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525 Twenty-third St. N.W.
Washington, DC. 20037

www.paho.org

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Exposure to Secondhand Tobacco Smoke in the Americas

A Human Rights Perspective

Acknowledgments

This paper was written by Heather Selin, PAHO Advisor on Tobacco Control and Javier Vasquez, PAHO Human Rights Specialist. It was reviewed by Armando Peruga, Chief of the PAHO Unit of Risk Assessment and Management and Heidi Jimenez, PAHO Chief Legal Counsel. Professor Allyn Taylor of the University of Maryland provided valuable comments on an earlier version of this paper. Any errors or omissions are the responsibility of the authors.

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This document is dedicated to Heather Crowe and to the many other workers who have died as a result of exposure to secondhand tobacco smoke

Exposure to Secondhand Tobacco Smoke in the Americas:

A HUMAN RIGHTS PERSPECTIVE

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Foreword

ealth is fundamental to human well-being and social and economic development. It is in recognition of this fact that the right to the enjoyment of the highest attainable standard of health and the right to physical, mental and moral integrity are enshrined in many international human rights instruments. Yet health is not always at the forefront of human rights discussions and, conversely, public health agencies too infrequently consider the human rights dimensions of their work.

The use of international human rights principles, treaties and standards should be seen not as an optional tool to promote and protect public health, but as an essential strategy to improve the health of people around the world. In the Region of the Americas, the UN and Inter-American systems of human rights provide individuals with effective mechanisms of protection for ensuring the implementation of the human rights obligations that have been accepted by governments.

The Pan American Health Organization (PAHO) has used a human rights approach in its work in a number of areas since 1999. For instance, PAHO has conducted technical workshops promoting human rights and fundamental freedoms in the context of HIV/AIDS, disabilities, mental health, the health of indigenous peoples and the health of older persons, among others. PAHO has also collaborated with regional human rights bodies through participation in technical hearings on health issues, collaboration in formulating human rights standards in the context of mental health, and formulation of technical opinions to interpret regional human rights treaties in the context of the right to the enjoyment of the highest attainable standard of health and other related human rights.

PAHO's newest initiative in health and human rights is the issue of exposure to secondhand tobacco smoke. This paper examines the high human and public health cost of exposure to tobacco smoke in the Americas and how inter-

national human rights law is an underutilized but powerful mechanism that can help diminish these costs. We hope that it will lead to improved strategies and greater success in eliminating this entirely preventable cause of death and disease in the Americas.

Dr. Mirta Roses Periago
Director, Pan American Health Organization

Introduction

Secondhand tobacco smoke (SHS), or passive smoking, is known to cause serious and often fatal diseases in nonsmokers. Exposure to SHS is ubiquitous across the Americas and has a large aggregate impact on health in the region. Exposure to SHS carries costs not only for individuals' rights but also for collective health care and productivity. Conversely, the strategies and actions that can ensure protection from SHS are effective, highly feasible and inexpensive. International human rights law provides governments with a useful legal framework to facilitate the implementation of effective laws and educational campaigns to protect the public from SHS.

"International human rights law provides governments with a useful legal framework to facilitate the implementation of effective laws and educational campaigns to protect the public from SHS."

The link between public health and human rights is well-established and the right to the enjoyment of the highest attainable standard of health as enshrined in the WHO Constitution (referred to in this paper as "the right to health") is now recognized as an important human rights issue by United Nations bodies and others.[i,1] In addition, domestic courts in India and Uganda have determined that SHS exposure violates human rights, resulting in the creation of smoke-free environments in those countries.

The World Health Organization Framework Convention on Tobacco Control (WHO FCTC), which entered into force in February 2005 and as of February 2006 had 124 contracting parties, acknowledges the human rights dimensions of tobacco control and requires parties to protect the public from SHS.

Despite the fact that exposure to SHS may hinder the exercise of basic human rights such as the right to life, the right to physical integrity and the right to health, and bears on other rights found in United Nations and Inter-American human rights instruments and in many national constitutions of

i See, for example, UN Economic and Social Council General Comment No. 14 (2000), *The right to the highest attainable standard of health (Article 12 of the International Covenant on Economic, Social and Cultural Rights)*, 11 August 2000; UN General Assembly Resolution 58/173, *The right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, 22 December 2003; Mann J, Gruskin S, Grodin M, Annas G, eds. *Health and Human Rights: A Reader*. Routledge, 1999; Taylor A et al, International health law instruments, and Grushkin S and Tarantola D, Health and human rights, both in *Oxford Textbook of Public Health, 4th edition*. Detels R, McEwen J, Beaglehole R, Tanaka H, eds. Oxford University Press, 2004.

the Americas, SHS exposure has not yet been discussed by international human rights bodies or generally incorporated into the human rights dialogue in the Americas.

This paper argues that SHS exposure should be addressed within an international human rights legal framework. It will discuss:

- the health effects of SHS exposure;
- the extent of SHS exposure, protection, and public knowledge in the Americas;
- the human rights issues and international and Inter-American human rights legal instruments most relevant to SHS exposure; and
- potential strategies and legal mechanisms necessary to ensure that citizens can exercise their human rights in order to be protected from exposure to SHS without discrimination.

HEALTH IMPACT OF SHS Exposure

Definition, chemical composition and toxicity of secondhand tobacco smoke

Secondhand tobacco smoke (SHS) is the smoke from the end of a burning cigarette or other tobacco product (sidestream smoke), and the smoke exhaled by the smoker (mainstream smoke). Tobacco smoke contains thousands of chemicals, at least 250 of which are known to be toxic or carcinogenic.[1] These include benzene, cadmium, formaldehyde and polycyclic aromatic hydrocarbons. The International Agency for Research in Cancer (IARC), the Environmental Protection Agency in the U.S. (U.S. EPA) and the National Toxicology Program of the US Department of Health and Human Services have all classified SHS as a human carcinogen.[2, 3, 4] In January 2006 the California Environmental Protection Agency (Cal EPA) identified environmental tobacco smoke (secondhand smoke) as a toxic air contaminant.

Due in part to the fact that tobacco smoke is composed of numerous carcinogens where mutagenicity is possible even at extremely low doses, no threshold for a safe level of exposure to SHS has been determined; in other words, there is no level of exposure at which SHS has been found to be harmless to humans.[2, 5] This precautionary recommendation of "no safe level of exposure" is a common approach to carcinogens by scientists and government agencies.[6, 7]

However, studies have shown that indoor environments with typical ventilation and with a range of smoking levels violate the United States Annual National Ambient Air Quality Standard for respirable particulate matter.[8, 9] The working lifetime mortality risk of a worker in a bar in the US with typical smoke concentrations has been estimated to be 7 per 1,000.[10] This level of risk is staggering in comparison to the *de minimis* risks (defined as an acceptable or tolerable level of risk"[ii]) established for other toxins:

ii For a useful overview of the concept of risk assessment, see Health *Canada's Federal Contaminated Site Risk Assessment In Canada Part I: Guidance on Human Health Preliminary Quantitative Risk Assessment (PQRA),* Appendix B, September 2004. Available at: http://www.hc-sc.gc.ca/ewh-semt/pubs/contamsite/part-partie_i/appendix-b-annexe_e.html

US EPA standard for the "most exposed individuals" under the Clean Air Act and for other hazardous air pollutants[11]	1 in 10,000 in lifetime
US EPA guidance to states for risk of each contaminant in surface water[11]	1 in 100,000
Hazardous waste management under the Comprehensive Environmental Response Compensation and Liability Act ("Superfund")[11]	1 in 10,000
US Occupational Health and Safety Administration (OSHA) definition of a "significant risk of material impairment of health"[10]	1 in 1,000
Risk level at which OSHA invariably regulates[10]	3 in 10,000
Risk level of US bar worker under typical circumstances[10]	**7 in 1,000**

In other words, workers exposed to tobacco smoke on a regular basis during their working life have a risk of cancer that is between 7 and 700 times higher than that established as *de minimis* for exposures to contaminants other than SHS.

Health effects

There is no controversy in the credible medical and scientific communities on the harm caused by passive smoking. Competent health and scientific organizations worldwide, including the Pan American Health Organization (PAHO), World Health Organization (WHO), IARC, the U.S. EPA, the California EPA and the U.S. Surgeon General, have determined that exposure to SHS poses a serious risk to health.[3, 5, 12, 13, 14] SHS exposure therefore clearly threatens health, life and physical integrity.

Most recently, the California Environmental Protection Agency (Cal EPA) in 2005 published an in-depth review of the scientific evidence as part of its proposal to identify SHS as a toxic air contaminant under California's health and safety code.[5] This review confirmed more than twenty years of evidence showing that SHS is responsible for a number of serious, and often fatal, illnesses in children and adults.

In children, exposure to SHS causes acute respiratory diseases including bronchitis and pneumonia, causes asthma and increases the quantity and seriousness of symptoms in children with pre-existing asthma, causes middle ear infections, and inhibits lung function. SHS exposure from maternal smoking (and possibly exposure of the mother to SHS) causes low birthweight babies, premature birth and Sudden Infant Death Syndrome (SIDS, or crib death).[15] In adults, exposure to SHS causes cancer of the lung and oral/nasal cavity, breast cancer in young, primarily pre-menopausal women, heart disease and heart attacks, and causes and exacerbates asthma.[5] The table in Appendix A, reproduced from the Cal EPA report, shows all of the health effects known and thought to be causally associated with SHS exposure.

