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Protection of the Right to Health: An Assessment of Tobacco Control in Ethiopia

By Eshetu Endayilalu

Addis Ababa, Ethiopia

May, 2020

Protection of the Right to Health: An Assessment of Tobacco Control in Ethiopia

A Thesis Submitted to the School of Law, Addis Ababa University, in partial fulfillment of the requirements for the award of the degree of LLM in Human Rights

By

Eshetu Endayilalu

Advisor

Abdi Jibril Ali (Assistant Professor)

Addis Ababa, Ethiopia

May, 2020

Declaration

I, Eshetu Endayilalu, hereby declare that this research paper is the result of my personal effort and original work that, it has never been submitted for any degree in any other University. To the best of my knowledge and belief, I also declare that any information used has been duly acknowledged.

Declared by: Eshetu Endayilalu

Signature:

Date:

Approval page

Approved by Board of Examiners

	Signature	Date
Advisor: Abdi Jibril Ali (Assistant Professor)	________	_______

Examiners:	Signature	Date
1. ________________________________	__________	________
2. _______________________________	___________	_______

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Acronyms

AAU - Addis Ababa University.

ACHPR - African Charter on Human and People's Rights.

ACRWC - African Charter on the Rights and Welfare of the Child.

ACmHPR - African Commission on Human and Peoples Rights.

CEDAW - International Convention on the Elimination of all forms of Discrimination against Women

CERD - International Convention on the Elimination of all forms of Racial Discrimination.

CESCR - Committee on International Covenant on Economic Social and Cultural Rights.

CESR: Center for Economic and Social Rights.

CMW - International Convention on the protection of Migrant Workers and Members of their families.

CRC - Convention on the Rights of the Child.

CRPD - Convention on the Rights of Persons with Disabilities.

CSOs - Civil Society Organizations.

DPSP - Directive Principles of State Policy.

EFDA- Ethiopian Food and Drug Authority.

EPHI - Ethiopian Public Health Institute.

FAG - Federal Attorney General.

FCTC - Framework Convention on Tobacco Control.

FDRE - Federal Democratic Republic of Ethiopia.

FMHACA - Ethiopian Food, Medicine and Healthcare Administration and control Authority.

GATS - Global Adult Tobacco Survey.

HRC - Human Right Council.

ICESCR - International Covenant on Economic Social and Cultural Rights.

HSDP- Health Sector Development Program.

HSTP - Health Sector Transformation Plan.

HIV/AIDS - Human Immunodeficiency Virus, Acquired Immune Deficiency Syndrome.

MOH - Ministry of Health.

MOFA - Ministry of Foreign Affairs.

MNCs - Multinational Companies.

NPPO - National Policy Principles and Objectives.

NCDs - Non communicable Diseases.

NGOs - Non-Governmental Organizations.

NHRIs - National Human Right Institutions.

NMRF - National Mechanism for Reporting and Follow up.

SECRs - Socio Economic and Cultural Rights.

SERAC - Socio Economic Rights Action Center.

SHS - Second Hand Smoke.

UDHR - Universal Declaration of Human Rights.

UN - United Nations.

UPR - Universal Periodic Review.

VDPA - Vienna Declaration and Programme of Action.

WHO - World Health Organization.

WHO FCTC -World Health Organization Framework Convention on Tobacco Control.

Abstract

The right to the highest attainable standard of physical and mental health had been recognized under several international regional and national legal instruments. General comment no. 14 adopted by CESCR had clarified its normative contents. Despite the recognition of the right under several binding instruments, tobacco has become a serious threat to public health which is inextricably linked with the individual right to health. ***Alike*** *global concerted efforts to tobacco control, Ethiopia has taken legal, policy and, institutional measures to curb the problem. With respect to the practice, the study found that the implementation of tobacco control laws in Ethiopia is ineffective mainly due to interference of the tobacco industry, resource scarcity, the existence of illicit tobacco trade, and shortage of experts among others. Ethiopia's reporting to treaty bodies and UPR reviews on tobacco control remains limited. The study, finally, provided recommendations on the mechanisms of rectifying the existing tobacco control challenges.*

CHAPTER ONE

INTRODUCTION

1.1 Background of the study

Health is a fundamental human right indispensable for the exercise of other human rights[1] and pre-requisite for life in dignity. The right to the enjoyment of the highest attainable standard of physical and mental health (right to health) typically pertains to the category of socio-economic rights. It is interrelated and interdependent with other sets of human rights.[2] It is inalienable and inherent to every human being without any sort of discrimination. Internationally it was first articulated in the 1946 Constitution of World Health Organization (WHO).[3]

Health is defined under the WHO constitution as a state of complete physical, mental, and social wellbeing and not merely as the absence of disease or infirmity.[4] Since then various international human rights instruments like the International Covenant on Economic, Social and Cultural Rights (ICESCR)[5] had recognized it. The right to health stipulated under those legal instruments, impose states' with a tripartite set of obligations to respect protect and fulfill.[6] Furthermore, the right to health is defined by the Committee on Economic, Social and Cultural Rights (CESCR) as inclusive right extending beyond timely and appropriate healthcare and includes underlying determinants of health.[7] Ethiopia is a party to several core human rights instruments recognizing the right to health and hence obliged to respect protect and fulfill it.

[1] CESCR, General Comment No. 14: the right to the highest attainable standard of health (article 12 of the covenant), (22nd session, 2000) U.N. Doc. E/C. 12/2000/4 (General comment No. 14), para. 1.

[2] World conference on human rights, Vienna Declaration and Programme of Action (1993) (VDPA), para. 5.

[3] Constitution of the World Health Organization, July 22, 1946, 62 Stat. 6349, 14 U.N.T.S. 185, reprinted in 15 DEP'T ST. BULL. 211 (Aug. 4, 1946) (Constitution of WHO), preamble, para. 3.

[4] Ibid para 2.

[5] International Covenant on Economic, Social and Cultural Rights (adopted 16 Dec. 1966, entered into force Jan. 3, 1976) 993 U.N.T.S. 3 (ICESCR), article 12.

[6] Magdalena Sepulveda and others "human rights reference handbook" (2004) university for peace 279.

[7] General comment No. 14 (n 1) para 11.

Despite the recognition of the right to health under different legal instruments, tobacco had been among the major causes for the infringement of the right to health.[8] Tobacco problem is a serious public health challenge and curbing it would inevitably serve to promote sustainable development and human rights in general besides protecting people's right to health. Thus, assessing the measures taken by Ethiopia to ensure the realization of the right to health in light of tobacco control becomes having paramount significance.

1.2 Statement of the problem

Although tobacco is a serious global health problem, the legal instruments for the promotion of public health in African countries had been criticized as ineffective in solving the growing tobacco problem.[9] Most African states have weak laws to control the increasing and widespread tobacco problem,[10] even though tobacco causes a double burden of disease in Africa when considered alongside AIDs and Malaria.[11]

Tobacco use is among the most dreadful but still avoidable cause of death and disease. According to WHO every year more than 8 million people die from tobacco use from which most tobacco-related deaths occur in low and middle-income countries.[12] Tobacco is also deadly for non-smokers in which second-hand tobacco smoke (SHS)[13] contributes to heart disease, cancer, and other diseases among which children are most vulnerable.[14] WHO declared that populations from developing countries face a continued threat from the growing epidemic of

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[8] David Reubi, "Making a Human Right to Tobacco Control: Expert and Advocacy Networks, Framing and the Right to Health" (2012) 7 Global Public Health S176.

[9] William Onzivu, "Public health and tobacco problem: international legal implications for Africa" (2001) 29 Georgia Journal of International and Comparative Law 223.

