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HUMAN RIGHTS QUARTERLY

The Human Rights of Children in Tobacco Control

Marie Elske C. Gispen & Brigit C.A. Toebes

ABSTRACT

Research demonstrates that tobacco morbidity and mortality disproportionately affects children, especially those living in low socioeconomic conditions. This article presents a systematic analysis of how international and regional human rights regimes may contribute to protecting and promoting specific aspects of child health and development in tobacco control enforcement. It reveals the blind spots and opportunities for a child-development specific rights-based approach to tobacco control. The article then demonstrates both the power and limitations of using international and regional human rights systems in countering the negative effects of tobacco.

I. INTRODUCTION

According to the World Health Organization (WHO), tobacco is one of the largest preventable causes of death, disease, and impoverishment and is

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amongst four behavioral risk factors linked to noncommunicable diseases (NCDs) such as cancer.[1] According to WHO estimates, approximately seven million people die each year from tobacco-related diseases: six million die due to tobacco consumption and 890,000 non-smokers die due to exposure to secondhand smoke (SHS).[2] Public health research demonstrates that tobacco use and exposure to SHS lead to increased risks of, among others, cancers, respiratory and cardiovascular diseases, impaired reproductive health, obstetric complications, and sudden death of, and low birth weight in, infants.[3] Moreover, frequent unprotected handling of tobacco leaves in tobacco farming may lead to nicotine poisoning.[4] In addition, poisoning from e-liquids used in electronic cigarettes may occur in cases where children inadvertently drink e-liquids or spill it onto their skin.[5]

Tobacco morbidity and mortality amount to epidemic proportions and often originate in childhood. Studies show that, in particular, those of low socioeconomic status (SES),[6] racial or ethnic minorities,[7] and children living in developing countries[8] are especially predisposed to the negative health and developmental consequences of the entire tobacco supply chain. In addition, research reveals that a wide-range of adverse tobacco-related and long-term health outcomes take root during prenatal and postnatal periods,[9] most adult smokers started smoking before the age of eighteen,[10] the tobacco

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1. *Tobacco Factsheet*, World Health Org. (9 Mar. 2018), http://www.who.int/mediacentre/factsheets/fs339/en/ [hereinafter *WHO Tobacco Factsheet*]; GBD 2015 Tobacco Collaborators, *Smoking Prevalence and Attributable Disease Burden in 195 Countries and Territories, 1990–2015: A Systematic Analysis from the Global Burden of Disease Study 2015*, 389 Lancet 1885, 1885 (2017).
2. *WHO Tobacco Factsheet*, *supra* note 1.
3. *Id.*; Luv D. Makadia et al., *Tobacco Use and Smoke Exposure in Children: New Trends, Harm, and Strategies to Improve Health Outcomes*, 17 Current Allergy & Asthma Rep. 1, 1 (2017); U.S. Dep't of Health & Human Serv., The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General 28 (2014) [hereinafter Surgeon General Report 2014]; W. Hofhuis et al., *Adverse Health Effects of Prenatal and Postnatal Tobacco Smoke Exposure on Children*, 88 Archives Disease in Childhood 1086, 1086 (2003).
4. *WHO Tobacco Factsheet*, *supra* note 1; Makadia et al., *supra* note 3, at 2.
5. On electronic cigarettes and human rights, see Marie Elske C. Gispen & Jacquelyn V. Veraldi, *A Human Rights Approach to the Regulation of Electronic Cigarettes*, *in* Regulation of Electronic Nicotine Delivery Systems (E-Cigarettes): National and International Legal Challenges (Lukasz Gruszczyńszki ed., forthcoming 2019); Makadia et al., *supra* note 3, at 2.
6. *See generally* Joanne S. Harrell et al., *Smoking Initiation in Youth: The Roles of Gender, Race, Socioeconomics, and Developmental Status,* 23 J. Adolescent Health 271 (1998); Johan P. Mackenbach et al., *Socioeconomic Inequalities in Health in 22 European Countries*, 358 New Eng. J. Med. 2468 (2008).
7. Harrell et al., *supra* note 6, at 271.
8. Harry A. Lando et al., *Tobacco is a Global Paediatric Concern*, 88 Bull. World Health Org. 1, 1 (2010).
9. Hofhuis et al., *supra* note 3, at 1086.
10. U.S. Dep't of Health & Human Serv., Preventing Tobacco Use Among Youth and Young Adults: A Report of the Surgeon General 8 (2012).

industry specifically targets children,[11] a smoking family member increases the chances of an adolescent starting to smoke,[12] and children are often exploited in tobacco farming.[13]

Children's vulnerability to tobacco-related harm is problematic because of its transgenerational component and because a state of good health and conditions for healthy development of children are cumulative by nature. Child-specific tobacco control is therefore not just a matter of public health, but also of sustainable development.[14] The starting point of this article is that human rights law and children's rights in particular can be a valuable mechanism to protect children against tobacco-related harm at different stages of childhood. Indeed, the Committee on the Rights of the Child (CRC Committee), which oversees the implementation of the 1989 Convention on the Rights of the Child (CRC), underscores that "[u]nderstanding the life course [of children] is essential in order to appreciate how health problems in childhood affect public health in general."[15] Moreover, in its penultimate general comment on the implementation of children's rights during adolescence, the CRC Committee emphasizes, for instance, that adolescents' potential "is widely compromised because States parties do not recognize or invest in the measures needed for them to enjoy their rights."[16] Hence,

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11. Surgeon General Report 2014, *supra* note 3, at 827; Jeffrey Drope et al., The Tobacco Atlas 18 (Jeffrey Drope & Neil W. Schluger eds., 6th ed. 2018). For additional quotes by the tobacco industry, see *Tobacco Company Marketing to Kids*, Campaign for Tobacco Free Kids (14 May 2001), https://www.tobaccofreekids.org/research/factsheets/pdf/0114.pdf.
12. Jo Leonardi-Bee et al., *Exposure to Parental and Sibling Smoking and the Risk of Smoking Uptake in Childhood and Adolescence: A Systematic Review and Meta-Analysis*, 66 Thorax 847, 847 (2011).
13. The negative health and developmental consequences of child labor and exploitation in tobacco farming usually receives less attention than the negative consequences of smoking and exposure to SHS. *See* Human Rights Watch, "The Harvest is in My Blood": Hazardous Child Labor in Tobacco Farming in Indonesia 6 (2016); Thomas E. Novotny et al., *The Environmental and Health Impacts of Tobacco Agriculture, Cigarette Manufacture and Consumption,* 93 Bull. World Health Org. 877, 877 (2015); Lando et al., *supra* note 8, at 1. *See also*, *Eliminating Child Labour in Tobacco Growing Foundation,* ECLT Found., https://www.eclt.org/en/about-child-labour.
14. The need to improve early child development also features in the Sustainable Development Goals. *See generally* Selina Lo et al., *A Good Start in Life Will Ensure a Sustainable Future for All,* 389 Lancet 8 (2017); Bernadette Daelmans et al., *Early Childhood Development: The Foundation of Sustainable Development,* 389 Lancet 9 (2017); Transforming Our World: The 2030 Agenda for Sustainable Development, *adopted* 25 Sept. 2015, G.A. Res. 70/1, U.N. GAOR, 70th Sess., U.N. Doc. A/Res/70/1 (*entered into force* 21 Oct. 2015).
15. General Comment No. 15, *On the Right of the Child to the Enjoyment of the Highest Attainable Standard of Health*, *adopted* 17 Apr. 2013, U.N. GAOR, Comm. on the Rts. of the Child, 62d Sess., ¶ 20, U.N. Doc. CRC/C/GC/15 (2013) [hereinafter GC 15 CRC].
16. General Comment No. 20, *On the Implementation of the Rights of the Child During Adolescence*, *adopted* 6 Dec. 2016, U.N. GAOR, Comm. on the Rts. of the Child, ¶ 3, U.N. Doc. CRC/C/GC/20 (2016) [hereinafter GC 20 CRC].

child health policies without taking into account the different unique stages of child development have profound implications for child health and development and society.[17]

While general work on tobacco control and human rights has addressed children's rights, a comprehensive analysis on children's rights specifically is lacking.[18] This article aims to fill this gap by presenting a systematic analysis of the question: what is the nature and scope of a government's obligations in international and regional human rights regimes to protect and promote specific aspects of child health and development at different stages of childhood in relation to tobacco control enforcement? As such, this article presents an in-depth follow-up to parts of the discussion in Carolyn Dresler and Stephen Marks' article "The Emerging Human Right to Tobacco Control," published in this journal in 2006.[19]

The article proceeds in three stages. First, it elaborates three umbrella concepts in light of the cumulative nature of child health and development: health capability as an ethical foundation of the right to health, the notion of evolving capacities, and the best interests of children as central principles of children's rights. The article subsequently presents a comprehensive analysis of the relevant international and regional human rights norms applicable to specific areas of tobacco-related harm at different stages of child development.[20] The article concludes by discussing the blind spots and opportunities of a child-rights approach to tobacco control at different stages of childhood.

This article presents a legal analysis. The methods used include literature and document analysis in the form of treaty interpretation. At the international level, a list of search terms were identified and applied to all (relevant) general comments, biennial documents, and concluding observations produced by

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17. *Id.*
18. Brigit Toebes et al., *A Missing Voice: The Human Rights of Children to a Tobacco-Free Environment,* 27 Tobacco Control 3, 3 (2018). For a general analysis into human rights aspects of tobacco control, see Carolyn Dresler & Stephen Marks, *The Emerging Human Right to Tobacco Control*, 28 Hum. Rts. Q. 599 (2006).
19. Dresler & Marks, *supra* note 18. While this article provides an update of the case law since 2006, the focus is more narrowly on the protection of the human rights of children in the context of tobacco.
20. For reasons of scope and limitation, the article focuses primarily on international human rights law as complemented by regional human rights regimes. For a comprehensive overview of human rights and tobacco control across regional human rights regimes, see Human Rights and Tobacco Control (Marie Elske C. Gispen & Brigit C.A. Toebes eds., forthcoming 2019) (manuscript on file with authors). Moreover, as a point of demarcation, in addition to the best interest of the child, the article focuses specifically on the right to health, the right to life, survival, and development, the right to information, and the right against exploitation. This article does not analyze other relevant rights in detail such as the right to education, but only references it in relation to specific relevant examples. See for instance Section IV. B on exploitation in tobacco farming.

the CRC Committee and all state reports submitted to the same body.[21] In addition, General Comment 14 of the CESCR Committee was scrutinized using the same systematic search strategy.[22] At the regional level, a systematic search was carried out in the work of the European Court of Human Rights (ECtHR) and the Committee on Economic and Social Rights of the Council of Europe, the Inter-American Court of and Commission on Human Rights, and the African Court of and Commission on Human and Peoples' Rights.[23] The findings were organized and analyzed with reference to the standard rules of treaty interpretation. These rules are codified in Articles 31 and 32 of the Vienna Convention on the Law of Treaties and are considered customary international law.[24] Throughout the analysis, the article adopts an inclusive approach by addressing all stages of development up to the common legal age of adulthood (eighteen years) and speaks to all facets of the tobacco supply chain that affect children: tobacco farming, consumption of tobacco products, and exposure to SHS.[25]

II. HEALTH CAPABILITY, EVOLVING CAPACITIES, AND THE BEST INTERESTS OF CHILDREN

As mentioned, this article uses three central ethical and legal concepts as umbrella principles to understand child health and development in light of

