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Regulating Secondhand Tobacco Smoke in the Americas: A Comparison of the Top Down and Bottom Up Approaches in Brazil and the United States

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I. Introduction

The tobacco epidemic has emerged as one of the major public health disasters of the twentieth century.[1] According to the World Health Organization (WHO), the tobacco epidemic killed 100 million people worldwide in the last century, and the twenty-first century could claim one billion more.[2] These deaths include the 600,000 nonsmokers who die annually from "passive smoking" or inhaling secondhand tobacco smoke (SHS). Tobacco use continues to be the single most preventable cause of death in the world today.[3]

For nonsmokers, the tobacco epidemic has been a human rights tragedy. Their involuntary exposure to SHS in the workplace and other public venues violates their fundamental right to a safe and clean environment and the internationally recognized right to health. No safe levels of exposure to SHS exist, even in ventilated areas.[4] There is no question that SHS is a carcinogen and that SHS exposure increases the risk of lung cancer, cardiovascular disease, and respiratory illnesses in nonsmokers.[5]

The violation of nonsmokers' human rights is a global phenomenon, surpassing all economic and geographic boundaries, but SHS disproportionately impacts the poor and vulnerable. WHO estimates that by 2030 there will be more than eight million tobacco-related deaths per year worldwide and eighty percent of those deaths will be in the developing world.[6] Furthermore, the tobacco epidemic will cause the most harm to low-income households and countries.[7] Children are particularly vulnerable to the adverse health effects of SHS. Numerous studies suggest that their exposure to SHS may cause leukemia, brain tumors, respiratory diseases, and sudden infant death syndrome.[8] Additional vulnerable groups include pregnant women, who cannot protect their fetuses from SHS exposure, and those working in the hospitality industry, whose jobs hold them captive to the toxic fumes of customers' cigarette smoke daily.

The Framework Convention on Tobacco Control (FCTC) established a global commitment to ending the tobacco epidemic.[9] Article 8 of the FCTC calls for universal protection from exposure to SHS in all public indoor places. Accordingly, Article 8 imposes a duty on governments to enact legislation to protect individuals against SHS because it threatens fundamental rights and freedoms.[10]

Almost five years after the FCTC entered into force in 2005, information on global progress toward a smoke-free world is now available. The global report card is rather dismal, but select countries have adopted legislation answering the call of Article 8. Among the Pan American States, Brazil and the United States have pursued exemplary, though opposite, legal approaches. Brazil has focused on comprehensive federal legislation followed by decentralization to the local level ("top down"), while the United States has emphasized local legislation, slowly making inroads at the federal level ("bottom up"). In both approaches, the assertion of human rights has advanced judicial and legislative efforts.

This article presents a comparative analysis of the legal approaches to regulate SHS in Brazil and the United States. Part II reviews the FCTC, its objective to achieve smoke-free public places, and the legal framework supporting freedom from SHS as a human right. Parts III and IV examine Brazil's top down and the United States' bottom up approaches to regulating SHS through legislative and judicial measures. Part V presents a comparative analysis of the two approaches and offers recommendations based on lessons learned from each approach. Because neither approach is perfect, Part V also discusses the role that the Inter-American Commission on Human Rights (IACHR) and the Inter-American Court on Human Rights can play to protect the fundamental right of nonsmokers to a smoke-free environment, regardless of their domestic laws.

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II. Secondhand Tobacco Smoke: A Human Rights Perspective

A. The Framework Convention on Tobacco Control and SHS

By the 1990s, the catastrophic and global consequences of the tobacco epidemic prompted the international public health community to take action. WHO responded by establishing the FCTC, the first treaty negotiated under WHO's authority. The FCTC garnered astounding global commitment, boasting 168 signatories and 167 current Parties.[11] It entered into effect on February 27, 2005 and legally binds eighty-seven percent of WHO Member States.

What the FCTC accomplished in breadth, it sacrificed in depth to garner wide global support.[12] The framework-convention protocol imposes light obligations, long-term deadlines, and aspirational liabilities. It also lacks realistic enforcement for noncompliance. Signatory countries need only "strive in good faith to ratify [the Convention], and show political commitment not to undermine the [Convention's] objectives."[13] Thus the FCTC garnered many signatures in exchange for shallow commitment.

Nonetheless, the FCTC provides clear goals for its Parties and guidelines for achieving them. The FCTC sets forth core-reduction provisions relating to the supply and demand of tobacco (Articles 6-17) and mechanisms for Parties' cooperation and exchange of information (Articles 20 and 22). In addition, Parties must report their progress toward fulfilling the core-reduction goals (Article 21). Given the flexibility of the framework convention, Parties can essentially set their own pace toward tobacco control, and reporting is voluntary in practice. In 2008, 81 countries (out of the expected 129) reported to WHO on their progress toward implementing the FCTC. The WHO summary of the Parties' 2008 reports indicates that countries vary widely in their efforts and progress toward fulfilling the core reduction goals.[14]

Among the FCTC's core reduction provisions is Article 8, which calls for protection from exposure to tobacco smoke in all enclosed public places:

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

According to public health officials, "protection from exposure to tobacco smoke" means no smoking in public indoor spaces. In 2007, the U.S. Surgeon General issued a report concluding that SHS cannot be effectively controlled by technical measures; a total ban on indoor smoking is necessary to protect nonsmokers.[15] WHO also formally acknowledged that ventilation techniques do not adequately control SHS indoors to the extent called for in Article 8.[16] Therefore, Article 8 calls for a total ban on smoking in enclosed public spaces.

For many WHO Member States, the goal of protecting nonsmokers from SHS is remote. Based on available data from 179 WHO Member States and one territory, WHO reports that:

- Only sixteen countries, representing five percent of the world's population, have comprehensive smoke-free laws;
- More than half of countries, accounting for nearly two-thirds of the world's population, allow smoking in government offices, workplaces, and other indoor places; and
- The overwhelming majority of countries have no smoke-free laws, very limited laws, or ineffective enforcement.[17]

Therefore, Article 8 remains an aspirational standard among the international community. Existing legislation and enforcement are inadequate, and countries have been slow to make improvements. In short, the tobacco epidemic is winning the global battle against SHS at the expense of nonsmokers' health.

B. Freedom from SHS as a Human Right

The FCTC does more than impose an obligation on states to protect against exposure to SHS. It implicitly recognizes a fundamental right to be free from SHS and links it with "the right of all people to the highest standard of health."[18] Moreover, WHO's guidelines on the implementation of Article 8 further clarifies that Parties' duties to protect from tobacco smoke is "grounded in fundamental human rights and freedoms," such as the rights to life and health.[19] These rights are recognized in international legal instruments, including the Convention on the Rights of the Child (CRC), the Convention on Elimination of all Forms of Discrimination against Women (CEDAW), and the International Covenant on Economic, Social and Cultural Rights (ICESCR), as well as in the preamble to the FCTC.[20]

Legal scholars recognize that the right to be free from SHS derives from a trio of internationally recognized human rights: the right to life, the right to health, and the right to freedom of information.[21] The Pan American Health Organization (PAHO)[22] further supports that freedom from tobacco smoke is encompassed by the rights to life, health, humane treatment, and fifteen additional internationally recognized human rights and fundamental freedoms.[23] Linking freedom from SHS to international human rights amplifies and strengthens that "smoke-free" right in several ways.

First, the smoke-free right becomes incorporated into United Nations (U.N.) treaties recognizing fundamental rights to life, health, and humane treatment.[24] So linked, the smoke-free right becomes legally enforceable in countries where these treaties have been ratified. These treaties generally have stronger enforcement mechanisms than the FCTC's flexible convention framework. In addition, the smoke-free right becomes enforceable through more legal instruments than just the FCTC. Thus linking the smoke-free right to human rights treaties amplifies and strengthens its enforceability.[25]

Second, the smoke-free right becomes enforceable even in countries that have not ratified the FCTC or U.N. treaties, assuming broader geographical scope.[26] By fitting the smoke-free right under the umbrella of the rights to life and health, the smoke-free right becomes incorporated into well-established international customary law. This body of law imposes binding obligations on countries even when they have not ratified particular legal instruments.[27] Again, the effect is to amplify, strengthen, and geographically expand the smoke-free right beyond the confines of the FCTC.

Third, linkage to international human rights treaties creates additional fora where the smoke-free may be enforced.[28] These international courts and institutions include the United Nations Committee on Economic, Social, and Cultural Rights, the United Nations Human Rights Committee, the European Court of Human Rights, the IACHR, and the Inter-American Court of Human Rights (Inter-American Court). The IACHR and the Inter-American Court will be discussed in more detail in Part V.

In summary, the right to a smoke-free environment derives from fundamental human rights, such as the rights to life, health, humane treatment, and freedom of information. These rights are recognized in U.N. human-rights treaties and international customary law. Thus the smoke-free right is stronger and more widely enforceable than the weak confines of the FCTC.