While increased exposure to SHS is likely to increase the risk of harm to health, adverse effects may occur even without long and sustained exposure. A recent analysis by the U.S. Centers for Disease Control and Prevention (CDC) concluded that a period of exposure of as little as 30 minutes is sufficient to cause myocardial infarction (heart attack) in people with existing cardiovascular disease. Based on this finding, the CDC issued a rare warning, advising people with existing cardiovascular disease to avoid any and all exposure to SHS.[16]

"Many SHS-caused illnesses such as cancer, heart disease and respiratory conditions are chronic and often lead to disability affecting capacity to work and to maintain an independent lifestyle."

Mortality and Morbidity Estimates

On a population level, Cal EPA estimates that SHS causes 3400 lung cancer deaths and between 23,000 and 70,000 heart disease deaths annually in the United States.[5] In children, SHS is estimated to be responsible for 430 cases of SIDS, 24,300 low birth weight babies, 71,900 pre-term deliveries, 200,000 episodes of asthma, and 790,000 medical visits due to otitis media (inner ear infection) annually in the US (Annex B). Detailed research would be needed to estimate the population impact of SHS on morbidity and mortality in the Americas. However, if the Cal EPA calculations were applied to the Americas based on population figures alone, the result would be at least 4 1⁄2 million negative health outcomes and at least 78,000 deaths annually, not including breast cancer diagnoses and deaths.[iii] Details of these calculations are found in Annex C.

Although mortality statistics most graphically illustrate the extent of harm caused by SHS exposure, morbidity (disease and illness) leading to disability is an important impact of SHS exposure. Many SHS-caused illnesses such as cancer, heart disease and respiratory conditions are chronic and often lead to disability affecting capacity to work and to maintain an independent lifestyle.

iii Calculations were made using the latest US SHS-related morbidity and mortality data available as reported in Cal EPA 2005 and using 2004 population estimates for the US and for the Americas. US data were multiplied by 2.96 to arrive at estimates for the Americas.

SHS Exposure, Protection and Public Knowledge in the Americas

Exposure to SHS

Data from the Global Youth Tobacco Survey (GYTS) indicate that SHS exposure is common in the Americas. Surveys of youth in school aged approximately 13-15 conducted between 1999 and 2003 found that 70 per cent of youth in Buenos Aires and Havana and 60% of youth in Santiago and Suriname are exposed to SHS in the home.[iv] Exposure levels in public places for these geographic locations were 88%, 65%, 72%, and 69%, respectively.

A study of SHS concentrations in various settings in seven Latin American countries found SHS in 94% of the locations surveyed. Bars and restaurants tended to have the highest concentrations, but SHS was also found in hospitals, schools, and government buildings, even in places where smoking was prohibited by law or policy. The study also found that in some cases of shared smoking and nonsmoking areas, smoke concentrations were ***higher*** in the nonsmoking than in the smoking areas.[17]

A study of workers at Mexico's National Institutes of Health showed that 91% were exposed to some degree of tobacco smoke, and 65% reported that the exposure caused them some discomfort and interfered with the performance of their work.[18] A study of non-smoking waiters in Sao Paulo compared expired carbon monoxide levels prior to and after a work shift of an average of nine hours, and found that the levels increased more than two-fold. The study discussed other possible sources of carbon monoxide exposure and concluded that the major contributor was secondhand cigarette smoke.[19]

iv Global Youth Tobacco Survey. Fact sheets and reports available at: www.cdc.gov/tobacco

There are very few binding laws in Latin America and the Caribbean that require smoke-free environments in any sectors, and those that do very rarely cover settings other than public transportation, the facilities of selected government ministries and the health and education sectors.[v] In many countries smoking is allowed even in health care facilities.[20] Even worse, laws in some countries actually ***require*** specific types of facilities to establish smoking areas.[vi]

*"…laws in some countries actually **require** specific types of facilities to establish smoking areas."*

A significant exception to this pattern in Latin America is Uruguay, which will require all indoor workplaces and public places, including clubs, bars and restaurants, to be smoke-free beginning March 1, 2006.[21]

Even in North America, where an increasing number of states, provinces and municipalities require almost all public places and workplaces to be smoke-free, less than one-third of the population currently lives in jurisdictions where smoking is prohibited in almost all workplaces.[22, 23, vii]

Protection also varies depending on type of workplace. Typically, offices and retail settings are the first places to prohibit smoking either by law or on a voluntary basis, and hospitality settings are the last. The hospitality sector also tends to have the highest concentrations of smoke. This means that bar, nightclub, and restaurant workers are generally exposed to higher levels of smoke than employees in other settings, and continue to be exposed for many years after their white-collar counterparts have achieved smoke-free work-places.[25, 26]

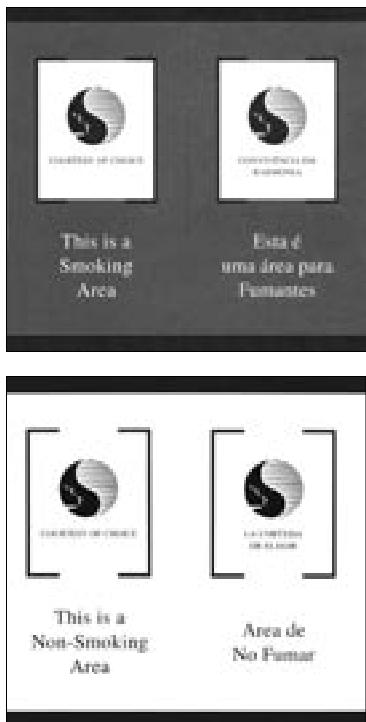
Public knowledge

There has been very little research investigating in-depth, specific knowledge of SHS effects. However, the few studies available from countries where there have been widespread public information campaigns and restrictions on smoking in public places show clearly that people are not aware of the risks of SHS, let alone their human rights and fundamental freedoms threatened by SHS exposure.[27] From these findings it is reasonable to assume an even lower level of knowledge in countries with fewer public education campaigns.

The Global Youth Tobacco Survey indicates at least a surface-level knowledge among youth that SHS is harmful. For example, 60% of students in Santiago, 68% in Jamaica, and 74% in Mexico City agreed with this fact. However, a

v PAHO review of national policies, unpublished.
vi For example, in Mexico, Ley General de Salud Art. 188.II, and Reglamento sobre Consumo de Tabaco, 27 June 2000 Cap. III Art. 9 & 10; and in Costa Rica, Ley No. 7501: La Asamblea Legislativa de la Republica de Costa Rica Decreta: Regulación del fumado Art. 2.
vii The situation in Canada and the US is continuously improving, but Canada in particular will see an enormous increase in protection on May 31, 2006, when provincial legislation requiring almost all workplaces in Ontario and Quebec to be smoke-free comes into force. The combined populations of these two provinces make up nearly two-thirds of Canada's entire population.

FIGURE 1. This table card from Brazil for the International Hotel & Restaurant Association's "Courtesy of Choice" program is typical of table cards found throughout Latin America.



wide range of literature has demonstrated that even in developed countries where the risks of smoking have been well-publicized, smokers are not aware of the type or magnitude of risk of tobacco use, nor do they believe that they are personally at higher risk.[28] This point is important because psychological studies have shown that in order to judge something to be a threat, an individual must know the specific consequences of the event or behavior (for example, that lung cancer causes a painful death, there is no cure and there is little chance of survival beyond five years) and the likelihood of risk (for example, that almost all lung cancers are caused by smoking, or that half of all smokers will die from a tobacco-caused disease).[29]

In Latin America and the Caribbean, in all but a handful of countries (for example, Argentina, Brazil, Mexico and Uruguay) there have been no consistent, widespread educational campaigns about the harm caused by SHS. Only Argentina, Costa Rica, Uruguay and a few municipalities (for example, Brasilia, Belo Horizonte and Rio de Janeiro in Brazil) have begun to actively promote smoke-free environments in a systematic fashion.[viii]

Tobacco industry misinformation campaigns

Not only is there insufficient public education about the health effects of SHS and protective measures, a great deal of misinformation about SHS has been promoted aggressively by tobacco companies.

Beginning in the early 1990s, Philip Morris and British American Tobacco embarked on the "Latin Project," a joint project designed to dispel concerns about the health risks of SHS exposure and to kill, delay, or weaken regulatory measures to restrict smoking in public places in Latin America. The campaign included the enlistment of scientists to study components other than SHS that play a role in indoor and outdoor air pollution, publication of scientific articles, sponsorship of scientific conferences and meetings of journalists, and engagement of the enlisted scientists with parliamentarians and other decision makers. This campaign has been well documented in the Pan American Health Organization's *Profits Over People* and elsewhere.[30, 31]

The industry aggressively promotes shared smoking and non-smoking areas to address SHS. In the Americas, it does this in part through the "Accommodation" and "Courtesy of Choice" programs targeted at restaurants and bars (Figure 1).

viii Review by PAHO technical staff based on visits to countries, information from PAHO country offices and results of the Regional Survey of Country-Specific Data, available at http://www.paho.org/tobacco/PatiosHome.asp .

Improved ventilation has also been promoted by tobacco companies as an alternative to smoking prohibitions, particularly in bars and restaurants. In addition to being ineffective in protecting health, ventilation "solutions" can mislead workers and patrons into believing that the ventilation system will protect them from the risks of SHS exposure, in the unlikely event that they are aware of the risks in the first place.