[10] Ibid p. 225.

[11] Ibid p. 228.

[12] World Health Organization, WHO report on the global tobacco epidemic (2019) p. 17.

[13] Second hand tobacco smoke implies tobacco smoke that is exhaled by smokers (e.g. tobacco emitted from the burning end of a cigarette) or which is given off by burning tobacco and which is inhaled by persons nearby involuntarily or passively by someone who is not smoking.

[14] World Health Organization (n 12) p. 77.

Non-Communicable Diseases (NCDs) like lung and heart diseases, to which tobacco is the main leading cause.[15]

Ethiopia being second-most populous country in Africa and one of the developing countries is not an exception to those challenges. The 2016 Global Adult Tobacco Survey (GATS) conducted in Ethiopia showed that though tobacco use is comparatively low in Ethiopia, the country is under risk of the tobacco epidemic given the shift of tobacco industries to target low and middle-income countries.[16] It also admitted exposure to SHS is prevalent in Ethiopia.[17] Researches had also shown the prevalence of tobacco consumption in Ethiopia in different places including universities.[18] Deaths attributable to tobacco related chronic diseases are considered as the leading cause of loss of life in Ethiopia.[19] Despite the prevalence and effect of the tobacco epidemic in Ethiopia, previous legal and policy frameworks on tobacco control in the country are argued to have gaps.[20]

The increasing deaths, diseases, and disability resulting from tobacco consumption and exposure to SHS unequivocally constitute a denial of the right to health. Indeed, the decisiveness of good health for dignified life is not questionable. As per the CESCR, the obligation to protect the right to health is violated when the state party fails to take necessary measures to defend persons in its territory from infringement of the right by third parties."[21] States' failure to discourage production, marketing, and consumption of tobacco products constitute a violation of the duty to protect the right to health.[22] Ethiopia's obligations on the right to health under international

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[15] Ibid p. 19.

[16] Ethiopian public Health Institute, Food, Medicine, and Healthcare Administration and Control Authority, WHO; and Center for disease control, Global Adult Tobacco Survey: Executive summary, Ethiopia (2016) (GATS).

[17] Ibid.

[18] Solomon Teferra, "Substance use among university students in Ethiopia: A systematic review and meta-analysis" (2018) 32 Ethiopian journal of health development 265.

[19] "Ethiopia's New Tobacco Control Law: A Step Forward That Needs to Be Complemented by Higher Taxes!" (*blogs.worldbank.org*) https://blogs.worldbank.org/health/ethiopia-s-new-tobacco-control-law-step-forward-needs-be-complemented-higher-taxes. Accessed April 15, 2020.

[20] Daniel Erku and Eyasu Tesfaye, "Tobacco Control and Prevention Efforts in Ethiopia Pre- and post-Ratification of WHO FCTC: Current Challenges and future Directions" (2019) 17 Tobacco Induced Diseases 1.

[21] General comment No. 14 (n 1) para 51.

[22] Ibid para 15.

human rights instruments had not been yet analyzed from the perspective of tobacco control legislations, policy and institutional frameworks, though the right to health and tobacco cannot be separated. Hence, it is the focus of this thesis.

1.3 Objectives of the research

1.3.1 General objective

The general objective of this study is assessing the protection of the right to health in Ethiopia with particular reference to tobacco control.

1.3.2 Specific objectives

The specific objectives of this research are:-

- ✓ To assess the normative contents of the right to health.
- ✓ To clearly indicate how tobacco control relates to the right to health.
- ✓ To discuss duties imposed by the right to health on states' in relation to tobacco control.
- ✓ To assess whether Ethiopia has clear, comprehensive and adequate laws, policies and institutions on tobacco control.
- ✓ To investigate whether tobacco control laws are effectively implemented in Ethiopia and challenges thereto.
- ✓ To assess Ethiopia's reporting status before human right bodies on tobacco control and evaluate whether all efforts made by Ethiopia comply with its international obligations emanating from the right to health and
- ✓ To provide recommendations as to the ways for the better protection of the right to health in relation to the growing tobacco epidemic in Ethiopia.

1.4 Research questions

In order to achieve the objectives of the research, the following research questions are framed:

- ✓ What are the normative contents of the right to health?
- ✓ How the right to health relates to tobacco control?
- ✓ What duties are implied on states particularly by right to health in relation to tobacco control?
- ✓ What are the international and national legal frameworks providing for tobacco control and institutional guarantees thereto in Ethiopia?

- ✓ Does Ethiopia effectively implement tobacco control laws? If not, what are the challenges of tobacco control in Ethiopia?
- ✓ What is the status of Ethiopia's reporting to international human right monitoring bodies in relation to tobacco control?
- ✓ Do the efforts made by Ethiopia concerning tobacco control comply with the state's obligations imposed by the right to health?
- ✓ What are the possible ways available to avoid the future devastating effects of tobacco to effectively protect people's right to health in Ethiopia?

1.5 Scope of the study

Tobacco may be raised in relation to several aspects like the right to work, child labor, social and economic impact, etc.…. however, the scope of this study is limited only to studying the nexus between the right to health and tobacco control. It is only delimited to dealing with the protection of the right to health in relation to tobacco control. Accordingly, the measures taken by Ethiopia on tobacco control are analyzed in light of the states' obligations imposed by the right to health.

1.6 Significance of the study

The researcher believes this thesis have the following significances:

- ✓ To create awareness on the part of the community as to how tobacco relates to their right to health.
- ✓ Help as reference to government authorities in adopting laws and policies.
- ✓ Serves as an input for the future researches to be conducted in the area.

1.7 Limitations of the study

The researcher faced with a shortage of well documented and comprehensive researches. Particularly, the lack of previous legislative history on tobacco control was one of the challenges encountered. Unavailability of government authorities to provide the necessary information at the right time was also the challenge I had come across.

1.8 Research methodology

Both primary and secondary sources of data are used in the thesis. Among primary sources legislations and interviews are used. Accordingly, national regional and international laws relating to right to the health and tobacco control are referred. Interviews are also conducted with

organs of the federal government having linkage with tobacco control particularly the Ministry of Health (MOH), Ethiopian Food and Drug Authority (EFDA), and Ethiopian Public Health Institute (EPHI). Moreover, books, articles, and various reports are used as secondary sources.

The research employed a qualitative research method in order to achieve the research objectives. Hence, it tries to analyze the strength and pitfalls of current Ethiopian legal regimes governing tobacco control in light of states' obligations on the right to health. The federal government authorities to the interview are selected purposively. Semi structured interview is employed in the thesis. The information obtained from the authorities is used to analyze how tobacco control regulatory norms are being implemented practically by the federal government in order to enhance the realization of the right to health.

1.9 Literature review

There are several pieces of research conducted in Ethiopia that slightly touching up the issue of tobacco control, nonetheless, there is no comprehensive literature work on the critical appraisal of the tobacco control efforts of Ethiopia and their practical enforcement in light of the state's obligations implied by the right to health.

Daniel Asfaw and Eyasu Teshome Tesfaye in their article "Tobacco control efforts in Ethiopia pre and post ratification of WHO FCTC: current challenges and future directions" have tried to review Ethiopia's tobacco control legislation and evaluated the compliance of National Tobacco Control Directive (NTCD) with WHO Framework Convention on Tobacco Control (FCTC). Challenges and future directions of implementing the NTCD were also discussed.

Edilu Shona in his article "banning smoking in public places under Ethiopian legal framework: some evidence from Hawassa city" reviewed Ethiopian laws banning smoking in public places and concluded laws banning smoking in public places are not comprehensive and are not effectively implemented to achieve their objectives in Hawassa city specifically.