C. Brazil and the United States: Two Models in the Americas

Within the Americas, Brazil and the United States serve as models for countries regulating SHS. These two "Model States" have made substantial progress in reducing the burden of SHS on their citizens. Their accomplishments have not come easy. Both countries are homes to powerful tobacco industries that have infiltrated their social, economic, and political infrastructures. Yet the Model States have persisted, and PAHO recently hailed their "significant and fast" progress in reducing exposure to SHS.[29]

Brazil and the United States are leaders in various tobacco industries. Brazil is the world leader in tobacco leaf export and the second-largest tobacco leaf producer.[30] Its states depend heavily on tobacco industries to support local economies and tax revenue.[31] The United States is the third-largest exporter of manufactured cigarettes, the third-largest tobacco leaf importer, and home to the largest transnational tobacco company, Altria/Philip Morris.[32]

Due to their proximity to tobacco companies, the Model States' anti-tobacco reforms have endured relentless interference by the tobacco industry. The influence of tobacco companies weakened the Model States' positions during FCTC negotiations.[33] The United States' subsequent failure to ratify the FCTC and Brazil's delay in doing so are largely attributed to industry influence.[34] Moreover, tobacco companies have donated huge sums to policymakers in the United States. For example, between 1997 and 2007, they contributed $34.7 million to federal candidates, political parties, and political action committees.[35] In 2008, tobacco companies made four million dollars in campaign contributions to federal candidates and political action committees, and spent twenty-nine million dollars to lobby Congress.[36] Political contributions are less transparent in Brazil,[37] but tobacco lobbying there is "vigorous."[38] In both Model States, the tobacco lobbies have a stranglehold on high-level policymakers.

The tobacco industry has influenced scientific communities as well, stymieing efforts to determine the adverse health effects of SHS. At the international level, tobacco companies sought to undermine a large-scale epidemiological study on the relationship between SHS and lung cancer.[39] Using undercover tactics, tobacco officials gained access to details about the study. The tobacco companies then launched a media campaign and conducted counter-research designed to undercut the study's finding that SHS caused lung cancer.[40] In Latin America, top tobacco

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companies launched the "Latin Project."[41] They recruited scientists to study non-tobacco pollutants and sponsored scientific conferences to downplay the risks of SHS, all under the guise of legitimate science.[42] These biased and bogus arguments were presented to policymakers through scientific channels to frustrate regulation of SHS. Similar tactics were used in the United States. For example, tobacco companies legally challenged a report by the US Environmental Protection Agency (EPA) identifying SHS as a carcinogen, specifically for lung cancer.[43] Although the EPA report had no direct regulatory effect, it galvanized the public health community and state legislators toward anti-smoking reforms. The case was ultimately dismissed because the EPA's publication of the report was not subject to judicial review.[44]

Despite the tobacco industry's tactics, the Model States have launched legislative initiatives to regulate SHS. Brazil has focused on federal legislation, followed by decentralization to the state and local levels — the "top down" approach. The United States, on the other hand, has made far more progress at the state and local levels, with little federal legislation — the "bottom up" approach.

Neither the top down nor the bottom up approach is perfect. In both countries, many public places remain unregulated for SHS.[45] As frontrunners in the global smoke-free movement, the Model States have grappled with legal and political hurdles to a greater extent than many of their fellow American States. Because of their diametric approaches, the Model States have jointly encountered a wide range of issues that likely await their American neighbors. Only sixty percent of PAHO Member States have ratified the FCTC and exposure to SHS remains universal and high in those countries.[46] The lessons learned from Brazil and the United States provide much-needed instruction on tackling typical legal and political hurdles. Brazil and the United States serve as Model States for their successes and their shortcomings in regulating SHS. Their legal approaches are discussed separately in the following sections.

III. Brazil: Top Down Approach to Regulating SHS

Brazil is a world leader in the fight against the tobacco epidemic. The country ratified the FCTC in 2005 and passed national legislation addressing most of its goals.[47] Brazil's restrictions on tobacco advertising, among the strictest and most comprehensive in the world, set a standard for international best practices.[48] Brazil's anti-tobacco commitment is bolstered by the nation's constitutional right to health.[49] Moreover, Brazil has ratified the ICESCR, which explicitly encompasses the international right to health ("enjoyment of the highest attainable standard of physical and mental health").[50] According to General Comment No. 14 of the ICESCR, the right to health includes the right to healthy natural and workplace environments, which requires the "prevention and reduction of the population's exposure to harmful substances such as . . . harmful chemicals or other detrimental environmental conditions."[51]

The hallmark of Brazil's smoke-free initiative is federal legislation. Implementation at the state and local levels has proven difficult due to lack of regulatory coordination, inadequate local resources, and courts' struggle to interpret federal law. State and local smoke-free laws have only just begun to surface, and their constitutionality is not yet settled.

Despite its difficulties, top down legislation, in conjunction with Brazil's overall tobacco control program, has accomplished much in protecting Brazilian citizens from SHS. SHS exposure in the nation's public and private spaces has decreased dramatically, owing to the over fifty percent reduction in overall prevalence of adult smoking since 1989 and the continuing decrease in household smoking.[52] Nonetheless, many Brazilians remain unprotected and seven deaths per day in Brazil are attributable to SHS.[53] Furthermore, SHS in Brazil may disproportionately impact the less educated and less affluent, evidenced by the higher prevalence of smoking in their households.[54]

A. Federal Law

In 1996, Brazil passed Federal Law No. 9294 (Law 9294), which prohibits the use of cigarettes, cigarillos, cigars, pipes, or any other tobacco product in enclosed collective areas, private or public, except in areas designated exclusively for smoking, which must be isolated and properly ventilated.[55] While commendable for its universal applicability, Law 9294 does not meet the smoke-free standard of Article 8 of the FCTC, which prohibits smoking in all public indoor areas. The exception for designated smoking areas vastly weakens the law, since no ventilation techniques are known to protect against SHS.[56] The only places where smoking is entirely banned in Brazil are in aircraft, other public transportation, and facilities owned by the Ministry of Health.[57]

Law 9294 has also has proven difficult to enforce because courts differ on how to interpret "areas designated exclusively for smoking." According to a 2009 report by the O'Neill Institute, one interpretation holds that designated smoking rooms cannot be used to serve food or drinks, or for any other purpose.[58] Under another interpretation, designated smoking areas are simply areas for smoking, without restriction on services or activities offered there.[59] These interpretations are vastly different – the former would bring the hospitality industry to a halt, whereas the latter would permit business as usual. The regulation promulgated under Law 9294 (Decree 2018) does little to clarify the definitions of "enclosed collective areas" and "areas designated exclusively for smoking."[60]

There is general agreement that Law 9294 and Decree 2018 need to be clarified, but attempts stalled until recently. The Agência Nacional de Vigilância Sanitária (the National Health Surveillance Agency, ANVISA) is responsible for issuing regulations under Law 9294 and it drafted a proposed regulation (ANVISA Resolution No. 527 (2006)) to clarify Decree 2018.[61] Simultaneously, the Instituto National de Cáncer (the National Cancer Institute (INCA) within the Ministry of Health) proposed a draft amendment of Law 9294 for the National Congress's consideration. ANVISA withdrew its resolution in view of INCA's draft amendment, which languished at the end of 2009.[62] For a while, tobacco-control efforts reached a stalemate on the legislative and regulatory fronts.

The stalemate may soon resolve due to recent progress toward additional federal legislation. In March 2010, the Brazilian Senate's Committee on Constitution, Justice, and Citizenship (JCC) approved a proposed bill (PLS 315/08) that would amend Law 9294 to require 100% smoke-free public spaces.[63] Numerous public health and medical organizations showed support for the bill,[64] and, according to the JCC rapporteur, the amendment would finally align Brazil's federal laws with the FCTC's Article 8

objective. Following the JCC's favorable vote, the bill must be approved by the Brazilian Commission for Social Affairs before being considered by Congress.[65]

In addition to formal legislation, two interministerial ordinances establish nonbinding recommendations on smoking restrictions in Brazil's indoor spaces.[66] First, Interministerial Ordinance 3257 recommends measures to restrict smoking in workplaces and determines the designation of smoking areas, which must be isolated and properly ventilated. This Ordinance, passed in 1988, long predates Law 9294 and is less important than Decree 2018. Interministerial Ordinance 1498 recommends that health and teaching institutions implement tobacco-free environment programs and award certificates to those entities with exemplary tobacco-control policies.

