly enforced, the industry has moved to promotional techniques and point of sale advertising that remains oriented towards youth.[70]

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at School, and in Public Places on Teenage Smoking: Cross Sectional Study, 324 Brit. Med. J. (2000); Arthur J. Farkas et al., *Association between Household and Workplace Smoking Restrictions and Adolescent Smoking,* 284 J. Am. Med. Assn. 717 (2000).

69. Nicola Evans, et al., *Influence of Tobacco Marketing and Exposure to Smokers on Adolescent Susceptibility to Smoking,* 87 J. Nat. Cancer Inst. 1538 (1995).

70. Christine Bump has reviewed restrictions on tobacco product advertising in the United States and the European Union, in light of the FCTC. In particular, she notes that the Federal Cigarette Labeling and Advertising Act of 1965 does not apply to sales outside the United States. She also reviews various bans by European countries and the EU Directive on Tobacco Advertising and notes that only three of the fifteen EU members

As this occurs, the states must enforce the intent of their regulations, as was recently achieved in the United Kingdom. Denying an appeal by the tobacco industry to weaken the advertising rules, the High Court ruled in favor of the UK Department of Health on a regulation that restricts the point of sale advertising of tobacco to an A5 size advertisement in toto and that includes a health warning at least 30 percent of this size.[71]

The tobacco industry pursues many avenues to reach one of its key target markets—teenagers and young adults. One of the largest spectator sports in the world is Formula One racing, and the tobacco industry has been actively involved in this sport. The cars allow significant space for labeling with visible logos, particularly effective for a large television market. British American Tobacco (BAT) is the majority shareholder of the British American Racing Company and makes certain that their cars are labeled with a logo to represent the company.[72] BAT uses Formula One racing to target the young adults in emerging Asian markets with their specific brands and has marketing plans for merchandizing racing car models with logos of their cigarette brands. The tobacco industry also sells or gives away promotional items, such as apparel with logos or trinkets, knowing that teens who own a tobacco promotional product are three times more likely to start smoking than those who do not own such a product.[73] This promotional behavior has utilized a significant portion of the advertising budget of the tobacco industry, and has been remarkably successful in reaching teenagers. The impact of tobacco advertising on youth has not escaped the notice of the Committee on the Rights of the Child. In its General Comment 4, it urged states parties "to regulate or prohibit information on and marketing of substances such as alcohol and tobacco, particularly when it targets children and adolescents."[74]

The tobacco industry is targeting children directly in the developing world, despite their legal constraints from doing so in more developed countries such as the United States, United Kingdom, Canada, or Australia. As discussed earlier, people who smoke generally begin as children or adolescents; and an estimated 82,000 to 99,000 children begin smoking each day.[75] It is only by instituting and enforcing laws and regulations that

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ban point-of-sale advertising. *See* Christine P. Bump, *Comments—Close But No Cigar: The WHO Framework Convention on Tobacco Control's Futile Ban on Tobacco Advertising*, 17 Emory Int'l L. Rev. 1251, 1301 (2004). She notes further that the FCTC does not mandate a ban on tobacco advertising. *Id.* at 1302–03.

71. British Am. Tobacco UK Ltd. & Others v. Sec'y of State for Health [2004] EWHC 2493 (Admin.), *available at* http://www.bailii.org/ew/cases/EWHC/Admin/2004/2493.html.
72. Joshua Carlyle et al., *British American Tobacco and Formula One Motor Racing*, 329 Brit. Med. S. 104 (2004).
73. John P. Pierce et al., *Tobacco Industry Promotion of Cigarettes and Adolescent Smoking*, 279 J. Am. Med. Assn. 511 (1998).
74. CRC, CG 4, *supra* note 66, ¶ 25.
75. Jha & Chaloupka, Curbing the Epidemic, *supra* note 1, at 19.

will put a stop to the aggressive advertising and marketing by the tobacco industry aimed at children and adolescents, which has already captured this market in the developed world.

The tobacco industry recognizes that new smokers arise from the ranks of children. Advertisements such as the very successful Joe Camel campaign are illustrative of the intentional marketing to children and this campaign is still in use in developing countries despite it being illegal in more developed countries.[76] The inadequacy of legislation and enforcement of measures to prevent such blatant disregard for the health of children, by enticing them to smoke and consequently becoming addicted to cigarettes, is one of the most egregious failings of states to meet their obligations to protect the right to health of children. They have additional responsibilities with regard to tobacco production.

c. Children in Tobacco Production

As tobacco is a very labor-intensive crop, countries with low labor costs grow it, involving all available labor, including women and children, with negative consequences for their educational and development opportunities. Children are kept from school to assist in labor of planting, picking, curing, gathering firewood, and transporting the crop to the auction houses.[77] The Tobacco Association of Malawi (TAMA) admitted in 2000 that it uses child labor in the country's plantations.[78] The problem varies from country to country, as children may be used to plant or harvest tobacco, or for example, in India where they frequently are used to hand roll bidis. It is estimated that 218 million children are in the labor force, and 126 million are in hazardous work; for example, in Malawi alone it is estimated that over 100,000 children are involved in tobacco production.[79]

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76. *See* U.S. Dept. Health & Human Services, Reducing Tobacco Use: A Report of the Surgeon General 194 (2000); *see also* WHO Framework Convention on Tobacco Control, *adopted* 21 May 2003, art. 3, *available at* http://www.who.int/tobacco/fctc/text/final/en/ [hereinafter FCTC] (restricting advertising, promotion and sponsorship); *see also* WHO, Fatal Deception: The Tobacco Industry's "New" Global Standards for Tobacco Marketing (2001), *available at* http://www.who.int/tobacco/media/en/fatal_deception.pdf (for a discussion of the tobacco industry's interest in pursuing "voluntary advertising regulations").
77. H. Muwanga-Bayego, *Tobacco Growing in Uganda: The Environment and Women Pay the Price*, 3 Tobacco Control 255, 255–56 (1994).
78. Brian Ligomeka, African Eye News Service (S. Afr.), 16 Nov. 2000, *available at* http://www.humanrights-it.org/ita/parte2c.htm; Brian Ligomeka, African Eye News Service (S. Afr.), *Malawi Ups'* [sic] *Pressure Against Child Labour At Tobacco Estates*, 8 Dec. 2000, *available at* http://www.humanrights-it.org/ita/parte2c.htm.
79. International Labour Organization, Report of the Director General: The End of Child Labour: Within Reach, at xi (International Labour Conference, 95th Sess., 2006), *available at* http://www.ilo.org/public/english/standards/relm/ilc/ilc95/pdf/rep-i-b.pdf; for the number of children involved in Malawi tobacco production, see Child Labor News Service Release–March 15, 2002, *Tobacco Industry Accused of Engaging Children,* 15 Mar. 2002, *available at* http://www.hrea.org/lists/child-rights/markup/msg00022.html.

The children's rights issues relative to the production of tobacco concern primarily the employment of children as laborers to grow tobacco. Tobacco is very labor intensive, requiring significant individual attention to each plant, from seedling to harvesting of individual tobacco leaves. As a result, children are utilized as cheap or unpaid labor, not only exposing them to hard work for long hours, but also increasing the risk of green tobacco sickness and poisoning from fertilizers and pesticides.[80] Their exposure to toxic products, including the nicotine of the tobacco plant, during harvesting directly infringes on their right to health and a safe environment.

Children are at significantly increased risk for nicotine poisoning when harvesting the tobacco leaves. Green tobacco sickness (GTS) is basically the effect of nicotine that is released during the harvesting, cutting, or loading of the tobacco leaves and that is readily absorbed through the skin. (This fact is taken advantage of by the pharmaceutical industry with the nicotine replacement therapy in the form of a skin patch.) GTS is manifested by weakness, headache, nausea, vomiting, dizziness, abdominal cramps, breathing difficulty, pallor, diarrhea, and changes in blood pressure or rate—all recognized symptoms of nicotine toxicity. Unfortunately, GTS appears to be progressively more likely the younger the worker: 58 percent with GTS were under twenty-nine years old with 32 percent between the ages of fourteen and nineteen.[81] Although GTS has been mainly described in the developed world, the effects would be expected anywhere that tobacco is harvested. The problem in a poor developing country, in contrast to North Carolina, is one of recognizing and treating the symptoms. In addition, accessible healthcare may not be an option for some farmers suffering from GTS symptoms.

The second children's rights issue is that work in the tobacco fields prevents the children from attending school, thus, severely limiting or eliminating their ability to obtain an education. The Convention on the Rights of the Child stipulates:

> States Parties recognise the right of the child to be protected from economic exploitation and from performing any work that is likely to be hazardous or to interfere with the child's education, or to be harmful to the child's health or physical, mental, spiritual, moral or social development.[82]

For a developing country struggling economically and utilizing their children as part of a necessary workforce in the production of tobacco,

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80. International Labour Organization, International Programme on the Elimination of Child Labour: Safety and Health Fact Sheet: Hazardous Child Labour in Agriculture: An Overview (Mar. 2004), *available at* http://www.ilo.org/public/english/standards/ipec/publ/download/factsheets/fs_agriculture_0304.pdf. *See also* Jeffrey S. McBride et al., *Green Tobacco Sickness*, 7 Tobacco Control 294, 294–98 (1998) (for effect of nicotine on youth).
81. *Id.*
82. Convention on the Rights of the Child, *supra* note 59, art. 32.

the ability to implement and enforce this right may be difficult. This issue of child labor should be addressed as part of the overarching review of tobacco production processes and how the multinational tobacco corporations implement them. Similar to issues related to the environment, malnutrition, and slavery, the problems of child labor and the production of tobacco are multifaceted. All of these problems are created by the financial constraints imposed by the attempt of farmers in poor and developing countries to improve their economic status.

