Creating Smoke-Free Places Through the UN Convention on the Rights of Persons With Disabilities

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In some high-, middle-, and low-income countries, law has been employed to limit individuals' secondhand smoke exposure. Innovative legal tools are still needed, especially in low- and middle-income countries where smoking prevalence continues to rise.

For some persons with severe respiratory conditions, the presence of secondhand smoke is intolerable and prevents their entrance into restaurants and other venues. With its adoption of the Convention on the Rights of Persons with Disabilities (CRPD) in 2006, the United Nations gave countries a new way to promote the rights of disabled individuals and simultaneously address secondhand smoke exposure.

We analyze the CRPD's potential to advance tobacco control goals and offer recommendations for advocates, policymakers, and others seeking to apply this approach. (*Am J Public Health.* 2013;103:1748–1753. doi:10.2105/AJPH.2012.301174)

TOBACCO USE IS ONE OF THE leading preventable causes of morbidity and mortality worldwide and is responsible for nearly 6 million deaths annually.[1] Approximately 1.3 billion people smoke either cigarettes or *bidis* (the latter consisting of low-grade tobacco and used in South Asia),[2] and about 80% of these smokers live in low- or middle-income countries (LMICs).[3] Although the tobacco industry asserts that tobacco production is a source of economic growth—especially for LMICs—estimates suggest that when health costs are factored in, world tobacco production and use results in a net loss of $200 billion USD annually.[4]

The health consequences of tobacco use are not limited to individuals who use tobacco; they are also experienced by nontobacco users, primarily through exposure to secondhand smoke. In 2004, secondhand smoke was responsible for approximately 600 000 deaths and approximately 10.9 million disability adjusted life years worldwide.[5] During the same period, an estimated 40% of children, 33% of male nonsmokers, and 35% of female nonsmokers were exposed to secondhand smoke. Respiratory illnesses represent the largest disease burden from secondhand smoke, with approximately 6 million lower respiratory infections among children younger than 5 years, 1.2 million cases of asthma among adults, and 650 000 cases of asthma among children worldwide in 2004.[5] For some individuals, particularly those with chronic, severe respiratory conditions, the presence of secondhand smoke is intolerable because it makes breathing exceptionally difficult.

In both high-income countries and LMICs, the law has increasingly been used to limit individuals' exposure to secondhand smoke. For at least the past 2 decades, governments throughout the world have employed legislation to establish smoke-free indoor environments, although challenges remain with the implementation, enforcement, and comprehensiveness of these laws.[6] Although progress has been made, innovative legal tools to address secondhand smoke exposure are critical, especially in LMICs where smoking prevalence continues to rise.[7]

The United Nations gave countries a new way to promote the rights of disabled individuals and simultaneously tackle secondhand smoke exposure with its adoption of the Convention on the Rights of Persons with Disabilities (CRPD) in 2006. The CRPD introduces protections for disabled persons—including those with severe respiratory conditions and accompanying intolerance to smoke exposure—into international law. Because it provides a legal foundation to argue that indoor smoking restrictions are a necessary accommodation for those with certain chronic respiratory conditions, the CRPD complements the goals of the World Health Organization's (WHO's) Framework Convention on Tobacco Control. We analyze the CRPD's potential to advance tobacco control efforts, and offer recommendations for advocates, policymakers, and other stakeholders who seek to capitalize on this novel approach.

LEGAL APPROACHES TO SECONDHAND SMOKE

A number of legal approaches to secondhand smoke have been adopted in both high-income countries and LMICs. These strategies have included legislation, litigation, and regulation.