Other works like Emmanuel Rudatsikira et al, in their article "prevalence and determinants of adolescent tobacco smoking in Addis Ababa", S. Getachew et al, in their work "Prevalence and risk factors for initiating tobacco and alcohol consumption in adolescents living in urban and rural Ethiopia" and Shangfeng Tang et al in their work "Prevalence of smoking among men in Ethiopia and Kenya: A cross-sectional study" all showed the prevalence of tobacco consumption

in Ethiopia in the study areas and suggested measures to be taken. However, those studies do not provide a comprehensive understanding of the protection of the right to health in Ethiopia with critical appraisal of the measures taken on tobacco control which is the main theme of this study.

1.10 Organization of the thesis

The thesis has five chapters. The first chapter is an introduction which is the proposal. Chapter two deals about the right to health in general in which issues like the meaning, normative foundations, sate duties etc.… of the right to health are discussed. Chapter three discusses the nexus between the right to health and tobacco control. Chapter four deals with the measures taken by Ethiopia on tobacco control to protect the right to health. This part critically assesses tobacco control efforts made by Ethiopia in line with the state's obligations imposed by the right to health. The practical enforcement of tobacco control laws in the federal gov't of Ethiopia and challenges thereto is also discussed. Finally, chapter five provided a holistic conclusion and plausible recommendations.

CHAPTER TWO

THE RIGHT TO HEALTH UNDER INTERNATIONAL HUMAN RIGHTS LAW

2.1 General overview of the right to health

Understanding what health is imperative because the right to health is not the same as health itself and a claim to the right to health cannot be understood to cure incurable diseases.[23] Previously health was considered part of the private realm than the public and considered merely as the absence of disease however, later its meaning was extended.[24]

Health is defined under Black's law dictionary as a state of being hale, sound, or whole in body, mind, or soul; well-being.[25] The constitution of WHO considers health as more than the mere absence of disease or infirmity."[26] The Ottawa Charter reaffirms the basic tenant of public health providing health not only as an individual issue, rather includes social dimensions.[27] The above descriptions indicate that health is beyond the absence of disease and is a state of affirmative well-being. Hence, it is concerned with more than medical care, disease, and infirmity.[28]

The right to health is a fundamental part of the birthright of all human beings crucial for dignified human life.[29] Hence, other rights become meaningless unless the person is healthy. It is understood as the right to the highest attainable standard of physical and mental health, rather than an unconditional right to be healthy. It shares the most important characteristics of socio-economic rights that is requiring states to take steps to progressively achieve the realization of the right to the maximum of their available resources.

[23] Steven D Jamar, 'The International Human Right to Health' (1994) 22 SU L Rev 1.

[24] Ibid.

[25] Black's law dictionary (Rev. 4th ed. 1968) 852.

[26] Constitution of WHO (n 3) preamble, para, 2.

[27] World Health Organization, Ottawa Charter for Health Promotion (1986).

[28] Jamar (n 22).

[29] Mahesh Sharma Poudel, 'Right to Health and Its Jurisprudence: An Overview' (2011) 5 NJA LJ 215.

2.2 Normative frameworks on the right to health

2.2.1 International legal frameworks

The recognition of the right to health can be traced back to the inception of the UN and its Charter can be considered as containing the seeds of support for the right to health as it requires states to promote a better standard of life[30] and solutions to international health challenges.[31] Although the charter does not declare the right to health for individuals, its inclusion of the statement "to seeking solutions to international health problems" indicates the fundamental and deeply rooted nature of the right to health.[32] The UDHR stipulates "everyone has the right to a standard of living adequate for the health and wellbeing of himself and of his family.[33] Although UDHR has clearly recognized the right to health, there are arguments on its binding nature however, mostly accepted scholarly position including this researcher holds that it has reached the status of international customary law.[34] The ICESCR explicitly recognized the right to health.[35] It is considered a major treaty recognizing the right to health.[36] Steps to be taken by the state parties to the covenant to achieve the full realization of the right to health provided under article 12 (2) are vital for tobacco control. The standard to be attained in the covenant is not a minimal standard, but the "highest attainable."

The ICCPR had not included the right to health expressly however, the provisions stipulating for the right to life,[37] freedom to seek, receive and impart information,[38] freedom from torture,[39] among others has direct relevance to the right to health. This is strengthened by VDPA that

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[30] Charter of the United Nations (1945), preamble, para. 1.

[31] Ibid art 55(b).

[32] Jamar (n 23).

[33] Universal Declaration of Human Rights (adopted 10 December 1948), UNGA res. 217A (III), UN Doc A/810, (UDHR) art. 25.

[34] Hurst Hannum, "The status on the universal declaration of human rights in national and international law" (1996) 25 GA.J. INT'L & COMP. L. VOL 287.

[35] ICESCR (n 5) art 12.

[36] Philip Alston & Gerard Quinn, "The Nature and Scope of States Parties Obligations under the International Covenant on Economic, Social and Cultural Rights. (1987) 156 HUM. RTS.Q 9.

[37] International Covenant on Civil and Political Rights (adopted 16 December 1966, entered into force 23 March 1976) 999 UNTS 171, (ICCPR) art 6.

[38] Ibid art 19(2).

[39] Ibid art 7.

reaffirmed the interrelatedness and interdependence of all human rights.[40] CRC further requires state parties to recognize the rights of the child to the attainment of the highest attainable standard of health.[41] The convention's focus on the best interest of the child[42] and life, survival, and development[43] as its grand principles is also vital for the protection of children's right to health. Provisions relevant for the protection of the right to health is also stipulated under CERD[44] and CEDAW.[45] CEDAW uses the phrase "protection of health" rather than the right to the enjoyment of health as such the word "protection" implies the taking of steps to create the conditions conducive to good health or to avoid conditions adverse to health.[46] The right to health is also provided under CRPD.**[47]** The convention's clear stipulation of the right to life of persons with disabilities[48] is significant for the protection of the right to health. CMW also provides for the protection of right to health.[49]

Though not human right instrument, the WHO constitution provides for the right to health.[50] Further, the Declaration of Alma-Ata strongly reaffirmed health as a fundamental human right whose attainment is the most important worldwide social goal.[51] The sustainable development

[40] VDPA (n 2).

[41] Convention on the Rights of the Child (adopted Nov. 20, 1989, entered into force Sept. 2, 1990) 1577 U.N.T.S. 3, (CRC) art 23(1).

[42] Ibid art 3(1).

[43] Ibid art 6.

[44] International Convention on the Elimination of All Forms of Racial Discrimination (adopted in Mar. 7, 1966, entered into force Jan. 4, 1969) 660 U.N.T.S. 195, (CERD) art 5(e) (iv).

[45] Convention on the Elimination of All Forms of Discrimination against Women (adopted 18 December 1979, entered into force Sept. 3, 1981) 1249 U.N.T.S. 13 (CEDAW) art 12(1).

[46] Jamar (n 22).

[47] Convention on the Rights of Persons with Disabilities (adopted in 2006 and entered in to force in 2008) UN Doc. A/61/611, (CRPD) art 1, 4, and 25.

[48] Ibid article 10.

[49] International Convention on the protection of all Migrant Workers and Members of their Families (adopted 18 December 1990, entered into force 1 July 2003) UNGA res/45/158, (CMW) article 28.

[50] Constitution of WHO (n 3), preamble, para. 4.

[51] Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September (1978).

goal three which states ensuring healthy lives for all at all stages[52] is also imperative for the right to health.