The International Labour Organisation (ILO) has recognized the particular plight of children used in tobacco farming throughout the world. An interesting group has formed a foundation that ostensibly has a goal of protecting children from child labor exploitation. The main members of Elimination of Child Labour in Tobacco Growing (ECLT) are representatives of the MNC tobacco producers.[83] Other members include related workers' unions.[84] The ILO acts as a technical advisor to their board. British American Tobacco (BAT) is one of the three founding members of the ECLT. Its published view on human rights and child labor is "that universally recognised fundamental human rights should be respected."[85] Furthermore, BAT affirms: "We have helped establish the Eliminating Child Labour in Tobacco Growing (ECLT) foundation, and aim to be an active and constructive founding member. We are committed to the principles of protecting children from child labour exploitation, believing their development—as well as that of their communities and countries—is best served through education, not child labour. We do not employ children in our operations."[86]

Philip Morris International (Altria) is also publicly committed to eliminating child labor. In the Philippines, Altria, through ECLT, commissioned a

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83. The International Tobacco Growers Association (ITGA), Universal Leaf Tobacco Co., Inc. (#1 tobacco leaf purchaser); Dimon Incorporated (#2 tobacco leaf purchaser); Standard Commercial (#3 tobacco leaf purchaser); Philip Morris (now called Altria, #1 tobacco manufacturer); British American Tobacco (#2 tobacco manufacturer); Japan Tobacco Inc. (#3 tobacco manufacturer); Gallaher Group PLC, Imperial Tobacco Group PLC, Scandinavian Tobacco Company, Altadis, and Tribac Leaf Limited. The Altria group of Philip Morris International and Philip Morris USA were listed separately at the ECLT site. *See* ECLT Foundation, Foundation Members, *available at* www.eclt.org/members/index.html. Dimon Tobacco merged with Standard Commercial Corporation to become Alliance One and will be located in North Carolina. *See* ABC 13, Dimon Tobacco Moving to North Carolina, *available at* http://www.wset.com/news/stories/0405/217894.html.
84. International Union of Food, Agricultural, Hotel, Restaurant, Catering, Tobacco and Allied Workers Associations. *See* ECLT Foundation, *supra* note 83.
85. British American Tobacco, Social Report 2004/05: Addressing Human Rights, *available at* http://www.bat.com/OneWeb/sites/uk__3mnfen.nsf/vwPagesWebLive/DO6EMDEP?opendocument&SID=4D8BA98E97ADD3D5F7DF4779906023B7&DTC=&TMP=1.
86. *Id. See also* British American Tobacco, Corporate Social Responsibility: Eliminating Child Labour, *available at* http://www.bat.com/OneWeb/sites/uk__3mnfen.nsf/vwPagesWebLive/DO52AQDT?opendocument&SID=4D8BA98E97ADD3D5F7DF4779906023B7&DTC=&TMP=.

study on child labor in tobacco[87] and subsequently provided 100 scholarships to the most needy tobacco farmers in order to assist their children to attend school.[88] ECLT has projects in other countries that demonstrate the extent of awareness by the founding members of ECLT of the magnitude of the problems caused by child labor.

3. Women's Rights

The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), adopted in 1981, provides for a women's right to health and safety in working conditions and the expectation of the delivery of healthcare, including information and counseling.[89] As noted above, few women in the developing world smoke: approximately 9 percent of women in low-income countries smoke as compared to approximately 21 percent in high-income countries.[90] In sub-Saharan Africa, only 10 percent of women smoke, 5 percent in the Middle East and North Africa, and 1 to 4 percent in Asia; the rates for their male counterparts are much higher. In many countries, it is still considered socially unacceptable for women to smoke. In addition, women are unaware of the health risks to themselves and their family associated with smoking. For example, women do not recognize their risk of lung cancer, as they believe it to be a disease of men. Women in the developed world believe that their biggest risk of cancer is from breast cancer, yet in the United States, 1.8 times more women die from lung cancer than breast cancer.[91] Smoking causes at least 90 percent of lung cancers in women.[92] In the 1930s in the United States, lung cancer deaths rates were 2.5 cases per 100,000 women. By 1990, it had risen more than twelve-fold to over thirty cases per 100,000.[93] More recently, from 1992 through 1998,

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87. ECLT Foundation Program in the Philippines with the Department of Labor and Employment (DOLE) 2003–2005, Eliminating Child Labour in the Tobacco Industry (ECLTI) Project, *available at* http://www.eclt.org/filestore/DOLEProgramme.pdf.
88. *See* Eliminating Child Labour in Tobacco Foundation (ECLT), Philippines Project Update: December 2004, *available at* http://www.eclt.org/activities/projects/philippines_updatedec04.html.
89. Convention on the Elimination of All Forms of Discrimination Against Women, *adopted* 18 Dec. 1979, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, arts. 11(1)f, 12, 14(2)b, U.N. Doc. A/34/46 (1980) (*entered into force* 3 Sept. 1981), 1249 U.N.T.S. 13, *reprinted in* 19 I.L.M. 33 (1980).
90. *See* Tobacco Control in Developing Countries, *supra* note 9, at 18. *See also* Judith Mackay & Michael P. Eriksen, WHO, The Tobacco Atlas 26 (2006).
91. Ahmedin Jemal et al., *Cancer Statistics, 2005*, 55 CA: Cancer J. Clin. 10, 12 (2005). Estimated 2005 female lung cancer deaths are 74,150 and 40,410 for breast cancer in the US.
92. Michael J. Thun et al., *Age and the Exposure-Response Relationships between Cigarette Smoking and Premature Death in Cancer Prevention Study II, in* Changes in Cigarette-Related Disease Risks and Their Implication for Prevention and Control 383, 393 (National Institutes of Health: National Cancer Institute ed., 1997).
93. Elizabeth Healey Baldini & Gary M. Strauss, *Women and Lung Cancer: Waiting to Exhale,* 112 Chest S229 (1997).

lung cancer mortality was 34 per 100,000.[94] Between 1950 and 1991, the lung cancer incidence in the United States rose 550 percent in women as compared to 200 percent for men.[95] Recent statistics from Canada have shown a 46 percent increase since 1988 in the lung cancer death rates in women.[96] In fifteen countries in the European Union, death rates went from 7.7 per 100,000 in the late 1950s to 14.3 per 100,000 in the early 1990s.[97] Rates of lung cancer have rapidly increased in women in Ireland, UK, Netherlands, Denmark, and Hungary due to increased rates of smoking.[98] In all of these countries, the rates of lung cancer will soon surpass their rates of deaths from breast cancer.

As discussed earlier, developing countries can be "staged" by the number of women who smoke and subsequently die from lung cancer, one of the large number of tobacco-related diseases that affects the health and well-being of women. In the developing world, smoking is more likely to affect the body's responses to malnutrition and prevalent infectious diseases. If a woman is in a high-risk region for tuberculosis, she may be at increased risk of tuberculosis infection either from her smoking or from exposure to passive smoking.[99] A large study of tuberculosis performed only in men in India has demonstrated that smoking causes half of the deaths from tuberculosis.[100] As the rates of smoking in women is just starting to increase, the types of smoking related diseases in women, in developing countries, is as yet unknown. We can only make assumptions based on experience from the increased smoking in women in more developed countries or extrapolated from the experience in men.

Women who smoke also experience significantly more risks while they are pregnant. Women who smoke have lower birth weight babies, which is already an issue in a malnourished environment; the delivery is more likely to be premature; and the baby will have less developed pulmonary tissue.[101]

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94. Holly L. Howe et al., *Annual Report to the Nation on the Status of Cancer (1973 Through 1998), Featuring Cancers with Recent Increasing Trends*, 93 J. Nat'l Cancer Inst., 824, 824–42 (2001).
95. Lawrence Garfinkel & Edwin Silverberg, *Lung Cancer Smoking Trends in the United States over the Past 25 Years,* 41 CA: Cancer J. for Clinicians 137 (1991).
96. Canadian Cancer Society, Latest Cancer Statistics Released by Canadian Cancer Society—Cancer Incidence and Death Rates Dropping, *available at* http://www.cancer.ca/ccs/internet/mediareleaselist/0,3208,3172_15232_39119674_langIden,00.htm.
97. Fabio Levi et al., *Trends in Mortality from Cancer in the European Union, 1955–94,* 354 Lancet 742, 742 (1999).
98. P. Brennan & I. Bray, *Recent Trends and Future Directions for Lung Cancer Mortality in Europe*, 87 Brit. J. Cancer 43 (2002).
99. N. Ariyothai et al., *Cigarette Smoking and its Relation to Pulmonary Tuberculosis Adults*, 35 Southeast Asian J. Tropical Med. & Pub. Health 219 (2004).
100. Vendhan Gajalakshmi et al., *Smoking and Mortality from Tuberculosis and Other Diseases in India Retrospective Study of 43 000 Adult Male Deaths and 35 000 Controls*, 362 Lancet 507 (2003).
101. NCI, Health Effects of Exposure to Environmental Tobacco Smoke, *supra* note 28, at ES5.

The health of the child is subsequently affected as discussed previously. Smoking thus significantly affects not only the health of the woman, but also that of her unborn child and the other children in her household. Few women are aware of the significance of this risk in the developed world, and even less so in the developing world.