In summary:

- exposure to secondhand smoke poses a serious health risk both to adults and children and threatens basic human rights such as the right to life, physical integrity and health, and safe working conditions;
- children and adults in the Americas are regularly exposed to SHS in homes, public places and workplaces;
- few workers in the Americas are covered by laws protecting them from smoke in the workplace;
- the last workers to be protected – workers in the hospitality industry – tend to be those likely to have the highest exposure;
- the public is generally unaware of the nature and extent of the risk of exposure to SHS;
- very few countries have comprehensive public education campaigns to adequately inform the public about the risks of secondhand smoke; and
- active campaigns by tobacco companies designed to downplay the risks of SHS and to promote "solutions" that do not protect nonsmokers, such as improved ventilation and shared smoking and nonsmoking areas, have further contributed to lack of knowledge and weakening of political will to regulate smoking in workplaces and public places.

Secondhand SMOKE AND Human Rights INSTRUMENTS

Introduction

In recent years the link between public health – and tobacco in particular – and human rights has become well-established.[32] Human rights instruments and principles form a core part of the work of WHO and other UN bodies and health organizations.[33, ix] and, as discussed below, have been used in domestic courts to provide protection from SHS.

Domestic constitutional and workers' safety laws and SHS

Exposure to SHS specifically has been linked to legally protected human rights in a number of jurisdictions. Two significant instances are found in India and Uganda.

In 2001 the Supreme Court of India in Murli S. Deora *v.* Union of India determined that passive smoking was injurious to health and ordered the national government and state and territorial governments to "take effective steps to ensure prohibiting smoking in public places." The decision notes that the

> fundamental right guaranteed under Article 21 of the Constitution of India, inter alia, provides that none shall be deprived of his life without due process of law. Then – why a non-smoker should be afflicted by various diseases including lung cancer or of heart, only because he is required to go to public places? Is it not indirectly depriving of his life without any process of law? The answer is obviously 'yes.' Undisputedly, smoking is injurious to health and may affect the health of smokers but there is no reason that health of passive smokers should also be injuriously affected. In any case, there is no reason to compel non-smokers to be helpless victims of air pollution.[34]

In 2003, the Indian government responded to the Court's decision with *The Cigarettes and other Tobacco Products (Prohibition of Advertisement and*

ix See World Health Organization, 25 Questions & Answers on Health & Human Rights. *Health & Human Rights Publication Series*, Issue No. 1, July 2002.

Regulation of Trade and Commerce, Production, Supply and Distribution) Act, 2003, which required a range of public places to become smoke-free beginning 1 May 2004. On 5 February 2004, India ratified the Framework Convention on Tobacco Control (FCTC), which requires parties to provide protection from exposure to SHS in all indoor public places and workplaces (Article 8).

In Uganda, the High Court ruled in the case of TEAN *v*. AG that smoking in public places violates the right to life and the right to a clean and healthy environment under Uganda's constitution.[35] The Court ordered Uganda's National Environment Management Authority (NEMA) to make regulations prohibiting smoking in public places within one year of the ruling. NEMA did so and the prohibition took effect on March 12, 2004.[36]

Exposure to SHS has also been addressed as a workers' rights issue. One well-publicized example was the decision of the Ontario Workplace Safety and Insurance Board in Canada to award Heather Crowe, a nonsmoking waitress, compensation as a result of her contracting terminal lung cancer due to exposure to SHS on the job. The adjudicator concluded that there was a clear causal connection between Ms. Crowe's illness and her work.[37] Ms. Crowe has been featured in a Health Canada public education campaign on secondhand smoke in the workplace (Figure 2).[x] Similarly, courts in the United States have awarded plaintiffs workers' compensation and disability benefits. Courts in the US have held that exposure to SHS in the workplace and elsewhere discriminates against those with pre-existing disabilities, such as asthma.[38] US courts have also ruled that exposure of prison inmates to SHS may violate their Eighth Amendment right (of the US Constitution) to not be subjected to "cruel and unusual punishment."[39, 40]

FIGURE 2. Health Canada's "Heather Crowe" campaign on secondhand smoke in the workplace.

International binding and nonbinding human rights instruments[xi]

The rights cited in the domestic decisions discussed above are reflected in United Nations, Inter-American, European and African human rights instruments and other legal instruments. These are reinforced by international guidelines providing recommendations for interpreting how these rights are best protected.

x Information on Health Canada's secondhand smoke awareness campaign highlighting Heather Crowe's story is available at: http://www.hc-sc.gc.ca/hl-vs/tobac-tabac/second/do-faire/ribbon-ruban/threat-menace_e.html

xi In this context, "binding human rights instruments" refers to pacts, protocols, accords, charters, conventions or treaties that commit States that ratify them to protect and promote respect for human rights. States that are parties to these instruments are obligated to ensure that government laws, polices, plans and practices conform to binding international human rights law. "Nonbinding human rights instruments" refers to resolutions, guidelines, recommendations, or similar official communications issued by international organizations with regard to a human rights issue or topic and can be used to interpret human rights conventions or treaties. Nonbinding instruments do not create obligations under international human rights law.

"SHS in social settings isolates those with a particular intolerance for smoke, thus undermining their social well-being."

International binding human rights instruments

There are five UN and four Inter-American major human rights instruments relevant to SHS exposure:

- Universal Declaration of Human Rights[41];
- International Covenant on Civil and Political Rights[42];
- International Covenant on Economic, Social and Cultural Rights[43];
- Convention on the Elimination of All Forms of Discrimination against Women[44];
- Convention on the Rights of the Child[45];
- American Declaration of the Rights and Duties of Man[46];
- American Convention on Human Rights (Pact of San José)[47];
- Additional Protocol to the American Convention on Human Rights in the area of Economic, Social and Cultural Rights (Protocol of San Salvador)[48]; and the
- Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women (Convention of Belem do Para)[49]

Although the wording and scope of obligations varies among human rights instruments, there are a number of provisions common to these instruments whose principles are undermined by exposure to SHS. The central common rights and principles in these instruments relevant to SHS exposure and potential actions a State can take to uphold them are summarized below. Annexes D and E contain the text for the relevant provisions of each of the instruments and a list of the States that have ratified them.

Right to Life Exposure to SHS causes diseases that are often fatal. Governments have the power to regulate exposure to SHS in most settings and to educate the public on the risks of SHS and how to protect themselves and their families.

Right to Physical, Mental and Moral Integrity and Right to Health (including prevention of occupational diseases and education on prevention) Exposure to SHS harms physical integrity and may also harm mental integrity. In addition, SHS in social settings isolates those with a particular intolerance for smoke (such as those with asthma or other respiratory problems), thus undermining their social well-being. This harm is particularly compelling when exposure is unavoidable, such as in workplaces, and where the victims are not in a position to defend themselves, as in the case of children.

For adults, most exposure to tobacco smoke occurs in the workplace. Since workplaces, both public and private, are subject to government regulation, disease caused by SHS can be prevented by regulatory measures requiring public places and workplaces to be smoke-free. Govern-

ments also have the means to communicate to the population, through media campaigns and through mandated health warnings on tobacco packages, the health effects of SHS exposure and the need for smoke-free homes, public places and workplaces.

Rights of the Child Exposure of children to SHS threatens the rights of the child. Governments can minimize exposure in the home by conducting education campaigns aimed at parents and by eliminating children's exposure in public places and workplaces through regulation. Smoke-free workplaces also modify parental behavior, leading parents to smoke less and/or to step outside the home to smoke.

Right to Equal Protection Protection from SHS is unequal and arbitrary. There are large geographic, social and occupational inequities in legal protection from exposure to SHS. To further exacerbate the discrimination and inequity, the occupations that are least regulated tend to pay less and therefore workers in these occupations have diminished ability to pay for health care. Regulation at national level of all workplaces and public places can equalize protection.

Right to Freedom of Thought and Expression This right includes freedom to seek and receive information and ideas, for example, through public information campaigns and labels on tobacco packaging warning about the risks of SHS exposure.

Just, Equitable, and Satisfactory Conditions of Work Exposure to SHS in the workplace seriously compromises health and safety, both through the impact of SHS on health and through the danger posed by cigarette-caused fires. Governments have the authority to eliminate smoking in the workplace and hold employers responsible for enforcement.

Right to a Healthy Environment Secondhand smoke is a significant cause of indoor air pollution in many settings of the Americas. The current reality, where children and adults are forced to breathe smoke in the course of their daily lives – in workplaces, homes, shopping centers, bars and restaurants, schools, health care centers, sporting facilities – does not meet the standard of a healthy indoor environment. Governments can incorporate smoke-free environments into environmental health and clean air policies.

Protection of Persons with Disabilities SHS-caused diseases often result in disabilities. Conversely, pre-existing conditions or disabilities such as asthma, other respiratory diseases or heart conditions hinder the right to work and partake in the life of the community if SHS is present. These disabilities can be prevented and accommodated by legally mandated smoke-free environments.

"Governments are obligated to enact domestic legislation to enable citizens to exercise these rights."

Obligation to Enact Legislation It is not enough for these rights to exist in international law. Governments are obligated to enact domestic legislation to enable citizens to exercise these rights. Governments have the authority to pass legislation to require most workplaces and public places to be smoke-free (federal systems are more complex, as discussed below). This obligation, which is central to strategies to reduce exposure to SHS, will be discussed in more detail below.