2.2.2 Regional legal frameworks

The European Social Charter provides for the right to the protection of health.[53] It reinforces that the right to health is more than a right to medical care and includes the whole range of causes of ill health.[54] The Additional Protocol of the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (Protocol of San Salvador) specifically provides for the right to health.[55] Similarly, the 1948 American Declaration on the Rights and Duties of Man stipulated every person's right to the preservation of his health to the extent permitted by public and community resources.[56] In the African human right system the right to health is recognized under the African Charter,[57] the African Charter on the Rights and welfare of the Child[58] and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa.[59] Above all the widespread ratification of health-related international and regional treaties resulted in the customary norm of a binding international human right to health.[60]

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[52] United Nations, Transforming our world - the 2030 agenda for sustainable development A/RES/70/1, goal 3.

[53] Council of Europe, European social charter (Revised), 3 May 1996, ETS 163, art 11(1-3).

[54] Jamar (n 23).

[55] Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social, and Cultural Rights (adopted 17 Nov., 1988), art 10.

[56] American Declaration on the Right and Duties of Man (Adopted by the Ninth International Conference of American States, 1948), art XI.

[57] African Charter on Human and Peoples" Rights (adopted 1 June, 1981, entered into force 21 Oct., 1986) (ACHPR), art 16(1).

[58] African Charter on the Rights and Welfare of the Child (adopted 11 July, 1990, entered into force 29, Nov. 1999) (ACRWC), art 14(1).

[59] Protocol to the African Charter on Human and Peoples Right on the Rights of Women in Africa (adopted 11 July, 2003, entered in to force in 25 Nov. 2005), art 14 (1).

[60] Eleanor D. Kinney, "The international human right to health: what does this mean for our nation and world" (2001) 34 Indiana law review 1457

2.3 Normative contents of the right to health

The right to health is not the right to be healthy rather it is the right to the enjoyment of facilities, goods, services, and conditions necessary for the realization of the right to the highest attainable standard of health.[61]

General comment 14 identifies key contents of the right to health. Firstly, the right to health is broad and inclusive right.[62] The right to health is frequently associated with access to health care and building of hospitals, however, the right extends beyond that. It is closely related and dependent upon the realization of other human rights including the right to food, housing, work, education, human dignity, and life.[63] The phrase "highest attainable standard of physical and mental health" in the ICESCR extends beyond timely and appropriate health care and includes underlying determinants of health such as healthy occupational and environmental conditions and access to health-related education.[64]

Secondly, the right to health contains both freedoms and entitlements.[65] Freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment, and experimentation.[66] On the other hand, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health which among others includes; the right to prevention, treatment and, control of diseases.[67]

Thirdly, the right to health in all its forms contains four interrelated and essential elements (availability, accessibility, acceptability and, good quality of public health facilities, goods, and services) whose application depends on the conditions prevailing in a given state party.[68] Availability connotes functioning public health and health care facilities, goods and, services

[61] General comment No. 14 (n 1), para 8.

[62] Ibid para 11.

[63] Ibid para 3.

[64] Ibid para 11.

[65] Ibid para 8.

[66] Ibid.

[67] World health organization, Office of the United Nations High Commissioner for Human Rights, right to health, fact sheet no. 31 (2008) (fact sheet No. 31) p. 3.

[68] General comment No. 14 (n 1), para 12.

within the state are available in sufficient quantity.[69] Accessibility implies both physical and financial accessibility of health care facilities, goods, and services for all on the basis of non-discrimination.[70] Acceptability implies that all health facilities, goods, and services must be respectful of medical ethics and culturally appropriate.[71] Those facilities, goods, and services must be scientifically and medically appropriate and having good quality.[72] This particularly requires trained health professionals, scientifically approved and unexpired drugs. Hence, the right to health includes healthy natural and workplace environment, right to prevention, treatment, and control of disease and right to health facilities, goods, and services.[73]

2.4 The relation between the right to health and other human rights

Human rights are interdependent and interrelated.[74] Violating the right to health necessarily impairs the enjoyment of other human rights, such as the rights to education or work, and vice versa. The value provided to the underlying determinants of health, meaning the conditions which protect and promote the right to health beyond health services, goods, and facilities, indicates that the right to health is dependent on and contributes to the realization of many other human rights.[75] Hence, without protecting other rights, an individual's right to health cannot be realized. Therefore, those rights and freedoms constitute integral components of the right to health. Further, since rights overlap in some occasions the right to health may offer protection similar to that of other rights.[76] The right to health may overlap with the right to life where it concerns the prevention of infant mortality. Moreover, the right to health is inextricably related to the right to access information. In the *SERAC* case, the African Commission stated the relation between right to health and the right to a healthy and clean environment which require the government 'to desist from carrying out or sponsoring or tolerating any practice, policy or legal

[69] Ibid para 12(a).

[70] Ibid para 12(b).

[71] Ibid para 12(c)

[72] Ibid para 12(d)

[73] Nihal Jayawickrama, *The judicial application of human rights law: national regional and international jurisprudence* (Cambridge university press 2002) 883.

[74] VDPA (n 2).

[75] Fact sheet No. 31 (n 67).

[76] Brigit Toebes, 'Towards an Improved Understanding of the International Human Right to Health' (1999) 21 Human Rights Quarterly 661.

measures violating the integrity of the individual.'[77] Thus, the right to health is both dependent upon and interrelated with other human rights.

2.5 Obligation of states and the right to health

Generally states have the primary obligation to protect and promote the right to health and such obligations are clearly provided under international human rights treaties and customary law.[78] State obligations on the right to health are general obligations and the tripartite set of obligations. General obligation can be grasped from article 2 of the ICESCR and two sets of general obligations can be inferred from it, i.e. progressive realization and minimum core obligations.

2.5.1 General obligations

2.5.1.1 Progressive realization

As the right to health is subject to progressive realization and its related resource constraint, the legal obligation of developing states seems to have a lower standard than what is required of developed states.[79] The principle of progressive realization provided under article 2(1) of ICESCR requires states to take steps in order to operationalize the right to health only to the maximum of its available resources with a view to achieving the full realization of the right. The obligation to take steps implies that state parties have to establish a reasonable action program towards the full realization of the rights and to start its implementation within a reasonable short time. As long as states' compliance efforts move as expeditiously and effectively as possible for the realization of article 12 of ICESCR, there will be no problem. Above all, the right to health can be realized progressively because the standards for its full realization are defined by changing socio-economic circumstances.[80]

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[77] *Social and Economic Rights Action Center (SERAC) and Center for Economic and Social Rights (CESR) v Nigeria* (ACmHPR 2001), para 51.

[78] United Nations, Statute of the International Court of Justice (18 April 1946), Article 38(1) (a and b).

[79] Asbjorn Eide (ed.), '*Economic, Social and Cultural Rights as Human Rights',* in Asbjorn Eide and others (eds.), *Economic, Social and Cultural Rights,* (2nd ed.), (Martinus Nijhoff Publishers 2001) 27.

[80] Christopher Mbazira, "Enforcing the economic, social and cultural rights in the African Charter on Human and Peoples' Rights: Twenty years of redundancy, progression and significant strides" (2006) 6 African Human Rights Law Journal 333.