The cost of caring for the smoker, whether male or female, adult or child, can adversely affect the healthcare budget for the family or country. The healthcare costs of smoking-related illnesses in poorer countries is unknown, both because the delivery of services can be very different from that in richer countries and cost analyses have been less sophisticated. However, it is estimated that low and middle income countries spend about 2 percent of their gross domestic product on healthcare.[102] As countries improve their economic status, usually their healthcare services and cost of services also increase. Unfortunately, the rate of smoking and consequently, smoking related diseases also have increased, requiring increased proportions of the healthcare budget. This increase in the cost of healthcare will necessarily be reflected in the availability of the services to the poor, particularly to women and children.

Yet, the transnational tobacco industry is targeting girls and women. The success of the cigarette manufacturers' promotion to women has had an important consequence in the United States, Canada and United Kingdom and unfortunately will probably be similarly replicated throughout the world. Norway has a remarkably high rate of 32 percent of women who smoke.[103] Although it remains socially less unacceptable for women to smoke, times are changing. And, with these changes, as women move out of the home and into the more formal workforce, they often develop the deadly habit of cigarette smoking. Initially in developing nations, younger women with higher education levels may become the early adopters of smoking, contrary to the current inverse social gradient of smoking found in the developed nations.[104] The tobacco industry is eagerly helping women to appear more independent as popular slogans demonstrates: "You've come a long way, Baby"; "It's a woman thing";[105] and "Find your voice."[106]

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102. Tobacco Control in Developing Countries, *supra* note 9, at 34.
103. Tobacco Control Country Profiles 298 (Omar Shafey et al. eds., 2d ed. 2003).
104. Women and Smoking, *supra* note 15.
105. *See* Tobacco Documents Online, You've Come a Long Way, Baby, *available at* http://tobaccodocuments.org/pollay_ads/Virg14.14.html#images; Tobacco Documents Online, Virginia Slims: It's a Woman Thing, *available at* http://tobaccodocuments.org/pollay_ads/Virg09.05b.html.
106. CDC notes,

> In 1968, Philip Morris marketed Virginia Slims cigarettes to women with an advertising strategy showing canny insight into the importance of the emerging women's movement. The slogan "You've come a long way, Baby" later gave way to "It's a woman thing" in the mid-1990s, and more recently the "Find your voice" campaign featuring women of diverse racial and ethnic backgrounds. The underlying message of these campaigns has been that smoking is related to women's

In Sri Lanka, where 99 percent of the women are non-smokers, the local tobacco company places young women at shopping malls and on university campuses where they provide free cigarettes and merchandise to other women.[107] The tobacco industry knows that its future lies with women. It has been demonstrated through industry documents that the tobacco companies carefully design their advertising to identify with the psychosocial needs of different subgroups of women—targeted to different cultures and countries.[108]

Women and girls are entitled to the information that would allow them to make an informed decision whether to start smoking or to quit. It is particularly important in the low- and middle-income countries, where women have not yet experienced the steep increase in their numbers who smoke, that they be provided with the information that smoking is one of their biggest health risks—both to themselves and to their family. Providing information and counseling, required by CEDAW,[109] is particularly critical for women in the developing world. The governments are obligated to either have the tobacco industry provide true and accurate information about the deadly aspects of their products, or the government must provide such information. This information is best provided before either the woman or child begins the very addictive habit in order to obtain the best opportunities to decrease the rates of smoking. In other words, preventing initiation to smoking through interventions before addiction occurs is a critical strategy for the individual and for public health.

It is counterintuitive to expect the tobacco industry to describe accurately the health consequences that predictably occur from their products. Most of the tobacco companies still resist the scientifically proven facts of the health outcomes from people who use their products. Under legal constraints, labeling of tobacco products with large print warnings and pictorial warnings have become increasingly common.[110] Therefore, it behooves the governments and international agencies to impose labeling and to launch

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freedom, emancipation, and empowerment. *See* CDC, Marketing Cigarettes to Women—Fact Sheet, History of Advertising Strategies, *available at http://www.cdc.gov/tobacco/sgr/sgr_forwomen/factsheet_marketing.htm.*

107. Tamsyn Seimon, *Strategic Marketing of Cigarettes to Young People in Sri Lanka: "Go Ahead-I want to see you smoke it Now,"* 7 Tobacco Control 429 (1998).
108. S.J. Anderson et al., *Emotions for Sale: Cigarette Advertising and Women's Psychosocial Needs,* 14 Tobacco Control 127 (2005).
109. See CEDAW, *supra* note 89, art. 14(2)(b), which stipulates that women should "have access to adequate healthcare facilities, including information, counseling."
110. Cigarette or tobacco warning labels are variable around the world. Progressively, countries are finding that pictorial warnings have significant impact on influencing smokers to initiate quitting. D. Hammond et al., *Impact of the Graphic Canadian Warning Labels on Adult Smoking Behaviour,* 12 Tobacco Control 391, 391–95 (2003). These Canadian pictorial warnings were required on all cigarette packages by June 2001. *See* Health Canada, Graphic Health Warnings, *available at* http://www.hc-sc.gc.ca/hl-vs/tobac-tabac/legislation/label-etiquette/graph/index_e.html.

thorough and widespread information campaigns about the health dangers of smoking—particularly to women and children, as required by CEDAW and CRC. This distribution of educational materials and counseling would also be the most cost effective method of addressing this impending massive public health epidemic, rather than waiting for the manifestation of actual physical diseases.

B. The Human Right to Tobacco Control

When the main human rights instruments cited above were drafted, the idea that production, marketing, and consumption of tobacco were contrary to human rights was not considered, because smoking was widely accepted in all parts of the world. It was also true that during the active period of human rights standard-setting, essentially from the 1950s through the 1970s, several issues, such as violence against women and reproductive human cloning, had not been addressed in terms of universal human rights norms. Subsequently, public awareness of their significance and the political will to do something about them contributed to their being acknowledged as violations of internationally recognized human rights. The topic of violence against women was finally addressed in the Declaration of 1993 and the appointment of a Special Rapporteur. Reproductive human cloning was not dealt with as a human rights issue until the Council of Europe drafted a protocol to its Biomedicine Convention and UNESCO adopted its Declaration of 1997. It was also true of the human right to water until the adoption by the Committee on Economic, Social and Cultural Rights in 2002 of the General Comment on the Right to Water.[111]

Our claim is that the evidence has become so compelling and the policy priorities have evolved so far that a strong case can be made for the emergence of an implied derivative human right to tobacco control. The analogy with the right to water is perhaps the most apt insofar as the Committee drew on three main arguments: one based on evidence, one on logic, and the third on legal construction.

First, knowledge of the problems of water created by the failure to guarantee access to it was uncontested and required urgent action. The Committee noted that "Over one billion persons lack access to a basic water supply, while several billion do not have access to adequate sanitation, which is the

111. The Right to Water (arts. 11 and 12 of the International Covenant on Economic, Social and Cultural Rights), General Comment No. 15, U.N. ESCOR, Comm. on Econ., Soc. & Cult. Rts., 29th Sess., U.N. Doc. E/C.12/2002/11 (2002) [hereinafter General Comment 15].

primary cause of water contamination and diseases linked to water."[112] The evidence is compelling of a causal relation between great human suffering and the problem of water supply.

The second argument is based on a logical construction, according to which water as a human right is a necessary consequence of the nature of this commodity. The Committee argues as follows: "Water is a limited natural resource and a public good fundamental for life and health. The human right to water is indispensable for leading a life in human dignity. It is a prerequisite for the realization of other human rights."[113]

The third basis for positing the right to water as a human right was the legal interpretation of existing human rights norms as the foundation for the right. The title of the General Comment on the right to water mentions Articles 11 and 12 of the International Covenant on Economic, Social and Cultural Rights and the Committee explains how these two rights (adequate standard of living and health) are "inextricably related" to the right to water. The General Comment also notes that: "The right to water has been recognized in a wide range of international documents, including treaties, declarations and other standards."[114] The Committee relates the right to water to other human rights, including the right to life, the right to adequate food, the right to gain a living by work, the right to take part in cultural life, as well as certain rights in the Convention on the Elimination of All Forms of Discrimination against Women and the Convention on the Rights of the Child.

Following the pattern of other general comments, the Committee then addresses the normative content of the right to water in terms of availability, quality, accessibility, and information and devotes special attention to issues of discrimination and vulnerable groups.

The human right to tobacco control lends itself to a similar analysis. First is evidence of the magnitude of the problem. As discussed in some detail above, extensive evidence is available regarding tobacco-related diseases, which kill 5 million people per year and this figure will reach 10 million by 2023. It is the largest cause of preventable death in the world.[115] Such evidence is on a scale similar to the importance of water to human existence.

Second is the logical argument that consumption of tobacco is lethal when used as intended and that production and marketing are harmful. The extensive and preventable impact of tobacco on mortality and morbidity is incontestable. Therefore, control of such deadly and harmful activity is imperative to protect life and livelihoods.

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112. The Committee cited WHO data for this claim. *See id.* ¶ 1, n.1.
113. *Id.*
114. *Id.* ¶ 4.
115. World Health Report 2003, *supra* note 8, at 91.

The third element is the legal construction of the right. Like the right to water, the right to tobacco control, although not mentioned in the basic human rights instruments, derives from the right to life and the right to health. It would simply be unthinkable for a state to claim to have fulfilled its obligations to respect, protect, and fulfill the right to health without an effective tobacco control program. Similarly, it would be difficult to consider that a country was carrying out its minimum core obligation regarding the right to health if it did not implement the right of everyone to adequate tobacco control. Its obligations to improve "all aspects of environmental and industrial hygiene" and to prevent, treat, and control epidemic diseases would be neglected if it did not respect the right to tobacco control.