Other international binding instruments: the World Health Organization Framework Convention on Tobacco Control (WHO FCTC)

The WHO FCTC was adopted by consensus by the World Health Assembly in May 2003. The treaty entered into force on 27 February 2005 and as of February 2006 had been ratified, accepted by or acceded to by 124 WHO Member States. The WHO FCTC recognizes the relationship between human rights and tobacco in its preamble:

> ...Recalling Article 12 of the International Covenant on Economic, Social and Cultural Rights, adopted by the United Nations General Assembly on 16 December 1966, which states that it is the right of everyone to the enjoyment of the highest attainable standard of physical and mental health,
> ...Recalling also the preamble to the Constitution of the World Health Organization, which states 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, political belief, economic or social condition,
> ... Recalling that the Convention on the Elimination of All Forms of Discrimination against Women, adopted by the United Nations General Assembly on 18 December 1979, provides that States Parties to that Convention shall take appropriate measures to eliminate discrimination against women in the field of health care,
> ... Recalling further that the Convention on the Rights of the Child, adopted by the United Nations General Assembly on 20 November 1989, provides that States Parties to that Convention recognize the right of the child to the enjoyment of the highest attainable standard of health...

The FCTC includes specific obligations to provide protection from SHS exposure and to inform the public of its risks. The central obligation of parties related to SHS is found in Article 8, *Protection from exposure to tobacco smoke:*

> 1. Parties recognize that scientific evidence has unequivocally established that exposure to tobacco smoke causes death, disease and disability.
> 2. Each Party shall adopt and implement in areas of existing national juris-

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

Other obligations relate to the availability of information to the public. Article 11, *Packaging and labelling of tobacco products*, requires parties to implement health warnings comprising 30% of the main surfaces of the packaging within three years of the treaty's entry into force for a party: Article 12, *Education, communication, training and public awareness*, further emphasizes the importance of public education about SHS, requiring parties to adopt measures to promote, among other things:

> (a) broad access to effective and comprehensive educational and public awareness programmes on the health risks including the addictive characteristics of tobacco consumption and exposure to tobacco smoke;
> (b) public awareness about the health risks of tobacco consumption and exposure to tobacco smoke, and about the benefits of the cessation of tobacco use and tobacco-free lifestyles as specified in Article 14.2; ...

"The WHO FCTC requires parties to adopt measures and to promote public awareness about the health risks of exposure to tobacco smoke."

International nonbinding instruments, standards and guidelines

Numerous international nonbinding instruments and standards provide recommendations, guidelines and strategies to protect the public from SHS and to increase awareness of the harm caused by SHS. As stated above, these instruments are useful in interpreting States' international human rights obligations. Within the Americas, the central mandate from governments to address SHS is the Pan American Health Organization's ***Directing Council Resolution CD43.R12, 2001***, which urges PAHO Member States to, *inter alia*:

> protect all nonsmokers, in particular children and pregnant women, from exposure to second-hand smoke through elimination of smoking in government facilities, health care facilities, and educational institutions as a priority, and through the creation of smoke-free environments in workplaces and public places as soon as possible, recognizing that smoke-free environments also promote cessation and prevent initiation of tobacco use.[51]

Other important guidelines and recommendations have been issued by PAHO, WHO and the World Bank, including the following.

Pan American Health Organization: ***Developing Legislation for Tobacco Control: Template and Guidelines***[52] These guidelines set out the scien-

tific and health justification for eliminating smoking in all indoor public places and workplaces, and provide legislative guidance to do so. The guidelines also summarize the usefulness of package warnings in communicating the risks associated with SHS exposure, and the ability of effective warnings to change behavior.

World Health Organization: ***Tobacco Control Legislation: An Introductory Guide***[53] This guide provides background and recommendations on the process of developing, drafting, enforcing and evaluating tobacco control legislation, including legislation requiring smoke-free environments and package warnings.

World Health Organization: ***Building Blocks for Tobacco Control: A Handbook***[54] This resource provides broad-ranging recommendations on creating an infrastructure to implement and maintain tobacco control programs and policies. Among other measures it highlights smoke-free environments, package warnings, and public education campaigns as cost-effective measures to reduce tobacco use and exposure to SHS.

World Bank: ***Curbing the Epidemic: Governments and the Economics of Tobacco Control***[28] This publication, available in at least 13 languages, sets out the economic case for tobacco control and places policy interventions such as smoke-free environments, package warnings and mandated public information campaigns among the most cost-effective measures to reduce tobacco use.

All of these guidelines or standards are consistent in their conclusions:

- 100% smoke-free environments in all indoor workplaces and public places are necessary to protect the public from SHS
- Public education campaigns and other communications strategies, such as mandated health warnings on tobacco packaging, are necessary and cost-effective measures to ensure that the public is aware of the risk of SHS exposure and has the knowledge to take steps to reduce or eliminate their and their families' exposure.

HOW HUMAN RIGHTS INSTRUMENTS CAN INFORM Strategies TO Protect individuals FROM SHS Exposure

What are the best strategies to enable citizens of the Americas to exercise their rights to life, personal integrity, physical and mental health and other human rights undermined by SHS exposure? How can they be applied, and how much will they cost?

International law and the FCTC provide a clear roadmap for action, with the following offering guidance on central strategies:

- WHO FCTC Article 8, which calls for protection from SHS in ALL indoor public places, public transportation and workplaces;
- WHO FCTC Article 12, which calls for broad access to education and public awareness programs on the health risks of SHS exposure;
- the review, enactment and implementation of legislation, policies, plans and practices consistent with international human rights law;
- the equal protection of all citizens without discrimination consistent with international human rights law; and
- accessibility to clear information about SHS exposure consistent with a person's right to seek and receive information under the right to freedom of expression in international human rights law.

Further guiding interpretation of these obligations is the scientific evidence showing that elimination of tobacco smoke indoors is the only scientifically-based strategy to adequately protect people from the risk of harm caused by SHS exposure (see Figure 3) and therefore their right to life and the highest attainable standard of physical and mental health. The human rights and fundamental freedoms enshrined in international human rights treaties and the scientific evidence point to a strategy of maximum protection that, for those States that have ratified the treaties discussed above, implies an obligation to eliminate

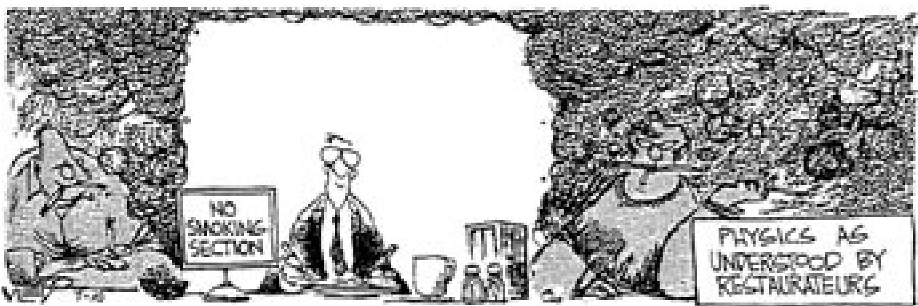


FIGURE 3. Shared smoking and nonsmoking areas do not protect from SHS.

tobacco smoke in all indoor workplaces and public places, including public transportation. This strategy can ensure the equal protection of all citizens in accordance with general international human rights norms and standards.

Supporting such legislation that fulfills States' human rights commitments should be a strategy of public education and information to ensure that the public is aware of the risks of SHS exposure as well as how to exercise their human rights enshrined in international law, to encourage voluntary policies where regulation is generally not acceptable or feasible (such as the home), and to build public support that will enable the successful implementation of legislation in accordance with regional and international human rights obligations.

Implementation of legislation to provide equal and maximum protection

Possibly the most important obligation under international human rights law is the obligation to implement legislation, policies, plans and practices to ensure that international human rights are truly protected at the domestic level. If this doesn't occur, international law is reduced to a statement of principle that is never put into practice. National governments have the authority to regulate smoking in public places and both public and private workplaces and should implement laws, policies, plans and practices, guided by their human rights obligations, that require all of these settings to be 100% smoke-free indoors. In some circumstances, smoke-free outdoor settings may also need to be smoke-free.

National governments in federated states usually have the authority to at least make federal workplaces and public places smoke-free. In federated states where there is overlapping and ambiguous authority to regulate smoking, federal governments should regulate where they can (certainly in all federal government facilities) and pass legislation explicitly granting sub-jurisdictions the authority to make workplaces and other settings smoke-free. They can also work actively with sub-jurisdictions to urge implementation of smoke-free legislation and provide incentives to do so.

All legislation and other domestic measures should include language linking the measures to the protection of relevant human rights enshrined in international and Inter-American human rights instruments.

Are there alternatives to legislation or policies requiring 100% smoke-free environments that would protect public health? As described above, shared smoking and non-smoking areas have a minimal if any impact on health protection, and have been dismissed by health and scientific experts as an inadequate solution. Advocates and cartoonists have likened this approach to designating urinating and non-urinating sections in a swimming pool (Figure 4). In addition to common sense telling us that there is not an invisible barrier that prevents smoke from drifting into non-smoking areas, measurements of air quality have shown that toxins from tobacco smoke mix throughout a space, even through walls if the spaces share ventilation systems.[55] And while better ventilation is obviously desirable and may increase comfort, it does not provide health protection from the toxins in tobacco smoke. This has been acknowledged by the American Society of Heating, Refrigeration and Air-Conditioning Engineers (ASHRAE) which provides ventilation guidelines.[56, 57] Therefore, the implementation of smoke-free environments is the only solution that adequately protects health.