B. State and Local Law

Progress toward smoke-free environments at the state and local levels has been slow. To effectively implement Law 9294, state and local officials require clear guidance on how to enforce ill-defined "designated smoking areas." Decree 2018 has not served that purpose well and either ANVISA's proposed regulation or INCA's proposed legislative amendment, whichever passes, will be much welcomed. In the meantime, ANVISA is developing guidelines on how to apply Law 9294 and public agents were trained to implement the law in 2006.[67]

Whether ANVISA will be able to provide meaningful guidance is questionable. Law 9294 calls for properly ventilated designated smoking areas in enclosed spaces – an oxymoron in light of later scientific evidence. It is now well accepted in the public health community that no ventilation controls can protect nonsmokers against SHS in enclosed spaces. State and local legislators may have to wait for an amendment to Law 9294 before trying to implement it in a significant way.

In the meantime, some states and municipalities have initiated their own smoke-free laws and programs. Their progress is difficult to quantify because there are no databases of state and municipal laws related to tobacco control.[68] From what little information is known, tobacco-control coverage varies and the majority of implementation programs are concentrated in three of Brazil's twenty-six states.[69]

In August 2009, São Paulo, Brazil's most populous and economically prominent state, passed a law (São Paulo Law No. 13541) banning smoking in enclosed public spaces with no exception for designated smoking areas.[70] The São Paulo law exceeds the reach of Law 9294 and provides the full protection guaranteed by Article 8 of the FCTC. Noncompliance results in monetary penalties and closure of the establishment upon a repeat offense.[71] Although São Paulo has attempted such a ban before, it failed due to weak enforcement and public apathy.[72] This time around, São Paulo reports over ninety-nine percent compliance by its pubs, restaurants, and hotels.[73] Although the law prompted a litany of lawsuits, state courts have so far upheld the law.[74]

The São Paulo law is a revolutionary test case for Brazil that may spur more rapid progress. No doubt many states and municipalities are watching to see how courts resolve the preemption issue (i.e., whether states' and municipalities' strict smoke-free laws are preempted by the weak federal law). Many state and municipal laws have been challenged as preempted and thus unconstitutional by the hospitality industry (often a front for tobacco companies).[75] A non-governmental organization (Aliança de Controle do Tobagismo (ACT)) recently commissioned a legal analysis on the preemption issue, which was presented to the Interministerial National Commission for FCTC Implementation (CONICQ).[76]

INCA's tobacco control program supplements legislative initiatives, but it has faltered recently. INCA coordinates the federal tobacco program with state and local anti-tobacco regulations and activities. INCA acted as an intermediary in the first agreements between the National Health Fund and State Health Secretariats in 1999.[77] From these agreements, states and municipalities developed smoking control programs and established a network of focal points in major cities. This network started to localize tobacco control efforts, but progress waned due to high turnover of trained staff for political reasons.[78] Furthermore, the program abruptly lost funding when the mechanism INCA had used to transfer federal funds to states and municipalities was eliminated.[79] INCA has pledged to revive it efforts to assist municipal implementation of Law 9294.[80]

C. Summary of Brazil's Top Down Legal Approach

In summary, Brazil's top down approach consists mainly of a weak federal law that is difficult for courts to interpret and thus not locally enforced. Federal regulations have done little to clarify the law, and further progress has been frustrated by lack of coordination between the two bodies sharing authority for federal tobacco programs. Limited though it may be, the success of the federal tobacco program thus far is due in large part to its management by a public health agency that is isolated from the tobacco lobby and political pressures. States and municipalities have begun to enact strict smoke-free laws, but their status will remain unclear until the Brazilian Supreme Court decides whether they are preempted by the weak federal law.

IV. United States: Bottom Up Approach to Regulating SHS

The United States' bottom up approach consists mainly of municipal and state smoke-free laws, which are not uniform throughout the country. SHS regulation at the federal level is sparse due to the strength of the tobacco lobby. Overall, the bottom up approach has significantly reduced nonsmokers' exposure to SHS since 1986, evidenced by survey and epidemiological data.[81] Regulatory gaps still expose many vulnerable groups to high levels of SHS, including children, certain ethnic groups (in particular, blacks and Hispanic women), low-income individuals, and workers in the hospitality and transportation industries.[82]

A. Local Law

Of the three levels of government in the United States, local ordinances afford the best protection against SHS. The city or county officials responsible for enacting ordinances are far more responsive to their local boards of health and residents than the tobacco industry. These local ordinances are usually well known in their communities and enforced by local officers. Furthermore, the independence and dispersed locations of the 3000+ municipalities that restrict smoking keep the tobacco industry at bay.[83]

Local ordinances vary in their coverage of smoke-free facilities. Generally, they require one or more of 100% percent smoke-free workplaces, 100% smoke-free restaurants, and 100% smoke-free freestanding bars.[84] Some municipalities also restrict smoking in outdoor areas (e.g., near building entrances and windows, parks, beaches, or sporting and entertainment venues).[85] These local laws vary in substance, but Americans' for Nonsmokers' Rights provides a model ordinance that guides most jurisdictions tackling the issue.[86] The model ordinance guarantees "the right of nonsmokers to breathe smoke-free air."[87] The model ordinance also finds support in the smoke-free laws of the international community.[88]

Although it is not common practice local governments can channel international treaties directly to their communities, even when those treaties not ratified in the United States. For example, the City of San Francisco has adopted an ordinance implementing CEDAW[89] and the New York City Human Rights Law incorporates CEDAW and Committee on the Elimination of Racial Discrimination.[90] In theory, city governments could adopt Article 8 of the FCTC (relating to SHS).

Local ordinances represent the "bottom" of the bottom up approach and provide a strong base for nonsmokers' rights. Unfortunately, they also are vulnerable to preemption by more relaxed federal and states laws. Federal preemption has not truly threatened local ordinances due to the tobacco industry's ability to frustrate higher-level legislation. The more Congress frees itself from the grip of Big Tobacco, the greater the threat that a more lenient federal law will preempt local smoke-free laws.

Preemption by state law presents a more immediate and continuing threat. Currently thirteen states have smoke-free laws with preemptive provisions, which may offer more or less protection than existing local laws.[91] Some local ordinances have survived preemption challenges under state law; others have not. State courts have found implied preemption based on statutes silent on preemption, ambiguous or conflicting preemption clauses, collections of state statutes (all silent on preemption), or state constitutions.[92] Only explicit non-preemption clauses in state statutes guarantee that a local smoke-free ordinance will stand.

It is important to resolve preemption issues as soon as possible, since that threat alone can chill local smoke-free efforts. For example, after a smoke-free law in San Jose survived a preemption challenge by the California State Department of Health a network of local ordinances were rapidly enacted throughout the state.[93] These local smoke-free laws filled the gaps in the state law, making California the first Article 8-compliant state. Thus, although preemption threatens local laws, resolving the issue can galvanize rapid progress toward smoke-free environments.

B. State Law

States protect their residents from SHS using statutes, constitutions, and common law. While state smoke-free laws are becoming more common, many do not meet the FCTC's Article 8 standard. State common law helps to fill the gaps, and state courts are often receptive to creative legal theories incorporating fundamental rights.

1. State Statutes and Constitutions

States have enacted laws to restrict SHS in various institutional settings (e.g., correctional facilities, child care and juvenile centers, hospitals, and adult residential care facilities).[94] Currently twenty-seven states, Washington, DC, and Puerto Rico have passed smoke-free laws that cover restaurants and bars.[95] Four additional states have smoke-free laws that cover restaurants but exempt stand-alone bars. Only fifteen states and Puerto Rico have enacted one hundred percent smoke-free laws for all state-regulated casinos and gaming facilities.

Several states offer constitutional protection from SHS. Florida's constitution specifically recites a smoke-free provision but permits exceptions (e.g., stand-alone bars).[96] Montana's constitution recognizes a broader "right to a clean and healthful environment" as an inalienable right.[97] Similarly, the New York state constitution imposes an obligation on the state to protect and promote the health of its inhabitants.[98] Such a broad, health-related constitutional right is also helpful as a legal tool to protect against SHS. State courts can, and often do, look to international human rights treaties (ratified or not) to interpret their own constitutions and statutes.[99]

State courts may also apply more general statutes to protect the right to a smoke-free environment, aided by interpretative tools of their choosing, including international human rights norms. For example, in *In re Julie Anne*, a child custody proceeding, a Court of Common Pleas relied on Ohio's "best interest of the child" statute and the doctrine of *parens patriae* (state acts as "parent of the nation") to restrain parents and others from smoking in a child's presence.[100] To determine what was in the "best interest" of the child, the court looked to the CRC (not ratified by the United States but serving as international customary law) and its finding that imposes a "duty as a matter of human rights to reduce children's compelled exposure to tobacco smoke."[101] The court also relied on U.S. Supreme Court cases suggesting that smoking is not a fundamental right and took judicial notice of overwhelming scientific evidence that SHS causes and aggravates diseases in children.[102] Using this powerful doctrinal combination, the court prohibited SHS from the child's presence in private residences and motor vehicles, arguably exceeding the FCTC's Article 8 standard. *In re Julie Anne* embodies a child's right to a smoke-free home.