The relation to other rights is also demonstrable, whether it be the right to food, the right to information, the right to work, or the right to protection of the child, among other rights. The right to information, for example, has a measurable impact on the realization of the right to tobacco control. Indeed, when access to information about the risks of tobacco is readily available to the society, particularly to youth, striking changes can be seen in tobacco consumption. In California, aggressive and relatively well-funded educational programs have lowered the smoking rates to 15.4 percent overall, which is a greater than 32 percent decline over the past six years.[116] As a consequence of California's comprehensive tobacco control program since 1988, a dramatic drop in both cardiovascular disease and lung cancer incidence has been documented.[117] This program is probably the best example of a comprehensive program that encompasses prohibition of advertising to youth, information campaigns aimed particularly at youth to prevent initiation, and legislation that emphasizes clean indoor air with smokefree workplaces. As a result, the outcome has been a demonstrable reduction in per capita consumption of cigarettes, a reduction in the number of people who smoke, and a reduction in the number of tobacco related medical illnesses.

Improving the access to smoking cessation interventions, such as those provided through the National Health Service (NHS) in the United Kingdom is a cost-effective practice.[118] The program in the United Kingdom began in

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116. In 1988, California approved Proposition 99, which provided a 25-cent tax on each pack of cigarettes, with 5 cents earmarked for tobacco control. This has allowed California to be very proactive in tobacco control compared to the other states. *See* California Dept. of Health Services, Proposition 99 and the Legislative Mandate for the California Tobacco Control Program, *available at* http://www.dhs.ca.gov/tobacco/html/about.htm.
117. James M. Lightwood & Stanton A. Glantz, *Short-Term Economic and Health Benefits of Smoking Cessation: Myocardial Infarction and Stroke*, 96 Circulation 1089 (1997); Joaquin Barnoya & Stanton Glantz, *Association of the California Tobacco Control Program with Declines in Lung Cancer Incidence*, 15 Cancer Causes & Control 689 (2004).
118. Christine Godfrey et al., *The Cost-Effectiveness of the English Smoking Treatment Services: Evidence from Practice*, 100 Addiction (Suppl. 2) 70 (2005).

2001 and provides ready access to expert assistance and pharmacotherapy, as recommended by national smoking cessation guidelines. It was the first national program to emphasize the importance of smoking cessation for the national public health.[119] No other country has as yet instituted such a national program with financial support behind medications to help people stop smoking. Outcome studies have determined that this financial investment through the medical system, which supports both counseling and pharmacotherapy, substantially delivers an "estimated cost per life-year saved," which was significantly better than standard accepted benchmarks.[120] It is predictable that, as people stop smoking with effective programs such as the NHS, the number of illnesses and deaths caused from tobacco should also decline in the near future.

It is no longer necessary to wait until further information is acquired before implementation of methodologies that are effective in decreasing the health effects from tobacco. Comprehensive smokefree policies have been demonstrated to quickly decrease smoking rates. One of the most basic of these methods is the dissemination of information about the known harmful effects of tobacco, particularly to populations that are currently uninformed. Similarly, children should be protected from the onslaught of well-crafted advertisements specifically designed to attract their attention. If children can be prevented from being seduced before becoming addicted, there will be a smaller population of smokers requiring smoking cessation interventions. New York City demonstrated an 11 percent decline in smoking rates over just one year from 2002–2003 as a result of comprehensive tobacco control policy that included public education programs, smokefree workplaces, nicotine replacement therapy for smoking cessation programs, and tax increases.[121] A comprehensive tobacco control program provides a circumferential agenda and is essential for the public health of the society, particularly of vulnerable groups.

The relationship to tobacco control and malnutrition is immediate and measurable. In many developing countries, tobacco is grown as a cash crop in preference to growing foodstuffs. As a result, the farmer is dependent on an adequate return on the sale of the tobacco to support purchase of food and shelter. The economic realities of growing tobacco, particularly for the

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119. Dept. of Health (United Kingdom), NHS Smoking Cessation Services: Service and Monitoring Guidance 2001–02, *available at* http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4008602&chk=SYvQYW.

120. Martin Raw et al., *Lessons from the English Smoking Treatment Services*, 100 Addiction (Suppl. 2) 84, 84 (2005).

121. Press Release, New York City Department of Health and Mental Hygiene, Office of Communications, New York City's Smoking Rate Declines Rapidly From 2002 To 2003, The Most Significant One-Year Drop Ever Recorded (12 May 2004), *available at* http://www.nyc.gov/html/doh/html/press_archive04/pr052-0512.shtml.

small farmer results in persistent poverty due to high input costs, low crop prices, and the significant labor required, often involving the entire family. As a result, little money is available for purchase of food. In addition, if one or more of the family units consume tobacco, the effect on cash outflow for the purchase of the addictive product affects the remaining amount for food. In addition, tobacco consumption affects the individual's basal metabolic rate and adds to the caloric needs of the individual. All of these factors combine to result in an insufficient number of daily caloric intake to maintain adequate nutrition—both for the individual and the family.

By shifting a farmer who grows tobacco and is economically struggling due to market forces to growing a more sustainable and/or edible crop, one of the etiologies of malnutrition due to tobacco will be modified. The responsibility for helping the individual farmer to shift crops should come from the state or international community as a result of their commitment to the concept of this essential right to be free from hunger. Specifically, the ICESCR states:

> The States Parties to the present Covenant, recognizing the fundamental right of everyone to be free from hunger, shall take, individually and through international cooperation, the measures, including specific programmes, which are needed: (a) To improve methods of production, conservation and distribution of food by making full use of technical and scientific knowledge, by disseminating knowledge of the principles of nutrition and by developing or reforming agrarian systems in such a way as to achieve the most efficient development and utilization of natural resources.[122]

The tobacco companies that are responsible for both the purchase of the tobacco farm product and the production of the consumed product are transnational and reside in wealthy developed nations. Multinationals tobacco companies intentionally control the buying price of the crop and the farmer becomes financially dependent on the industry for loans to buy tobacco seeds, fertilizer, or pesticides.[123] Article 6 of the ICESCR on the right of everyone to work affirms that it is the duty of the state party to assure that the right is fully realized "under conditions safeguarding fundamental political and economic freedoms to the individual." The financial trap resulting from these loans from the multinational tobacco industry and the frequent inability to repay the loans due to underpayment for their crop seriously hinders the farmer's economic freedom.

122. ICESCR, *supra* note 37, art. 11(2).
123. Christian Aid has documented examples in Brazil of how Souza Cruz, a subsidiary of British American Tobacco, affects the income and health of its contracted tobacco farmers. *See* Christian Aid, Hooked on Tobacco, *available at* http://www.christian-aid.org.uk/indepth/0201bat/batsum.htm. Indentured servitude occurs on the manufacture side also, and with children, as their freedom is sold to produce bidis in India. *See* CBS News, Tobacco Slaves in India (29 Aug. 2000), *available at* http://www.cbsnews.com/stories/1999/11/22/60II/main71386.shtml.

These examples serve to illustrate the normative character of the human right to tobacco control, which could be summarized in terms of accessibility, appropriateness, and accountability. Accessibility could include access to information on effects of tobacco use, to treatment for diseases caused by tobacco, and to therapies to reduce addiction to tobacco. Appropriateness could include adapting interventions to the specific types of tobacco consumption that prevail in a given society and the cultural significance of patterns of use, making adjustments for religious practices, which may need to be respected while reducing harm. Accountability could address the liability of companies for harm caused to the health and deflection of resources in the healthcare system due to the need to respond to the consequences of tobacco use. In the discussion of international cooperation, due attention could be given to the Framework Convention for Tobacco Control. Thus, in the current state of scientific knowledge on the epidemic and of international human rights law, it is possible to define the normative content of the derivative human right to tobacco control. Whether this right has serious prospects of being effectively implemented is the second criterion for recognizing it as a human right, to which we now turn.

IV. PROSPECTS FOR IMPLEMENTING THE RIGHT TO TOBACCO CONTROL

A. Globalization and Regulation of Multinational Enterprises

Liberalization of trade and the intensification of communication have connected people to one another and to their environment in ways that both enhance and jeopardize public health. Foreign direct investment through multinational corporations has resulted in the exchange of technology and creation of jobs that investors claim is a positive impact on economic development, especially in poor countries.

However, the analysis of the policies and practices of the transnational tobacco corporations (TNCs) shows little concern for the health and welfare of the population of the countries where they conduct their operations, whether in production or marketing of their product. On the contrary, their behavior has significantly negative effects on the health of individuals, their society, and the environment. One tobacco TNC actually developed an analysis of how tobacco provided economic benefit to the developing country because cigarette smokers died younger than non-smokers, thus creating less of a healthcare burden on the society. The study and its conclusions have been refuted based on numerous errors and assumptions by the tobacco industry and its consulting firm.[124]

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124. Hana Ross, *Critique of the Philip Morris Study of the Cost of Smoking in the Czech Republic,* 6 Nicotine & Tobacco Res. 181 (2004).