FIGURE 4. Shared smoking and non-smoking sections are like urinating and non-urinating sections in a swimming pool. Would you jump in?

Legislative measures should be accompanied or preceded by the educational measures described below in order to gain public support for smoke-free environments and to ease enforcement by ensuring that employers, managers and workers are aware of their rights and responsibilities. Signage requirements can reinforce educational campaigns and facilitate enforcement by including specific health information on non-smoking signs (for example, “Secondhand tobacco smoke causes cancer in non-smokers. For your health, this building is smoke-free.” or “To protect the health of our clients and employees, smoking is prohibited in this building.”)

A significant barrier to the implementation of smoke-free environments in hospitality settings has been the misperception that smoke-free environments harm business. This claim is solidly contradicted by all available evidence but manages to persist through the efforts of tobacco companies and their allies. Therefore, in most jurisdictions, education laying to rest this myth will be an important part of the implementation of smoke-free hospitality venues.

Public education and information dissemination to ensure public awareness of risks and ability to exercise rights

"It is the obligation of governments that subscribe to international human rights law to ensure that the public is able to seek and receive information relevant to the risks of SHS exposure."

Rights cannot be protected if citizens are not informed of their rights, the risks of SHS exposure or any other relevant information necessary to make decisions and take action to avoid risk. A key component of the right to freedom of expression in international human rights law is the right to seek and receive information. It is the obligation of governments that subscribe to international human rights law to ensure that the public is able to seek and receive information relevant to the risks of SHS exposure. Governments have the responsibility – whether directly or through support to other institutions to do so – to adequately inform the public about the specific health risks of SHS exposure and their consequences, about what measures will protect individuals and their families, and the rights of citizens under various human rights laws. This information is particularly important for parents, workers in general and public health personnel. With this information, the public can weigh the importance of avoiding SHS or protecting others from it. Without it, the public's health is seriously at risk.

Studies indicate that most children's exposure to tobacco smoke usually occurs in the home. Because protection in the home is generally dependent upon voluntary behavior rather than laws, public education campaigns specifically need to communicate information to parents about SHS harm and how to minimize exposure, and the right of children to be protected. Parents and other caregivers who smoke should readily have access to information telling them that they should smoke only out of doors, away from other family members. More generally, the public should know that SHS exposure puts them at risk of disease and that involuntary exposure hinders their right to life, health and other rights.

The two most effective means of informing the public about SHS harm so that people can exercise their rights are widespread public education campaigns and legislatively-mandated package health messages. In addition to their importance in stimulating behavior change, public information campaigns build public support for legislation to make public places and workplaces smoke-free.

Messages can be communicated through mass media campaigns on billboards, television, radio and print publications and by supporting community organizations to incorporate SHS messages into their activities. Health care providers should be trained to ask not only about the smoking status of their

clients, but also whether or not their clients and families are exposed to SHS or are exposing others by smoking in their presence.

Workers and employers need to have access to information about their rights and responsibilities. Employers and workers groups, including unions, should be recruited as active partners and provided with relevant information. The first priority for education should be in the sectors where exposure to SHS is the highest, such as bars and restaurants. Employers should be persuaded to voluntarily make their premises smoke-free until legislation is put in place, emphasizing the right of workers to a safe and healthy workplace.

The public information medium that can be guaranteed to reach all smokers – and nonsmokers as well through displays at point of sale, on restaurant tables and as street litter – is the tobacco package. Governments should require the packaging of all tobacco products sold in the country (including imports) to carry conspicuous, graphic, informative health warnings informing consumers of SHS harm and other health consequences of tobacco use. The exact content and format should be mandated by law, following the guidelines set out in Article 11 of the WHO FCTC. Key components are that the warnings be specific, that they take up at least 50% of the main faces of the package (in the top half), and that they use graphics as well as bold text to convey their messages.

Only four countries in the Americas – Brazil, Canada, Venezuela and, as of April 2006, Uruguay – have effectively used package messages to communicate health information, including SHS risks, to consumers. These countries require packages to carry large, graphic images accompanied by text (Figures 5 - 8). Studies of the impact of the warnings from Canada and Brazil indicate that the warnings were very effective at conveying health risks, motivating smokers to try to quit, and motivating smokers to smoke outdoors and away from their families more often. [59, 60, xii]

Finally, training workshops should be conducted for government officials, civil society, workers and employers to build awareness of the threat of secondhand exposure to human rights enshrined in international and national law and to build capacity to use the human rights legal framework as an effective mechanism to protect the public from SHS.

FIGURE 5. Brazil package warnings focusing on secondhand smoke harm.

FIGURE 6. Canadian package warnings focusing on secondhand smoke harm.

xii A number of evaluation surveys have been conducted by Health Canada, available at: http://www.hc-sc.gc.ca/hl-vs/tobac-tabac/research-recherche/por-rop/impact/index_e.html and by the Canadian Cancer Society, available at: http://www.cancer.ca/ccs/internet/standard/0,3182,3172_334419_436437_langId-en,00.html

FIGURE 7. Venezuelan package warnings focusing on secondhand smoke harm.

FIGURE 8. Uruguay will require image-based warnings in April 2006.

Cost and feasibility of strategies

Dozens of countries have implemented the interventions discussed above without significant difficulty. Normally, public reaction to tobacco control policies – excluding the inevitable opposition from tobacco companies – is very favorable. When legislation is accompanied by education and advance preparation, implementation is relatively smooth.

Interventions to fulfill the human rights of individuals through protection from SHS exposure are cost-effective by public health standards and administrative standards. The most powerful interventions are implemented through legislation. While public information campaigns will require some initial investment, this investment will diminish over time as smoke-free environments become a societal norm.

Jurisdictions requiring almost all indoor workplaces (including bars and restaurants) to be 100% smoke-free

Countries
Ireland, Italy, New Zealand, Norway, Scotland (U.K.), Sweden, Uruguay

US states and Canadian and Australian provinces & territories
California, Connecticut, Delaware, Maine, Massachusetts, New York, Rhode Island, Vermont, Washington, Manitoba, New Brunswick, Newfoundland and Labrador, Northwest Territories, Nunavut, Ontario, Quebec, Queensland, Tasmania

The cost of package warnings, other than that required for the development of the regulations, is borne primarily by tobacco companies. In fact, cost-estimate benefits conducted by the Australian and Canadian governments prior to implementation of graphic warnings estimated that the net benefit of package warnings would be more than AU$2 billion and more than CD$4 billion, respectively.[61, 62]

Key Actors AND Actions

Governments, civil society and international organizations all have key roles to play in ensuring the fulfillment of basic human rights through protection from SHS.

The Pan American Health Organization (PAHO), as the specialized UN and OAS agency for health in the Americas, has a central role to play in linking public health to human rights. PAHO should:

- disseminate and promote the international human rights instruments that protect the life, health, and other rights of people exposed to SHS;
- advise PAHO Member States on policies, programs and legislation related to SHS necessary to fulfill human rights obligations;
- collaborate with international human rights bodies, such as the Inter-American Commission on Human Rights, and special rapporteurs in providing technical opinions, participating in hearings and conducting *in loco* visits to assess protection of human rights *vis a vis* SHS exposure;[xiii]
- provide training and technical expertise to governments and civil society to raise awareness of human rights undermined by SHS exposure and of national, regional and international mechanisms to exercise and monitor those rights; and
- publish and disseminate technical documents outlining the human rights framework applicable to SHS exposure.

Governments have the responsibility to:

- understand the implications of their international human rights obligations with regard to protection from SHS exposure;
- implement legislation, policies, plans and practices to provide maximum protection (at minimum, all indoor workplaces and public places) from SHS, guided by human rights instruments and the WHO FCTC,

xiii For example, some of the functions of the Inter-American Commission on Human Rights are to review and grant decisions regarding petitions concerning alleged violations of human rights recognized in the American Convention on Human Rights and other Inter-American instruments, visit OAS Member States and review their compliance with Regional human rights treaties, request that States adopt precautionary measures to prevent irreparable harm to persons and conduct general and specific hearings on human rights issues or individual cases. For further information see http://www.iachr.org

and to include references to human rights obligations in domestic SHS-related measures;[xiv] and

- directly and in cooperation with civil society and multilateral institutions, conduct public communication campaigns (including implementation of package warnings conforming with or exceeding FCTC requirements) informing the public of the harm caused by SHS and the human rights basis for protection.

Civil society should:

- engage decision makers and opinion leaders by promoting how international human rights instruments that enshrine the right to life, health, and other human rights apply to SHS exposure;
- educate the public and individuals about their human rights and how to exercise those rights;
- develop networks of organizations available to facilitate the use of human rights instruments and systems by individuals to protect themselves from SHS exposure.

"Governments have the responsibility to implement legislation, policies, plans and practices to provide maximum protection from SHS, guided by human rights instruments and the WHO FCTC."

xiv According to international human rights treaties such as the American Convention on Human Rights (Article 2), States Parties undertake to adopt legislative or other measures as may be necessary to fulfill the rights and freedoms which are enshrined in the Convention.