If a given state party to the ICESCR is unable to implement its obligations, it can claim assistance from the international community.[81] A state has a margin of appreciation in progressively realizing the right to health, it has, however, to do that in good faith.[82] One point to be noticed here is the manner how the ACHPR framed state obligations. It is different from the ICESCR in article 2(1) because the ACHPR does not refer to the notion of progressive realization as state parties undertake to adopt legislative or other measures to give effect to the rights and freedoms recognized in the charter.[83] Consequently, scholars suggest that the ACHPR imposes an immediate obligation on states to ensure the realization of the right to health irrespective of resource availability.[84] Nonetheless, such view is not acceptable because at least for reasons that the economic realities of most African states do not afford the immediate application of socio-economic rights under the ACHPR[85] and socio-economic rights have dynamic nature of standards.[86]

Moreover, such a line of resource blind interpretation seems unrealistic in the African human right system because in the *Purohit and others vs. Gambia* the African Commission stated that due to resource limitation, African countries, in general, are incapable of ensuring the full realization of the right to health.[87]

The manner how state obligation is framed under ACHPR in relation to the right to health shows that it is unquestionably subject to progressive realization,[88] hence, its realization require substantial resources. Broadly considered even countries endowed with economic resources are yet to fully realize the right to health and have often raised the defense of resource in relation to

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[81] Charter of the United Nations, art 1(3), 56, art 2(1) of ICESCR.

[82] Vienna Convention on the Law of Treaties (adopted May 23, 1969, entered into force January 27, 1980), art 26.

[83] ACHPR (n 57) art 1.

[84] Fons Coomans, "The Ogoni case before the African Commission on Human and People's Right" (2003) 52 International and comparative law quarterly 749.

[85] Mbazira (n 80) p. 340-41.

[86] Bahar Jibril, "The justiciability and enforcement of the right to health under the African human right system" (2012) 1 Haramaya law review 29.

[87] *Purohit and others vs. Gambia*, (ACmHR 2001), para 84.

[88] Chidi Odinkalu (eds.), '*Implementing economic, social and cultural rights under the African Charter on Human and Peoples' Rights',* in M Evans & R Murray (eds.), *The African Charter on Human and Peoples' Rights: The system in practice, 1986-2000* (Cambridge University Press 2002) 178.

socio-economic rights generally.[89] Above all the Limburg Principles specify that the obligation of progressive achievement exists independently of the increase in resources and hence it requires effective use of available resources.[90]

2.5.1.2 Minimum core obligations

Minimum core obligations constitute a set of elements that states have to guarantee immediately, irrespective of the available resources. It implies elements without which the right loses its significance. Hence some obligations have an immediate effect which includes guaranteeing the right to health in a non-discriminatory manner, developing a plan of action and specific legislation etc.….. Further, states should refrain from taking and implementing deliberately retrogressive measures resulting in the denial of existing rights.

Resource scarcity does not relieve states of such minimum obligations in respect of the implementation of the right to health. The CESCR identified the core obligation of states concerning the right to health which includes the right of access to health facilities, goods, and services on a non-discriminatory basis, especially for vulnerable or marginalized groups among others.[91] The Committee also confirmed some state obligations as a comparable priority.[92] The CESCR has stated while the minimum core obligations are resource-dependent to some extent they should be given priority by states in their effort to realize the rights under the ICESCR. Any justification by the state parties to the ICESCR for their failure to observe the minimum core obligations is not acceptable since the minimum core obligations are non derogable.[93] The minimum core obligations of the right to health are also non-derogable in the African human right system.[94]

[89] Mbazira (n 80).

[90] Limburg Principles on the Implementation of the International Covenant on Economic Social and Cultural Rights, UN. doc. E/CN.4/1987/17, para. 23.

[91] General comment No. 14 (n 1), para. 43.

[92] Ibid para 44.

[93] Ibid para 47.

[94] African Commission on Human and Peoples Right, Principles and Guidelines on the Implementation of Economic Social and Cultural Rights in the African Charter on Human and People's Rights (2010) (principles) para. 17.

2.5.2 The tripartite set of obligations

2.5.2.1 The obligation to respect

The obligation to respect refers to the obligation to refrain from interfering directly or indirectly with the enjoyment of the right to health. It prohibits state intervention in the enjoyment of the right to health in situations which are not admissible under any legal limitations and reservation clauses. States should, for instance, refrain from marketing unsafe drugs, from withholding, censoring, and misrepresenting health information, from denying or limiting access to health care services.

Obligation to respect also includes the obligation to abstain from discriminatory practices preventing or impairing access to the right to health. Further, it implies state obligations not to arbitrarily exclude anyone from health care. If a state withdraws from areas relevant to human rights like privatizing the healthcare and leave it for the free market, consequently, state obligation to respect such rights is diminished.[95] Finally it has to be noted that obligation to respect is not subject to the notion of progressive realization rather it involves state obligation to refrain from violating the right to health.[96]

2.5.2.2 The obligation to protect

The obligation to protect requires states to affirmatively prevent violations of the right to health by third parties.[97] It requires states to adopt legislative or other proactive measures to ensure that private actors do not act contrary to health standards while providing health care or other services, for example, by regulating tobacco products. The state is under the duty to protect individuals from acts by third parties that may be harmful to their right to health. Obligation to protect includes direct regulation and intervention by states in restricting marketing and advertising of certain goods such as tobacco products in order to protect public health.[98]

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[95] Manfred Nowak, *Introduction to international human rights regimes* (Marthinus Nijhoff publishers 2003) 49.

[96] Stanley Ibe, "Beyond justiciability: Realizing the promise of socio-economic rights in Nigeria" (2007) African Human Rights Law Journal 225.

[97] Maastricht Guidelines on the Violation of Economic Social and Cultural Rights (1997), para. 6.

[98] CESCR, General comment No. 24: State obligations under the International Covenant on Economic, Social, and Cultural Rights in the context of business activities, (61st session, 2017), E/C.12/GC/24, para. 19.

2.5.2.3 The obligation to fulfill

The obligation to fulfill requires states to adopt appropriate legislative, administrative, budgetary, judicial, promotional, and other measures for the full realization of the right to health.[99] This requires states, for instance, to adopt national health policy or health plan concerning both public and private sectors, ensuring equal access for all to the underlying determinants of health, and provide information and counseling on health-related issues like the impact of drugs and other harmful substances. The duty to fulfill includes the obligation to facilitate, promote, and provide.[100] It requires states to take positive measures that enable and assist individuals and communities to enjoy the right to health.[101] When individuals or groups are unable to realize the right on their own, states have an obligation to provide.[102] The obligation to fulfill (promote) includes fostering recognition of factors favoring positive health results, such as, research and provision of information; ensuring that health services are culturally appropriate.[103] It require state parties to undertake actions that create maintain and restore the health of the population. The duty to promote the right to health is highly important for the realization of the right from tobacco control perspective since health education is significant for effective tobacco control.

2.6 Conceptualizing violation of the right to health

A violation of the ICESCR is a failure by the state party to comply with the obligations stipulated in the covenant.[104] That failures concerning the right to health may be acts of commission or omission particularly the failure to fulfill the minimum core obligation of the right to health,[105] or the failure to provide sufficient health protection and violations related to gender discrimination.[106]

Governments that deliberately withhold potentially lifesaving information about exposure to toxic substances may expose citizens to unnecessary illness and death, hence results violation of

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[99] Maastricht Guidelines (n 97), para. 6.

[100] Ibid.

[101] General comment No. 14 (n 1), para. 37.

[102] Ibid.

[103] Ibid.

[104] Limburg Principles (n 90), para. 70.

[105] Maastricht guidelines (n 97), para. 14 and 15.

[106] Ibid para 12.

duty to respect. Public policies that encourage the use of tobacco violate the obligation to respect. Tobacco companies in some countries, which provide significant sources of government revenues, discourage governments to educate citizens about the health effects of cigarette smoking hence, governments failed to adopt regulations and tax policies to discourage use.[107]

Duty to protect is violated due to failure of a state to formulate and implement legislative measures and public policies when appropriate and necessary to safeguard the right to health for persons within its jurisdiction. Thus, failure to discourage the production, marketing and consumption of tobacco products is violation of duty to protect. Although governments could prohibit, restrict, or discourage smoking, political pressures from producers and others with economic interests may attempt to block such initiatives.