A significant development in the complex area of human rights accountability of TNCs was the adoption of the "Norms on the responsibilities of transnational corporations and other business enterprises with regard to human rights" by the Sub-Commission on the Promotion and Protection of Human Rights on 13 August 2003. According to this text:

> Transnational corporations and other business enterprises shall carry out their activities in accordance with national laws, regulations, administrative practices and policies relating to the preservation of the environment of the countries in which they operate, as well as in accordance with relevant international agreements, principles, objectives, responsibilities and standards with regard to the environment as well as human rights, public health and safety, bioethics and the precautionary principle, and shall generally conduct their activities in a manner contributing to the wider goal of sustainable development.[125]

The most significant from the perspective of tobacco control is paragraph 13, which reads:

> Transnational corporations and other business enterprises shall act in accordance with fair business, marketing and advertising practices and shall take all necessary steps to ensure the safety and quality of the goods and services they provide, including observance of the precautionary principle. Nor shall they produce, distribute, market, or advertise harmful or potentially harmful products for use by consumers.[126]

In the commentary, several additional clarifications are of particular relevance to tobacco control. For example:

> Transnational corporations and other business enterprises shall ensure that all goods and services they produce, distribute, or market are capable of use for the purposes claimed, safe for intended and reasonably foreseeable uses, do not endanger the life or health of consumers, and are regularly monitored and tested to ensure compliance with these standards, in the context of reasonable usage and custom. They shall adhere to relevant international standards so as to avoid variations in the quality of products that would have detrimental effects on consumers, especially in States lacking specific regulations on product quality.[127]

The commentary also deals with labeling and advertising. It requires:

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125. *Norms on the Responsibilities of Transnational Corporations and Other Business Enterprises with Regard to Human Rights,* U.N. ESCOR, Comm'n on Hum. Rts., 55th Sess., Agenda Item 4, ¶ 14*,* U.N. Doc. E/CN.4/Sub.2/2003/12/Rev.2 (2003).
126. *Id.* ¶ 13.
127. *Commentary on the Norms on the Responsibilities of Transnational Corporations and Other Business Enterprises with Regard to Human Rights*, U.N. ESCOR, Comm'n on Hum. Rts., 55th Sess., Agenda Item 4, ¶ 13(c), U.N. Doc. E/CN.4/Sub.2/2003/38/Rev.2 (2003).

> Any information provided by a transnational corporation or other business enterprise with regard to the purchase, use, content, maintenance, storage and disposal of its products and services shall be provided in a clear, comprehensible and prominently visible manner and in the language officially recognized by the country in which such products or services are provided.[128]

Moreover it provides that:

> [W]here a product is potentially harmful to the consumer, transnational corporations and other business enterprises shall disclose all appropriate information on the contents and possible hazardous effects of the products they produce through proper labeling, informative and accurate advertising and other appropriate methods. In particular, they shall warn if death or serious injury is probable from a defect, use, or misuse.[129]

However, the economic realities of the least developed countries limit their capacity to place health or environmental regulatory constraints on an industry in which so many of their citizens are involved. Beyond the consumption of manufactured tobacco products, the impact of growing tobacco on the health of the farmers and the erosion of the environment are often beyond the control of the country where the multinational tobacco corporations invests. Its headquarters are located in the most developed countries, whose regulation rarely extends to the operations in the less developed states.

Among the obstacles to accountability of multinational tobacco corporations is the reluctance of governments to regulate out of fear that the corporations will take their investment to another, more compliant country. For example, a regulation requiring education of farmers and their families about the health effects of growing tobacco, of the economic impact of tobacco use on the family, including its health and ability to provide food or shelter, or regulations that would alter the use of pesticides, fertilizers, or choice of crop would clearly be costly to the TNCs. In addition, the tobacco industry is remarkably resourceful in creating a façade of good will, such as its involvement with the ILO in theoretically combating child labor practices through the ECLT Foundation. Even if the government of a poor country had the political will to regulate or legislate a code of practice for the industry in the areas discussed in this article, the cost of providing meaningful enforcement and oversight and remedies for abuses are likely to be prohibitive.

At least one prominent member of the tobacco industry, BAT, has noted that its practices had a negative impact on human rights.[130] Whether the to-

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128. *Id.* ¶ 13(d).
129. *Id.* ¶ 13(e).
130. *See* BAT, *supra* note 85.

bacco TNCs are truly sincere about promoting human rights in the countries in which they operate (which for all intents and purposes, are all countries of the world), remains to be seen. However, this company has theoretically embraced many aspects of the UN Global Compact, although it has not formally joined it, and claims that it will not be complicit in human rights abuses.[131] How BAT reconciles this claim with ongoing advertising, marketing, and promotion to youth globally of a product that kills 50 percent of its users is unclear. Perhaps as the tobacco companies pursue their interests in improving their image of corporate social responsibility through such organizations as ECLT and through a grant of £3.8 million to fund an international center on corporate social responsibility at the University of Nottingham,[132] they will become more transparent and address the human rights impact of their operations.

B. UN human Rights Mechanisms for the Protection of the Right to Tobacco Control

There are several mechanisms functioning under the Charter-based and the treaty-based mechanisms of the United Nations that may serve to advance the human right to tobacco control.

The most obvious body among the treaty bodies to deal with the issue is the Committee on Economic, Social and Cultural Rights, which issued the General Comments on the right to health and on the right to water. Those two documents provide most of the arguments in favor of the right to tobacco control as a derivative right. The Committee could, in subsequent General Comments or even in a special General Comment on human rights and tobacco control, articulate the specific obligations of states parties to the ICESCR in the matter of tobacco control. Other treaty bodies, such as the CRC and CEDAW, could include a discussion of tobacco control in general comments. These bodies can also address tobacco control in their discussion with states parties of reports and in the concluding observations.

In 2002, the Commission on Human Rights created the position of Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, with a mandate to collect information, to report on the status of the right throughout the world, and to make recommendations on appropriate measures to promote and pro-

131. The UN Global Compact—the membership was searched for the three major tobacco companies Philip Morris (Altria), British American Tobacco, Japan Tobacco and they were not identified as members. United Nations Global Compact, *available at* http://www.unglobalcompact.org/.

132. Richard Smith, *Should Nottingham University Give Back its Tobacco Money?*, 322 Brit Med. J. 1118–19 (2001).

tect its realization.[133] Paul Hunt was appointed to this position and focused his reports on infectious diseases, safe water, sanitation, violence, poverty, and migration of health professionals, but not on tobacco. Now that the Framework Convention on Tobacco Control (FCTC), to be discussed below, has been ratified, the Special Rapporteur will be able to use it as a basis to focus attention on the importance of tobacco control for the realization of the right to health. In addition, due to the magnitude of death and disease burden that rivals or even surpasses other headline- grabbing epidemics of our day, a "day of general discussion" could be called by the Committee on Economic, Social and Cultural Rights, in cooperation with the Special Rapporteur on the Right to Health, to draw attention to the specific human rights issues surrounding tobacco.

The Commission on Human Rights decided in 2005 to create the position of special representative on the issue of human rights and transnational corporations and other business enterprises.[134] In August 2005, Kofi Annan appointed John Ruggie of Harvard to serve as the first Special Representative on human rights, transnational corporations, and other business enterprises. The Executive Director of Corporate Accountability International commented:

> The role of Special Representative on issues of human rights and TNCs carries enormous responsibility. Corporate Accountability International has campaigned for nearly three decades to protect people from dangerous corporate actions, including . . . Philip Morris/Altria's interference in public health policies. The United Nations World Health Organization has since passed . . . the groundbreaking global tobacco treaty . . . to defend people from these corporate abuses. The United Nations creation of a Special Representative on human rights and transnational corporations is an important step for the corporate accountability

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133. U.N. Comm'n on Hum. Rts. Res. 2002/31, *adopted* 22 Apr. 2002. This mandate was updated in U.N. Comm'n on Hum. Rts., Res. 2004/27.

134. U.N. Comm'n on Hum. Rts. Res. 2005/69, *adopted* 20 Apr. 2005, by a recorded vote of forty-nine votes to three, with one abstention. The mandate includes:

> (a) To identify and clarify standards of corporate responsibility and accountability for transnational corporations and other business enterprises with regard to human rights;
>
> (b) To elaborate on the role of States in effectively regulating and adjudicating the role of transnational corporations and other business enterprises with regard to human rights, including through international cooperation;
>
> (c) To research and clarify the implications for transnational corporations and other business enterprises of concepts such as "complicity" and "sphere of influence";
>
> (d) To develop materials and methodologies for undertaking human rights impact assessments of the activities of transnational corporations and other business enterprises;
>
> (e) To compile a compendium of best practices of States and transnational corporations and other business enterprises.

> movement, acknowledging the need for more comprehensive international control of corporate abuses.[135]

The Special Representative will no doubt be expected by others as well to scrutinize tobacco companies in light of the FCTC and human rights standards, such as the 2003 Norms discussed above. Judging from the first interim report of the Special Representative, the prospects for the use of the Norms to assess the human rights impact of tobacco TNCs are dim. Indeed, Professor Ruggie states unequivocally with reference to the drafting of the Norms that "[e]ven leaving aside the highly contentious though largely symbolic proposal to monitor firms and provide for reparation payments to victims, its exaggerated legal claims and conceptual ambiguities created confusion and doubt even among many mainstream international lawyers and other impartial observers."[136] He concludes that "the divisive debate over the Norms obscures rather than illuminates promising areas of consensus and cooperation among business, civil society, governments and international institutions with respect to human rights."[137] Nevertheless, he acknowledges that "normative undertakings and advocacy are essential ingredients for the continued development of the human rights regime in relation to business"[138] and is guided by "principled pragmatism," which he defines as "an unflinching commitment to the principle of strengthening the promotion and protection of human rights as it relates to business, coupled with a pragmatic attachment to what works best in creating change where it matters most - in the daily lives of people."[139] This approach certainly leaves room for addressing forthrightly the human rights implications of the actions of tobacco TNCs and of state-owned tobacco enterprises.