Moving Forward

This paper has tried to establish the link between SHS exposure and basic human rights enshrined in international law. The information provided should help individuals understand and exercise the rights that may be hindered by their exposure to SHS. It should also, in outlining how obligations under international human rights law apply to protection from SHS exposure, facilitate the implementation of laws requiring smoke-free workplaces and public places across the Region of the Americas.

Smoke-free environments are becoming more of a reality every day in many countries. Human rights law provides a valuable framework to help ensure that they become a reality in all countries bound by human rights obligations. It is hoped that this paper will help bring SHS into the dialogue of human rights organizations and advocates and motivate action to ensure the individual exercise of human rights to reduce SHS exposure.

The Pan American Health Organization (PAHO) has worked with human rights organizations to highlight the link between health and human rights law in the context of mental health, HIV/AIDS, ageing, disabilities and the health of indigenous peoples. This experience and technical cooperation is available to guide governments, civil society, and human rights bodies in using the human rights framework to promote and protect individuals' health vis a vis SHS. Please see contact details under "Resources" below.

Resources

Pan American Health Organization
tobacco@paho.org
www.paho.org/tobacco

World Health Organization
http://www.who.int/topics/human_rights/en/
http://www.who.int/tobacco

Office of the High Commissioner for Human Rights
http://www.unhchr.ch/html/hchr.htm

Special Rapporteur on the Right of everyone to the enjoyment of the highest attainable standard of physical and mental health
http://www.ohchr.org/english/issues/health/right/index.htm

Inter-American Commission on Human Rights
http://www.cidh.org/

WHO/PAHO Collaborating Center on Human Rights Law
Center for Law & the Public's Health (Georgetown University Law Center and John Hopkins' School of Public Health)
http://www.publichealthlaw.net

UN Human Rights Legal Instruments
Universal Declaration of Human Rights
http://www.unhchr.ch/udhr/lang/eng.htm

International Covenant on Civil and Political Rights
http://www.unhchr.ch/html/menu3/b/a_ccpr.htm

International Covenant on Economic, Social and Cultural Rights
http://www.unhchr.ch/html/menu3/b/a_cescr.htm

Convention on the Elimination of All Forms of Discrimination against Women
http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm

Convention on the Rights of the Child
http://www.unhchr.ch/html/menu3/b/k2crc.htm

Inter-American Legal Instruments
American Declaration of the Rights and Duties of Man
http://www.cidh.org/Basicos/basic2.htm

American Convention on Human Rights (Pact of San José)
http://www.cidh.org/Basicos/basic3.htm

Additional Protocol to the American Convention on Human Rights in the area of Economic, Social and Cultural Rights (Protocol of San Salvador)
http://www.cidh.org/Basicos/basic5.htm

Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women (Convention of Belem do Para)
http://www.cidh.org/Basicos/basic13.htm

WHO Framework Convention on Tobacco Control (FCTC)
http://www.who.int/tobacco/framework/en/

Non-Governmental Organizations
American University Human Rights Law Clinic, the Washington College of Law
http://www.wcl.american.edu/clinical/inter.cfm

American University Human Rights Center, the Washington College of Law
http://www.wcl.american.edu/humright/center/

Center for Justice and International Law
http://www.cejil.org/main.cfm?switch=i

Tobacco Law Center
http://www.tobaccolawcenter.org/

Americans for Non-Smokers' Rights
http://www.no-smoke.org/

Physicians for a Smoke-Free Canada
www.smoke-free.ca

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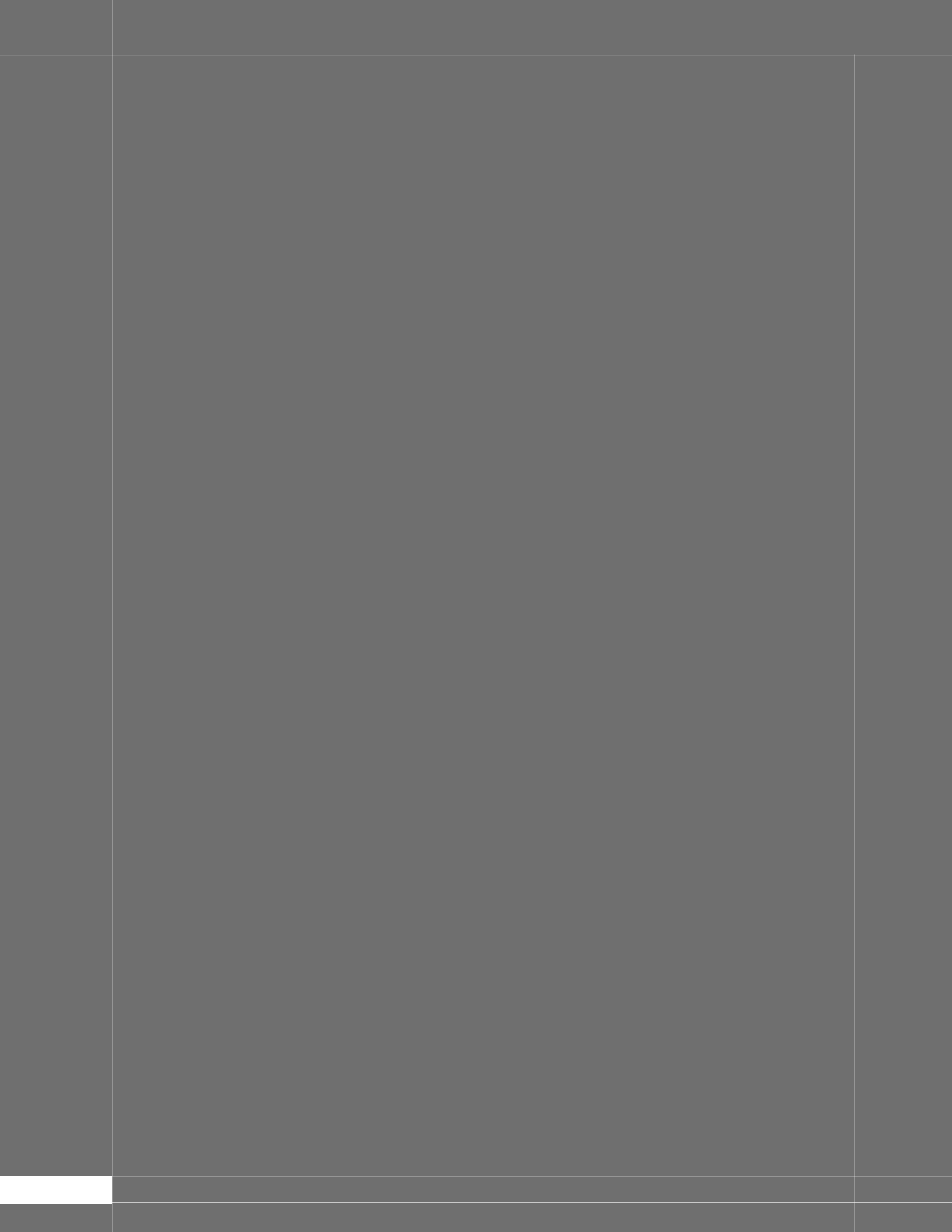

Annex A

California Environmental Protection Agency's assessment of health effects associated with exposure to SHS (2005)

Effects Causally Associated with ETS Exposure
Developmental Effects
Fetal growth: Low birth weight and decrease in birth weight
Sudden Infant Death Syndrome (SIDS)
Pre-term Delivery
Respiratory Effects
Acute lower respiratory tract infections in children (e.g., bronchitis and pneumonia)
Asthma induction and exacerbation in children and adults
Chronic respiratory symptoms in children
Eye and nasal irritation in adults
Middle ear infections in children
Carcinogenic Effects
Lung cancer
Nasal sinus cancer
Breast cancer in younger, primarily premenopausal women
Cardiovascular Effects
Heart disease mortality
Acute and chronic coronary heart disease morbidity
Altered vascular properties
Effects with Suggestive Evidence of a Causal Association with ETS Exposure
Reproductive and Developmental Effects
Spontaneous abortion, Intrauterine Growth Retardation
Adverse impact on cognition and behavior
Allergic sensitization
Decreased pulmonary function growth
Adverse effects on fertility or fecundability
Cardiovascular and Hematological Effects
Elevated risk of stroke in adults
Respiratory Effects
Exacerbation of cystic fibrosis
Chronic respiratory symptoms in adults
Carcinogenic Effects
Cervical cancer
Brain cancer and lymphomas in children
Nasopharyngeal cancer
All cancers – adult and child

Annex B

California Environmental Protection Agency attributable risks associated with SHS exposure (2005)