2.7 Mechanisms of accountability for the right to health

In its general comment no. 9 the CESCR stressed that the central obligation of state parties to the ICESCR is to ensure that the rights recognized by the covenant are fulfilled.[108] Thus, unless proper avenues are created to ensure state accountability for right to health, the right will amount to mere rhetoric.[109] Except there exist mechanisms which are rapid, effective and available to all for preventing infringement or imposing a penalty on the infringing state, it cannot be said that these prohibitions have any legal effectiveness.[110] Lack of conceptual clarity is among the main problems of enforcing the right to health.[111]

Mechanisms of accountability may include judicial, quasi-judicial, administrative or political. The purpose of each mechanism is to ensure that governments are answerable for their actions or

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[107] Audrey R Chapman, 'Conceptualizing the Right to Health: A Violations Approach' (1998) 65 Tennessee law review 389.

[108] CESCR, General comment No. 9: The domestic application of the Covenant, (19th session, 1998), U.N. Doc. E/C.12/1998/24, para. 1.

[109] Ebenezer Duroja, “Monitoring the right to health and sexual and reproductive health at the national level: some considerations for African government” (2009) 42 the Comparative and International Law Journal of Southern Africa 227.

[110] Jose Echeverria, 'The Right to Health from the Legal Viewpoint' (1983) 17 Rev Juridica U Inter PR 213.

[111] Toebes (n 76).

inactions regarding the right to health and that right holders have effective remedies when their rights have been violated.[112]

The provision of judicial remedies for rights considered justiciable under the national legal systems is among crucial measures related to the domestic implementation of rights. *Minister of Health v. Treatment Action Campaign* can be a good example.[113] National human rights institutions (NHRIs) are also important domestic monitoring mechanisms promoting and protecting human rights having quasi-judicial functions.[114] Advising the Government and recommending policy or legislative changes, handling complaints, carrying out investigations, ensuring the ratification and implementation of international human rights treaties, and providing training and public education are among their major mandates.[115] The treaty monitoring bodies established both at the regional and UN human right systems also play vital role for the implementation of the right to health once domestic remedies are exhausted.

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[112] Helen Potts, *Accountability and the right to the highest attainable standard* of health (University of Essex, Human rights Centre 2005) 13.

[113] Fact sheet No. 31 (n 67), p. 33.

[114] Principles relating to the Status of National Institutions (Paris principles) adopted by the General Assembly Resolution 48/134 of Dec 1993, para 1. See also CESCR, General Comment No. 10: The role of national human right institutions in the protection of social, economic and cultural rights, (19th session, 1998), U.N. Doc. E/C.12/1998/25.

[115] Paris principles, para. 3(a-g).

CHAPTER THREE

THE RIGHT TO HEALTH AND TOBACCO CONTROL

3.1 Prevalence and perceived impacts of global tobacco epidemic

3.1.1 Global prevalence of tobacco epidemic

Globally, 942 million men and 175 million women aged 15 or older are current smokers.[116] There are significant number of people exposed to secondhand smoke (SHS), an estimated one fifth of male and one third of females globally were exposed to SHS,[117] showing how the issue needs concrete action.

3.1.2 Perceived impact of tobacco products

The overwhelming magnitude of tobacco epidemic as a public health disaster had been widely accepted and scientifically undisputable.[118] The massive impact of tobacco on health is also admitted by the WHO.[119] State parties to FCTC recognized devastating health consequences of tobacco consumption and exposure to tobacco smoke.[120] 10 million people are estimated to die from smoking related disease by 2030 from which 70% will occur in developing world where smoking rates are comparatively lower.[121] Approximately half of regular smokers die from their addiction.[122] Smoking causes approximately 90% of lung cancers and contributes up to 30% of all cancers.[123] Tobacco consumption is a major cause of death from non-communicable disease

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[116] Drope Jeffrey et al, The tobacco atlas, (6th ed. American cancer society and vital strategies 2018).

[117] Ibid.

[118] United States. Public health office. Office of the surgeon general office on smoking and health, the health consequences of smoking: A report of the surgeon general. (Dept. of health and human and service, centers for disease control and prevention, National center for chronic disease prevention and health promotion, office of smoking and health: Washington, DC 2004).

[119] R Beaglehole and others, shaping the future (world health organization 2003).

[120] World Health Organization, Framework Convention on Tobacco Control (2003), (FCTC), article 3.

[121] Carolyn Dresler and Stephen P Marks, "The Emerging Human Right to Tobacco Control" (2006) 28 Human Rights Quarterly 599.

[122] Richard Doll and others, "Mortality in Relation to Smoking: 50 Years' Observations on Male British Doctors" (2004) 328 BMJ 1519.

[123] Dresler and Marks (n 121).

like heart disease, cancers and respiratory diseases.[124] Children and women who are active in tobacco farming seriously suffer from their health risks.[125]

State parties to the FCTC recognized that scientific evidence has unequivocally established that exposure to tobacco smoke causes death, disease and disability.[126] Moreover, since tobacco consumption is highest among the poor members of the society, it highly contributes to the poverty through loss of income, leading cause of diseases and death; hence, tobacco and poverty form a vicious circle which is difficult to escape.[127] Beside health risks of tobacco product, tobacco cultivation initially degrade the natural environment.[128]

Given the multifaceted impact of tobacco consumption, cessation is the main measure that could decrease the risk of premature morbidity and mortality because the earlier smoker quits, the more decrease in risk of premature sickness and death will be.[129] Most of the perceived short term benefits of tobacco use recognized in the past are entirely discredited today as long term disadvantage of it squarely supersedes its benefits.[130] To sum up, tobacco production and consumption carries no social benefit but causes plethora of social harms.

3.2 The human right dimension of tobacco control with emphasis on the right to health

Despite the impacts of tobacco, less attention has been given on the application of human right perspective to tobacco control.[131] As such public health planners have not regarded human rights as important to tobacco control efforts.[132] This was mainly because when the international human rights were emerged, the fact that production, marketing and consumption of tobacco were not

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[124] World Health Organization, *World Health Statistics 2012.* (World Health Organization (2012).

[125] Dresler and Marks (n 121).

[126] FCTC (n 120), article 7(1).

[127] World Health Organization, *Tobacco and Poverty : A Vicious Circle.* (World Health Organization 2004).

[128] HJ Geist, "Global Assessment of Deforestation Related to Tobacco Farming" (1999) 8 Tobacco Control 18.

[129] JE Henningfield, "Tobacco Dependence Treatment: Scientific Challenges; Public Health Opportunities" (2000) 9 Tobacco Control 3i.

[130] James D Fry and Agnes Chong, 'Smoke and Mirrors: Reconciling the Right to Health and the Right to Tobacco in Times of Armed Conflict' (2017) 39 Houston Journal of international law 489.

[131] Dresler and Marks (n 121).