C. Regional Protection of the Right to Tobacco Control

The regional human rights regimes have dealt more with the protection of civil and political rights than economic, social, and cultural rights. Nevertheless, all three functioning regional systems have incorporated human rights norms relating to economic, social, and cultural rights and have addressed

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135. Statement from Kathryn Mulvey, Executive Director Corporate Accountability International (3 Aug. 2005) (published by PRNewswire), *available at* http://www.prnewswire.com/cgi-bin/stories.pl?ACCT=104&STORY=/www/story/08-03-2005/0004081980&EDATE=.
136. *Promotion and Protection of Human Rights: Interim Report of the Special Representative of the Secretary-General on the Issue of Human Rights and Transnational Corporations and Other Business Enterprises*, U.N. ESCOR, Comm'n on Hum. Rts., 62d Sess., Agenda Item 17, ¶ 59, U.N. Doc. E/CN.4/2006/97 (2006).
137. *Id.* ¶ 59.
138. *Id.*
139. *Id.* ¶ 81.

health issues in the context of their more traditional mandates. It is, therefore, instructive to consider how the European and Inter-American Commissions and Courts of Human Rights and the African Commission on Human and People's Rights have contributed jurisprudential elements to the idea of a human right to tobacco control.

1. The European Convention

As Melissa Crow notes in her study on human rights strategies to promote tobacco control,[140] the European Commission on Human Rights "has issued instructive jurisprudence in response to individual petitions alleging violations of the rights to life, respect for private and family life, and freedom to receive information based on various aspects of States Parties' tobacco control legislation."[141] She cites several interesting cases concerning these rights, which we will review briefly to illustrate that elements are beginning to fall into place, which, if related to other trends discussed in this article, contribute to an emerging human right to tobacco control.

In the *Wöckel* case,[142] the European Commission on Human Rights interpreted Articles 2 and 8 of the European Convention as not requiring Germany to do more than it had in prohibiting smoking in public and thus declared inadmissible a citizen's request for more elaborate measures.[143] The case acknowledged a margin of appreciation within the context of a state's duty to control tobacco consumption. Crow considers that the case "provides guidance regarding the scope of States Parties' affirmative obligations to protect non-smokers from the risks of exposure to secondhand smoke."[144] In *Keenan v. United Kingdom*,[145] the Court considered the duty of prison officials to take preventive steps if a prisoner manifests suicidal intentions. Crow makes an interesting analogy to tobacco control:

> While the risk of contracting life-threatening diseases from smoking or exposure to secondhand smoke may be less immediate than the risk of suicide in Keenan, it should be no less evident to government authorities. Nicotine addiction renders smokers, like persons in custody, particularly vulnerable to tobacco-related diseases and death. As in Keenan, this heightened vulnerability should be construed to impose a corresponding duty on government authorities to take reasonable precautions to protect their citizens. At a minimum, such precautions should include the public dissemination of information regarding the health

140. *See* Crow, *supra* note 3.
141. *Id.* at 235, referring specifically to European Convention for the Protection of Human Rights and Fundamental Freedoms, *opened for signature* 4 Nov. 1950, 213 U.N.T.S. 221, Europ. T.S. No. 5, arts. 2, 8, 10 (*entered into force* 3 Sept. 1953).
142. Wöckel v. Germany, App. No. 32165/96, Eur. Comm'n H.R. (1998).
143. *Id. cited in* Crow, *supra* note 3, at 235–36.
144. Crow, *supra* note 3, at 236.
145. Keenan v. United Kingdom, App. No. 27229/95, Eur. Ct. Hum. Rts. (3 Apr. 2001).

> risks of tobacco use, the imposition of cigarette warning label requirements, and prohibitions on misleading and deceptive tobacco advertisements.[146]

Several other cases examined by the European Commission on Human Rights and the European Court of Justice (ECJ) addressed tobacco advertising.[147] The European Parliament and Council had adopted an Advertising Directive containing prohibitions on all direct and indirect advertising of tobacco products and the tobacco industry's sponsorship of events.[148] In formulating his recommendations in the cases, the Advocate General drew upon the reasoning of the European Court of Human Rights concerning limitations on commercial speech and found that banning of tobacco advertising "could be justified only if it would reduce tobacco consumption and if less restrictive measures would not be equally effective."[149] Eventually the ECJ annulled the Advertising Directive and the EU adopted legislation prohibiting tobacco advertising and sponsorship by tobacco companies of Formula One motor racing and similar events.[150] Crow notes in this regard,

> While affirming the human rights dimension of tobacco production, marketing, and consumption, the ECHR's decisions accord a "margin of appreciation" to national governments regarding the precise parameters of an effective tobacco regulatory regime. Its judgments, with which States Parties to the European Convention are legally bound to comply, are significant not only for their effect on the conduct of European governments, but also for their potential impact on the reasoning of other international human rights institutions and national courts throughout the world.[151]

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146. Crow, *supra* note 3, at 236 (footnotes omitted). She finds further support for this argument in a concurring opinion in 1998 case to the effect that the Convention prohibits a government from withholding information about "circumstances which foreseeably, and on substantial grounds, present a real risk of danger to health and physical integrity." *Id.* at 387. Another case involving freedom of expression was *Österreichische Schutzgemeinschaft für Nichtraucher and Rockenbauer v. Austria*, which concerned the use of the Camel trademark in an anti-smoking campaign. The Austrian court had found that the use of the Camel trademark in an anti-tobacco campaign was in violation trademark law because applicant association of non-smokers did not demonstrate that there was a special reason to single out the Camel brand. Had it done so, presumably the court would have justified protecting the association's freedom of expression notwithstanding the law restricting use of the trademark. *Id.* at 238, *citing* Österreichische Schutzgemeinschaft Fur Nichtraucher and Rockenbauer v. Austria, App. No. 17200/91, Eur. Comm'n Hum. Rts. (1991). Although the non-smokers association lost the case, the Commission seemed ready to allow freedom of expression to attack brands, which mislead consumers regarding risks of harm to health from tobacco.
147. Crow, *supra* note 3, at 238. Crow cites to two ECJ cases. Case C-376/98, Germany v. Parliament and Council, 2000 E.C.R. I-8419; Case C-74, R. v. Secretary of State for Health, ex parte Imperial Tobacco Ltd, 2000 E.C.R. I-8599.
148. Crow, *supra* note 3, at 238–39.
149. *Id.* at 239.
150. *Id.* at 239.
151. *Id.* at 235–36 (note omitted).

The European Court has also considered the harmful effects of smoking as part of the overcrowding of prisons. In the *Case of Novoselov v. Russia*,[152] which Crow did not include in her study, the applicant alleged a violation of Article 3 of the Convention due to the conditions of his detention in an overcrowded facility of Novorossiysk, Russia. The Court noted from the applicant's submission; "The lack of adequate ventilation was further aggravated by a general tolerance to smoking in the cell. For the applicant, who was a non-smoker, that was another severe, inescapable effect of the overcrowding."[153] The Court considered that

> the State must ensure that a person is detained in conditions which are compatible with respect for his human dignity, that the manner and method of the execution of the measure do not subject him to distress or hardship of an intensity exceeding the unavoidable level of suffering inherent in detention and that, given the practical demands of imprisonment, his health and well-being are adequately secured . . . , [adding that] one must consider their cumulative effects as well as the applicant's specific allegations.[154]

While the court did not refer specifically to the applicant being a non-smoker, it noted that "the Government's admissions that the cell windows were covered with metal shutters blocking access of fresh air and natural light."[155] The court found a violation of Article 3 and awarded damages.

2. The American Convention

Crow also looks at the cases decided within the Inter-American System and finds that "[t]o date, no tobacco-related human rights petitions appear to have been filed in this system,"[156] although she sees "great potential for progress" in light of the "far-reaching protection to the rights of vulnerable groups, including persons with mental disabilities, women, and children" by the Inter-American Commission and Court.[157] She advocates, in particular, the use of individual petition on behalf of children and adolescents influenced by the tobacco industry's promotion of tobacco use and exposure to secondhand smoke during childhood.[158] She also urges using human rights to promote tobacco control in the region, as well as the use of the advisory jurisdiction of the Inter-American Court "regarding the tobacco control implications of relevant norms in the American Convention or other treaties concerning the protection of human rights in the Americas."[159]

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152. Novoselov v. Russia, App. No. 66460/01, Eur. Ct. Hum. Rts. (2 June 2005).
153. *Id.* ¶ 34.
154. *Id.* ¶ 39.
155. *Id.* ¶ 44.
156. Crow, *supra* note 3, at 240.
157. *Id.* at 241.
158. *Id.*
159. *Id.*

The provisions of the American Convention she sees as pertinent are the right to life (Article 4(1)), which has been interpreted to include "conditions that guarantee a dignified existence";[160] the rights to physical integrity and freedom from cruel, inhuman, or degrading punishment or treatment (Article 5); and freedom of information and expression (Article 13).[161] With respect to the latter, she considers the report by the Inter-American Commission on human rights in Ecuador, in which it concluded that the government had an obligation in inform the indigenous populations of the expected environmental impact in areas where government-licensed companies were to engage in oil exploitation. She sees this case as a precedent for tobacco control insofar as "governments may be required to counter misrepresentations by tobacco companies about the health consequences of smoking and exposure to secondhand smoke, and the effectiveness of particular tobacco control strategies."[162]

3. The African Charter

The third regional system of human rights protection is that of the African Charter on Human and People's Rights, adopted in 1981.[163] It has been ratified by fifty-one of the fifty-three members of the African Union, Ethiopia and Eritrea being the only holdouts. The "Banjul" Charter (named after the city where it was signed) is particularly important for the issues of tobacco control because it was written by and for developing countries, many of which are affected by the tobacco industry. The relevant rights to tobacco control are the rights to health, protection of children and the family, protection from foreign economic exploitation, the right to a satisfactory environment, and the duty to promote the rights in the Charter.