	Conclusion OEHHA 1997	Conclusion OEHHA 1997	Conclusion Update	Conclusion Update
Outcome	Annual Excess # in CA	Annual Excess # in US	Annual Excess # in CA	Annual Excess # in US
Pregnancy: Low birth weight Pre-term delivery	1,200-2,200	9,700-18,600	1,600 [1] 4,700 [1]	24,500 [2] 71,900 [2]
Asthma (in children):				
# Episodes [3]			31,000 [4]	202,300 [5]
# New cases	960-3120	8,000-26,000	N/A	N/A
#Exacerbations	48,000-120,000	400,000-1,000,000		
Lower respiratory illness	18,000-36,000	150,000-300,000	N/A	N/A
Otitis media visits	78,600-188,700	700,000-1,600,000	50,200	790,000 [6]
SIDS	120	1,900-2,700	21 [7]	430 [8]
Cardiac death (Ischemic heart disease death)	4,200-7,440	35,000-62,000	3,600 (range: 1,700-5,500)[9]	46,000 (range: 22,700-69,600) [10]
Lung cancer death	360	3000	400 [11]	3400
Breast cancer – diagnosis in younger, primarily premeno-pausal women			All studies: OR 1.68 (95% CI 1.31-2.15) [12] Best studies: OR 2.20 (95% CI 1.69-2.87) Approximate 68-120% increased risk	

1 Based on California Dept Health Services (CDHS, 2000a), Table 2-6, Number and percent of live births with selected medical characteristics by race/ethnic group of mother, California 2000, and Gilpin et al. (2001).
2 Based on CDC (2002b) National Vital Statistics Report. Vol 51(2) 2002. Births: Final data for 2001, and on adult females reporting exposure to ETS in NHANES III for 1995 (Pirkle et al., 1996).
3 The data to distinguish number of new cases from number of exacerbations were not available for the updated calculations; thus, OEHHA considered that these estimates were best described as number of episodes.
4 Based on number of asthma attacks or episodes in previous 12 months for 0-17 year olds. Calculated from California Health Interview Survey for 2001.
5 Based on number of asthma attacks or episodes in previous 12 months for 0-14 year olds in Mannino et al. (2002b) CDC-MMWR 51(SS01)).
6 Based on Freid et al. (1998) National Center for Health Statistics Series 13 No. 137. Ambulatory Health Care Visits by Children: Principal Diagnosis and Place of Visit for yrs 1993-1995.
7 Based on California Dept Health Services (CDHS, 2000b), Table 4-10 for yr 2000 Leading causes of infant death by race/ethnic group of child, California 2000.
8 Based on CDC (2002a) National Center for Health Statistics (2002). www.cdc.gov/nchs/fastats/infort.htm for yr 2000.
9 Based on California Dept Health Services (CDHS, 2000c), Table 5-7, Deaths, death rates, and age-adjusted death rates for leading causes by sex, California, 1999- 2000.
10 Based on Anderson and Arias (2003). National Vital Statistics Report. Vol 51(9) Table 2 for yr 2000 Ischemic heart diseases including AMI.
11 Assuming California exposure and death rates are similar to national rates and California population is 12% of national population.
12 OEHHA is unable at this time to calculate an attributable risk as it is not possible to account accurately for the portion attributable to other known risk factors. The OR for all studies is based on our meta-analysis of all studies with risk estimates for younger primarily premenopausal women. The OR for best studies is based on the OR for studies which evaluated younger primarily premenopausal women and which did a better job of ascertaining exposure – see Part B Section 7.4.1.3.2 and Table 7.4.1I.
N/A = data not available. Citations for documents cited in above table appear in Part B Chapter 1 references.

Annex C

Risk estimates for SHS exposure in the Americas based on California Environmental Protection Agency (2005) estimates adjusted for population[xv]

Outcome		Americas estimate
Pregnancy	Low Birth Weight	71,928
	Pre-Term Delivery	212,824
Asthma (children)	episodes	598,808
	new cases	23,680 – 76,960
	exacerbation	1,184,000 – 2,960,000
Lower respiratory illness		444,000 – 888,000
Otitis media visits (to health professional)		2,338,400
SIDS		1,273
Cardiac death (Ischemic heart disease death)		67,192 – 206,016
Lung cancer death		10,064
Breast cancer – diagnosis in pre-menopausal women		Between 68%-220% increased risk
Total annual deaths		**78,532 – 217,356**
Total annual negative health outcomes		**4,660,816 – 6,934,096 (not including breast cancer)**

xv Calculations were made using the latest US SHS-related morbidity and mortality data available as reported in Cal EPA 2005 and using 2004 population estimates for the US and for the Americas. US data were multiplied by 2.96 to arrive at estimates for the Americas.

Annex D

UN human rights legal instruments relevant to secondhand smoke exposure

Right / Provision	Legal Instrument				
	Universal Declaration of Human Rights	**International Covenant on Civil and Political Rights**	**International Covenant on Economic, Social and Cultural Rights**	**Convention on the Rights of the Child**	**Convention on the Elimination of All Forms of Discrimination against Women**
Right to life	**3.** Everyone has the right to life, liberty and security of person.	**6.**1. Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life.		**6.**1. States Parties recognize that every child has the inherent right to life. 2. States Parties shall ensure to the maximum extent possible the survival and development of the child.	
Right to physical, mental and moral integrity/ health			**12.**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	**19.**1. States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child. **24.**1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services. 2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures: (a) To diminish infant and child mortality; (b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care; (c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;	

UN human rights legal instruments relevant to secondhand smoke exposure

Right / Provision	Legal Instrument				
	Universal Declaration of Human Rights	International Covenant on Civil and Political Rights	International Covenant on Economic, Social and Cultural Rights	Convention on the Rights of the Child	Convention on the Elimination of All Forms of Discrimination against Women
Right to physical, mental and moral integrity/ health (cont.)				(d) To ensure appropriate pre-natal and post-natal health care for mothers; (e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents; (f) To develop preventive health care, guidance for parents and family planning education and services. 3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.	
Rights of the child			**10.** The States Parties to the present Covenant recognize that: 3. Special measures of protection and assistance should be taken on behalf of all children and young persons without any discrimination for reasons of parentage or other conditions. Children and young persons should be protected from economic and social exploitation. Their employment in work harmful to their morals or health or dangerous to life or likely to hamper their normal development should be punishable by law. States should also set age limits below which the paid employment of child labour should be prohibited and punishable by law.		
Right to non-discrimination/equal protection	**2.** Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour,	**2**.1. Each State Party to the present Covenant undertakes to respect and to ensure to all individuals within its territory and	**2**.2. The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised		

UN human rights legal instruments relevant to secondhand smoke exposure

Right / Provision	Legal Instrument				
	Universal Declaration of Human Rights	International Covenant on Civil and Political Rights	International Covenant on Economic, Social and Cultural Rights	Convention on the Rights of the Child	Convention on the Elimination of All Forms of Discrimination against Women
Right to non-discrimination/equal protection (cont.)	sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Furthermore, no distinction shall be made on the basis of the political, jurisdictional or international status of the country or territory to which a person belongs, whether it be independent, trust, non-self-governing or under any other limitation of sovereignty. **7.** All are equal before the law and are entitled without any discrimination to equal protection of the law. All are entitled to equal protection against any discrimination in violation of this Declaration and against any incitement to such discrimination.	subject to its jurisdiction the rights recognized in the present Covenant, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. **26.** All persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.	without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.		
Right to freedom of expression	**19.** Everyone has the right to freedom of opinion and expression; this right includes freedom to hold opinions without interference and to seek, receive and impart information and ideas through any media and regardless of frontiers.	**19.**2. Everyone shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of his choice.			
Right to safe and healthy working conditions	**23.** (1) Everyone has the right to work, to free choice of employment, to just and favourable conditions of work and to protection against unemployment.		**7.** The States Parties to the present Covenant recognize the right of everyone to the enjoyment of just and favourable conditions of work which ensure, in particular:	**32.**1. States Parties recognize 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.	**11.**1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of employment in

UN human rights legal instruments relevant to secondhand smoke exposure

Right / Provision	Legal Instrument				
	Universal Declaration of Human Rights	International Covenant on Civil and Political Rights	International Covenant on Economic, Social and Cultural Rights	Convention on the Rights of the Child	Convention on the Elimination of All Forms of Discrimination against Women
Right to safe and healthy working conditions (cont.)			(b) Safe and healthy working conditions		order to ensure, on a basis of equality of men and women, the same rights, in particular: (f) The right to protection of health and to safety in working conditions,including the safeguarding of the function of reproduction. **11.** 2. In order to prevent discrimination against women on the grounds of marriage or maternity and to ensure their effective right to work, States Parties shall take appropriate measures: (d) To provide special protection to women during pregnancy in types of work proved to be harmful to them.
Right to a healthy environment				**24.**2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures: (c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution.	
Rights of persons with disabilities				**23.**1. States Parties recognize that a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community.	

UN human rights legal instruments relevant to secondhand smoke exposure

Right / Provision	Legal Instrument				
	Universal Declaration of Human Rights	International Covenant on Civil and Political Rights	International Covenant on Economic, Social and Cultural Rights	Convention on the Rights of the Child	Convention on the Elimination of All Forms of Discrimination against Women
Right to humane treatment	**5.** No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.	**7.** No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.			
Right to wholesome recreation / culture			**15.**1. The States Parties to the present Covenant recognize the right of everyone: (a) To take part in cultural life.	**31.**1. States Parties recognize the right of the child to rest and leisure, to engage in play and recreational activities appropriate to the age of the child and to participate freely in cultural life and the arts. 2. States Parties shall respect and promote the right of the child to participate fully in cultural and artistic life and shall encourage the provision of appropriate and equal opportunities for cultural, artistic, recreational and leisure activity.	
Obligation to enact legislation		**2.**2. Where not already provided for by existing legislative or other measures, each State Party to the present Covenant undertakes to take the necessary steps, in accordance with its constitutional processes and with the provisions of the present Covenant, to adopt such laws or other measures as may be necessary to give effect to the rights recognized in the present Covenant.	**2.**1. Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.	**4.** States Parties shall undertake all appropriate legislative, administrative, and other measures for the implementation of the rights recognized in the present Convention. With regard to economic, social and cultural rights, States Parties shall undertake such measures to the maximum extent of their available resources and, where needed, within the framework of international co-operation.	