One of the most straightforward approaches has been to restrict smoking in certain public places. As of July 2012, the majority of US states and territories had clean indoor air laws applicable to restaurants (37 jurisdictions), bars (31 jurisdictions), or other workplaces (32 jurisdictions). In addition, another 520 US localities had municipal ordinances applicable to all workplaces, restaurants, and bars.[8] Globally, high-income countries including Ireland and France have successfully adopted smoke-free laws. LMICs have been somewhat slower to adopt comprehensive smoke-free legislation at the national level. For example, of the 15 LMICs within the Bloomberg Initiative to Reduce Tobacco Use,[9] several nations—including Brazil and Turkey—prohibit smoking in bars and

restaurants. However, few if any of these countries are 100% smoke-free in all indoor environments.[10]

Among the newest legislative approaches to secondhand smoke exposure is the expansion of places where smoking is prohibited to include even some "private" spaces, such as multiunit public housing.[11,12] For example, as of 2012, 4 US states and Puerto Rico had enacted laws restricting smoking in cars when children were present. Other places have enacted similar laws, including several Australian and Canadian jurisdictions. Public support for such laws appears to be generally strong.[13]

Litigation against tobacco companies or others alleging harm from secondhand smoke has been brought at least as far back as the 1970s. A number of these lawsuits have been successful. Notable among these victories is *Broin v Philip Morris*, filed in 1991. *Broin* involved a class action lawsuit brought against the 6 major US cigarette makers by current and former flight attendants. A settlement was reached in 1997 which included, in part, substantial funding from defendants to establish the Flight Attendant Medical Research Institute to study the problem of secondhand smoke.[14] Some other lawsuits have been less successful and commentators have expressed mixed views about the relative effectiveness of litigation in fostering social change.[15–17]

Perhaps most relevant to the CRPD have been prior efforts to use disability law to force businesses or other public places to become smoke-free. In the United States, the Americans with Disabilities Act prohibits public accommodations from discriminating against disabled persons.[18] Within the very limited number of lawsuits that have used the Americans with Disabilities Act to argue for smoke-free environments, there are 2 primary cases. In *Staron v McDonalds*, a federal Court of Appeals concluded that a complete restriction on smoking might be a reasonable accommodation for several restaurant patrons who were especially sensitive to secondhand smoke.[19] The case settled before a final determination was made regarding the reasonableness of a complete smoking ban. In *Emery v Caravan of Dreams*, by comparison, a federal district court concluded that a theater could not be required to eliminate all smoking to accommodate smoke-sensitive patrons because this would cause serious economic hardship to the theater that fundamentally altered the nature of the business.[20] Both cases, however, were decided more than 15 years ago, before more recent research on the effectiveness of smoking restrictions and the absence of economic harms for affected businesses.[21] In addition, in the years since these cases were decided, the evidence base demonstrating health harms from secondhand smoke exposure has become much stronger.[22] Very few (if any) secondhand smoke cases have recently been brought under the Americans with Disabilities Act, suggesting the need for new legal approaches to smoke-free venues and disability.

CRPD AS A NEW LEGAL TOOL

As the newest UN human rights treaty, the CRPD offers a unique opportunity to advance tobacco control through the lens of disability rights. Before the development and implementation of the CRPD, the rights of disabled persons had been on the UN agenda for several decades.

Development of the CRPD

Initially, in the 1940s and 1950s, the United Nations focused on the welfare of disabled individuals, including opportunities for job training and rehabilitation for those with physical disabilities.[23] By the 1970s, the United Nations' perspective had shifted to emphasize the need for better integration of disabled persons into society and, ultimately, the protection of their human rights.[24] For example, in 1971 the UN General Assembly adopted the Declaration on the Rights of Mentally Retarded Persons, and 4 years later it adopted the Declaration on the Rights of Disabled Persons.[25,26] Taken together, these declarations affirmed that mentally and physically disabled persons have "the same rights as other human beings."[27] Although UN declarations are not legally binding for member states, they offer guidance and reflect core principles.

In 1993, the UN General Assembly adopted the Standard Rules on Equalization of Opportunities for Persons with Disabilities. The Standard Rules contain a roadmap for countries "to ensure that girls, boys, women and men with disabilities, as members of their societies, may exercise the same rights and obligations as others."[26] Although the Standard Rules had no legally binding effect, their development was intended to stimulate action at the regional, national, and international levels relative to disability rights policy.