On the right to health, the African Charter stipulates:

> 1. Every individual shall have the right to enjoy the best attainable state of physical and mental health.
>
> 2. States Parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.[164]

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160. *Id.* at 242, *citing* Villagran Morales et al. Case ("Street Children Case"), Inter-Am. C.H.R. (ser. C), No. 63 (1999).
161. Crow, *supra* note 3, at 243.
162. *Id.* at 244–45, *citing* Report on the Situation of Human Rights in Ecuador, Inter-Am. C.H.R., OAS Doc. OEA/ser. L./V./II.96, doc. 10 rev. 1, ch. IX (1997).
163. African Charter on Human and Peoples' Rights, *adopted* 27 June 1981, O.A.U. Doc. CAB/LEG/67/3 Rev. 5 (*entered into force* 21 Oct. 1986), *reprinted in* 21 I.L.M. 58 (1982).
164. *Id.* art. 16.

Tobacco control policies may properly be considered as among the "necessary measures to protect the health of their people." Protection of children within the family against exposure to tobacco may be regarded as consistent with the obligations under Article 18, which requires the state to protect the family and "take care of its physical health and moral health." Article 21(5) is relevant to abusive practices by tobacco growers, especially international tobacco companies to the extent that they qualify as "international monopolies" that engage in "foreign economic exploitation," which states parties are obliged to eliminate "as to enable their peoples to fully benefit from the advantages derived from their national resources."

The production side of tobacco also involves, as shown above, environmental damage, and Article 24 of the Banjul Charter affirms the right of all people "to a general satisfactory environment favorable to their development." To the extent that people have a right to be protected from tobacco as part of the right to health and to the environment, states parties to the African Charter have a "duty to promote and ensure through teaching, education and publication, the respect of the rights and freedoms contained in the present Charter and to see to it that these freedoms and rights as well as corresponding obligations and duties are understood."[165]

The African Commission has not dealt directly with tobacco but it has interpreted provisions of the Banjul Charter relating to health, environment, food, and natural resources as creating duties on states parties to protect their population from harmful practices of transnational corporations. In the case of the *Center for Economic and Social Rights v. Nigeria*,[166] the Commission held that the Nigerian government violated these obligations when it failed to protect the Ogoni people from the harm caused by the Nigerian National Petroleum Corporation-Shell Consortium in the exploitation of oil in the delta region. The Commission found that people had been arbitrarily executed, and villages, food resources and farmlands destroyed in violation of individual rights to nondiscrimination (Article 2), life (Article 4) and property (Article 14), also the right to health (Article 14) and the right to protection of the family (Article 18). In the present context the most interesting dimension of the case relates to the establishment of violations of Articles 21 and 24, already mentioned. The Commission was unclear as to who were the beneficiaries of all the rights that were found to have been violated but from the formulation of Articles 21 and 24 as peoples' collective rights and the frequent references in the Commission's report to the Ogoni people (or, occasionally, "the Ogoni population" or "the Ogonis"), one may draw the conclusion that it was the development-related rights of the Ogoni people that were violated by Nigeria as a state.

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165. *Id.* art. 25.
166. Communication No. 155/96, Afr. Comm'n Hum. & Peoples' Rts., paras. 50–55, 64–66 (June 6, 2001), *available at* http://www1.umn.edu/humanrts/africa/comcases/155-96b.html.

The Commission considered that Article 24 of the African Charter required the State "to take reasonable and other measures to prevent pollution and ecological degradation, to promote conservation, and to secure an ecologically sustainable development and use of natural resources."[167] Further it provides that:

> Government compliance with the spirit of Articles 16 and 24 of the African Charter must also include ordering or at least permitting independent scientific monitoring of threatened environments, requiring and publicizing environmental and social impact studies prior to any major industrial development, undertaking appropriate monitoring and providing information to those communities exposed to hazardous materials and activities and providing meaningful opportunities for individuals to be heard and to participate in the development decisions affecting their communities.[168]

The Commission also found a violation of Article 21, the purpose of which is to "restore co-operative economic development."[169] Specifically, it stated:

> Contrary to its Charter obligations and despite such internationally established principles, the Nigerian Government has given the green light to private actors, and the oil Companies in particular, to devastatingly affect the well-being of the Ogonis. By any measure of standards, its practice falls short of the minimum conduct expected of governments, and therefore, is in violation of Article 21 of the African Charter.[170]

The Commission continues with a discussion of the general right to development provision in Article 22 of the Charter, not as an independent right but as an element in the implicitly recognized right to food.[171] Although the Commission does not include a finding of a violation of Article 22 in its recapitulation of findings, its conclusion under this heading is quite clear:

> The government's treatment of the Ogonis has violated all three minimum duties of the right to food. The government has destroyed food sources through its security forces and State Oil Company; has allowed private oil companies to destroy food sources; and, through terror, has created significant obstacles to Ogoni communities trying to feed themselves. The Nigerian government has again fallen short of what is expected of it as under the provisions of the African Charter and international human rights standards, and hence, is in violation of the right to food of the Ogonis.[172]

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167. *Id.* ¶ 52.
168. *Id.* ¶ 53.
169. *Id.* ¶ 56.
170. *Id.* ¶ 59.
171. *Id.* ¶ 64.
172. *Id.* ¶ 66.

Like the institutions responsible for the implementation of the American Convention, the African Commission and the newly-established Court, may be called upon to address the impact of tobacco production, marketing, and consumption on the realization of the rights to health, resources, development, and food in the region. The normative basis and the early elements of jurisprudence are in place for the judicial recognition of a human right to tobacco control.

D. Framework Convention on Tobacco Control

The WHO Framework Convention on Tobacco Control (FCTC) was adopted unanimously by the 56th World Health Assembly on 21 May 2003. The required forty ratifications were reached on 30 November 2004 and the convention came into force on 27 February 2005. As of May 2006, there were 168 signatories and 126 states parties.[173] The intent of the Parties, as expressed in the first preambular paragraph, is "to give priority to their right to protect public health."[174] The reference to a "right" here is not from the perspective of human rights but rather from the sovereign right of states to deal with social problem occurring within its territory. The text in general is relatively human rights-neutral, although the nineteenth preambular paragraph recalls Article 12 of the ICESCR and preambular paragraphs 20, 22, and 23 mention, respectively, the WHO constitutional reference to health as a human right, the CEDAW provision on discrimination in healthcare, and the CRC provision on the child's right to health.

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173. As of May 2006, the states parties are: Albania, Armenia, Australia, Austria, Azerbaijan, Bangladesh, Barbados, Belarus, Belize, Belgium, Benin, Bhutan, Bolivia, Botswana, Brazil, Brunei Darussalam, Bulgaria, Burundi, Cambodia, Cameroon, Canada, Cape Verde, Central African Republic, Chad, Chile, China, Comoros, Cook Islands, Cyprus, Democratic People's Republic of Korea, Democratic Republic of Congo, Denmark, Djibouti, Egypt, Equatorial Guinea, Estonia, European Community, Fiji, Finland, France, Georgia, Germany, Greece, Ghana, Guatemala, Guyana, Honduras, Hungary, Kiribati, Iceland, India, Iran, Ireland, Israel, Jamaica, Japan, Jordan, Kenya, Latvia, Lesotho, Lebanon, Libyan Arab Jamahiriya, Lithuania, Luxembourg, Madagascar, Malaysia, Maldives, Mali, Malta, Marshall Islands, Mauritania, Mauritius, Mexico, Micronesia (Federated States of), Mongolia, Myanmar, Namibia, Nauru, Netherlands, New Zealand, Niger, Nigeria, Niue, Norway, Oman, Pakistan, Palau, Panama, Peru, Philippines, Portugal, Qatar, Republic of Korea, Romania, Rwanda, Saint Lucia, San Marino, Sao Tome and Principe, Samoa, Saudi Arabia, Senegal, Serbia & Montenegro, Seychelles, Singapore, Slovakia, Slovenia, Solomon Islands, South Africa, Spain, Sri Lanka, Sudan, Swaziland, Sweden, Syrian Arab Republic, Thailand, Timor-Leste, Togo, Tonga, Trinidad and Tobago, Turkey, Tuvalu, United Arab Emirates, United Kingdom of Great Britain and Northern Ireland, Uruguay, Vanuatu, and Viet Nam. *See* WHO, Updates Status of the WHO Framework Convention on Tobacco Control, *available at* http://www.who.int/tobacco/framework/countrylist/en/index.html.

174. FCTC, *supra* note 76, pmbl.

The object and purpose of the convention, as stated in Article 3 is "to protect present and future generations form the devastating health, social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke." This concern over the social, economic, and environmental consequences of tobacco is reflected throughout the preamble, in which the parties express their serious concern "about the increase in the worldwide consumption and production of cigarettes and other tobacco products, particularly in developing countries, as well as about the burden this places on families, on the poor, and on national health systems."[175] The FCTC defines seven guiding principles for the implementation of the convention, which are not expressed in human rights terms but clearly involve human rights standards. The first guiding principle, for example, is that everyone should be informed about the dangers of tobacco consumption, which in effect reaffirms the right to information.[176] Another relevant guiding principle is the need to take measures to protect persons from exposure to tobacco smoke and to prevent initiation into smoking, with special mention of indigenous people and gender-specific risks.[177] Although expressed in terms of "political commitment" these responses to the devastating consequences of consumption and exposure clarify the measures expected of governments to meet their obligations under the right to health. The guiding principles on "technical and financial assistance to aid the economic transition of tobacco growers and workers . . . in developing countr[ies]"[178] and of international cooperation "to establish and implement effective tobacco control programmes"[179] are directly relevant to the right to development, as is the "participation of civil society."[180]

The FCTC enumerates the obligations of state parties to assure progressive reduction of tobacco consumption and exposure, including cooperation and coordination with other regional and international organizations. Some of the measures include taxation and prohibition of sales to minors, as well as regulation of ETS, contents of tobacco products, disclosure of the contents, and appropriate packaging and labeling of tobacco products. Critically, Article 12 addresses the education and communication that must occur to promote the public's awareness of all of the health risks from primary and secondary cigarette smoke or other tobacco use and from tobacco production.