Parties from the Americas to UN Treaties
Universal Declaration of Human Rights: not subject to ratification
International Covenant on Civil and Political Rights: Argentina, Barbados, Belize, Bolivia, Brazil, Canada, Chile, Colombia, Costa Rica, Dominica, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, United States of America, Uruguay, Venezuela
International Covenant on Economic, Social and Cultural Rights: Argentina, Barbados, Bolivia, Brazil, Canada, Chile, Colombia, Costa Rica, Dominica, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Vincent ant the Grenadines, Suriname, Trinidad and Tobago, Uruguay, Venezuela
Convention on the Elimination of All Forms of Discrimination against Women: Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Bolivia, Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominica, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Kitts and Nevis, Saint Lucia, Saint Vincent ant the Grenadines, Suriname, Trinidad and Tobago, Uruguay, Venezuela
Convention on the Rights of the Child: Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Bolivia, Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominica, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Kitts and Nevis, Saint Lucia, Saint Vincent ant the Grenadines, Suriname, Trinidad and Tobago, Uruguay, Venezuela.

Annex E

Inter-American human rights legal instruments relevant to secondhand smoke exposure

Right / Provision	Legal Instrument			
	American Declaration of the Rights and Duties of Man	American Convention on Human Rights (Pact of San José)	Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (Protocol of San Salvador)	Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women (Convention of Belem do Para)
Right to life	**I.** Every human being has the right to life, liberty and the security of his person.	**4. Right to Life** 1. Every person has the right to have his life respected. This right shall be protected by law and, in general, from the moment of conception. No one shall be arbitrarily deprived of his life.		**4.** Every woman has the right to the recognition, enjoyment, exercise and protection of all human rights and freedoms embodied in regional and international human rights instruments. These rights include, among others: a. The right to have her life respected;
Right to physical, mental and moral integrity/ health	**XI.** Every person has the right to the preservation of his health through sanitary and social measures relating to food, clothing, housing and medical care, to the extent permitted by public and community resources.	**5. Right to Humane Treatment** 1. Every person has the right to have his physical, mental, and moral integrity respected.	**10. Right to Health** 1. Everyone shall have the right to health, understood to mean the enjoyment of the highest level of physical, mental and social well-being. 2. In order to ensure the exercise of the right to health, the States Parties agree to recognize health as a public good and, particularly, to adopt the following measures to ensure that right: d. Prevention and treatment of endemic, occupational and other diseases; e. Education of the population on the prevention and treatment of health problems,	**4.** Every woman has the right to the recognition, enjoyment, exercise and protection of all human rights and freedoms embodied in regional and international human rights instruments. These rights include, among others: b. The right to have her physical, mental and moral integrity respected;
Rights of the child	**VII.** All women, during pregnancy and the nursing period, and all children have the right to special protection, care and aid. **XXX.** It is the duty of every person to aid, support, educate and protect his minor children, and it is the duty of children to honor their parents always and to aid, support and protect them when they need it.	**19. Rights of the Child** Every minor child has the right to the measures of protection required by his condition as a minor on the part of his family, society, and the state.		

Inter-American human rights legal instruments relevant to secondhand smoke exposure

Right / Provision	Legal Instrument			
	American Declaration of the Rights and Duties of Man	**American Convention on Human Rights (Pact of San José)**	**Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (Protocol of San Salvador)**	**Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women (Convention of Belem do Para)**
Right to non-discrimination/equal protection	**II.** All persons are equal before the law and have the rights and duties established in this Declaration, without distinction as to race, sex, language, creed or any other factor.	**1. Obligation to Respect Rights** 1. The States Parties to this Convention undertake to respect the rights and freedoms recognized herein and to ensure to all persons subject to their jurisdiction the free and full exercise of those rights and freedoms, without any discrimination for reasons of race, color, sex, language, religion, political or other opinion, national or social origin, economic status, birth, or any other social condition. **24. Right to Equal Protection** All persons are equal before the law. Consequently, they are entitled, without discrimination, to equal protection of the law.	**3. Obligation of nondiscrimination** The State Parties to this Protocol undertake to guarantee the exercise of the rights set forth herein without discrimination of any kind for reasons related to race, color, sex, language, religion, political or other opinions, national or social origin, economic status, birth or any other social condition.	
Right to freedom of expression	**IV.** Every person has the right to freedom of investigation, of opinion, and of the expression and dissemination of ideas, by any medium whatsoever.	**13. Freedom of Thought and Expression** **1.** Everyone has the right to freedom of thought and expression. This right includes freedom to seek, receive, and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing, in print, in the form of art, or through any other medium of one's choice.		
Right to safe and healthy working conditions	**XIV.** Every person has the right to work, under proper conditions, and to follow his vocation freely, insofar as existing conditions of employment permit.		**7. Just, Equitable, and Satisfactory Conditions of Work** The States Parties to this Protocol recognize that the right to work to which the foregoing refers presupposes that everyone shall enjoy that right under just, equitable, and satisfactory conditions, which the States Parties undertake to guarantee in their internal legislation, particularly with respect to: **e. Safety and hygiene at work;**	

Inter-American human rights legal instruments relevant to secondhand smoke exposure

Right / Provision	Legal Instrument			
	American Declaration of the Rights and Duties of Man	American Convention on Human Rights (Pact of San José)	Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (Protocol of San Salvador)	Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women (Convention of Belem do Para)
Right to a healthy environment			**11. Right to a Healthy Environment** 1. Everyone shall have the right to live in a healthy environment and to have access to basic public services. 2. The States Parties shall promote the protection, preservation, and improvement of the environment.	
Rights of persons with disabilities			**18. Protection of the Handicapped** Everyone affected by a diminution of his physical or mental capacities is entitled to receive special attention designed to help him achieve the greatest possible development of his personality. The States Parties agree to adopt such measures as may be necessary for this purpose and, especially, to: a. Undertake programs specifically aimed at providing the handicapped with the resources and environment needed for attaining this goal, including work programs consistent with their possibilities and freely accepted by them or their legal representatives, as the case may be; c. Include the consideration of solutions to specific requirements arising from needs of this group as a priority component of their urban development plans;	
Right to humane treatment		**5. Right to Humane Treatment** 2. No one shall be subjected to torture or to cruel, inhuman, or degrading punishment or treatment. All persons deprived of their liberty shall be treated with respect for the inherent dignity of the human person.		
Right to wholesome recreation / culture	**XV.** Every person has the right to leisure time, to wholesome recreation, and to the opportunity for advantageous use of his free time to his spiritual, cultural and physical benefit.		**14. Right to the Benefits of Culture** 1. The States Parties to this Protocol recognize the right of everyone: a. To take part in the cultural and artistic life of the community;	

Inter-American human rights legal instruments relevant to secondhand smoke exposure

Right / Provision	Legal Instrument			
	American Declaration of the Rights and Duties of Man	American Convention on Human Rights (Pact of San José)	Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (Protocol of San Salvador)	Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women (Convention of Belem do Para)
Obligation to enact legislation		**2. Domestic Legal Effects** Where the exercise of any of the rights or freedoms referred to in 1 is not already ensured by legislative or other provisions, the States Parties undertake to adopt, in accordance with their constitutional processes and the provisions of this Convention, such legislative or other measures as may be necessary to give effect to those rights or freedoms.	**1. Obligation to Adopt Measures** The States Parties to this Additional Protocol to the American Convention on Human Rights undertake to adopt the necessary measures, both domestically and through international cooperation, especially economic and technical, to the extent allowed by their available resources, and taking into account their degree of development, for the purpose of achieving progressively and pursuant to their internal legislations, the full observance of the rights recognized in this Protocol. **2. Obligation to Enact Domestic Legislation** If the exercise of the rights set forth in this Protocol is not already guaranteed by legislative or other provisions, the States Parties undertake to adopt, in accordance with their constitutional processes and the provisions of this Protocol, such legislative or other measures as may be necessary for making those rights a reality.	**7.** The States Parties condemn all forms of violence against women and agree to pursue, by all appropriate means and without delay, policies to prevent, punish and eradicate such violence and undertake to: h. adopt such legislative or other measures as may be necessary to give effect to this Convention.

Parties to Inter-American Treaties

American Declaration of the Rights and Duties of Man: not subject to ratification

American Convention on Human Rights (Pact of San José): Argentina, Barbados, Bolivia, Brazil, Chile, Colombia, Costa Rica, Dominica, Ecuador, El Salvador, Grenada, Guatemala, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Dominican Republic, Suriname, Trinidad and Tobago, Uruguay, Venezuela

Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (Protocol of San Salvador): Argentina, Brazil, Colombia, Costa Rica, Ecuador, El Salvador, Guatemala, Mexico, Panama, Paraguay, Peru, Suriname, Uruguay

Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women (Convention of Belem do Para): Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Bolivia, Brazil, Chile, Colombia, Costa Rica, Dominica, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines, Suriname, Trinidad and Tobago, Uruguay, Venezuela