At the beginning of the 21st century, the United Nations established an ad hoc committee tasked with drafting a convention to protect the rights of disabled persons.[28] This committee met several times between 2002 and 2006 to create the text of the CRPD; it also drafted an Optional Protocol, which provides a mechanism for the United Nations to learn about potential violations of the CRPD. The UN General Assembly officially adopted the CRPD in December 2006. The convention, along with the Optional Protocol, opened for signature from member states in March 2007 and entered into force approximately 1 year later.[29] The United Nations maintains a standing Committee on the Rights of Persons with Disabilities to oversee the implementation and monitoring of the CRPD.[30]

Disability Under the CRPD

The CRPD deliberately employs a broad definition of disability, noting that "disability is an evolving concept" informed by societal attitudes and environmental challenges.[31] It defines disabled persons as

> those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.[32]

The convention explicitly prohibits disability-based discrimination, which it defines as

> any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.[33]

Several sections (called articles) within the CRPD provide

specificity regarding its application. Article 27 addresses disabled individuals' right to "safe and healthy working conditions." Article 29 concerns their right to "participat[e] in nongovernmental organizations and associations concerned with the public and political life of the country," and Article 30 recognizes their right to take part in "cultural life," including "recreational, leisure and sporting activities."

The CRPD's expansive definition of disability, coupled with its definition of discrimination, has important implications for tobacco control. The functional limitations associated with certain chronic respiratory conditions—such as cystic fibrosis, chronic obstructive pulmonary disease, or severe asthma[34]—likely meet the CRPD's definition of "disabled" and, thus, would entitle affected persons to benefit from its protections. For some individuals with these types of serious long-term respiratory conditions, difficulties associated with breathing are dramatically exacerbated by the presence of tobacco smoke.[22] In other words, tobacco smoke may function as a "barrier [that] hinder[s] their full and effective participation in society."[32] If the presence of tobacco smoke effectively prohibits them from entering a venue such as a restaurant, bar, hotel, or office, then it constitutes discrimination under the terms of the CRPD.

Reasonable Accommodations

The CRPD requires public and private sector entities to make "reasonable accommodations" when disability-based discrimination arises.[35] The convention provides some parameters for determining whether an accommodation is "reasonable," explaining that this refers to "necessary and appropriate modification[s] and adjustments not imposing a disproportionate or undue burden."[33] The CRPD does not provide additional specificity about determinations of "undue burden." However, the *United Nations Handbook for Parliamentarians on the CPRD and Its Optional Protocol*, which serves as an implementation guide for the CRPD, explains that some countries have legislatively established parameters to consider, such as

> the practicability of the changes required, the cost involved, the nature, size and resources of the entity involved, the availability of other financial support, occupational health and safety implications, and the impact on the operations of the entity.[36]

If the requested modification would constitute a disproportionate or undue burden for a public or private sector entity, then the failure to make that modification is not considered discrimination.

Individuals with chronic respiratory conditions and accompanying smoke sensitivity—along with members of the global tobacco control community—should therefore be prepared to demonstrate that the implementation of smoke-free environments, through indoor smoking restrictions, is a reasonable accommodation that does not impose an undue burden. Using the factors listed in the *Handbook for Parliamentarians* as a guide, advocates should consider the costs associated with smoke-free environments; the practicality and effectiveness of the requested change; and the likely impact of a smoke-free environment on the operations of public and private entities.

Although some LMICs, such as Brazil, Pakistan, and Turkey, have recently enacted partial indoor-smoking restrictions,[6] most economic evaluations of indoor-smoking restrictions have focused on the US hospitality industry.[21] These studies have repeatedly found that indoor-smoking restrictions have either no effect on businesses' revenues or a slightly positive impact.[37–41] Positive impacts may be attributed to nonsmokers increasing their patronage of smoke-free venues.[42,43] Studies have also recently determined that the implementation of smoking bans is associated with decreases in hospital admissions for respiratory diseases such as asthma.[44,45] The practicality and effectiveness of indoor-smoking restrictions has been repeatedly confirmed by studies conducted in high-, middle-, and low-income countries.[22,46,47] The WHO has stated that these restrictions are the only option for complete protection from secondhand smoke.[48] Additionally, studies have found that alternatives short of a complete restriction, such as separate smoking rooms or ventilation and filtration systems, do not offer effective protection from secondhand smoke and its related residues.[49–52] This is a critical point for individuals with serious sensitivities to tobacco smoke, as measures short of an indoor-smoking restriction may not provide effective relief.