21. The search terms used for the general comments, concluding observations and biennial documents 1 through 31 and 52 through 59 were *tobacco, *smoking, *harmful/harmful substance, *well-being, *development, *life/lifestyle, *early/early childhood, *cumulative (health), *vulnerability, *standard of living, *neglect, *prevention, *intervention, *future prospects, *business, and *exploitation. A smaller list of search terms was used to search all state reports and biennial documents 32 through 51. This smaller list of terms includes *tobacco, *smoke/smoking, *harmful/harmful substance(s), *business, and *economic exploitation. All terms were searched independently by using the Ctrl-F function.
22. General Comment 14 of the CESCR Committee has been included in the systematic analysis because this is the most authoritative interpretation of the normative scope and content of the right to health. No other work of human rights bodies has been systematically searched, yet via snowball search techniques, other documents have been included. *See* General Comment No. 14, *The Right to the Highest Attainable Standard of Health, adopted* 11 May 2000, U.N. ESCOR, Comm. on Econ., Soc. & Cult. Rts., 22d Sess., U.N. Doc. E/C.12/2000/4 (2000) [hereinafter GC 14 CESCR].
23. Non-binding regional human rights instruments such as the ASEAN Human Rights Declaration and Universal Islamic Declaration of Human Rights have not been included in the analysis. The search terms used at the regional level included *tobacco and *smoke/smoking.
24. Vienna Convention on the Law of Treaties, U.N. Doc. A/CONF.39/27 (1969), 1155 U.N.T.S. 331 (*entered into force* 27 Jan. 1980), *reprinted in* 8 I.L.M. 679 (1969) [hereinafter VCLT]. For an example of the customary international law status of the VCLT rules of treaty interpretation, see Arbitral Award of 31 July 1989 (Guinea-Bissau v. Sen.), 1991 I.C.J. 53 (12 Nov.).
25. Exposure to SHS may take the form of "side-stream" or "mainstream" smoke; while the former refers to smoke emitted by burning, for instance, a cigarette itself, the latter is the smoke exhaled by the individual smoking. *See* Makadia et al., *supra* note 3, at 3.

the health and development rights of children. First, health capability is a theoretical concept used to justify the right to health of individuals, including both access to care and the underlying determinants of health. Health capability is often understood as comprising health agency and health functioning, and is therefore both process and outcome-oriented.[26] As Jennifer Ruger holds, individuals have the "ability to achieve [the] health goals they value and act as agents of their own health."[27] In the literature, there is much debate about children's agency, especially within the broader scope of capability and agency theories.[28] For various reasons, however, children are increasingly included in the capability concept, going beyond viewing them as mere recipients of care to viewing them as agents with their own set of capacities related to their development, and hence naturally also to their health.[29]

Genetics not only determine health, but also build on health at birth and foundations laid during childhood. It depends on the social determinants of health and epigenetics.[30] Researchers hold that structural inequalities in maternal disadvantages during pregnancy, and the interaction of biological factors, the environment, sociopolitical structures, and SES in particular, largely influence health at birth and long-term outcomes including health, education, and income.[31] Human rights law supports capability theories

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26. *See generally* Jennifer Prah Ruger, *Health Capability: Conceptualization and Operationalization*, 100 Am. J. Pub. Health 41 (2010); Sridhar Venkatapuram, Health Justice: An Argument from the Capabilities Approach (2011).
27. Ruger, *supra* note 26, at 42.
28. *See, e.g.*, Noam Peleg, *Reconceptualising the Child's Right to Development: Children and the Capability Approach*, 21 Int'l J. Child. Rts. 523 (2013); Rosalind Dixon & Martha C. Nussbaum, *Children's Rights and a Capabilities Approach: The Question of Special Priority*, 97 Cornell L. Rev 549 (2012); Deryck Beyleveld, The Dialectical Necessity of Morality: An Analysis and Defense of Alan Gewirth's Argument to the Principle of Generic Consistency (1991); Deryck Beyleveld & Roger Brownsword, Human Dignity in Bioethics and Biolaw (2001); Allison James, *Agency*, *in* The Palgrave Handbook of Childhood Studies 34 (Jens Qvortrup et al. eds., 2009).
29. Peleg, *supra* note 28, at 537; Hinke Haisma et al., *Towards a Capability Approach to Child Growth: A Theoretical Framework*, 14 Maternal & Child Nutrition 1, 1 (2018).
30. *See generally* Peter D. Gluckman et al., *Effect of In Utero and Early-Life Conditions on Adult Health and Disease,* 359 New Eng. J. Med. 61 (2008); Brigit Toebes & Karien Stronks, *Closing the Gap: A Human Rights Approach to the Social Determinants of Health,* 23 Eur. J. Health. L. 510 (2016).
31. *See generally* Anna Aizer & Janet Currie, *The Intergenerational Transmission of Inequality: Maternal Disadvantage and Health at Birth,* 344 Sci. 856 (2014); Shirley A. Russ et al., *A Lifecourse Approach to Health Development: Implications for the Maternal and Child Health Research Agenda,* 18 Maternal & Child Health J. 497 (2014); Robert H. Bradley & Robert F. Corwyn, *Socioeconomic Status and Child Development,* 53 Ann. Rev. Psychol. 371 (2002); Laurie J. Bauman et al., *Cumulative Social Disadvantage and Child Health,* 117 Pediatrics 1321 (2006); Nancy E. Adler et al., *Socioeconomic Status and Health: The Challenge of the Gradient,* 49 Am. Psychol. 15 (1994) (Adler and others demonstrate that there is a gradient link between health and SES in adults, which means that low-SES is associated with poor health outcomes and better health outcomes are gradually observed with improved SES. Their work has been used as a baseline for child-specific analysis in this context). *See also*, Venkatapuram, *supra* note 26.

of health and development and may be a valuable mechanism to require states to create such enabling environments. Noam Peleg argues that the capability approach could use a normative framework to reconceptualize children's right to development, "promot[ing] respect for a child's agency and active participation in her own growth."[32] Thus, using capability theory and health capability as normative starting points requires acknowledging that the ability of children to obtain and maintain a state of good health goes beyond merely viewing children as passive subjects of protection. Rather, it is important to view them as rights-holders, to create enabling environments to support their health and well-being at different stages of childhood, and to take into account that tobacco affects their health, well-being, and development at different stages and in different ways.[33]

Second, children's evolving capacities influence the creation of enabling environments for children. Respecting the evolving capacities of children is a central feature of the CRC framework and requires striking a balance, in a given case, between protection and empowerment of children.[34] The gradual scale of evolving capacities aligns with a child's development and results in justifying both protective and empowering approaches to child rights protection based on the CRC. This implies that tobacco control for children could be protective for young children and empower adolescents at the same time. Simultaneously, it may also have a protective function in specific vulnerable settings. As the CRC Committee states, "[c]hildren at risk because of their family and social environments require special attention in order to enhance their coping and life skills and promote protective and supportive environments."[35]

Third, the best interests of the child principle, as included in Article 3(1) CRC, is an important legal mechanism that systematically protects the particular needs and desires of children of all ages in public law and policy-making, as well as in relation to tobacco control.[36] Article 3 CRC thus plays an important role in shaping what exactly governments must do to protect and promote enabling environments for children.

On the basis of Article 3 CRC, states must take all appropriate legal, and other, measures to ensure that "[i]n all actions concerning children, whether undertaken by public or private social welfare institutions, courts

32. Peleg, *supra* note 28, at 523.
33. *Id.* at 537.
34. For more information on evolving capacities, see Gerison Lansdown, The Evolving Capacities of the Child (2005).
35. GC 15 CRC, *supra* note 15, ¶ 39.
36. The latter technically falls within the remit of the Convention on the Rights of the Child, *adopted* 20 Nov. 1989, G.A. Res. 44/25, U.N. GAOR, 44th Sess., art. 3(1), U.N. Doc. A/44/49 (1989), 1577 U.N.T.S. 3 (*entered into force* 2 Sept. 1990) [hereinafter CRC]. However, Article 12 is commonly used to support Article 3(1). *Id.* art. 12.

of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration."[37] Article 24 of the Charter of Fundamental Rights of the European Union reaffirms this approach.[38] Article 17 of the American Convention on Human Rights (ACHR), which deals with the best interests of children in family law specifically, marginally references the best interests of the child norm.[39]

The protection of the best interests of the child is one of the four general principles of the CRC—together with Article 2 (non-discrimination), Article 6 (life, survival and development), and Article 12 (expression of views).[40] According to the CRC Committee, the best interests norm is a threefold concept: it is a substantive right, fundamental interpretative principle, and rule of procedure.[41] In these capacities, the norm aims at supporting the enjoyment of the rights included in the CRC and at promoting the "holistic development of the child."[42] Such holistic development fits squarely into the concept of health capability and the necessary creation of enabling environments respecting the evolving capacities of children. Most jurisprudence and analytic debates on the notion, however, have thus far focused primarily on its role and function in general and in family law related matters. Its broader implications for public health law and policy, including in the area of tobacco control, are largely unexplored.[43]

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37. *Id.* art. 3(1–(2).
38. Charter of Fundamental Rights of the European Union, *adopted* 1 Dec. 2009, art. 24, E.U. Doc. 2000/C364/01.
39. American Convention on Human Rights, *signed* 22 Nov. 1969, art. 17, O.A.S. Doc. OEA/Ser.L/V/II.23, doc. 21, rev. 6 (1979), O.A.S.T.S. No. 36, 1144 U.N.T.S. 143 (*entered into force* 18 July 1978) [hereinafter ACHR].
40. General Comment No. 5, *General Measures of Implementation of the Convention on the Rights of the Child (arts. 4, 42 and 44, para. 6)*, *adopted* 27 Nov. 2003, U.N. GAOR, Comm. on the Rts. of the Child, 34th Sess., ¶ 12, U.N. Doc. CRC/GC/2003/5 (2003) [hereinafter GC 5 CRC].
41. General Comment No. 14, *On the Rights of the Child to Have His or Her Best Interests Taken as a Primary Consideration (art. 3, para. 1)*, *adopted* 29 May 2013, U.N. GAOR, Comm. on the Rts. of the Child, ¶ 6, U.N. Doc. CRC/C/GC/14 (2013) [hereinafter GC 14 CRC].
42. *Id.* ¶ 4.
43. *See* John Eekelaar, *The Role of the Best Interests Principle in Decisions Affecting Children and Decisions About Children,* 23 Int'l J. Child. Rts. 3, 4 (2015). The CRC Committee does refer to the importance of the best interest norm for law and policymaking, stating that the best interests norm is, alongside a substantive right and fundamental interpretive legal principle, a rule of procedure which as such holds clear potential for law and policy-making. It also stresses that Child Rights Impact Assessments are important to take into account the impact law and policy may have on children. *See* GC 14 CRC, *supra* note 41, ¶ ¶ 6, 35. The best interests norm, however, is also criticized for hampering instead of fostering child rights protection. *See, e.g.*, Nigel Cantwell, *Are "Best Interests" a Pillar or a Problem for Implementing the Human Rights of Children?*, *in* The United Nations Convention on the Rights of the Child: Taking Stock After 25 Years and Looking Ahead 61 (Ton Liefaard & Julia Sloth-Nielsen eds., 2016).

III. THE UNBORN CHILD

There is ample research showing that maternal smoking during pregnancy (MSP) leads to different adverse health outcomes in children. Analyzing the use of human rights law to protect children at different stages of childhood against tobacco-related harm thus naturally starts with the unborn child. This section analyzes the legal position of unborn children and the level of protection they should receive under human rights law. While not denying the rights of the mother, this section primarily focuses on the status of unborn children and their level of protection under human rights law as relevant to tobacco control measures. For reasons of scope and focus, the article does not systematically balance the level of protection for the unborn with the human rights of the mother.