[132] World Health Organization, The world health report: changing history (World Health Organization 2004).

considered contrary to human right standards since smoking was accepted in most parts of the world.[133] Nonetheless, currently the application of human right framework is beginning to emerge in the tobacco control.[134]

From the right to health perspective, public health at the local, national and global level is highly affected by production, marketing and consumption of tobacco.[135] Thus, at least three cluster of human right norms are significant to tobacco control; right to health (including safe and healthy working condition), child right (including freedom from child labor) and women's right. The main legal basis for a human right based approach to tobacco control is derived from article 12 of ICESCR and its general comment no. 14. The protection from SHS, tobacco production regulation, marketing restrictions and efforts to decrease tobacco consumption are covered by general comment 14.[136] The CESCR under general comment 14 also stated industrial hygiene as used in article 12(2) (b) of ICESCR refers to discourage the use of tobacco and exposure to SHS. Hence tobacco control is unequivocally a human right issue. According to general comment 14 article 12(2)(c) which requires the prevention, treatment and control of epidemic, endemic, occupational and other diseases, undoubtedly applies to health risks of growing, or using tobacco. Education of health risks of production and consumption of tobacco is obligation of state parties to ICESCR. From the perspective of child rights, beside the evidential SHS impact on children, it was asserted that children growing in a household where the parents smoke are more likely to initiate smoking themselves.[137] CESCR recommends the prevention and reduction of the population exposure to harmful substances that directly or indirectly impact human health.[138]

Children who are participating in tobacco production are specifically subjected to diseases as the substances there are proved to be toxic. On the other hand the smoking by the women not only

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[133] Dresler and Marks (n 121).

[134] Melissa E. Crow, "Smokescreens and state responsibility: Using human rights strategies to promote global tobacco control" (2004) 29 Yale journal of international law 209.

[135] Dresler and Marks (n 121).

[136] General comment No. 14 (n 1), para 15 and 51.

[137] J O'Loughlin and others, "One-Year Predictors of Smoking Initiation and Continued Smoking among Elementary Schoolchildren in Multiethnic, Low-Income, Inner-City Neighborhoods" (1998) 7 Tobacco Control 268.

[138] General comment No. 14 (n 1), para. 15.

affects their health rather it also affects their unborn child and children in their household. The Committee on the Rights of the Child stated children's access to appropriate information concerning tobacco and other harmful substances is vital for the effective promotion of their rights.[139]

The existing clear connection between the right to health and tobacco control can be shown in several ways. Accordingly, measures to reduce tobacco epidemic can improve health of individuals and the population, whereas lack of regulation results in violation of states obligations relating to the right to health.

Generally, the right to health involves avoiding socio-economic challenges to health and well-being. That is why the right to health can exist only in a context where socio economic rights as well as civil and political rights are respected.[140] The right to health is seriously threatened by the sale and consumption of tobacco product hence, the right health implies tobacco control.[141] The FCTC unequivocally shows that tobacco control is inextricably linked to CEDAW and CRC.[142] Thus, the core elements of the right to health from the point of view of tobacco control require state parties to protect the right to health of people through banning smoking at public places and taking affirmative measures to the extent of its available resources to protect people from ruthless marketing tactics of tobacco companies. Therefore, since tobacco is a human right issue and related to the right to health, it includes both health freedoms and entitlements.[143]

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[139] Committee on the Rights of the Child, General Comment No. 4: Adolescent health and development in the context of the Convention on the Rights of the Child, (33rd session, 2003), CRC/GC/2003/4, (General comment No. 4), para. 10.

[140] Rangitta de Silva de Alwis and Richard Daynard, "Re-conceptualizing human rights to challenge tobacco" (2008) 17 Mich St U Coll L J Int'l L 291.

[141] Ibid.

[142] FCTC (n 120), preamble para 21 and 22.

[143] Chuan-feng Wu, 'State responsibility for tobacco control: the right to health perspective ' (2008) 3 Asian J WTO & Int'l Health L & Pol'y 379.

3.3 Non-state actors and right to health: Responsibility of tobacco companies

Traditionally, treaties provided states as the only duty bearers of human right violations, indicating the duty on states to regulate non-state actors and private enterprises.[144] Though private sector can contribute to the promotion of human rights, its negative effects are not deniable.[145] Hence, businesses are considered to have some responsibility on human rights in general and the right to health in particular. When the state is not directly responsible for the wrongdoings of non-state actors, they can be held liable for inaction or failure to take sufficient precautions to safeguard right to health.

The legal grounds for the responsibility of multinational companies for the violation of human rights had been subjected to academic debate.[146] Among the initiatives underrun for human right responsibility of non-state actors, adoption of ''Norms on the Responsibilities of Transnational Corporations and Other Business Enterprises with Regard to Human Rights"[147] in 2003 is notable. However, there is no consensus within the international community on the authoritativeness of the norms.

While underscoring that governments bear primary responsibility for the protection of human rights, the Norms impose obligations on transnational corporations and other business enterprises "within their respective spheres of activity and influence…to promote, ensure respect of and protect human rights recognized in international as well as national law.''[148] Particular to tobacco control, the Norms include provision concerning those protecting the rights to the highest attainable standard of physical and mental health[149] and a safe and healthy working

[144] Steven R Ratner, "Corporations and human rights: A theory of legal responsibility" (2001) 111 The Yale law journal 443.

[145] David weissbrodt and Muria Kruger (ed.), "*Human right responsibility of businesses as non-state actors*" in Philip Alston (ed.), *Non-state actors and human rights* (oxford university press 2005) 25.

[146] ME Crow, "The human right responsibility of multinational tobacco companies'" (2005) 14 Tobacco Control ii14.

[147] Norms on the Responsibilities of Transnational Corporations and Other Business Enterprises with regard to human rights (2003), (E/CN.4/Sub.2/2003/12/Rev.2).

[148] Ibid para 1.

[149] Ibid para 12.

environment.[150] Further, about consumer protection the norms require businesses to refrain from production, distribution, marketing or advertising harmful or potentially harmful products for use by consumers.[151] The literal understanding of this provision implies the sale of cigarettes is inconsistent with the norms. Further, the norms emphasize tobacco industries to stop targeting women, children and other vulnerable groups.

The Norms anticipated that companies' compliance will be monitored by the UN and other international and national mechanisms already in existence or yet to be created with input from NGOs and other relevant stakeholders.[152] In circumstances where the monitoring discloses that a company's failure to comply with the Norms has resulted in harm to an individual or community, the company may be required to pay reparations.[153] Further, governments are expected to promulgate laws and regulations conducive to the implementation of the Norms[154] which could bolster tobacco control.

Recently the United Nations Guiding Principles on Business and Human rights was adopted. The UN Human Right Council unanimously endorsed the guiding principles by adopting Resolution 17/4. The guiding principles has provisions dealing with the corporate responsibility to respect human rights which are important for the right to health.[155] Business enterprises are required to respect human rights.[156] Accordingly, they are required to avoid infringing human rights of others and remedy violations to which they are involved.[157] Businesses are encouraged to carryout human rights due diligence.[158] Hence they are encouraged to conduct human rights impact assessment through which they assess their actual and potential human rights impacts. In the case where the business enterprises found that they have caused or contributed to adverse

[150] Ibid para 7.

[151] Ibid para 13.

[152] Ibid para 16.

[153] Ibid para 18.

[154] Ibid para 17.

[155] United Nations Guiding Principles on Business and Human Rights: Implementing the United Nations 'Protect, Respect and Remedy' Framework (2011) p. 13. Available at https://www.ohchr.org/documents/publications/guidingprinciplesbusinesshr_en.pdf. Accessed May 6, 2020.

[156] Ibid.

[157] Ibid.

[158] Ibid p. 17.

impacts, their obligations to respect human rights requires active engagement in remediation, either by itself or in cooperation with other actors.