State statutes, in combination with local laws, go a long way to protect residents from SHS. According to the Americans for Nonsmoker's Rights Foundation, seventy-one percent of the U.S. population is covered by a state, or local law requiring smoke-free workplaces, restaurants, or bars; forty-one percent of the U.S. population is covered by laws that require all three venues to be smoke-free.[103] Still, substantial gaps in official laws require courts to look elsewhere for legal doctrine.

2. State Common Law

Courts have relied on state common law to find the right to a smoke-free workplace and rental residence. The common-law approach is powerful because it allows courts to consider evolving social and cultural values, including society's increasing disdain for SHS.[104] At the same time, common law may compromise human rights when society does not fully recognize them. Nonetheless, because of their receptiveness to creative legal theories, state courts can provide a favorable forum for implementing human rights.[105]

Courts have applied common law to protect an employee's right to a smoke-free environment, though remedies are limited. In *Shimp v. New Jersey Bell Telephone Co.*, the Superior Court of New Jersey recognized the common-

law right to a safe working environment and ordered the employer to prohibit smoking in working and customer-service areas.[106] Groundbreaking as the case was in 1976, the court limited the smoke-free right by stating that employees "should have a reasonably accessible area in which to smoke" at work, such as the lunchroom and lounge.[107] Similarly, in *Smith v. Western Electric Co.*, the Missouri Court of Appeals allowed an employee to proceed with a claim that his employer breached a common-law duty to provide a reasonably safe workplace by permitting smoking.[108] The court found an injunction to be the appropriate remedy because monetary damages could not compensate for the health effects of SHS.[109]

In the *Shimp* and *Smith* cases, preemption threatened the viability of the nonsmoker-employees' claims. Fortunately, the only federal law arguably preempting states' abilities to regulate SHS contained a nonpreemption clause.[110] The *Shimp* and *Smith* courts held that the nonpreemption clause of the Occupational Safety and Health Act (OSH Act) did not preempt a common law claim asserting the right to a safe working environment.[111]

In another notable case, *Gainsborough St. Realty Trust v. Haile*, a Massachusetts housing court recognized a tenant's common-law right to quiet enjoyment in a rented residence. In *Gainsborough*, the landlord breached the covenant of quiet enjoyment by failing to prevent smoke from seeping in from an adjacent unit. The court awarded the tenant withheld rent ($4350) but rejected the tenant's claim for damages for smoke-induced asthma (six million dollars), citing failure to prove causation.[112]

Finally, state courts may also consult international human rights treaties to determine the limits of positive rights under state common law or use customary international norms when developing state common law.[113]

C. Federal Law

The United States has neither ratified the FCTC nor enacted comprehensive federal legislation to control SHS. Narrow federal laws prohibit smoking on domestic and international airline flights and in enclosed areas of school facilities.[114] Under executive order, smoking is prohibited in all interior spaces and nearby outdoor areas owned, rented, or leased by the Executive Branch.[115]

No federal regulations control indoor smoking. The Occupational Safety and Health Administration (OSHA) once proposed a rule to regulate environmental tobacco smoke, citing authority from the OSH Act.[116] OSHA withdrew the proposed rule seven years later, in view of the numerous state and local smoke-free laws passed in the interim.[117] An advocacy group that initially challenged OSHA's failure to issue a final rule dropped its claim for fear that OSHA would issue a weak rule preempting strong existing and future state and local laws.[118] The EPA has no authority to regulate indoor air quality, though it can provide guidance. For example, the agency's 1992 report classifying SHS as a carcinogen is frequently cited in state court cases and state and local anti-smoking laws.

Recently Congress passed a comprehensive law granting the Food and Drug Administration authority to regulate tobacco products (the Family Smoking Prevention and Tobacco Control and Federal Retirement Reform Act of 2009).[119] Although the Act does not address SHS, it is nonetheless noteworthy because it represents what Congress can practically accomplish, given the powerful tobacco lobby. The Act favors the tobacco industry on certain issues, for example, by partially preempting state and local laws and staffing the scientific advisory committee with tobacco industry representatives.[120] If Congress were to enact legislation restricting indoor smoking, the tobacco lobby and preemption remain real threats. It is hard to say whether such legislation would be an advance or a setback for the smoke-free movement.

Federal case law addressing SHS exposure is likewise limited. The Americans with Disabilities Act (ADA) has supported some successful claims, but the doctrine that has emerged provides limited protection to nonsmokers.[121] An ADA plaintiff must show an existing disability (e.g., asthma or a respiratory condition) and thus must have been exposed to SHS for a substantial time and sustained significant physical harm. The U.S. Supreme Court addressed the issue in *Helling v. McKinney*, holding that a prisoner's exposure to unreasonable levels of SHS supported a viable claim under the Eighth Amendment (prohibiting cruel and unusual punishment).[122] Finally, federal courts are generally unreceptive toward arguments derived from international human rights treaties (most of which have not been ratified by the United States), even when offered as persuasive authority.[123]

Summary of the United States' Bottom up Legal Approach

In summary, the United States' bottom up approach emphasizes state and local codified laws, supplemented by state common law establishing the right to live and work in smoke-free environments. State courts have embraced rights-based arguments, considering fundamental rights from various sources, including international human rights treaties as persuasive or interpretive authority. Compared to their state counterparts, federal statutes and case law offer very limited protection from SHS. If federal statutory law were to emerge, it would likely be weakened by the tobacco lobby and threaten preemption of stronger state and local smoke-free laws.

V. Evaluation of the Top Down and Bottom Up Approaches

A. Legal Analysis and Recommendations

The above discussion highlights the differences and similarities between Brazil's top down and the United States' bottom up approaches. On the one hand, Brazil's framework is top heavy, dominated by a universal, though weak, federal law. Courts have been preoccupied with interpreting the ambiguous federal law and have done little to advance nonsmokers' rights. The United States, on the other hand, has a pyramid-type framework, with a strong base of local and state laws but sparse federal legislation. State courts have advanced nonsmokers' rights through nonstatutory authorities. Beyond these differences, Brazil and the United States have similarly struggled with the preemption threat and influence of the tobacco lobby at the federal level.

The comparative analysis of Brazil's and the United States' approaches may be summarized as follows:

Brazil: Top Down Approach	United States: Bottom Up Approach
Top: Universal, though weak, smoke-free law permitting designated smoking areas. FCTC ratified.	**Top**: Smattering of federal smoke-free measures covering small portion of population. FCTC not ratified.
Bottom: Few local and state smoke-free laws, though more are emerging.	**Bottom**: Strong network of local and state smoke-free laws, though not uniform throughout the country.
Courts: Interpretive difficulties prevent implementation of federal smoke-free law.	**Courts**: State courts advance nonsmokers' rights by relying on nonstatutory authority.
Preemption: Threat that state and local laws are preempted by existing federal law, an issue to be settled by Brazil's Supreme Court.	**Preemption**: Some local laws have been preempted by state laws. Threat that state and local laws will be preempted by future federal law.
Tobacco Lobby managed by sequestering tobacco control program in remote, federal public health body (INCA).	**Tobacco Lobby** managed by concentrating smoke-free initiatives in local authorities responsive to local public health boards.

In view of the lessons learned from the Model States, the following recommendations are offered to assist other Pan American States in their smoke-free initiatives:

Recommendation #1: Plan for Preemption

Regardless of whether the top down or bottom up approach is used, lower levels of government have more practical freedom to enact smoke-free laws because they are more remote from the tobacco lobby and cooperate closely with public health officials. Local laws will likely exceed the protection from SHS afforded by state and federal laws and regulations. As such, preemption of local laws is a predictable issue.

Therefore, it is important to plan for preemption. First, if a federal or state law or regulation is pending, public health advocates should urge that an explicit preemption clause be included to permit municipalities to act with certainty.[124] Second, if such legislation or regulation already exists, the preemption question should be resolved as soon as possible so that uncertainty does not chill local legislation. Historically, the preemption issue is settled *ex post* when the ordinance is challenged in court. But an *ex ante* approach is advisable when planning ordinances. Local officials can request guidance or advisory opinions on preemption from federal and state legislators and regulators. While such feedback is nonbinding, it could signal legislators' and regulators' positions early on and possibly suppress a preemption challenge later. Third, local authorities should examine higher-level statutes and regulations, along with interpretive court decisions, to identify possible preemption issues.[125] If a statute or regulation is ambiguous, it may be possible to tailor the language of an ordinance to increase its chances of surviving a preemption challenge.

Recommendation #2: Sequester the Primary Regulators from the Tobacco Lobby

History instructs that wherever the tobacco lobby concentrates its efforts, legislative efforts falter. Brazil managed to overcome this legislative suppression by focusing regulatory efforts in a public health agency (INCA) out of the tobacco lobby's reach.[126] The United States achieved the same by diffusing regulatory efforts over thousands of municipal authorities too numerous for the tobacco lobby to fight. In both cases, these regulatory "safe harbors" enabled smoke-free initiatives to flourish.