Studies demonstrate that MSP leads to a range of obstetric complications.[44] The specific risks associated with both MSP and in-utero exposure to SHS include prenatal reduced lung growth and impaired lung function, low birth weight, preterm birth, still birth, neonatal and infant mortality, and congenital anomalies.[45] Medical research suggests that postnatal tobacco-related harm mostly leads to acute health concerns in children, while prenatal tobacco-related harm caused by, for instance, MSP leads to lifelong health and developmental problems.[46] The cumulative and transgenerational nature of ill health related to tobacco is thus evident. For instance, MSP leads to increased risks of asthma and wheezing in adolescents.[47] Daughters of mothers who smoked during pregnancy are subsequently more likely to

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44. Hofhuis et al., *supra* note 3, at 1086.
45. On reduced lung growth and impaired lung function, see generally James. P. Hanrahan et al., *The Effect of Maternal Smoking During Pregnancy on Early Infant Lung Function*, 145 Am. Rev. Respiratory Disease 1129 (1992); E.A. Mitchell & J. Milerad, *Smoking and Sudden Infant Death Syndrome,* 21 Rev. Envtl. Health 81 (2006). On low birth weight and preterm birth, see generally Ting-Jung Ko et al., *Parental Smoking During Pregnancy and Its Association with Low Birth Weight, Small for Gestational Age, and Preterm Birth Offspring: A Birth Cohort Study*, 55 Pediatrics & Neonatology 20 (2014); Arpana Agrawal et al., *The Effects of Maternal Smoking During Pregnancy on Offspring Outcomes*, 50 Preventive Med. 13 (2010). On still birth, see generally Takawira C. Marufu et al., *Maternal Smoking and the Risk of Still Birth: Systematic Review and Meta-Analysis*, 15 BMC Pub. Health 239 (2015); Beth L. Pineles et al., *Systematic Review and Meta-Analysis of Perinatal Death and Maternal Exposure to Tobacco Smoke During Pregnancy*, 184 Am. J. Epidemiology 87 (2016). On congenital anomalies, see generally Richard L. Naeye, *Relationship of Cigarette Smoking to Congenital Anomalies and Perinatal Death: A Prospective Study*, 90 Am. J. Pathology 289 (1978). *See also* Hofhuis et al., *supra* note 3, at 1086; Jasper V. Been et al., *Effect of Smoke-Free Legislation on Perinatal and Child Health: A Systematic Review and Meta-Analysis*, 383 Lancet 1549, 1549 (2014).
46. Hofhuis et al., *supra* note 3, at 1089.
47. Elysia M. Hollams et al., *Persistent Effects of Maternal Smoking during Pregnancy on Lung Function and Asthma in Adolescents,* 189 Am. J. Respiratory Critical Care Med. 401, 402 (2014).

smoke during their own pregnancy and impose the same transgenerational effect on their offspring.[48] In general, public health research demonstrates that prenatal tobacco-related harm leads to a subordinate start to life.[49]

The particular vulnerability of unborn children stems from the fact that their organs, in particular their lungs, are under progressive development,[50] and that they fully depend on their mother while in-utero. Medical and public health data demonstrates that ensuring health capability for children necessarily implies creating conditions that prevent children's exposure to smoking and SHS during pregnancy. This raises the question: what would be the nature and scope of protecting the interests of unborn children under human rights law?

A. Legal Protection of Unborn Children

Children's rights, laid down mainly in the CRC, reflect a sub-catalogue of human rights applicable to those falling within the legal definition of a child. Based on Article 1 CRC, "a child means every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier."[51] Article 2 of the African Charter on the Rights and Welfare of the Child (ACRWC) enshrines a similar definition.[52] Article 19 of the ACHR and Article 24 of the Charter of Fundamental Rights of the European Union reaffirm children's rights, but do not include a legal definition.[53] The mandate of the recently established Rapporteur on the Rights of the Child of the Organization of American States (OAS) reiterates the legal scope and definition of the child as laid down in the CRC.[54] While both the CRC and the ACRWC define a clear maximum age limit to determine the scope to which the treaties apply, these instruments do not set a minimum age for children. As such, it is unclear whether based on international and regional

48. Collette N. Ncube & Beth A. Mueller, *Daughters of Mothers who Smoke: A Population-Based Cohort Study of Maternal Prenatal Tobacco Use and Subsequent Prenatal Smoking in Offspring*, 31 Paediatric & Perinatal Epidemiology 14, 14 (2017).
49. G. Banderali et al., *Short and Long Term Health Effects of Parental Tobacco Smoking During Pregnancy and Lactation: A Descriptive Review*, 13 J. Translational Med. 327, 328 (2015); Allan Hackshaw et al., *Maternal Smoking in Pregnancy and Birth Defects: A Systematic Review based on 173 687 Malformed Cases and 11.7 Million Controls*, 17 Hum. Reprod. Update 589, 590 (2011).
50. Been et al., *supra* note 45, at 1549.
51. CRC, *supra* note 36, art. 1.
52. African Charter on the Rights and Welfare of the Child, *adopted* 11 July 1990, art. 2, O.A.U. Doc. CAB/LEG/24.9/49 (*entered into force* 29 Nov. 1999).
53. ACHR, *supra* note 39, art. 19; Charter of Fundamental Rights of the European Union, *supra* note 38, art. 24.
54. *Inter-Am. Comm'n. on Hum. Rts., The Rights of the Child in the Inter-American Human Rights System*, Inter-Am. C.H.R., O.A.S. Doc. OEA/Ser.L/V/II.133, doc. 34 (2008).

human rights law states are obligated to protect unborn children from adverse health and developmental outcomes rooted in prenatal tobacco exposure.

By virtue of Article 1 of the Universal Declaration of Human Rights (UDHR), "[a]ll human beings are born free and equal in dignity and rights."[55] The United Nations General Assembly (UNGA) adopted the Declaration of the Rights of the Child (DRC) in 1959 with the clear purpose to ensure that all children "shall enjoy all the rights set forth in [the UDHR]."[56] The UNGA explicitly acknowledges the importance of prenatal protection, stating in its preamble "the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth."[57] The DRC formed the basis of the CRC. The importance of prenatal protection, however, did not result in a legally binding text.

Nevertheless, the preamble of the CRC confirms the importance of prenatal protection, using the exact same wording as the DRC. The unborn child is certainly part of the realm of human rights; however, the drafters of the CRC could evidently not agree on the level of legal protection unborn children should receive.[58]

The drafters specifically asked to include in the *travaux préparatoires* of the CRC that by highlighting the importance of protecting the unborn child in the CRC's preamble, they did not "intend to prejudice the interpretation of article 1 or any other provision of the [CRC]."[59] In sum, international human rights law demonstrates that unborn children fall within the scope of human rights law but do not receive *lex lata* legal protection.[60] This leads to a fundamental gap in applying children's rights to the case of tobacco-related harm. As mentioned above, public health data shows that prenatal exposure to tobacco smoke and MSP results in one of the most pressing adverse transgenerational and cumulative health and developmental outcomes in later life.

This gap does not entirely exculpate governments from protecting unborn children. Indeed, although unborn children seem excluded from the legal

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55. Universal Declaration of Human Rights, *adopted* 10 Dec. 1948, G.A. Res. 217A (III), U.N. GAOR, 3d Sess., art. 1, U.N. Doc. A/RES/3/217A (1948).
56. *Declaration of the Rights of the Child*, G.A. Res. 14/1386, U.N. GAOR, 14th Sess., Agenda Item 64, Principal 1 (1959).
57. *Id.* pmbl.
58. *See generally* Rita Joseph, Human Rights and the Unborn Child (2009).
59. *Report of the Working Group on a Draft Convention on the Rights of the Child*, U.N. ESCOR, 45th Sess., Agenda Item 13, ¶ 43, U.N. Doc. E/CN.4/1989/48 (1989). *See also* Joseph, *supra* note 58, at 124.
60. The level of protection found at the domestic level amongst CRC States parties may be different. The Syrian government, for instance, extends the right to life, survival, and development to the embryonic stage and thus sets a clear prenatal minimum standard. *See Consideration of Reports Submitted by States Parties Under Article 44 of the Convention: Syrian Arab Republic*, U.N. GAOR, Comm. on the Rts. of the Child, ¶ 29, U.N. Doc. CRC/C/SYR/3–4/Add.1 (2010).

definition of a child within the CRC, this does not mean that they are *a priori* excluded from any protection. First, general rules of treaty interpretation dictate that states should interpret and give effect to the legal instruments that they are a party to in good faith and in light of the object and purpose of the instrument.[61] Since protection of the unborn child is part of the preamble of the CRC, states should, on principle and at a minimum, respect the interests of unborn children.[62]

Second, one can question the conceptualization of unborn children in the CRC in light of its own key principles. One of David Archard's philosophical conceptualizations of the unborn child focuses on the "future child whilst it is as yet unborn."[63] In this reading, the emphasis is not on questions of whether unborn children should receive legal protection and, if so, what the scope of this protection is, or should be. Instead, the focus is on the rights of children after birth and the derivation of prenatal conditions from the potential harm caused to the future child.[64]

Similar to the best interests norm of Article 3 CRC, the CRC Committee considers the right to life, survival, and development in Article 6 CRC as one of the Convention's four general principles.[65] In addition to Article 3 CRC, Article 6 CRC is also a cornerstone in ensuring health capability of children. Hence, excluding unborn children from the protection against tobacco-related harm seems contrary to the central principles of the CRC itself. The government of Colombia, for instance, holds that children deserve protection against, among others, "exposure during pregnancy to alcohol or any type of psychoactive substance that might affect their physical or mental development or their life expectancy."[66] Clearly, there is an argument for tobacco being a psychoactive substance. This clear extension of protection, raised by Colombia, should be understood in light of the Inter-American human rights system in which, by law, the legal protection of the right to life is extended to unborn children in general.

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61. VCLT, *supra* note 24, art. 31(1).
62. Joseph argues in this respect that unborn children should receive legal protection because the UDHR is considered customary international law and the drafters of both the UDHR and DRC clearly had the protection of unborn children in mind, showing how the later CRC is built on the UDHR and DRC respectively. Joseph, *supra* note 58, at 1, 3–4
63. David Archard, Children: Rights and Childhood 22 (3d ed. 2015).
64. *Id.* at 21–22.
65. GC 5 CRC, *supra* note 40, ¶ 12. The four general principles include non-discrimination, best interests of the child, the right to life, survival, and development, and the child's right to express his or her views freely. *Id.*
66. *Consideration of Reports Submitted by States Parties under Article 12, Paragraph 1, of the Optional Protocol to the Convention on the Rights of the Child on the Sale of Children, Child Prostitution and Child Pornography: Colombia*, U.N. GAOR, Comm. on the Rts. of the Child, ¶ 78, U.N. Doc. CRC/C/OPSC/COL/1 (2009).