One of the most controversial articles of the FCTC is Article 13, which recommends prohibition of all advertising, promotion and sponsorship of tobacco products. As discussed previously, marketing of the products, which

175. *Id.*
176. *Id.* art. 4(1).
177. *Id.* art. 4(2)(c).
178. *Id.* art. 4(6).
179. *Id.* art. 4(3).
180. *Id.* art. 4(7).

is significantly aimed at youth and women, is the mechanism by which the tobacco industry entices non-users to become users (and ultimately addicted users) of their products. The tobacco industry obviously is very opposed to this aspect of the FCTC because of the anticipated impact on revenues that would result by decreasing the number of new tobacco users by elimination of advertising.

The FCTC is relatively weak and less comprehensive on issues relative to the production of tobacco. Article 17 merely refers to the obligation of parties to "promote, as appropriate, economically viable alternatives for tobacco workers, growers and, as the case may be, individual sellers." Article 18, also quite brief, requires parties to "have due regard to the protection of the environment and the health of persons in relation to the environment in respect of tobacco cultivation and manufacture within their respective territories." These articles do not deal with specific issues of soil and water degradation and deforestation that occur with tobacco farming, nor do they specifically address the health concerns of the men, women, and children who work to seed, fertilize, apply pesticides, and harvest the tobacco. In addition, the predatory practices of the tobacco industries relative to the pricing of the harvested leaf are not addressed.

The importance of the economic integration of tobacco farming and its relevance to the financial development of low- or middle-income countries and their ability to have a sustainable development constitutes a minimal part of the FCTC. The FCTC was drafted to deal mainly with tobacco consumption and less with production or supply. The World Bank recommends that changes on the supply side actually have little impact on the consumption of tobacco and greater effects on public health can be achieved by pursuing restrictions on the consumption rather than supply side (excepting smuggling) of tobacco.[181] As consumption is considered by the public health community as the major contributor to ill health globally, it is understandable that little was said about tobacco production. However, public health and sustainable development, which includes a sustainable environment, are inextricably linked. Production and consumption of tobacco emerge clearly as human rights issues when considered in their full complexity, beginning with the intertwining of the right to health and the rights to individual dignity and to participate in and benefit from sustainable economic development. Tobacco production and use not only affect the health of the individual but also that of the family and society at large. The FCTC document only addresses the most urgent individual and public health needs relative to tobacco consumption, without dealing comprehensively with the societal dimensions. As such, it provides an excellent starting point for a legally grounded enumeration of steps to implement the human right to tobacco control.

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181. *See* Jha & Chaloupka, Curbing the Epidemic, *supra* note 1, at 7.

One of the exceptional aspects of the FCTC is Article 30, which allows for no reservations to the Convention. This provision could be important in reducing the capacity of countries where tobacco MNCs are headquartered (such Philip Morris/Altria in the United States) to intimidate trading partners into entering reservations with respect to obligations seen as detrimental to the interests of these companies. Specifically, the United States is most concerned about Article 13, which prohibits tobacco advertising, promotion, and sponsorship, and has attempted to make it possible to enter reservations with respect to this article. The United States also claims that the US Constitution includes advertising under First Amendment protection of free speech.[182] Therefore, the United States would wish to retain the right to advertise—both in the United States and in any other country. It is particularly for this reason that Article 30 provides for no reservations. As discussed above, restrictions on advertising are one of the strongest features of the FCTC to promote tobacco control.[183]

V. CONCLUSION

Tobacco is a naturally occurring plant, used for centuries in societies for religious or cultural purposes without systematic documentation of harm. However, it is now recognized as the only legal product that, when used as intended, kills 50 percent of its consumers. Over 5 million die from tobacco-related deaths every year. It is the leading preventable cause of death in the world. We have demonstrated in this article the magnitude of the problem and its human rights dimensions.

Large multinational corporations now control the cultivating, manufacturing, marketing, and selling of tobacco products in the globalized economy of the twenty-first century. At the same time, the industry generates income for farmers, traders, retailers, advertising agencies, corporate stockholders, and national treasuries. Tobacco products are legal and tobacco control has only begun in the last decades to be considered a legitimate and indeed necessary dimension of sound public policy. Under these circumstances,

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182. Henry A. Waxman, *The Future of the Global Tobacco Treaty Negotiations,* 346 New Eng. J. Med. 937 (2002). The notes by the European Network for Smoking Prevention of the negotiations for the FCTC, 18–21 and 24–28 February 2003, contain a concise summary of the positions held by countries on the final text, including the US position with respect to the article on advertising that reservations must be allowed. *See* European Network for Smoking Prevention (ENSP), ENSP Report on INB6 (2003), *available at* http://www.ensp.org/files/Mission_Report_INB6.doc.

183. Letter from US Senator Barbara Boxer et al., to US President George W. Bush (19 Mar. 2002), *available at* http://fctc.org/archives/INB4_senators_letter.shtml (this letter from eight US Senators urged the new negotiating team to be more supportive of public health and less supportive of tobacco industry interests).

one may ask whether it is appropriate to consider tobacco control as a human rights issue. Do the producing, marketing, and consuming of a legal product violate human rights? Does a human rights framework provide any useful insights for dealing with this complex set of issues?

We answer both questions in the affirmative. The evidence is incontrovertible that the rights to life, to health, to livelihoods, to education, to food, to a healthy environment, and to development are seriously affected by the tobacco industry. A particularly dangerous trend is reflected in the staging model of the epidemic, according to which prevalence of smoking by women is expected to peak in the next decades, followed by sharp increases in female deaths due to smoking, particularly in low- and medium-income countries. Tobacco control is therefore more than sound public health; it is a necessary strategy to ensure the human rights of the affected populations.

The main contention of this article is that tobacco control is not only a valid approach to fulfilling the right to health but it is so crucial that a human right to tobacco control is emerging in the practice of states and international institutions. The purpose of making this claim is not to contribute to the proliferation of rights but rather to identify the elements of a *norm de lega ferenda*. The evidence of the progressive emergence of the human right to tobacco control lies in the extensive use of legal restraints on advertising and on smoking in public places. The right to privacy and property were regarded a few decades ago as prevailing over any public interest in legal restraints on smoking; today, more and more countries are now willing to adopt smokefree environment legislation, to restrict advertising, and to require labeling and education to warn of the harmful effects of smoking. Several UN and regional mechanisms have adopted guidelines and even made judicial determinations to advance the human right to tobacco control.

The principal obstacle to recognizing tobacco control as a human right is determining who should be held accountable for the human rights deprivations that result from the legal operations of the tobacco industry. The culprits for most tobacco control advocates are the oligopolies that dominate the industry. However, these multinational corporations are theoretically operating within the law and in accordance with the rules of international trade.

The principal general treaty of international law seeking to limit the impact of the operations of these corporations, the FCTC, barely mentions human rights. Nevertheless, it provides the most comprehensive set of measures for tobacco control and has become definitional of what tobacco control means. The full implementation of the FCTC may, therefore, be regarded as a significant component of the obligation to fulfill the right to health and the core strategy of the derivative human right to tobacco control. We recommend that, at a minimum, a subcommittee reporting to the Conference of Parties should be formed to address the human rights obligations of states parties and the ways in which the fulfillment of those obligations

can complement compliance with the FCTC. Special attention should first be paid to the most under-served, those with the least ability to speak for themselves—the children and the women in the least economically developed countries—who suffer the consequences of cultivation, manufacture, and household consumption of tobacco and the increasingly aggressive gender-specific marketing for cigarette consumption.

Some human rights mechanisms of the UN are beginning to build the elements of an internationally recognized right to tobacco control. The special rapporteur on the right to health has courageously addressed pressing issues of his mandate but not tobacco control so far. We believe the issue is important enough to be the subject of a day of discussion with the special rapporteur during the Human Rights Council. The newly established special representative on human rights and transnational corporations is particularly well positioned to monitor progress toward corporate accountability for the harmful effects of tobacco and thereby add another building block to this emerging human right. The treaty monitoring bodies, especially the CESCR, CEDAW, and CRC, and the regional courts and commissions on human rights have all contributed elements to establishing the normative basis for a human right to tobacco control. A day of general discussion, a general comment, an interpretation by a regional court of the duty of state parties to deal with tobacco companies with the same firmness they have dealt with oil companies are all potential developments that may contribute to advancing this right.

The parallel with the human right to water is a telling one: Today 1 billion people lack access to a basic water supply and over 1 billion people smoke with a 50 percent chance of dying from it and millions more affected by the cultivation of tobacco. Both access to water and tobacco control are so essential to the rights to life and health that the protection of those rights is inconceivable without acknowledging the specificity of these two derivative human rights. The human right to tobacco control will probably take another decade to be formally recognized, but the essential components are already emerging in the practice of states and international institutions.