Recommendation #3: Connect the Top and the Bottom Through Fundamental Rights

Article 8 of the FCTC represents the "top" or highest-level authority calling for a smoke-free world, supported by the international community. Article 8 articulates the strongest declaration of the fundamental right to a smoke-free environment, linking it to the right to health in human rights treaties and international customary law. The strength of the smoke-free right is compromised by the aspirational nature of the FCTC.

At the "bottom" are local laws, representing the lowest level of authority. These laws have the virtue of being practical and enforceable.

The top and the bottom should be connected to combine the virtues of both. Accordingly, Article 8 of the FCTC should be directly incorporated into local smoke-free ordinances. There is no legal reason why this cannot be done. PAHO has offered model federal legislation on tobacco control for the Pan American States.[127] Similarly, a model ordinance incorporating Article 8 should be available as well.

Recommendation #4: Build Legal Doctrine in Receptive Courts

Courts can provide a forum to advance nonsmokers' rights when legislative measures falter. In countries where international human rights treaties have been codified in domestic statutes, courts may extend the enforceable right to health to protect nonsmokers' right to a smoke-free environment. In countries where the international right to health is not explicitly incorporated into domestic laws, courts may still be receptive to the use of international customary law as persuasive or interpretive authority. For example, courts may use treaties to interpret domestic statutes or constitutions embodying a right to health, or to define a positive right to health in nonstatutory law. This approach would provide legal precedent for using international customary law to bolster the right to a smoke-free environment. Furthermore, the use of these treaties in court decisions strengthens their place in international customary law, making them more available to support future claims to a smoke-free right.

Recommendation #5: Use Scientific Research on SHS to Identify Legal Approaches.

The two Model States successfully used the results of scientific research to advance SHS reforms. In Brazil, federal laws and regulations gained support as scientific research revealed the harmful effects of SHS. In the United States, state laws, local ordinances, and judicial opinions similarly cited scientific findings and publications on SHS.

Ongoing research on SHS continues to provide evidence that may support novel legal approaches. For example, scientists have recently discovered that certain nonsmokers, identifiable by particular genetic markers, are more susceptible to developing lung cancer.[128] Further research may confirm that certain individuals are disproportionately harmed by SHS. As such, they may form a "vulnerable group" warranting heightened protection under international human rights laws. Their genetic predisposition to lung cancer may qualify as a "disability" under the ADA, allowing them to obtain an injunction against smoking in the workplace before sustaining harm from SHS.

In addition, researchers recently discovered that residual nicotine from tobacco smoke adsorbed to indoor surfaces react to form new carcinogenic substances – in essence, "thirdhand smoke."[129] According to the researchers, thirdhand smoke presents a previously unappreciated health hazard through dermal exposure, dust inhalation, and ingestion.[130] If further research reveals significant health consequences, exposure to thirdhand smoke may support new legal theories. For example, a nonsmoker harmed by exposure to thirdhand smoke may be able to bring a claim against a former smoker-tenant or former smoker-owner of a used car.

B. Inter-American Commission and Court on Human Rights

Brazil's top down and the United States' bottom up approaches have enabled rapid and significant progress toward smoke-free environments. But both approaches leave gaps, due to incomplete regulatory schemes and ineffective enforcement efforts. As a result, many individuals in the Model States are involuntarily exposed to SHS on a regular basis. By failing to guarantee a smoke-free environment for all, these States violate the internationally recognized right to health.

When American States fail to protect human rights, the Inter-American System provides a forum for aggrieved individuals. The System consists of the Inter-American Commission on Human Rights and the Inter-American Court on Human Rights. Its jurisdiction is established by the American Convention on Human Rights ("American Convention") and the American Declaration on the Rights and Duties of Man ("American Declaration").[131] The Commission's primary purpose is to address human rights violations in the thirty-five Member States of the Organization of American States (OAS).[132]

Under the Inter-American System, an aggrieved individual must first exhaust remedies under domestic law.[133] If the individual is denied domestic remedies, he may file a petition with the Commission against the Member State allegedly violating a human right recognized by the American Convention.[134] The Commission investigates the case and works with the parties to reach an amicable settlement.[135] If that fails and the Commission finds a human rights violation, the Commission may make recommendations binding on the State Party and monitor for compliance or refer the case to the Court.[136] If appropriate, the Court considers the case and issues a judgment legally binding on Member States that have ratified the American Convention.

Not all Member States have ratified the American Convention. Currently 24 out of 35 OAS countries are parties to the Convention, and 11 are nonparties. For non-Convention Party States, the Commission applies the American Declaration. The Declaration is not a legal, binding document but defines rights recognized by international customary law (at least in part[137]), including the right to life.[138] The Commission may still make recommendations, but they are not binding on non-Convention Party States.[139] These cases also cannot be referred to the Court, though they can be published in the Commission's annual report. The publication alone can be helpful to reveal a human-rights problem and prompt dialog to address it.

The Inter-American System has not explicitly recognized exposure to SHS as a human-rights violation. Neither the Commission nor the Court has faced the issue directly. However, they must recognize the right to life under Article 4 of the American Convention (or Article I of the American Declaration). Recently, the Court's interpretation has evolved to encompass the right to a "dignified life" or "dignified existence," and, implicitly, the right to health.[140] The Court clarified the positive right to a dignified life and the State's affirmative duty to protect that right, particularly for vulnerable groups in *Yakye Axa Indigenous Community v. Paraguay* and *Sawhoyamaxa Indigenous Community v. Paraguay*.[141]

In *Ximines-Lopes v. Brazil*,[142] the Court elaborated on the State's affirmative duty to protect the right to a dignified life. There, the Court established States' affirmative duty to regulate public healthcare systems that threaten the right to a dignified life.[143] The scope of the *Ximines-Lopes* duty to regulate public healthcare is not yet clear. It has been viewed in light of General Comment No. 14 of the ICESCR, clarifying States' duties to protect the right to health: "Violations of the right to health can occur through the direct action of States or other entities insufficiently regulated by the States."[144] Thus *Ximines-Lopes* and General Comment No. 14 suggest that "a state should not be liable for a human rights violation if there are adequate state guidelines and monitoring."[145]

Under the standard of *Yakye Axa*, *Sawhoyamax*, and *Ximines-Lopes*, a right-to-life violation requires that (i) state authorities knew or should have known about a situation posing an immediate and certain risk to life (knowledge requirement); and (ii) state authorities failed to take necessary measures to prevent or avoid such risk within the scope of their authority (state inaction),[146] where (iii) that authority may be derived from Article 2 of the American Convention,[147] not necessarily from domestic legislation.[148]

Already supported by the human-rights community, the case for recognizing the right to a smoke-free environment under Article 4 is now more compelling under the Court's broadened view of the right to life.[149] Applying the standard for a right-to-life violation in this context, the knowledge requirement is satisfied, as OAS Member States certainly know of the internationally publicized, life-threatening effects of SHS. State inaction is apparent in particular States, since many have failed to adopt or enforce adequate measures to protect the right to a smoke-free environment. This inaction leaves many vulnerable groups (e.g., women, children, and the poor) at risk for life-threatening conditions. Even in the absence of domestic authority, States are obligated to use their authority under Article 2 of the American Convention to regulate SHS.

If the right to a smoke-free environment were recognized under Article 4, the Commission could require certain actions by a State that has failed to protect that right. For example, the Commission could require a State to regulate environments where SHS threatens vulnerable groups. This outcome could prompt a State to adopt or enforce legislation to regulate SHS.

Brazil and the United States serve as Model States for considering right-to-life violations in the Inter-American System. Brazil represents the 24 OAS States that have ratified the American Convention, while the United States represents the 11 non-Convention Party States. Because the right-to-life analysis is conducted differently for Convention Party and non-Convention Party States, they considered separately here.

Brazil as a Model for Convention Party States

Brazil ratified the American Convention, and, accordingly, the Inter-American Commission may apply the right-to-life standard of Article 2, demand compliance with the Commission's recommendations, and refer the case to the Inter-American Court, if necessary. A petition could be filed by a Brazilian individual whose right to health has been violated due to SHS exposure and who was unable to obtain an adequate remedy under domestic laws. Assuming the Commission recognized the right to a smoke-free environment under Article 4, the Court's right-to-dignified-life doctrine would be applied as follows: (i) Brazilian state officials *have knowledge* that Law 9294 does not adequately protect nonsmokers from SHS since, according to its own Ministry of Health, designated smoking areas (ventilated or not) do not work as protective measures;[150] and (ii) the State has *failed to take necessary actions* to protect the right to life by failing to enforce Law 9294 in most municipalities. (The state of São Paulo and the handful of smoke-free municipalities are the exception in Brazil.) Furthermore, even if Law 9294 were fully enforced throughout the country, Brazil still fails to fulfill the *Ximines-Lopes* duty to regulate public health. That sole federal law regulating SHS permits designated smoking areas in enclosed public spaces, which, even when ventilated, fail to protect nonsmokers from SHS.