Third, the current *lex lata* level of protection of unborn children typically derives from competing interests between the mother and the unborn child in abortion cases. However, protecting the (future) health of children by creating conditions to optimize health is typically not a matter of abortion. The CRC Committee also interprets the right to health of children (Article 24 CRC) to include preventive health care and controlling noncommunicable diseases by ensuring, among others, "healthy and non-violent lifestyles for pregnant women [and] their spouses/partners."[67] In other words, in light of the right to health, prenatal tobacco control interventions also appear to be important, and hence support the inclusion of the interests of unborn children in the legal realm of the CRC. As part of the effective realization of the right to health, the CRC Committee stresses the importance of Article 6 CRC:

> a number of determinants need to be considered for the realization of children's right to health, including individual factors such as age, sex, educational attainment, socioeconomic status and domicile . . . the violence that threatens the life and survival of children as part of their immediate environment; and structural determinants, including policies, administrative structures and systems, social and cultural values and norms. Among the key determinants of children's health, nutrition and development are the realization of the mother's right to health and the role of parents and other caregivers. A significant number of infant deaths occur during the neonatal period, related to the poor health of the mother prior to, and during, the pregnancy. . . . The health and health-related behaviours of parents and other significant adults have a major impact on children's health.[68]

It is imperative that the CRC Committee derives prenatal conditions from the potential harm caused to the future child. The CRC Committee's recommendations to state parties to "introduce and strengthen prenatal care for children" support this proposition as well.[69]

Some states parties explicitly follow this line of reasoning. In their state reporting submitted to the CRC Committee, the Canadian government refers to prenatal tobacco-related harm by referring to "children born of smoking mothers" when interpreting Article 6 CRC in relation to tobacco control.[70] The Federated States of Micronesia, in 1996, already explicitly referred to the impact tobacco use might have on unborn children in light of Article 6 as a general principle of the CRC.[71] In its 2017 report, Angola also emphasizes,

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67. GC 15 CRC, *supra* note 15, ¶ 62.
68. *Id.* ¶ ¶ 17–18.
69. General Comment No. 9, *The Rights of Children with Disabilities, adopted* 27 Feb. 2007, U.N. GAOR, Comm. on the Rts. of the Child, 43th Sess., ¶ 53, U.N. Doc. CRC/C/GC/9 (2007).
70. *Consideration of Reports Submitted by States Parties under Article 44 of the Convention: Canada*, U.N. GAOR, Comm. on the Rts. of the Child, ¶ 280, U.N. Doc. CRC/C/83/Add.6 (2003).
71. *Consideration of Reports Submitted by States Parties under Article 44 of the Convention: Federated States of Micronesia*, U.N. GAOR, Comm. on the Rts. of the Child, ¶ 162, U.N. Doc. CRC/C/28/Add.5 (1996).

drawing from Article 6 CRC, that "increas[ing] life expectancy at birth" is one of the core purposes of their efforts to promote healthy lifestyles and to "prevent and fight alcoholism, tobacco abuse, drugs and accidents."[72] The United Kingdom refers to taking steps to reduce MSP as among the most cost effective measures to reduce infant mortality, and thus clearly mentions the protection of unborn children in light of its efforts under Article 6 CRC.[73] Drawing on the earlier link with the right to health of children under Article 24 CRC, New Zealand also includes tobacco control to protect unborn children within the remit of the CRC and refers to "effective health promotion about baby-safe environments . . . particularly on . . . smoking during pregnancy."[74] Other examples of countries that explicitly connect tobacco control to prenatal and antenatal care or care for unborn children in consideration of Article 24 CRC include Belgium,[75] Mauritius,[76] and Luxembourg.[77]

The nature of these references evidence an emerging state practice, under the CRC, to take into account the interests of unborn children as to tobacco-control in order to protect the life expectancy and overall development of the future child. Yet, it would be overreaching to conclude that countries expanded the legal scope of the CRC to grant *lex lata* legal protection to unborn children. Moreover, in the absence of any relevant ruling on this matter, the scope of such protection remains unclear. Any conclusion as to the extent international human rights law protects children from prenatal tobacco-related harm thus largely remains a matter of guesswork.

At the regional level, Article 4 of the ACHR holds that the right to life "shall be protected by law and, in general, from the moment of conception."[78] The ACHR therefore includes unborn children in the legally binding realm of human rights. Judges of the Inter-American Court of Human Rights (IACtHR) have explicitly acknowledged prenatal harm in view of Article 4

72. *Consideration of Reports Submitted by States Parties under Article 44 of the Convention: Angola*, U.N. GAOR, Comm. on the Rts. of the Child, ¶ 102, U.N. Doc. CRC/C/AGO/5–7 (2017).
73. *Consideration of Reports Submitted by States Parties under Article 44 of the Convention: United Kingdom of Great Britain and Northern Ireland*, U.N. GAOR, Comm. on the Rts. of the Child, ¶ 160, U.N. Doc. CRC/C/GBR/4 (2008).
74. *Consideration of Reports Submitted by States Parties under Article 44 of the Convention: New Zealand*, U.N. GAOR, Comm. on the Rts. of the Child, ¶ 269, U.N. Doc. CRC/C/NZL3–4, (2010).
75. *Consideration of Reports Submitted by States Parties under Article 44 of the Convention: Belgium*, U.N. GAOR, Comm. on the Rts. of the Child, ¶ 540(a), U.N. Doc. CRC/C/83/Add.2 (2000).
76. *Consideration of Reports Submitted by States Parties under Article 44 of the Convention: Mauritius*, U.N. GAOR, Comm. on the Rts. of the Child, ¶ 367, U.N. Doc. CRC/C/65/Add.35 (2005).
77. *Consideration of Reports Submitted by States Parties under Article 44 of the Convention: Luxembourg*, U.N. GAOR, Comm. on the Rts. of the Child, ¶ 321, U.N. Doc. CRC/C/LUX/3–4 (2012).
78. ACHR, *supra* note 39, art. 4(1).

ACHR.[79] Despite this legally binding inclusion, unborn children do not receive absolute protection in general, or from prenatal tobacco harm specifically, under the ACHR. Moreover, in the *Murillo* case, the Inter-American Court recognizes that "the protection of the right to life . . . is not absolute, but rather gradual and incremental according to its development, since it is not an absolute and unconditional obligation, but entails understanding that exceptions to the general rule are admissible."[80] In other words, any level of protection depends on the development of the embryo and the interests of the mother as balanced against the health of the unborn child.

Unlike Article 4 ACHR, Article 2 of the European Convention on Human Rights (ECHR) is silent on the temporal limitations of the right to life.[81] Based on the case law of the ECtHR, the issue of when the right to life begins falls within the margin of appreciation of states parties.[82] Yet, the case law of the ECtHR establishes that Article 2 ECHR does not regard unborn children as persons, as a result of which unborn children lack direct protection under the ECHR[83] The ECtHR also states that if the unborn child does have a right to life, the mother's rights and interests implicitly limit this right.[84] Nonetheless, the Court has not ruled out the possibility that, in certain circumstances, safeguards may extend to the unborn child.[85] However, similar to the Inter-American human rights system, the scope of application of such relative protection remains unclear.

It appears that regional human rights bodies do generate a relative *lex lata* level of legal protection. However, in the absence of case law on the application of such relative protection regarding tobacco control, any conclusion on this protection in relation to tobacco would be speculative.

IV. NEWBORNS TO CHILDREN IN EARLY CHILDHOOD

As was illustrated above, prenatal tobacco-related harm, in particular, is at the root of adverse health outcomes in early childhood, adolescence, and adult life. In addition, postnatal tobacco-related harm also leads to increased health and developmental risks in children and may aggravate those risks already associated with prenatal harm.

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79. Álvaro Paúl, *Controversial Conceptions: The Unborn and the American Convention on Human Rights,* 9 Loy. U. Chi. Int'l L. Rev. 209, 211 (2012).
80. Artavia Murillo et al. ("In Vitro Fertilization") v. Costa Rica, Inter-Am. Ct. H.R., No. 85/10, ¶ 264 (28 Nov. 2012).
81. Vo v. France, App. No. 53924/00, 2004-VIII Eur. Ct. H.R., ¶ 75.
82. *Id.* ¶ 82.
83. *Id.* ¶ 61.
84. *Id.* ¶ 80.
85. *Id.* ¶ 61 (with reference to Bruggeman and Scheuten).

Postnatal tobacco-related harm is associated with a wide range of adverse health and developmental outcomes in newborns, infants, and children in early childhood. Risks associated to SHS include increased risks of asthma, respiratory infections, and other respiratory diseases.[86] While there is generally no safe level of exposure to SHS, the particular health risks in newborns and early childhood are different from the health risks for adults.[87] Exposure to SHS in childhood is associated with increased risks of developing NCDs such as lung cancer in later life, which again demonstrates the cumulative nature of (child) health and well-being.[88] Moreover, poor socioeconomic conditions increase the risk of exposure to SHS in (early) childhood.[89]

In addition to the particular risks of exposure to SHS in this phase of development, researchers hold that 82,000 to 99,000 children globally start smoking per day, of which a large group is said to be below the age of ten.[90] Reports also demonstrate that in Indonesia , for example, there is evidence of toddlers smoking heavily.[91] Moreover, young children are included in tobacco farming.[92] As early to late adolescence reflects the age group in which smoking and tobacco farming might be most acute, the particular problems and obligations of governments in this respect Section V discusses.

Newborns and infants are particularly vulnerable to tobacco-related harms for a myriad of reasons: their organs, specifically their lungs, are under progressive development,[93] they have higher breathing rates, which causes them to inhale more polluted air,[94] they cannot protect themselves, and they spend most of their time at home. The specific vulnerability of children in early childhood builds on the vulnerability of infants. Their respiratory system remains more vulnerable than that of older children and adults. And although they gradually experience more freedom than infants do, they are still highly dependent on their caretakers. Children in early childhood are generally not capable of protecting themselves nor do they have the cognitive capacity to comprehend the long-term consequences of tobacco-related harm. Given the potential cumulative negative health and developmental

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86. Dana Best et al., *Technical Report—Secondhand and Prenatal Tobacco Smoke Exposure*, 124 Pediatrics 1017, 1019 (2009).
87. Surgeon General Report 2014, *supra* note 3, at 5.
88. Been et al., *supra* note 45, at 1549.
89. Makadia et al., *supra* note 3, at 3.
90. Lando et al., *supra* note 8, at 1. *See generally* Joseph V. Schwab, *The Epidemiology and Health Effects of Tobacco Use*, 7 Current Pediatric Rev. 81 (2011).
91. Kate Hodal, *Indonesia's Smoking Epidemic—An Old Problem Getting Younger*, The Guardian (22 Mar. 2012), https://www.theguardian.com/world/2012/mar/22/indonesias-smoking-epidemic; Michael Eriksen et al., The Tobacco Atlas 80 (5th ed. 2015).
92. *Id.*
93. Been et al., *supra* note 45, at 1549.
94. Fiona C. Goldizen et al., *Respiratory Effects of Air Pollution on Children*, 51 Pediatric Pulmonology 94, 94 (2016); Sang-Hyun Hwang et al., *Environmental Tobacco Smoke and Children's Health,* 55 Korean J. of Pediatrics 35, 36 (2012).

impact of SHS exposure, the question is, what are the rights that obligate governments to protect children against SHS and to create conditions that enhance their health capability?

A. Exposure to SHS

Analysis of the human rights framework shows that states have human rights obligations to protect children against exposure to SHS. The CESCR Committee overseeing the implementation of the 1966 International Covenant on Economic, Social, and Cultural Rights (ICESCR) emphasizes the inclusive nature of the right to health in Article 12 ICESCR and underscores that the right to health "extends to the underlying determinants of health, such as . . . a healthy environment."[95] While generally states parties should protect any child against the negative health consequences associated with SHS, the work of treaty monitoring bodies demonstrates that they hold particular obligations towards young children.

The CESCR Committee interprets that Article 12(2) ICESCR "outlines the need to take measures to reduce infant mortality and promote the healthy development of infants and children."[96] Article 24 CRC also obligates governments to reduce infant and child mortality, as well as to ensure preventive care.[97] Moreover, on the basis of the right to life, survival, and development (Article 6 CRC) states have to both recognize the inherent right to life of children and undertake the commitment to "ensure to the maximum extent possible the survival and development of the child."[98] The CRC Committee interprets the scope of Article 6 in its General Comment 7 on children's rights in early childhood to include all aspects of development, while acknowledging that physical health is one of the key priorities.[99] The Committee stresses that preventable diseases remain an obstacle to realizing rights in early childhood.[100] While not mentioned explicitly by the CRC Committee in this context, tobacco-related harm and the related medical consequences clearly fall within the remit of preventable diseases. The CRC Committee urges states parties to "take all possible measures to improve perinatal care for mothers and babies . . . and create conditions that promote the well-being of all young children during this critical phase

95. GC 14 CESCR, *supra* note 22, ¶ 4.
96. *Id.* ¶ 22.
97. CRC, *supra* note 36, art. 24(1)(a), (d).
98. *Id.* art. 6.
99. General Comment No. 7, *Implementing Child Rights in Early Childhood*, U.N. GAOR, Comm. on the Rts. of the Child, 40th Sess., ¶ 10, U.N. Doc. CRC/C/GC/7/Rev.1 (2006).
100. *Id.*

of their lives."[101] Tobacco control measures aimed at protecting newborns against tobacco smoke exposure fit squarely into this obligation. In fact, the CRC Committee explicitly considers that states parties

> should take measures to address the dangers and risks that local environmental pollution poses to children's health in all settings. Adequate housing that includes . . . a smoke-free environment . . . are core requirements to a healthy upbringing and development.[102]

One could also understand this obligation in light of Article 27 CRC, which reflects the right of children to an adequate standard of living.[103] Although young children spend a lot of time at home and hence effective tobacco control measures would apply in such context, states parties generally do not refer to adopting tobacco control measures that apply to home settings in their reporting to the CRC. While governments hold obligations to protect children against SHS based on the CRC, the scope of this protection remains unclear. Nevertheless, the reference of the CRC Committee to in-house smoke-free environments is a clear indicator that governments should extend their tobacco control regulations to in-house settings, which goes beyond the public smoking ban included in Article 8 WHO Framework Convention on Tobacco Control (FCTC).[104]

While the CRC includes a clear framework for protecting children against SHS, the regional human rights monitoring bodies of the Council of Europe and the Inter-American Court of and Commission on Human Rights only address the issue to a limited extent.