Finally, in most instances smoking restrictions are unlikely to influence the operations of public or private entities. For example, in the case of bars or restaurants, fundamental operations—namely the provision of food or drink—would not be impacted by a smoking restriction. The exception to this argument arises for venues devoted to the use of tobacco products, such as hookah bars or tobacconist shops. A smoking restriction would fundamentally alter the nature of these types of businesses, which would likely be viewed as an undue burden. Aside from these types of tobacco-specialist businesses, indoor-smoking restrictions should be viewed as reasonable accommodations under the CRPD.

Enforcement Provisions

The CRPD requires countries to provide reports within 2 years of ratification and at subsequent 4-year intervals.[53] The United Nations maintains a body of experts, known as the Committee on the Rights of Persons with Disabilities, to evaluate and respond to countries' reports, and countries are required to answer inquiries from this committee regarding their implementation of the CRPD.[54,55] In addition, the CRPD's Optional Protocol creates a mechanism for individuals and groups to file complaints with the Committee on the Rights of Persons with Disabilities, if they believe that their rights under the convention have been violated.[56] The committee can then contact the country in question to assess the situation. Disabled individuals who believe their country has failed to promote and implement indoor-smoking restrictions, in accordance with the principles of the CRPD, can employ these mechanisms. This argument has not yet been tested, so advocates should be prepared to justify why indoor smoking restrictions are reasonable accommodations under the CRPD.

CRPD AND FRAMEWORK CONVENTION ON TOBACCO CONTROL

Although the CRPD can, independently, be employed as

a tobacco control policy tool, it can also be used to complement the goals established by the WHO's Framework Convention on Tobacco Control (FCTC). The FCTC provides a roadmap for regional, national, and international tobacco control efforts, with the ultimate objective of

> protect[ing] present and future generations from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke.[57]

The FCTC opened for signature in 2003 and it entered into force in 2005, once 40 countries had ratified the convention.

In its preamble, the FCTC explicitly mentions several UN human rights treaties whose principles support global tobacco control efforts by espousing the right to health. These include the Convention on the Elimination of All Forms of Discrimination against Women[58] and the Convention on the Rights of the Child.[59] The CRPD was not adopted by the United Nations until 2006, 3 years after the FCTC opened for signature, which explains why it is not named in the FCTC's preamble. Although the conventions do not reference each other, they have overlapping goals, as Article 8 of the FCTC calls for countries to protect individuals from exposure to secondhand smoke at work and in public places through legal action.[60]

HOW ADVOCATES CAN USE THE CRPD

When the UN General Assembly formally adopts a treaty, it does not immediately become legally binding for member states. Signing a human rights treaty, such as the CRPD and its Optional Protocol, indicates a country's intention to eventually become bound by the treaty through ratification.[36] However, a country's signature does not guarantee that it will ultimately choose to ratify the treaty. Even if a country does ratify the treaty, it can attach reservations and declarations, meaning that the country clarifies how it, as a sovereign nation, will interpret certain sections of the document.

For advocates interested in using the CRPD as a tobacco control policy tool, a critical first step is determining whether their country has ratified the convention. Although the CRPD has already been ratified by 119 countries, many high, middle, and low-income nations have not yet done so.[61] In these instances, advocates should try to meet with relevant policymakers to educate them about the CRPD and particularly its potential to prevent secondhand smoke exposure. If their country has ratified or otherwise approved the FCTC, as most countries have,[62] advocates should emphasize the CRPD's ability to advance tobacco control goals in accordance with the FCTC's principles.