If the Commission found a right-to-life violation, it could recommend legislative or regulatory actions with which Brazil must comply. For example, the Commission could recommend that Brazil amend Law 9294 to require a smoke-free environment for all public indoor spaces in their entirety (no designated smoking areas). If Brazil did not comply with the recommendation, the case could be referred to the Court for a binding legal judgment.

The United States as a Model for Non-Convention Party States

The United States signed the American Convention but never ratified it or incorporated it into national law. (Both measures are required to enforce an international convention in the dualist system followed by the United States.) As such, while the Commission could consider a petition against the United States, the Commission would apply the American Declaration and could only make nonbinding recommendations to rectify a human rights violation.

Assuming the Commission recognized the right to a smoke-free environment under Article 1 of the American Declaration, the Commission could apply the right-to-dignified-life doctrine as international customary law: (i) U.S. state officials *have knowledge* that its citizens are exposed to levels of SHS in public spaces that cause numerous life-threatening conditions, evidenced by the U.S. Surgeon General's 2006 Report; and (ii) the State has *failed to take necessary actions* to protect the right to life by failing to adopt nation-wide legislation restricting SHS in all public spaces. Indeed, the lack of federal legislation is evidence that the United States has not even attempted to fulfill the *Ximines-Lopes* duty to regulate public health.

If the Commission found a right-to-life violation, it could recommend legislative or regulatory actions, though they would not bind the United States. Still, the case could be published in the Commission's annual report. The mere recognition that inadequate protection from SHS violates the right to life would create a foothold in international customary law. The publication could also assist advocacy groups in the United States and elsewhere to legally support their arguments for stronger regulation of SHS.

Summary

The Inter-American System promises a powerful means to address human rights violations associated with SHS. Given the Court's recent expansion of the right to life, vulnerable individuals may pursue a new forum when OAS Member States have failed to protect their right to a smoke-free environment. Furthermore, the Inter-American Commission and Court can prompt states to adopt or strengthen their efforts to regulate SHS.

VI. Conclusion

For nonsmokers, secondhand smoke represents an unjust public health threat and a human rights tragedy. Article 8 of the Framework Convention on Tobacco Control declares the right to a smoke-free environment and calls on States to protect that right. Sadly, the smoke-free standard of Article 8 remains an aspirational goal for many countries.

Brazil and the United States have made outstanding progress in regulating secondhand smoke and thus serve as Model States for countries embarking on smoke-free initiatives. The Model States have pursued diametric legal approaches (top down and bottom up, respectively), and, between the two of them, have tested a range of regulatory tactics. Successful tactics include the sequestration of regulators from the tobacco lobby, the use of rights-based arguments in receptive courts, and the involvement of public health officials in regulatory efforts. In both approaches, preemption by weak federal law and the influence of tobacco industry at the federal level present substantial challenges.

Neither Brazil's top down nor the United States' bottom up approach is perfect. The Inter-American System provides a forum to assert the right to a smoke-free environment when domestic laws fall short. The Inter-American Court on Human Rights recently expanded the scope of the right to life in the American Convention on Human Rights, suggesting that States may have an affirmative duty to protect the right to a smoke-free environment.

By understanding the successes and challenges of regulating secondhand smoke, States can eventually fulfill the goal of guaranteeing a smoke-free environment to all of their citizens.

[1] Roemer, et al., *Origins of the WHO Framework Convention on Tobacco Control*, Am. J. Pub. Health 2005, 95(6): 936-938.
[2] *WHO Report on the Global Tobacco Epidemic 2008 – The MPOWER Package*, at 6, *available at* http://www.int/tobacco/mpower/2008/en/index.html [hereinafter "WHO MPOWER 2008 Report"].
[3] *Id*. at 8.
[4] WHO Guidelines for implementation: Article 5.3, Article 8, Article 11, Article 13 (2009), at 23, *available at* http://www.who.int.fctc/guidelines/en [hereinafter "FCTC Implementation Guidelines"].
[5] *See generally The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General* (2006), at Chapter 2 [hereinafter "2006 Surgeon General Report"].
[6] WHO MPOWER 2008 Report, *supra* note 2, at 7.
[7] *Id*. at 12.
[8] *See generally* 2006 Surgeon General Report, *supra* note 5, at Chapters 5 and 6.
[9] WHO Framework Convention on Tobacco Control, May 21, 2003 [hereinafter "FCTC"].
[10] FCTC Implementation Guidelines, *supra* note 4, at 20.
[11] Statistics reported by WHO, last updated October 22, 2009, *available at* http://www.who.int/fctc/signatories_parties/en/index.html.
[12] David P. Fidler, International Law and Public Health: Materials on and Analysis of Global Health Jurisprudence (2000) at 188-192.
[13] FCTC, *supra* note 9, at vi.
[14] WHO Reports of the Parties received by the Convention Secretariat and progress made internationally in implementation of the Convention, Second Summary Report (October 14, 2008), *available at* http://www.who.int/fctc/reporting/summary_analysis/en/index.html.
[15] 2006 Surgeon General Report, supra note 5, at 634-650.
[16] Conference of the Parties to the WHO FCTC, Decision FCTC/COP1(15) (March 23, 2006), at 47, *available at* http://apps.who.int/gb/fctc/PDF/cop1/FCTC_COP1_DIV8-en.pdf; *see also* FCTC Implementation Guidelines, *supra* note 4, at 23.
[17] WHO MPOWER 2008 Report, *supra* note 2, at 46.
[18] FCTC, *supra* note 9, at v.
[19] FCTC Implementation Guidelines, *supra* note 4, at 19-20 ("The duty to protection from tobacco smoke, embodied in the text of Article 8, is grounded in fundamental human rights and freedoms. Given the dangers of breathing second-hand tobacco smoke, the duty to protect from tobacco smoke is implicit in, *inter alia*, the right to life and the right to the highest attainable standard of health, as recognized in many international legal instruments . . . .").
[20] *Id*.
[21] Rangita de Silva de Alwis and Richard Daynard, *Reconceptualizing Human Rights to Challenge Tobacco*, 17 Mich. St. J. Int'l L. 291, 293 (2008–2009); Melissa E. Crow, *Smokescreens and State Responsibility: Using Human Rights Strategies to Promote Global Tobacco Control* (2004), at 211.
[22] PAHO serves as WHO's Regional Office for the Americas.
[23] PAHO, *Exposure to Secondhand Tobacco Smoke in the Americas: A Human Rights Perspective* (May 2006), *available at* http://new.paho.org/hq/index.php?lang=en, under Health and Human Rights.
[24] de Alwis and Daynard, *supra* note 22, at 297-298; *id.* at 16.
[25] *See id*. at 300.
[26] *Id.* at 300-301.
[27] *Id*. at 301.
[28] Melissa E. Crow, *Smokescreens and State Responsibility: Using Human Rights Strategies to Promote Global Tobacco Control*, 29 Yale J. Int'l L. 209, 230-246 (2004).
[29] PAHO Strategic Plan 2008-2012 Amended (DRAFT), Official Doc. No. 328, at page 8 (noting significant progress made recently in Brazil and Uruguay, as well as the United States, Canada, and Argentina at the subnational level) [hereinafter "PAHO Strategic Plan"].
[30] Omar Shafey, et al., *The Tobacco Atlas* (3rd ed. 2009), at 49 and 52 [hereinafter "Tobacco Atlas"].
[31] The O'Neill Institute, Campaign for Tobacco-Free Kids, and ACTbr, Shadow Report to the Periodic Report of the Government of Brazil, *Preventing, and Reducing Tobacco Use in Brazil: Pending Tasks*, United Nations Committee on Economic, Social, and Cultural Rights, 42nd Session Period (May 4-22, 2009) [hereinafter "O'Neill Report"], at 12; Food and Agriculture Organization of the United Nations, *Issues in the Global Tobacco Economy* (2003), at Chapter 2, *available at* http://www.fao.org/docrep/006/y4997e/y4997e04.htm.
[32] Tobacco Atlas, *supra* note 31, at 50-53. Note that Philip Morris International split from Altria in March 2008.
[33] Yves Beigbeder, *Tobacco, the Perfect Foe*, in *International Public Health* (2004), at 140-41.
[34] Thomas E. Novotny and Hadii M. Mamudu, The World Bank, *Progression of Tobacco Control Policies: Lessons from the United States and Implications for Global Action* (May 2008), at 32-34 [hereinafter "2008 World Bank Report"]; Stella A. Bialous, *Brazil: Growers' Lobby Stalls FCTC*, *Tobacco Control* 2004, 13: 323-24.
[35] Tobacco Atlas, *supra* note 31, at 60.
[36] Statistics *reported* at http://www.opensecrets.org.
[37] *Brazil and Tobacco Use: A Hard Nut to Crack*, Bulletin of the World Health Organization (Nov. 2009), 87(11), *available at* http://www.who.int/bulletin/volumes/87/11/09-031109/en/print.html [hereinafter "2009 WHO Bulletin"].
[38] Luisa M. da Costa e Silva Goldfarb, *Government Leadership in Tobacco Control: Brazil's Experience*, in Tobacco Control Policy: Strategies, Successes, and Setbacks (2003), at 40, *available at* http://www1.worldbank.org/tobacco/pdf/2850-Ch03.pdf.
[39] Elisa K. Ong and Stanton A. Glantz, *Tobacco industry efforts subverting International Agency for Research on Cancer's second-hand smoke study,* The Lancet 2000, 355: 1253-59.
[40] *Id*. at 1255-56.
[41] Joaquin Barnoya and Stanton A. Glantz, *Tobacco industry success in preventing regulation of SHS in Latin America: The "Latin Project,"* Tobacco Control 2002, 11: 305-14.
[42] *See generally id.*
[43] *See* 2006 Surgeon General Report, *supra* note 5, at 576 (providing an account of the legal challenge to the EPA's report).