In the past twenty years, the ECtHR and former Commission pay some attention to SHS in their case law. In 1998, the case of *Wöckel v. Germany*, before the former European Commission on Human Rights, dealt with the question of whether Germany is obliged, as claimed by the applicant, to enact legislation prohibiting smoking in public with the purpose to protect non-smokers.[105] In light of the "margin of appreciation" doctrine, the Commission held the applicant's right to life (Article 2 ECHR) and right to private and family life (Article 8 ECHR) unviolated. Balancing the competing interests between non-smokers and smokers, the Commission found that the absence of a general prohibition on tobacco advertising and on smoking did not amount to a violation of these rights.[106] Although the state was

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101. *Id.*
102. GC 15 CRC, *supra* note 15, ¶ 49.
103. CRC, *supra* note 36, art. 27.
104. WHO Framework Convention on Tobacco Control art. 8, *adopted* 21 May 2003, 42 I.L.M 518 (*entered into force* 27 Feb. 2005).
105. Wöckel v. Germany, App. No. 32165–96, 25 Eur. Comm'n on H.R. 156, at 8 (1998). *See also* Melissa E. Crow, *Smokescreens and State Responsibility: Using Human Rights Strategies to Promote Global Tobacco Control*, 29 Yale J. Int'l L. 209, 236 (2004).
106. Wöckel, 25 Eur. Comm'n on H.R. at 85.

left a considerable margin of appreciation, this decision recognized for the first time that Articles 2 and 8 ECHR hold positive obligations for states to protect non-smokers.[107]

There is also a range of ECtHR judgments dealing with SHS exposure during detention.[108] In several of these cases, the Court held that there was a violation of Article 3 ECHR (in particular the prohibition of inhuman and degrading treatment).[109] This body of case law provides a basis to argue that children in child-care institutions, hence falling under the immediate and exclusive responsibility of the government, require protection from SHS exposure.

In addition, and perhaps somewhat more remotely, the ECtHR's extensive body of case law on environmental health protection provides inspiration for addressing future SHS-related cases. Of particular relevance are cases concerning air pollution, given the parallels that exist between inhaling polluted air and exposure to SHS. This parallel is also visible in the CRC's approach on environmental health and adequate housing referring to smoke-free environments, as discussed above.[110]

In *Brincat and others v. Malta*, the Court held that the government should have been aware of the potential asbestos exposure to shipyard workers. It failed to satisfy its positive obligations under Articles 2 and 8 ECHR to legislate or take other practical measures to ensure that the applicants had adequate protection and information concerning the risks to their health and lives.[111] Hence similar to the above-mentioned SHS-cases, the ECtHR considered Articles 2 and 8 ECHR to include a positive obligation to ensure that individuals are not exposed to toxic air.

The other relevant body of the Council of Europe is the Committee on Economic and Social Rights (ECSR), the treaty body of the (Revised) European Social Charter (ESC). Several rights in the ESC are relevant to the protection of children against SHS, in particular Article 11 (right to protection of health) and Article 17 (right of children and young persons to social, medical, and legal assistance). Exposure to SHS has not been addressed within

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107. Crow, *supra* note 105, at 236.
108. *Inter alia*, Elefteriadis v. Romania, App. No. 38427/05, Eur. Ct. H.R (2011); Kalashnikov v. Russia, App. No. 47095/99, 2002-VI Eur. Ct. H.R. 99; Keenan v. the United Kingdom, App. No. 27229/95, 2001-III Eur. Ct. H.R. 95. Notably, the report of the Special Rapporteur on Prisons and Conditions of Detention in Africa refers to a smoking ban for juveniles in prisons, however, it also raises the concern that the authorities remain to smoke in front of them. *See* Special Rapporteur, *Prisons and Conditions of Detention in Africa*: *Mission to the Republic of South Africa*, African Comm'n Hum. & People's Rts. 45–46 (2004).
109. For example see Kalashnikov v. Russia, App. No. 47095/99, 2002-VI Eur. Ct. H.R. 93.
110. GC 15 CRC*, supra* note 15.
111. Brincat v. Malta, App. Nos. 60908/11, 62110/11, 62129/11, 62312/11 & 62338/11, 2014-V Eur. Ct. H.R ¶ ¶ 106, 116 (2014).

the framework of the collective complaint procedure.[112] Nonetheless, the ECSR pays ample attention to exposure to SHS within the framework of its state reporting procedure. For example, the ESCR suggests that the Greek Government may tackle its excessively high annual per capita cigarette consumption by "toughening the existing legislation (e.g. to prohibit the sale of tobacco to young people and ban smoking in public places, including on public transport, ban on billboard advertising and advertising in newspapers and magazines)."[113] The Committee's Conclusions in its state reporting procedure and the scope of the ESC provisions may serve as inspiration or a starting point for future cases.

Finally, the Inter-American Commission and Court have yet to address the exposure of children to SHS in their case law. In a recent hearing, the Inter-American Commission took up tobacco as a human rights issue, which may mark the start of further action in this field.[114]

B. Exploitation in Tobacco Farming

Aside from smoking and exposure to SHS, child labor exploitation in tobacco farming across the globe also exposes children in early childhood to tobacco-related harms. There is no conclusive global data on the amount of children exploited in tobacco farming, nor are there exact figures on the minimum age at which children work on tobacco plantations. However, while in many countries it is illegal for children below the age of eighteen to buy tobacco products, studies by Human Rights Watch reveal that children as young as seven have been exploited in the tobacco farming industry in the United States.[115]

Approximately 124 states engage in tobacco farming and children are often involved in informal agricultural industries leading to serious adverse health and developmental outcomes.[116] Children involved in tobacco farming typically suffer acute nicotine poisoning through unprotected handling of tobacco leaves. This may lead to feelings of drowsiness and headaches, as well as increasing children's risk of starting to smoke.[117] In fact, children

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112. For an analysis based on the Committee's conclusions in its reporting procedure, see *The European Social Charter*, HUDOC (2013).
113. ESCR, Conclusions XV-2 (2001), Greece, U.N. Doc. XV-2/def/GRC/11/3/EN.
114. Inter-American Commission on Human Rights Hearing: Tobacco Addiction and the Right to Health, Action on Smoking & Health (29 Mar. 2016), https://ash.org/hrcommission-advisory/.
115. Human Rights Watch, Tobacco's Hidden Children: Hazardous Child Labor in United States Tobacco Farming 22 (13 May 2014) [hereinafter HRW Tobacco's Hidden Children].
116. Eriksen et al., *supra* note 91, at 46.
117. Robert H. McKnight & Henry A. Spiller, *Green Tobacco Sickness in Children and Adolescents,* 120 Pub. Health Rep. 602, 602 (2005); Melody Powers Noland et al., *Use of Snuff, Chewing Tobacco, and Cigarettes Among Adolescents in a Tobacco-Producing Area*, 15 Addictive Behav. 517, 517 (1990).

face adverse health outcomes by merely living in a tobacco-producing region.[118] Apart from the risk of cumulative adverse health outcomes, children involved in tobacco farming also face serious developmental problems, including impaired educational opportunities, as they are often no longer going to school.[119] Moreover, research shows that in African countries tobacco farming also further undermines food security.[120] While clearly children's involvement in tobacco farming is a problem in both high and low-income countries, tobacco farming is particularly increasing in low and middle-income countries (LMICs).[121] Children from low-SES households especially have to work in tobacco farming to contribute to the household income.[122] In general, Anna Gilmore and colleagues observe that LMICs are of "growing importance . . . to the tobacco industry's future."[123]

The CRC Committee is concerned with how the informal economy in many countries, including in the agricultural sector, may jeopardize children's rights in a variety of ways. Involvement in work in informal economies may "prevent children from attending school, doing schoolwork and having adequate rest and play," which the CRC Committee holds could breach Article 28 (right to education), Article 29 (on the purposes of education), and Article 31 (right to leisure, rest, and culture) of the CRC.[124] The Committee emphasizes that states parties should adopt measures that "ensure that business activities take place within appropriate legal and institutional frameworks in all circumstances regardless of size or sector of the economy so that children's rights can be clearly recognized and protected."[125]

Moreover, Article 32(1) CRC includes the right to be protected from economic exploitation including "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."[126] In addition, Article 36 requires states parties to protect children from any type of exploitation harmful to "any aspect of the child's welfare." The CRC

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118. *See generally* Sabrina N. Nascimento et al., *Environmental Exposure and Effects on Health of Children From a Tobacco-Producing Region*, 24 Envtl. Sci. & Pollution Res. 2851 (2017).
119. Lando et al., *supra* note 8; Human Rights Watch, *supra* note 13, at 5; Cécile Allegra, *Bulgarian Tobacco Harvest Relies on Help from Children*, The Guardian (5 Feb. 2013), https://www.theguardian.com/world/2013/feb/05/bulgaria-children-tobacco-industry.
120. Teh-wei Hu & Anita H. Lee, *Tobacco Control and Tobacco Farming in African Countries*, 36 J. Pub. Health Pol'y 41, 46 (2015).
121. Drope et al., *supra* note 11, at 14.
122. *WHO Tobacco Factsheet*, *supra* note 1.
123. Anna B. Gilmore et al., *Exposing and Addressing Tobacco Industry Conduct in Low-Income and Middle-Income Countries*, 385 Lancet 1029, 1029 (2015).
124. General Comment No. 16, *State Obligations Regarding the Impact of the Business Sector on Children's Rights*, U.N. GAOR, Comm. on the Rts. of the Child, 62d Sess., ¶ 35, U.N. Doc. CRC/C/GC/16 (2013) [hereinafter GC 16 CRC].
125. *Id.* ¶ 36.
126. CRC, *supra* note 36, art. 32(1).