In countries that have already ratified the CRPD, advocates can employ the treaty's monitoring mechanisms to raise concerns related to secondhand smoke exposure. As a condition of ratifying the CRPD, countries must establish "focal points within government" to oversee implementation of the convention. In addition, the CRPD emphasizes the need for participation by "civil society, in particular persons with disabilities and their representative organizations" in each country's implementation and monitoring activities.[63] This suggests that tobacco control advocates should partner with relevant disability rights organizations—such as those focused on asthma or cystic fibrosis—when approaching a country's designated CRPD policymaker. Working together, tobacco control and disability rights advocates can strongly encourage countries to include information about legislative or other efforts (or lack thereof) to limit secondhand smoke exposure in their required reports to the UN Committee on the Rights of Persons with Disabilities. To facilitate this process, advocates can create materials for policymakers that compare a country's actual actions relative to smoking restrictions with actions that could be taken in fulfillment of the country's duties under the CRPD.[64]

In the 72 countries that have ratified the CRPD's Optional Protocol, an additional monitoring mechanism is available. In these countries, disabled persons can communicate directly with the UN Committee on the Rights of Persons with Disabilities over alleged violations of their rights.[65] These complaints cannot be made anonymously, must relate to rights protected by the CRPD, and can only be made after in-country remedies have proven fruitless. The Committee on the Rights of Persons with Disabilities can communicate directly with the relevant country about the complaint, and it can conduct an inquiry into the country's alleged violations of the CRPD.[66] The Committee on the Rights of Persons with Disabilities can then ask the country to provide a report explaining actions it has taken in response to the inquiry's findings and recommendations. For tobacco control advocates, the Optional Protocol provides an important opportunity to highlight a country's failure to enact or implement indoor smoking restrictions. Importantly, such a complaint must be initiated by an individual with a disability that includes a serious sensitivity to smoke, for whom a smoking restriction would be a reasonable accommodation. Given the significant monitoring tool provided by the Optional Protocol, advocates in countries that have not yet ratified it should work with policymakers—particularly those who have been deemed an official "focal point"—to prioritize its timely ratification.

There are practical limitations to enforcement of the CRPD's provisions. First, the CRPD and Optional Protocol have no legal effect in countries that have not ratified them. Second, after exhausting domestic remedies and those within the CRPD and Optional Protocol, advocates likely cannot engage in international litigation related to the convention's enforcement. This is because of both the lack of a designated international court to hear this type of dispute and the absence of procedures to guide and facilitate such an effort. Also, in some LMICs, the disability community may have limited resources to devote to the tobacco control potential of the CRPD.

CONCLUSIONS

The potential for mutual reinforcement between the CRPD and FCTC highlights the overlapping interests of the tobacco control and human rights communities. In recent years, scholars have called for the tobacco control movement to engage more directly with human rights advocates to advance their

shared goals.[67] They have noted that the well-established human rights and public health framework—which seeks to respect, protect, and fulfill the right to health—is broadly applicable to tobacco control efforts.[68,69] For example, the general right to health also includes the right to healthy homes, workplaces, and places of recreation free from exposure to secondhand smoke.[55] By synthesizing tobacco control principles and human rights norms, one can argue that governments are obliged to protect individuals from secondhand smoke exposure through mechanisms such as smoking restrictions.[70] This moral obligation, however, is not necessarily a legal mandate.

In some countries, law has proven to be an important and effective tool to limit individuals' exposure to secondhand smoke, particularly through indoor-smoking restrictions at the national or sub-national levels. Despite this progress, the prevalence of smoking continues to rise in LMICs, which often lack well-enforced legal mechanisms to curb secondhand smoke exposure. Therefore, new and innovative strategies, such as partnering with the disability and human rights communities, are needed to enhance global tobacco control efforts. By capitalizing on emerging legal tools such as the CRPD and establishing partnerships with relevant stakeholder groups, global tobacco control challenges—such as secondhand smoke exposure—can be surmounted. ■

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