[44] *Flue-Cured Tobacco Coop. Stabilization Corp. v. U.S. Envtl. Prot. Agency*, 313 F.3d 852, 862 (4th Cir. 2002).
[45] *WHO Report on the Global Tobacco Epidemic 2009: Implementing Smoke-Free Environments*, at Appendix V, *available at* http://www.who.int/tobacco/mpower/2009/Appendix_V_table_1.pdf [hereinafter "WHO 2009 Report"].
[46] PAHO Strategic Plan, *supra* note 30, at page 8, para. 25.
[47] Instituto National de Cáncer (INCA), Tobacco and Other Cancer Risk Factors Control Program ,Program Outcomes, Chapter 3 at 2-8, *available at* http://www.inca.gov.br/english/tobacco/programstate.pdf [hereinafter "INCA Program Outcomes"].
[48] Roberto Iglesias et al., *Tobacco Control in Brazil*, World Bank, HNP Discussion Paper (August 2007), at xii, *available at* http://siteresources.worldbank.org/BRAZILEXTN/Resources/TobaccoControlinBrazilenglishFinal.pdf?resourceurlname=TobaccoControlinBrazilenglishFinal.pdf [hereinafter "2007 World Bank Report"]
[49] Brazil Const., art. 196 (1988) ("Health is a right of all and a duty of the State and shall be guaranteed by means of social and economic policies aimed at reducing the risk of illness and other hazards and at the universal and equal access to actions and services for its promotion, protection and recovery.").
[50] International Covenant on Economic, Social, and Cultural Rights, art. 12(1).
[51] International Covenant on Economic, Social, and Cultural Rights, General Comment No. 14, art. 12(2)(b) (Nov. 8, 2000).
[52] WHO 2009 Report, *supra* note 46, at 84, Table 1.0.2 (reporting 14% adult daily smoking in 2006, down from 34% in 1989), *available at* http://www.who.int/tobacco/mpower/2009/Appendix_V_table_1.pdf. *See also* 2007 World Bank Report, *supra* note 49, at 13 and 25 (reporting an increase in nonsmoking households from 66% in 1995 to 73% in 2002).
[53] Statistics made available by Ministry of Health of Brazil, INCA, *available at* http://www.inca.gov.br. *See also* INCA's official press release in Portuguese (Aug. 22, 2008), *available at* http://www.inca.gov.br/releases/press_release_view.asp?ID=1855.
[54] 2007 World Bank Report, *supra* note 53, at 27.
[55] Brazil Federal Law No. 9294 (1996), art. 2.
[56] 2006 Surgeon General Report, *supra* note 5, at 649.
[57] Federal Law No. 10167 (2000) (amending Federal Law No. 9294); Ministry of Health Ordinance No. 2818 (1998).
[58] O'Neill Report, *supra* note 32, at 9.
[59] *Id*.
[60] *Id*. at 9-10.
[61] *Id*.
[62] *Id*.
[63] *See* press release at http://bibliotecademedicina.com.br/blog/?p=471&gtlang=en.
[64] *See* press release at http://bibliotecademedicina.com.br/blog/?p=466&gtlang=en (listing sixteen Brazilian organizations that sent motions in support of PL 315 and noting that 20 international public-health organizations sent letters to Brazilian senators to support the bill).
[65] *Id*.
[66] INCA Program Outcomes, *supra* note 48 at 4.
[67] 2007 World Bank Report, *supra* note 53, at 65.
[68] *Id*. at 68.
[69] *Id*. at 69.
[70] São Paulo Law No. 13541 (May 7, 2009).
[71] Stella Aguinaga Bialous and Stella Martins, Tobacco Control 2009, 18: 341, *available at* http://tobaccocontrol.bmj.com/content/18/5/341.full.pdf (noting fines of $435 to $870 for first offense, doubled fines for second offense, 48-hour closure for third offense, and 30-day closure for fourth offense).
[72] John Dunn and Ronaldo R. Laranjeira, *Smoke don't smoke – two steps forward, one step back*, Psych. Bull. (1996), 20: 688-89, *available at* http://pb.rcpsych.org/cgi/reprint/20/11/688.pdf.
[73] 2009 WHO Bulletin, *supra* note 38, at 805.
[74] David Simpson, *Tobacco Control* 2009, 18(5): 341-44, *available at* http://tobaccocontrol.bmj.com/content/18/5/341.full.pdf.
[75] *Id*.; 2009 WHO Bulletin, *supra* note 38.
[76] HealthBridge, *Strengthening FCTC Implementation in Brazil: Final Narrative and Financial Report* (April 2007), at 4, *available at* http://www.healthbridge.ca/tobacco_brazil_e.cfm.
[77] 2007 World Bank Report, *supra* note 53, at 61.
[78] *Id*. at 70-71.
[79] *Id*. at xii.
[80] http://www.inca.gov.br/english/tobacco_control.html
[81] *See generally* 2006 Surgeon General Report, *supra* note 5, at Chapter 4 ("Prevalence of Exposure to Secondhand Smoke").
[82] *See generally id*. at 133, 137-38, 650, and Chapters 4 and 6 ("Respiratory Effects in Children from Exposure to SHS").
[83] According to the Americans for Nonsmokers' Rights Foundation (ANRF), as of October 2009, 3052 municipalities in the US have local laws in effect that restrict where smoking is allowed, and 1678 municipalities have a local law in effect that restricts smoking in one or more outdoor areas (e.g., near building entrances and windows, parks, beaches, and sporting and entertainment venues). *Overview List – How many Smoke-free Laws?* (October 2009), *available at* www.no-smoke.org/pdf/mediaordlist.pdf [hereinafter "ANR Overview List"].
[84] A listing of municipalities with 100% smoke-free laws is available at http://www.no-smoke.org/pdf/100ordlisttabs.pdf.
[85] ANR Overview List, *supra* note 89.
[86] George P. Smith, *Cigarette Smoking as a Public Health Hazard: Crafting Common Law and Legislative Strategies for Abatement*, 11 Mich. St. U. J. Med. & L. 251, 296 (2007).
[87] Americans for Nonsmokers Rights, *Model Ordinance Prohibiting Smoking in All Workplaces and Public Places (100% Smoke-free)*, (May 2009), *available at* http://no-smoke.org/document.php?id=229.
[88] *Id*. at 2 and 4 (referring to the smoke-free laws of Canada, Bhutan, France, Ireland, New Zealand, Norway, Singapore, Uruguay, England, Northern Ireland, Scotland, and Wales).
[89] San Francisco, Cal., Admin. Code, Chap. 12K (Apr. 13, 1998).
[90] The New York City Human Rights Law, New York City, Admin. Code, Title 8 (May 2006).
[91] Americans for Nonsmokers' Rights maintains a list of preemptive states at http://www.no-smoke.org/pdf/preemptionmap.pdf and a Preemption Watch website tracking preemptive state bills at http://www. protectglobalcontrol.org/resource.php?id=9587. The website notes one preemptive bill pending as of December 11, 2009, though it would not weaken local laws.
[92] O'Connor et al., *Preemption of Local Smoke-Free Air Ordinances: The Implications of Judicial Opinions for Meeting National Health Objective*, Incidental Findings in Human Subjects Research (Summer 2008), 403-11.
[93] International Agency for Research on Cancer, Handbooks of Cancer Prevention, Vol. 13, Evaluating the Effectiveness of Smoke-free Policies 68-69 (WHO Press 2009), *available at* http://www.iarc.fr/en/publications/pdfs-online/prev/handbook13/handbook13.pdf.
[94] *See* Environmental Laws: Pollution: Regulations Restricting Smoking in Indoor Areas, state-by-state analysis (Thomson Reuters/West, 50-state survey, July 2009).
[95] ANR Overview List, *supra* note 89.
[96] Fla. Const., art. X, § 20 (2002).
[97] Mont. Const., art. 2, § 4 (1889).
[98] New York Const., art. XVII, § 3 (1938).
[99] Gabrielidis, *Human Rights Begin at Home: A Policy Analysis of Litigating International Human Rights in U.S. State Courts*, 12 Buff. Hum. Rts. L. Rev. 139, 175-77 (2002).
[100] *In re Julie Anne*, 780 N.E.2d 635 (Ohio Ct. Com. Pl. 2002) (*sua sponte* raising the issue of whether parents and others should be restrained from smoking in the presence of a child, answering in the affirmative, and ordering parents to restrain themselves and other from smoking in the child's presence).
[101] *Id*. at 639-40.
[102] *Id*. at 653-55 (citing *Helling v. McKinney*, 509 U.S. 25 (1993).
[103] ANR Overview List, *supra* note 89.
[104] Smith, *supra* note 92, at 260-62.
[105] Gabrielidis, *supra* note 105, at 169.
[106] *Shimp v. New Jersey Bell Tel. Co.*, 368 A.2d 408, 413, 415-16 (N.J. Super. Ct. 1976).