Committee emphasizes specifically that governments should regulate working conditions as such and adopt detailed safeguards to protect children from economic exploitation.[127] In relation to Kazakhstan, for instance, the CRC Committee raised its concern with the large number of "socially vulnerable children" involved in the tobacco industry.[128] On the other hand, Turkmenistan, reported that "it is not permitted to employ children to perform work that is hazardous to health" and that "it is forbidden for children to perform work connected with the manufacture or sale of tobacco products."[129]

Among the top tobacco-producing countries, only Malawi and Argentina refer to tobacco farming in their CRC country reports.[130] The Malawian government notes in its 1993 and 1998 reports that it will review domestic legislation that allows underage children to work in family business and agriculture,[131] including tobacco, and acknowledges that children remain heavily involved in tobacco farming.[132] However, it does not report on tobacco farming in its latest 2016 report.[133] Despite the seriousness of the matter, other tobacco-producing countries such as Mozambique,[134] Zambia,[135]

127. GC 16 CRC, *supra* note 124, ¶ 37.
128. *Report on the Forty-fifth Session of the Committee on the Rights of the Child*, U.N. GAOR, Comm. on the Rts. of the Child, 45th Sess., ¶ 445, U.N. Doc. CRC/C/45/3 (2007).
129. *Consideration of Reports Submitted by States Parties under Article 44 of the Convention: Turkmenistan*, U.N. GAOR, Comm. on the Rts. of the Child, ¶ 206, U.N. Doc. CRC/C/TKM/1 (2005).
130. *Consideration of Reports Submitted by States Parties under Article 44 of the Convention: Malawi*, U.N. GAOR, Comm. on the Rts. of the Child, ¶ 63, U.N. Doc. CRC/C/8/Add.43 (2001); *Consideration of Reports Submitted by States Parties under Article 44 of the Convention: Malawi,* U.N. GAOR, Comm. on the Rts. of the Child, ¶ 319, U.N. Doc. CRC/C/MWI/2 (2008); *Consideration of Reports Submitted by States Parties under Article 44 of the Convention: Argentina*, U.N. GAOR, Comm. on the Rts. of the Child, ¶ ¶ 856, 857, 860–61, U.N. Doc. CRC/C/ARG/3–4 (2009).
131. *Consideration of Reports Submitted by States Parties under Article 44 of the Convention: Malawi* (2001), *supra* note 130, ¶ 334.
132. *Consideration of Reports Submitted by States Parties under Article 44 of the Convention: Malawi* (2008), *supra* note 130, ¶ 319.
133. *See generally Consideration of Reports Submitted by States Parties under Article 44 of the Convention: Malawi*, U.N. GAOR, Comm. on the Rts. of the Child, U.N. Doc. CRC/C/MWI/3–5 (2016).
134. *See generally Consideration of Reports Submitted by States Parties under Article 44 of the Convention: Mozambique*, U.N. GAOR, Comm. on the Rts. of the Child, U.N. Doc. CRC/C/41/Add.11 (2001); *Consideration of Reports Submitted by States Parties under Article 44 of the Convention: Mozambique*, U.N. GAOR, Comm. on the Rts. of the Child, U.N. Doc. CRC/C/MOZ/CO/2 (2009).
135. *See generally Consideration of Reports Submitted by States Parties under Article 44 of the Convention: Zambia*, U.N. GAOR, Comm. on the Rts. of the Child, U.N. Doc. CRC/C/11/Add.25 (2002); *Consideration of Reports Submitted by States Parties under Article 44 of the Convention: Zambia*, U.N. GAOR, Comm. on the Rts. of the Child, U.N. Doc. CRC/C/ZMB/CO/2–4 (2016).

India,[136] Greece,[137] Indonesia,[138] and Pakistan[139] do not report on the issue in their CRC country reports.

Article 32(2) CRC requires governments to set a minimum age for admission to employment, as well as create conditions for the hours and conditions of work. Specifically, the CRC Committee interprets this obligation to include enforcement by states parties of international standards on minimum age of work and conditions of work, as the CRC itself does not set such a strict legally binding limit or requirement of conditions.[140] Article 3 of the 1973 International Labour Organization's Minimum Age Convention establishes that "[t]he minimum age for admission to any type of employment or work which by its nature or the circumstances in which it is carried out is likely to jeopardise the health, safety or morals of young persons shall not be less than 18 years."[141] In addition, Article 7 of the (Revised) European Social Charter prohibits child labor below fifteen years of age and employment of children above that age in "dangerous and unhealthy activities."[142] Recognizing the detrimental health and developmental impact on children involved in tobacco farming or merely living in tobacco farming regions,

136. *See generally Consideration of Reports Submitted by States Parties under Article 44 of the Convention: India*, U.N. GAOR, Comm. on the Rts. of the Child, U.N. Doc. CRC/C/28/Add.10 (1997); *Consideration of Reports Submitted by States Parties under Article 44 of the Convention: India*, U.N. GAOR, Comm. on the Rts. of the Child, U.N. Doc. CRC/C/93/Add.5 (2003); *Consideration of Reports Submitted by States Parties under Article 44 of the Convention: India*, U.N. GAOR, Comm. on the Rts. of the Child, U.N. Doc. CRC/C/IND/CO/3–4 (2014).
137. *See generally Consideration of Reports Submitted by States Parties under Article 44 of the Convention: Greece*, U.N. GAOR, Comm. on the Rts. of the Child, U.N. Doc. CRC/C/28/Add.17 (2001); *Consideration of Reports Submitted by States Parties under Article 44 of the Convention: Greece*, U.N. GAOR, Comm. on the Rts. of the Child, U.N. Doc. CRC/C/GRC/2–3 (2011).
138. *See generally Consideration of Reports Submitted by States Parties under Article 44 of the Convention: Indonesia*, U.N. GAOR, Comm. on the Rts. of the Child, U.N. Doc. CRC/C/3/Add.10 (1993); *Consideration of Reports Submitted by States Parties under Article 44 of the Convention: Indonesia*, U.N. GAOR, Comm. on the Rts. of the Child, U.N. Doc. CRC/C/65/Add.23 (2003); *Consideration of Reports Submitted by States Parties under Article 44 of the Convention: Indonesia*, U.N. GAOR, Comm. on the Rts. of the Child, U.N. Doc. CRC/C/IDN/3–4 (2012).
139. *See generally Consideration of Reports Submitted by States Parties under Article 44 of the Convention: Pakistan*, U.N. GAOR, Comm. on the Rts. of the Child, U.N. Doc. CRC/C/3/Add.13 (1993); *Consideration of Reports Submitted by States Parties under Article 44 of the Convention: Pakistan*, U.N. GAOR, Comm. on the Rts. of the Child, U.N. Doc. CRC/C/65/Add.21 (2003); *Consideration of Reports Submitted by States Parties under Article 44 of the Convention: Pakistan*, U.N. GAOR, Comm. on the Rts. of the Child, U.N. Doc. CRC/C/PAK/3–4 (2009); *Consideration of Reports Submitted by States Parties under Article 44 of the Convention: Pakistan*, U.N. GAOR, Comm. on the Rts. of the Child, U.N. Doc. CRC/C/PAK/5 (2015).
140. GC 16 CRC, *supra* note 124, ¶ 37.
141. Convention Concerning Minimum Age for Admission to Employment (ILO No. 138), *adopted* 26 June 1973, art. 3(1), 1015 U.N.T.S. 297 (*entered into force* 19 June 1976).
142. European Committee of Social Rights, Press Briefing Elements: Conclusions 2015, at 6 (2015).

international law disallows child involvement in business activities of the tobacco industries.

In order to protect children from such involvement, the CRC Committee holds that states parties should "prevent and mitigate [the] negative impact [of a business' activities] on children's right to health including . . . business relationships and within any global operations."[143] Hence, even if large tobacco companies do not employ children themselves or own tobacco farms which involve children, governments should still regulate all levels of the tobacco industry, including the large tobacco firms such that their business operations do not interfere with children's rights. Buying tobacco from farms or processing tobacco in factories in which children are involved conflicts with children's rights as included in the CRC. Governments are also bound to regulate the tobacco industry based on their obligation to promote and protect the best interests of the child.[144] In this interpretation of the norm, the government is required to regulate the tobacco industry to the extent that their decisions and actions positively, instead of negatively, affect children. Notably, even though human rights by nature invoke duties for states and do not legally bind private companies, the tobacco industry has a clear responsibility in the spirit of human rights.[145]

Apart from obligations directed towards children, the CRC Committee also interprets the scope of protecting children against (economic) exploitation to include clear obligations to support the working conditions of parents and caregivers. Working in informal industries including agriculture, and hence implicitly tobacco farming, often involves working long hours to gain sufficient income. According to the Committee, such long hours away from home hinders parents and caregivers in fulfilling their responsibilities as included in Article 18 CRC. Governments should therefore adopt measures to support families in earning decent subsistence-level income in a manner that enables them to fulfill their care giving roles.[146]

The regional bodies pay limited attention to child labor and have yet to address tobacco farming in this context. A 1997 Resolution of the Parliamentary Assembly of the Council of Europe addressed several dimensions of child labor exploitation, though it did not mention tobacco farming specifically.[147] Similarly, the ECSR more generally touched on the issue of child labor on several occasions, both in its collective complaint mecha-

143. GC 15 CRC, *supra* note 15, ¶ 80.
144. GC 14 CRC, *supra* note 41, ¶ 14(c).
145. Brigit Toebes, *Human Rights and the Tobacco Industry: An Unsuitable Alliance,* 7 Int'l J. Health Pol'y & Mgmt. 677, 677 (2018).
146. GC 16 CRC, *supra* note 124, ¶ ¶ 36–37.
147. Recommendation 1336: Combating Child Labour Exploitation as a Matter of Priority, *opened for signature* 26 June 1997, Council of Europe Parliamentary Assembly, ¶ 2, (1997).

nism and within the framework of its reporting procedure. In its decision of *International Commission Against Jurists v. Portugal*, the ESCR addressed the unhealthy working conditions of children in family businesses in Portugal under the age of fifteen.[148] Concluding that Article 7 (Revised) ESC applies in all labor sectors, the ESCR held that there was a violation of Article 7(1), which stipulates that the minimum age for employment shall be fifteen years of age.[149] This approach has potential relevance for young children working in tobacco farming.

V. EARLY TO LATE ADOLESCENCE

The 2017 WHO report on the Global Tobacco Epidemic estimates that 25 million children aged thirteen to fifteen smoke cigarettes.[150] The risk of children starting to smoke because of a set of transgenerational and socio-economic disadvantages is most acute during adolescence. Indeed, middle adolescence reflects a peak period in which children start to smoke.[151] Yet, as mentioned, there are some indications of toddlers and small children already smoking heavily.

There is a difference between first triers and regular smokers. Data demonstrates that 87 percent of all regular adult smokers smoke their first cigarette by the age of eighteen, in their late adolescence.[152] This data further underpins the vicious cumulative nature of tobacco-related harm, as most adult tobacco and nicotine addiction disorders root in (pre) adolescence. Indeed, research shows that starting to smoke at a young age increases the risk of NCDs, lung cancer, and cardiovascular diseases in later life.[153] Furthermore, researchers contend that, especially amongst adolescents, commencing smoking is not a rational decision.[154] Rather, the reason behind adolescents smoking strongly links to following a bad example and family

148. *See inter alia*, International Commission Against Jurists v. Portugal, ECSR, Complaint No. 1/1998, ¶ ¶ 6–7 (1999).
149. *Id.* ¶ ¶ 23–45.
150. World Health Org., WHO Report on the Global Tobacco Epidemic 2017: Monitoring Tobacco Use and Prevention Policies 57 (2017).
151. Paulien A. W. Nuyts et al., *Trends in age of Smoking Initiation in the Netherlands: A Shift Towards Older Ages?*, 113 Addiction Res. Rep. 524, 524 (2017).
152. Surgeon General Report 2014, *supra* note 3, at 12; For an earlier Surgeon General Report estimating 88 percent, see U.S. Dep't of Health & Human Serv., Youth & Tobacco: Preventing Tobacco Use Among Young People: A Report of the Surgeon General 51 (1994).
153. Norman Hymowitz, *Cigarette Smoking and Lung Cancer: Pediatric Roots*, 2012 Lung Cancer Int'l 1, 1 (2012).
154. *See, e.g.,* H. Tohid et al., *"Smoking is Worth the Risk": Understanding Adolescents' Rationalisation of Their Smoking Behaviour*, 24 Pertanika J. Soc. Sci. & Hum. 573, 581 (2016).

and parental smoking.[155] MSP even associates with early experimentation of tobacco use and increased likelihood of starting to smoke at an early age.[156] Other factors include peer influences,[157] educational achievements,[158] and socioeconomic status.[159] In fact, tobacco use and poverty lead to a vicious cycle.[160] The tobacco industry heavily and aggressively exploits these innate and structural vulnerabilities amongst adolescents to start smoking.

The tobacco industry views adolescents as "replacement smokers." It sells a product that—if used as intended—kills most of its users. In order to secure future income, it needs to recruit new smokers, adolescents, to replace those dying from their products. Even though the tobacco industry still claims that it only tries to influence the market behavior of adult smokers, quotes from internal documents reveal the opposite and demonstrate adolescents, in particular those in middle adolescence, are the key target.[161] If not restricted by tobacco control laws, the industry attracts children and lures them into smoking by, for example, adding flavors, presenting misleading information, and offering attractive packaging, as well as by direct and indirect advertisement.[162] Research demonstrates, for instance, that tobacco use in films contributes to child smoking.[163] Some researchers specifically focus on the potential harm of the uncontrolled marketing of Electronic Nico-

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155. *See, e.g.,* Karl G. Hill et al., *Family Influences on the Risk of Daily Smoking Initiation,* 37 J. Adolescent Health 202 (2005). Umar Ikram showed the particular influence of paternal smoking and smoking initiation amongst the youth in ethnic minority groups. *See* Umar Z. Ikram et al., *Parental Smoking and Adult Offspring's Smoking Behaviors in Ethnic Minority Groups: An Intergenerational Analysis in the HELIUS Study*, 20 Nicotine & Tobacco Res. 766 (2018).
156. Best et al., *supra* note 86, at 1019.
157. *See, e.g.,* Liesbeth Mercken et al., *Disentangling Social Selection and Social Influence Effects on Adolescent Smoking: The Importance of Reciprocity in Friendships*, 102 Addiction 1483 (2007); Vincent Lorant et al., *Social Network and Inequalities in Smoking Amongst School-Aged Adolescents in Six European Countries*, 62 Int'l J. Pub. Health 53 (2017).
158. Jaana M. Kinnunen et al., *Academic Well-Being and Smoking Among 14- to 17-year-old Schoolchildren in Six European Cities*, 50 J. Adolescence 56, 60 (2016).
159. Timo-Kolja Pförtner et al., *Socioeconomic Inequalities in the Impact of Tobacco Control Policies on Adolescent Smoking: A Multilevel Study in 29 European Countries*, 53 Addictive Behav. 58, 59 (2016).
160. Drope et al., *supra* note 11, at 30–31.
161. Drope et al., *supra* note 11, at 18; *Tobacco Company Marketing to Kids*, Campaign for Tobacco Free Kids (2018), https://www.tobaccofreekids.org/research/factsheets/pdf/0008.pdf; *Replacement Smokers*, Sick of Smoking, https://sickofsmoking.nl/en/feiten/replacement-smokers/.
162. World Health Org., WHO Report on the Global Tobacco Epidemic, 2013: Enforcing Bans on Tobacco Advertising, Promotion, and Sponsorship 25 (2013).
163. Robert J. Wellman et al., *The Extent to Which Tobacco Marketing and Tobacco Use in Films Contribute to Children's Use of Tobacco: A Meta-Analysis*, 160 Archives Pediatrics & Adolescent Med. 1285, 1285 (2006); Jo Leonardi-Bee et al., *Exposure to Parental and Sibling Smoking and the Risk of Smoking Uptake in Childhood and Adolescence: A Systematic Review and Meta-Analysis*, 66 Thorax 847, 847 (2011).

tine Delivery Systems (ENDS) such as electronic cigarettes by the tobacco industry on child health and development.[164] Yet, others are less worried, holding that ENDS may be an important harm reduction measure to help people quit smoking[165] and claiming that e-cigarette advertisements do not necessarily lead to increased tobacco use among children.[166] Aside from current debates on regulating e-cigarettes, however, children between thirteen and fifteen years old remain heavily exposed to tobacco advertisement.[167]

Under human rights law, governments hold clear obligations to protect children, and in particular adolescents, from tobacco use and the marketing of tobacco companies, and to promote and facilitate adequate information services to enable adolescents to make well-informed, healthy lifestyle choices. Apart from the clear vulnerability of adolescents becoming a victim of the tobacco industry, they also face increased health risks because of exposure to SHS and exploitation in tobacco farming.[168] The effects of exposure to SHS during adolescence and involvement in tobacco farming are similar to the negative health consequences experienced in infancy and early childhood as discussed in Section IV.

A. Tobacco use

Based on the right to health as included in Article 12 ICESCR, governments hold a general obligation to discourage people from using tobacco products.[169] The CRC Committee is concerned with tobacco use in adolescents and "reaffirms that the minimum age limit should be 18 years for . . . the purchase and consumption of alcohol and tobacco, in view of the degree of associated risk and harm."[170] Other than urging states to ratify the FCTC if they have not yet done so, the CRC Committee is not very explicit on which

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164. *See generally* Alisha Kamboj et al., *Pediatric Exposure to E-Cigarettes, Nicotine, and Tobacco Products in the United States*, 137 Pediatrics 1 (2016); Eriksen et al., *supra* note 91.
165. *See generally* Coral E. Gartner, *E-Cigarettes and Youth Smoking: Be Alert But Not Alarmed*, 27 Tobacco Control 359 (2018); Jamie Brown et al., *Real-World Effectiveness of E-Cigarettes When Used to Aid Smoking Cessation: A Cross-Sectional Population Study*, 109 Addiction 1531 (2014).
166. *See generally* Milica Vasiljevic et al., *Impact of Advertisements Promoting Candy-Like Flavoured E-Cigarettes on Appeal of Tobacco Smoking Among Children: An Experimental Study*, 25 Tobacco Control 107 (2016). For more information on human rights and the regulation of e-cigarettes, see Gispen & Veraldi, *supra* note 5.
167. Drope et al., *supra* note 11.
168. *See generally* HRW Tobacco's Hidden Children, *supra* note 115; Human Rights Watch, Teens of the Tobacco Fields: Child Labor in United States Tobacco Farming (2016).
169. GC 14 CESCR, *supra* note 22, ¶ 15.
170. GC 20 CRC, *supra* note 16, ¶ 40.

tobacco control interventions states should adopt to protect adolescents from tobacco use.[171] Bearing in mind Article 24 CRC, the CRC Committee urges governments to regulate the "sale of substances harmful to children's health and of the promotion of such items in places where children congregate," which implies that governments should take deliberate steps towards regulating the points of sale of tobacco products.[172] The reference to the FCTC further evidences the support of the CRC framework for the demand reduction measures such as price and tax regulations as included in Article 6 FCTC. While price and tax measures are generally considered among the most effective tobacco interventions, their implementation may also lead to unintentional negative consequences (both financial and stigma-related) among people—often from low-SES households—who will not stop or reduce smoking in response to these actions.[173] It is in the best interests of children from low-SES households to mitigate these possible negative consequences. A wide range of other rights including the right to education (Article 29 CRC), the right to an adequate standard of living (Article 27 CRC), and the right to rest and leisure (Article 31 CRC) also support this proposition.

States parties support the age limit the CRC Committee refers to in light of Article 6 CRC and their definition of a child within the CRC. This support relates both to prohibition of consumption by, and sales of tobacco products to, minors.[174] However, some countries also manage lower age restrictions, which Article 16 FCTC allows them to do. In its 2005 report, for example, Hungary places restrictions on "persons under the age of 18 to smoke in public institutions, at events organized in closed areas and means of public transport, even in areas marked for smoking," but—at least at that time—did not restrict the use of tobacco products to persons eighteen years and

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171. GC 15 CRC, *supra* note 15.
172. *Id.* ¶ 65.
173. Katherine T. Hirono & Katherine E. Smith, *Australia's $40 per Pack Cigarette Tax Plans: The Need to Consider Equity*, 27 Tobacco Control 229, 229 (2018).
174. *See, e.g., Consideration of Reports Submitted by States Parties under Article 44 of the Convention: Marshall Islands*, U.N. GAOR, Comm. on the Rts. of the Child, ¶ 22, U.N. Doc. CRC/C/93/Add.8 (2005); *Consideration of Reports Submitted by States Parties under Article 44 of the Convention: Turkey*, U.N. GAOR, Comm. on the Rts. of the Child, ¶ 124, U.N. Doc. CRC/C/OPSA/TUR/1 (2005); *Consideration of Reports Submitted by States Parties under Article 44 of the Convention: Lithuania*, U.N. GAOR, Comm. on the Rts. of the Child, ¶ 47, U.N. Doc. CRC/C/83/Add.14 (2005); *Consideration of Reports Submitted by States Parties under Article 44 of the Convention: Liechtenstein*, U.N. GAOR, Comm. on the Rts. of the Child, ¶ 90, U.N. Doc. CRC/C/136/Add.2 (2005); *Consideration of Reports Submitted by States Parties under Article 44 of the Convention: Thailand*, U.N. GAOR, Comm. on the Rts. of the Child, ¶ 122, U.N. Doc. CRC/C/83/Add.15 (2005); *Consideration of Reports Submitted by States Parties under Article 44 of the Convention: Ireland*, U.N. GAOR, Comm. on the Rts. of the Child, ¶ 228, U.N. Doc. CRC/C/IRL/2 (2005); *Consideration of Reports Submitted by States Parties under Article 44 of the Convention: Turkmenistan*, U.N. GAOR, Comm. on the Rts. of the Child, ¶ 213, U.N. Doc. CRC/C/TKM/1 (2005).

older.[175] Austria states that its "youth protection laws prohibit children and adolescents under the age of 16 from smoking and drinking either generally or in public, and the same applies to the dispensing of alcohol and tobacco to this age group."[176]

While the right to life, survival, and development (Article 6 CRC), as well as the right to health(Article 24 CRC), are the central rights on the basis of which governments hold obligations to protect children from starting to smoke, such efforts may also be understood considering the right to an adequate standard of living (Article 27 CRC) and protection against illicit drugs (Article 33 CRC). One could argue that a tobacco-free environment to protect children from smoking contributes to creating a safe environment mindful of Article 27 CRC. Even though, in its recent General Comment 20 on the implementation of children's rights during adolescence, the CRC Committee refers to categories of illicit drugs and tobacco separately, states parties have consistently interpreted their specific obligations based on Article 33 CRC to include tobacco control measures. They also refer to tobacco control and protection against illicit drugs in light of their obligations to protect children in vulnerable situations.[177]

B. Industry Marketing and Advertisement and Access to Health-Related Information

Industry marketing and advertisement with clear potential for negative health and developmental outcomes is widely condemned within human rights law. The CESCR Committee interprets the obligation to protect to include "such omissions as the failure to regulate the activities of . . . corporations . . . to prevent them from violating the right to health of others . . . e.g. . . .

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175. *Consideration of Reports Submitted by States Parties under Article 44 of the Convention: Hungary*, U.N. GAOR, Comm. on the Rts. of the Child, ¶ ¶ 96–97, U.N. Doc. CRC/C/70/Add.25 (2005).
176. *Consideration of Reports Submitted by States Parties under Article 44 of the Convention: Austria*, U.N. GAOR, Comm. on the Rts. of the Child, ¶ 698, U.N. Doc. CRC/C/83/Add.8 (2004).
177. For example, in the context of mentioning national endeavors aimed at achieving the objective of Article 33 CRC, Qatar discussed their study on the use of chewing tobacco by students. *See Consideration of Reports Submitted by States Parties under Article 44 of the Convention: Qatar*, U.N. GAOR, Comm. on the Rts. of the Child, ¶ 429, U.N. Doc. CRC/C/QAT/3–4 (2016). Likewise, Italy includes "cigarette smoking" in their measures aimed at protection in the sense of Article 33 CRC. *See Consideration of Reports Submitted by States Parties under Article 44 of the Convention: Italy*, U.N. GAOR, Comm. on the Rts. of the Child, ¶ 204, U.N. Doc. CRC/C/8/Add.18 (1995). As does Iceland, see *Consideration of Reports Submitted by States Parties under Article 44 of the Convention: Iceland*, U.N. GAOR, Comm. on the Rts. of the Child, ¶ 390, U.N. Doc. CRC/C/11/Add.6 (1995).

marketing and consumption of tobacco."[178] As was also seen in relation to tobacco farming, based on Articles 24 and 3 CRC, governments are, according to the CRC Committee, obliged to regulate the tobacco industry to the extent that their entire business operations no longer negatively affect the health and development of children.[179]

The CRC Committee emphasizes that all companies have an obligation of due diligence and that private companies should "refrain from the advertisement, marketing and sale to children of tobacco."[180] This fits squarely into the responsibility to respect of private sectors formulated in the Ruggie Principles on Business and Human Rights.[181] However, since states and not private actors are the primary legal duty-bearers within the human rights framework, the appeal by the CRC Committee on private companies should be understood as a reinforced obligation on part of the government to protect people by regulating industry behavior.