[107] *Id*. at 416.

[108] *Smith v. W. Elec. Co.*, 643 S.W.2d 10, 13-14 (Mo. Ct. App. 1982) (remanding and reversing trial court's dismissal for failure to state a claim upon which relief could be granted).

[109] *Id*. at 13.

[110] The Occupational Safety and Health Act of 1970, § 18(a), 29 U.S.C. § 653(b)(4) ("Nothing in this Act shall be construed to supersede or in any manner affect any workmen's compensation law or to enlarge or diminish or affect in any other manner the common law or statutory rights, duties, or liabilities of employers and employees under any law with respect to injuries, diseases, or death of employees arising out of, or in the course of, employment.").

[111] *Shimp*, 368 A.2d at 410-11; *Smith*, 643 S.W.2d at 13-14.

[112] *50-58 Gainsborough St. Realty Trust v. Haile*, No. 98-02279, 13.4 Tobacco Products Litigation Reporter 2.302 (Boston Housing Court, 1998), summarized in 12-4 Mealey's Litig. Rep. Tobacco 15 (1998).

[113] *See* Judith Resnik, *Law's Migration: American Exceptionalism, Silent Dialogues, and Federalism's Multiple Ports of Entry*, 115 Yale L. J. 1564 (2006).

[114] 14 C.F.R. Part 252 (Federal Aviation Administration's smoking ban on air carriers); No Child Left Behind Act of 2001, P.L. 107-110, 115 Stat. 1425 (Jan. 8, 2002), at §§ 4301-4304.

[115] Exec. Order No. 13,058, 65 Fed. Reg. 43451 (Aug. 13, 1997).

[116] Indoor Air Quality, 59 Fed. Reg. 15968 (Apr. 5, 1994).

[117] Indoor Air Quality, 66 Fed. Reg. 64946 (Dec. 17, 2001).

[118] Action on Smoking and Health, Press Release, Dec. 14, 2001, *available at* http://no-smoking.org/nov01/11-19-01-5.html.

[119] Pub. L. No. 111-13, 123 STAT. 1776 (2009).

[120] *See* sec. 203, § 5 (permitting states and localities to ban or restrict the time, place, and manner, but not content, of advertising or promotions of cigarettes), sec. 916 (Preservation of State and Local Authority), and sec. 917 (requiring two representatives of the tobacco manufacturing industry on the Tobacco Products Scientific Advisory Committee, one specifically representing small business interests and one representing tobacco growers, albeit as nonvoting members).

[121] Edward L. Sweda, *Lawsuits and SHS*, Tobacco Control 2004, 13(Suppl. 1): i61-i66.

[122] *Helling v. McKinney*, 509 US 25, 35 (1993) (affirming that prisoner stated a cause of action under the Eighth Amendment and remanding to district court to allow prisoner an opportunity to prove his allegations).

[123] Gabrielidis, *supra* note105, at 153-160.

[124] O'Connor, *supra* note 98, at 407 (noting recommendations that tobacco control and public health advocates should include an explicit nonpreemption clause in proposed smoke-free legislation).

[125] *See id.* at 408.

[126] *See* 2007 World Bank Report 2007, *supra* note 53, at 60 (noting that having INCA manage the tobacco-control program likely protected it from political pressures exerted by the government and the tobacco industry, due to INCA's location outside the capital); *see also* Goldfarb, *supra* note 39, at 44 (noting that when the Brazil's tobacco-control program was transferred from INCA to the capital from 1990 to 1992, tobacco-control efforts stalled until it was transferred back to INCA).

[127] PAHO, *Developing Legislation for Tobacco Control: Template and Guidelines* (May 2002), *available at* http://www.paho.org/English/HPP/HPM/TOH/tobacco_legislation.htm.

[128] Yafei Li et al., *Genetic variants and risk of lung cancer in never smokers: a genome-wide association study*, Lancet Oncology 2010, 11: 321-330.

[129] Mohamad Sleiman et al., *Formation of carcinogens indoors by surface-mediated reactions of nicotine with nitrous acid, leading to potential thirdhand smoke hazards,* Proc. Nat. Acad. Sci. 2010, published ahead of print on February 8, 2010, *available at* http://www.pnas.org/content/early/2010/02/04/0912820107.full.pdf+html.

[130] *Id.* (Abstract).

[131] American Convention on Human Rights, Nov. 22, 1969, art. 33, 1144 U.N.T.S. 143 [hereinafter "ACHR"]; American Declaration of the Rights and Duties of Man, OAS Res. XXX, International Conference of American States, 9th Conf., OAS Doc. OEA/ser. L./V./I.4 rev. (1948), *reprinted in* Organization of American States, Handbook of Existing Rules Pertaining to Human Rights 15, OAS Doc. OEA/ser. L./V./II.23, doc. 21 rev. 5 (1978).

[132] ACHR, *supra* note 113, art. 41.

[133] *Id*. art. 46.

[134] *Id*. art. 44, 1144 U.N.T.S. at 155. Articles 3-25 of the American Convention list recognized civil and political rights recognized by all ratifying Member States. Article 26 states economic, social, and cultural rights recognized by some ratifying Member States.

[135] *Id*. art. 48.

[136] *Id*. arts. 50 and 51.

[137] *See* Inter-Am. Ct. H.R. Basic Documents Pertaining to Human Rights in the Inter-American System at 7, OEA/Ser.L.V./II.82 doc.6 rev.1 (2003) (including the American Declaration as a basic document under Inter-American law).

[138] Am. Declaration of the Rights and Duties of Man, O.A.S. Res. XXX, adopted by the 9th Int'l Conference of the American States (1948), reprinted in Basic Documents Pertaining to Human Rights in the Inter-American System, OEA/Ser.L.V/II.82 doc. 6 rev. 1at 17 (1992), art. I.

[139] *See* Statute of the Inter-American Commission on Human Rights, OAS Res. 447, 9th Reg. Sess., art. 20 (1979) (granting the Inter-American Commission jurisdiction to examine communications regarding governments that are not parties to the ACHR and to make appropriate recommendations).

[140] Steven R. Keener and Javier Vasquez, *A Life Worth Living: Enforcement of the Right to Health Through the Right to Life in the Inter-American Court of Human Rights*, 40 Colum. Hum. Rts. L. Rev. 595, 618-19 (2009).

[141] *Yakye Axa Indigenous Comty. v. Paraguay*, 2005 Inter-Am. Ct. H.R. (ser. C) No. 125 (June 17, 2005), ¶¶ 161-62; *Sawhoyamaxa Indigenous Comty. v. Paraguay*, 2006 Inter-Am. Ct. H.R. (ser. C) No. 146 (Mar. 29, 2006), ¶ 153.

[142] *Ximines-Lopes v. Brazil*, 2006 Inter-Am. Ct. H.R. (ser. C) No. 149 (July 4, 2006), ¶¶ 89-90.

[143] *Id.*

[144] Keener and Vasquez, *supra* note 146 at 623.

[145] *Id.*

[146] *See Sahoyamaxa*, 2006 Inter-Am. Ct. H.R. (ser. C) No. 146 (Mar. 29, 2006), ¶ 155; *see also id.* at 614-15 (summarizing the standard set forth in *Sahayamaxa*).

[147] Article 2 of the ACHR requires that "[t]he States Parties undertake to adopt, in accordance with their constitutional processes and the provisions of this Convention, *such legislative or other measures as may be necessary to give effect to those rights or freedoms*." (emphasis added)

[148] *Ximines-Lopes*, 2006 Inter-Am. Ct. H.R. (ser. C) No. 149 (July 4, 2006), ¶¶ 89-90.

[149] Crow, *supra* note 29, at 240-45.

[150] *See* Ministry of Health Presentation, at Section 5.5.3, 18-19, *available at* http://www.inca.gov.br/english/tobacco/globalaction.pdf.