In view of the right to information as included in Article 17 CRC, the CRC Committee also urges states parties "to protect adolescents from information that is harmful to their health and development, while underscoring their right to information and material from diverse national and international sources."[182] Explicitly urging governments "to regulate or prohibit information on and marketing of substances such as alcohol and tobacco, particularly when it targets children and adolescents."[183] According to the CRC Committee, it is important not just to focus on the—traditional—offline world, but also to effectively include regulation of online space in order to protect children against promotion of substances harmful to their health.[184] Indeed, children and adolescents in particular should receive "accurate and objective information based on scientific evidence aimed at preventing and minimizing harm from substance use" including tobacco.[185] The CRC Committee recommends governments collaborate with WHO, UNICEF, and the United Nations Drug Control Programme (UNDCP) in this respect.[186]

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178. GC 14 CESCR, *supra* note 22, ¶ 51.
179. *See* GC 15 CRC, *supra* note 15, ¶ 80; GC 14 CRC, *supra* note 41, ¶ 14(c).
180. GC 15 CRC, *supra* note 15, ¶ 81.
181. *See generally* Special Representative of the Secretary-General, John Ruggie, *Report of the Special Representative of the Secretary-General on the Issue of Human Rights and Transnational Corporations and Other Business Enterprises*, U.N. GAOR, Hum. Rts. Council, 77th Sess., Agenda Item 3, U.N. Doc. A/HRC/17/31 (2011).
182. General Comment No. 4, *On Adolescent Health and Development in the Context of the Convention on the Rights of the Child*, U.N. GAOR, Comm. on the Rts. of the Child, 33d Sess., ¶ 21, U.N. Doc. CRC/GC/2003/4 (2003).
183. *Id.* ¶ 21.
184. GC 15 CRC, *supra* note 15; GC 20 CRC, *supra* note 16, ¶ 47.
185. GC 20 CRC, *supra* note 16, ¶ 64. *See also* General Comment No. 21, *On Children in Street Situations*, U.N. GAOR, Comm. on the Rts. of the Child, ¶ 42, U.N. Doc. CRC/C/GC/21 (2017).
186. *Report on the Twenty-Third Session*, U.N. GAOR, Comm. on the Rts. of the Child, ¶ 105, U.N. Doc. CRC/C/94 (2000).

While generally regional human rights bodies provide relatively little specific guidance in the area of tobacco control, the ECSR's state reporting procedure does refer to tobacco quite frequently. For instance, in its Conclusions analyzing Bosnia and Herzegovina, the ESCR recalls that "anti-smoking measures are particularly relevant for compliance with Article 11 since smoking is a major cause of avoidable death in developed countries" and it argues that "any prevention policy must restrict the supply of tobacco through controls on production, distribution, advertising and pricing."[187]

These types of statements reveal that the ESCR is very explicit in its state reporting procedure about the need to monitor and regulate tobacco use. Furthermore, while the ECSR's collective complaint mechanism has yet to address the matter of tobacco, the decision of the ECSR in *Interights* v. *Croatia*—that challenged the sexual education in curriculums in Croatia—provides inspiration for future cases addressing the state's duty to provide information on the harmful effects of tobacco.[188] Based on the right to protection of health within Article 11 ESC, the Committee holds that governments are under the obligation to provide scientifically accurate and nondiscriminatory sex education to youth that does not involve censoring, withholding, or intentionally misrepresenting information such as contraception.[189] Although this is not addressed explicitly, one could argue that this obligation also embraces the provision of evidence-based and neutral information regarding the harmful effects of tobacco.

Receiving evidence-based impartial health-related information is crucial for adolescents considering the evolving capacities of the child as a central idea supported in the CRC rights-framework. The CRC Committee holds that "[c]hildren require information and education on all aspects of health to enable them to make informed choices in relation to their lifestyle" including on the negative health consequences of tobacco.[190] Acknowledging the evolving capacities and autonomy of adolescents, the CESCR Committee also finds that "[s]tates parties should provide a safe and supportive environment for adolescents, that ensures the opportunity to participate in decisions affecting their health . . . to acquire appropriate information . . . and to negotiate the health-behaviour choices they make."[191] Consequently, while the CRC justifies and requires a protective approach in tobacco control for young children, the CRC requires consulting the views of adolescents in any developing tobacco control measures tailored to them. The opportunity to

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187. ESCR, Conclusions with Regard to Bosnia and Herzegovina (2017) in Relation to Art. 11, ¶ 3, U.N. Doc. 2017/def/BIH/11/3/EN (2017).
188. International Centre for the Legal Protection of Human Rights (INTERIGHTS) v. Croatia, ECSR, Complaint No. 45/2007 (2009).
189. *Id.* ¶ ¶ 43–66.
190. GC 15 CRC, *supra* note 15, ¶ 59; GC 20 CRC, *supra* note 16, ¶ 64.
191. GC 14 CESCR, *supra* note 22, ¶ 23.

participate and to be involved in decision-making is, according to the CRC Committee, one of the key factors "to promote the resilience and healthy development of adolescents."[192] This in itself may connect to Article 12 CRC, which obliges governments to ensure that each child that is capable of formulating his or her own views should be allowed to "express those views freely in all matters affecting the child."[193] Nevertheless, including the views of adolescents may still lead to strict tobacco control, as research demonstrates that adolescents view banning tobacco as positive and shows that increased tobacco control interventions has reduced uptake of smoking amongst youth.[194]

VI. CONCLUSIONS

This article presented a systematic analysis of the nature and scope of governments' obligations in international and regional human rights regimes to protect and promote specific aspects of child health and development in tobacco farming, consumption, and exposure to SHS. Such a child-rights approach is highly relevant, as most work in this area focuses more generally on human rights and tobacco control. Indeed, the importance of including the rights of children in tobacco control is increasingly acknowledged. However, thus far there has been little knowledge on the exact nature, scope, and implications of such an application.

Following the different stages of childhood, this article illuminates both the current blind spots and opportunities to enforcing child rights-specific tobacco control measures based on international and regional human rights regimes. As a general observation, this article concludes that the regional human rights systems analyzed essentially play a limited role in protecting children from the negative health and developmental consequences of tobacco, despite the clear potential of regional human rights bodies in ensuring accountability for human rights violations. This gap may be considered worrisome from the perspective of effective child rights protection in tobacco interventions. The proactive attitude of the ECSR in its reporting procedure sets an important example for other bodies to follow.

The international human rights framework, however, does provide a clear framework on children's rights protection in relation to tobacco control

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192. GC 20 CRC, *supra* note 16, ¶ 17.
193. CRC, *supra* note 36, art. 12. Similar to Articles 2, 3, and 6, Article 12 is considered a central principle underlying the CRC. *See also* GC 5 CRC, *supra* note 40, ¶ 12.
194. *See generally* Michael Schreuders et al., *To What Extent and Why Adolescents Do or Do Not Support Future Tobacco Control Measures: A Multimethod Study in the Netherlands*, 27 Tobacco Control 596 (2018); Michael J. Green et al., *Socioeconomic Position and Early Adolescent Smoking Development: Evidence From the British Youth Panel Survey (1994–2008)*, 25 Tobacco Control 203 (2016).

and preventive care. Following the different stages of child development, this international framework shows both opportunities and blind spots, particularly based on the CRC (see Table 1 below for a summary overview).

Table 1. Summary Overview of A Child-rights Approach to Tabacco Control At Different Stages of Childhood.

<table>
<tr><th>Unborn</th><th>Neonates</th><th>Early Childhood</th><th>Early Adolescence</th><th>Middle To Late Adolescence</th></tr>
<tr><td>Blind spots
Technically no rights holders.</td><td colspan="4">Blind spots
Open ended obligations; very few specific references to tobacco control interventions.</td></tr>
<tr><td>Opportunities
The CRC Committee and an increasing number of states parties consider prenatal care an integral aspect of Articles 6 and 24 CRC.</td><td colspan="2">Opportunities
Based on Articles 6, 24, and 27 CRC, governments should ensure smoke free environments to safeguard a healthy living environment. The CRC Committee encourages governments to create smoke-free housing.</td><td colspan="2">Based on Articles 6, 12, 17, and 24 CRC, governments should ensure access to adequate health-related information, involve adolescents in decision-making relating to their health, adopt other demand reduction measures, and offer cessation assistance in order to protect children against tobacco.</td></tr>
<tr><td></td><td colspan="4">Based on Article 3 CRC, governments should take into account the best interests of the child in revising and adopting tobacco control laws and policies.</td></tr>
<tr><td></td><td colspan="4">Based on Articles 17, 24, 32 and 36 CRC, governments should regulate the tobacco industry to the extent that their business activities no longer violate the rights of children and specially avoid any form of exploitation. This general obligation refers to all stages of the tobacco supply chain.</td></tr>
</table>

Prenatal tobacco-related harm is detrimental to children's health and development, and therefore adults and society. Nevertheless, unborn children do not receive explicit human rights protection, which is clearly a blind spot in developing a child-rights approach to tobacco control. Public health research demonstrating the serious cumulative and transgenerational components of tobacco-related harm and (ill) health evidence the need for a life-course approach in tobacco control. However, this prenatal development stage currently runs the risk of falling outside the legal remit of human rights law. At the same time, this risk is somewhat mitigated and the CRC in particular provides opportunities. The work of the CRC Committee and the state reports that they receive demonstrate a clear practice suggesting

governments understand prenatal care as part of their obligations under the right to health and the right to life, survival, and development.

Subsequently, following a child's development, governments hold clear obligations to protect children against exposure to SHS. In a general interpretation of the CRC, a protective approach is particularly acute for young children in light of their evolving capacities and the best interests norm. Moreover, the international human rights framework—as explicitly supported by the European human rights system—essentially prohibits children's involvement in any of the tobacco industry's business activities, including farming. As young children are already included in tobacco farming, such protection is already acute at this young age. Nevertheless, both protection against exposure to SHS and exploitation in tobacco farming are also relevant during adolescence. It furthermore flows from the analysis that the obligation to protect in light of the right to health means that governments should regulate the tobacco industry; not just to prevent children from being involved in tobacco farming, but also to the extent that their marketing and advertisement strategies no longer target children. Especially the latter is particularly critical for adolescents as they are often framed as "replacement smokers."

Apart from these opportunities for protecting neonates to adolescents, the international framework also shows some blind spots here. International human rights law reinforces that governments should ratify the FCTC and ensure access to neutral and evidence-based health-related information as demand reduction measures to ensure adolescents in particular can make well-informed lifestyle-related choices. Indeed, taking into account the evolving capacities of children, the CRC's current interpretation would require involving adolescents in developing tobacco control regulation aimed at demand reduction and cessation among this age group. However, international human rights law includes few concrete references to specific tobacco control interventions at any stage of the tobacco supply chain. Human rights law typically reflects open-ended obligations, which makes it difficult to develop a clear-cut list of minimum requirements to regulate the tobacco supply chain—similar to the obligations included in the FCTC. This leaves the questions: what is the minimum of tobacco control measures that states need to adopt in order to fulfill their obligations under human rights law? What is the continuum on which they should strive towards full realization of all rights and aspects included? Moreover, evolving capacities and the best interests of the child require a focus on specific fluidly defined age groups and on the different stages of childhood. Analyzing the nature and scope of tobacco demand-reduction measures for adolescents is not necessarily an adequate strategy for addressing the same problem in early childhood. While this is exactly what the concept of evolving capacities and best interests of the child are said to do, the CRC provides little guidance as to how states should do so. Is it feasible for governments to adopt a tobacco control program entirely tailored to the different stages of childhood and children's incremental development? Further investigation of these issues should be the subject of future research.