3.4 Global efforts to control tobacco epidemic

3.4.1 WHO Framework Convention on Tobacco Control

The FCTC was adopted with the primary intent of state parties to give priority to the protection of public health.[159] It is asserted to be relatively human right neutral though its preamble recalls the right to health provisions of ICESCR, CEDAW, and CRC.[160] The FCTC created general principles of normative consensus for international public health challenging the globalization of the tobacco pandemic.[161]

Though not formed in human right terms its guiding principles involves human right standards. The first guiding principle, for instance, provides that everyone should be informed about the dangers of tobacco consumption, affirming the right to information. The FCTC provided the obligation of state parties to assure progressive reduction of tobacco consumption and exposure to SHS. Taxation and prohibition of sales to minors, regulation of environmental smoking and contents of tobacco products, ban on tobacco advertising, promotion and sponsorship, disclosure of contents and appropriate packing and labeling of tobacco products are among the measures provided under FCTC. The FCTC addressing the global tobacco epidemic focuses on reducing both the demand for and supply of tobacco products. However, one of the interesting provisions in the convention is that it allows for no reservation[162] which could avoid abuse by Multinational Companies (MNCs).

Though FCTC is a binding treaty, it is difficult to conclude that it could be directly enforceable in domestic courts.[163] The recognition of margin of appreciation in the FCTC creates its domestic implementation challenging.[164] In relation to non-binding provisions in the treaty it is argued that

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[159] FCTC (n 120) preamble.

[160] Ibid.

[161] David P. Fidler, "International law and global public health" (1999) 48 The University of Kansas Law Review 1.

[162] FCTC (n 120), article 30.

[163] Oscar A Cabrera and Lawrence O Gostin, "Human Rights and the Framework Convention on Tobacco Control: Mutually Reinforcing Systems" (2011) 7 International Journal of Law in Context 285.

[164] Oscar A Cabrera and Alejandro Madrazo, "Human Rights as a Tool for Tobacco Control in Latin America" (2010) 52 Salud Pública de México S288.

had the FCTC established mandatory measures it could serve as a political obstacle to prevent global consensus on the treaty.[165] The central priority in the FCTC is to protect the right to health from third parties that may endanger the right.[166] Article 8 protects smokers and non-smokers alike from the harm it represents by restricting smoking in public places. Though FCTC is not a human right treaty, since it is an international treaty it can serve as a standard to measure whether states are fulfilling their obligations derived from the right to health.[167] FCTC failed to provide mandatory rules addressing clinical smoking cessation hence **depriving millions** already addicted vulnerable to the morbidity or mortality of smoking.[168] In this regard the FCTC cessation protocol could revitalize the right to health.

Unlike the WHO FCTC, the core international human right instruments rely on periodic reporting by the state parties to regularly monitor national implementation. Thus, by considering human rights and tobacco control as mutually reinforcing and complementary, the human right system can fill in the gaps of FCTC.[169] Nationally states need to take domestic legal and policy measures to curb the tobacco problem.[170]

3.4.2 Protocol to Eliminate Illicit Trade in Tobacco Products

The Protocol to Eliminate Illicit Trade in tobacco products was adopted by the consensus of the parties to the WHO FCTC in 2012.[171] It complements article 15 of the WHO FCTC which stipulates ways of countering illicit trade in tobacco products. Illegal tobacco trade obviously increases the accessibility and affordability of tobacco products hence, the protocol was adopted in response to the growing international illicit trade in tobacco products, which poses a severe

[165] Allyn L. Taylor, "An international regulatory strategy for global tobacco control" (1996) 21Yale Journal of International Law 257.

[166] FCTC (n 120), preamble.

[167] Cabrera and Gostin n (163).

[168] Benjamin Mason Meier, 'Breathing Life into the Framework Convention on Tobacco Control: Smoking Cessation and the Right to Health' (2005) 5 Yale Journal of Health Policy Law & Ethics 137.

[169] Alwis and Daynard (n 140).

[170] Oona A Hathaway, "Do Human Rights Treaties Make a Difference?" (2002) 111 the Yale Law Journal 1935.

[171] WHO FCTC Protocol to Illuminate Illicit Trades in Tobacco Products (2012).

danger to public health. Elimination of all forms of illicit trade in tobacco products is the main aim of the protocol.[172]

In reaction to those tobacco control efforts, the tobacco industries have invoked the rhetoric of fundamental rights to resist tobacco control laws and regulations.[173] The main arguments raised include restrictions on tobacco product use and promotion violates economic freedom, the right to property, and smoke-free legislations unreasonably affects the right to work.[174] Though an individual's liberty is limited due to the measures restricting smoking at public places it is however, justified as protecting public health in line with the principle of harm reduction.[175] To sum up, the power and legitimacy of the state to prevent illness, sufferings and early death can be used as a shield to rightly counter the arguments raised by tobacco industries against tobacco control efforts.

3.5 The jurisprudence of human right treaty bodies on tobacco control

The ACHPR recognized the right to health, protection of children and family, protection from foreign economic exploitation, right to satisfactory environment, and duty to promote rights in the charter. These rights may imply tobacco control. In the Principles and Guidelines on the Implementation of Economic Social and Cultural Rights in the ACHPR, the African Commission had stated that one of the cross-cutting obligations of states parties to the ACHPR is to protect individuals and peoples against environmental, industrial and occupational hazards, preventing air, land and water pollution,[176] which could include tobacco control. Although the African Commission had not considered the explicit case on tobacco control, its practice on creating state duties to protect their populations from harmful practices of transnational companies can be a ground for tobacco-related cases. When we see the jurisprudence of international treaty bodies to tobacco control the notable one is general comment no. 14 and 4 issued by CESCR and

[172] Ibid art 3.

[173] JE Katz, "Individual Rights Advocacy in Tobacco Control Policies: An Assessment and Recommendation" (2005) 14 Tobacco Control ii31.

[174] O'Neill institute for national and global health law, *Tobacco Industry Strategy in Latin American Courts: A litigation guide* (2012).

[175] Taiwo A Oriola, "Ethical and Legal Analyses of Policy Prohibiting Tobacco Smoking in Enclosed Public Spaces" (2009) 37 The Journal of Law, Medicine & Ethics 828.

[176] Principles (n 94) p. 26.

Committee on the Rights of the Child respectively. To start with the CESCR, it has interpreted article 12 as requiring state parties to implement tobacco control measures. It further recommended state parties to undertake information campaigns specifically in relation to the use of dangerous drugs and harmful substances.[177] The committee also concluded that the state party's responsibility in improving environmental and industrial hygiene covers measures to discourage tobacco, drugs, and other harmful substances.[178] Moreover, the general guidelines for the state reporting to the CESCR under articles 12 require state parties to provide information concerning measures taken by a state to control tobacco.[179]

The committee on the rights of the child in general comment No. 4 stated that for the states to promote children and adolescents civil rights and freedoms (fundamental for the health and development of the child) right of adolescents to access appropriate information is crucial particularly in relation to the use of tobacco and other harmful substances.[180] In relation to concluding observations, the CESCR after considering fourth periodic state report of Argentina stated its concern about the insufficient level of tobacco taxes and regulation on advertising campaigns and recommended the state party to adopt measures for the prevention of tobacco use especially to ban on advertising, increase tax level on tobacco to have deterrent effect and measures to provide information on the negative effects of tobacco use.[181] The Committee on the Rights of the Child also considered state report of South Africa and stated its concern about lack of adequate data on harmful substances abuse including tobacco use in the state and recommended that the state party ensure tobacco-related legislations are effectively enforced.[182] This all shows the emerging trend of human rights treaty bodies in considering tobacco as a human right issue.

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[177] General comment No. 14 (n 1), para. 36.

[178] Ibid para 15.

[179] Committee on economic, social and cultural rights, Guidelines on the treaty specific documents to be submitted by state parties under articles 16 and 17 of the ICESCR (2008), E/C.12/2008/2, para. 57(d).

[180] General comment No. 4 (n 139).

[181] CESCR, 'Concluding observation on the fourth periodic report of Argentina' (1 November 2018) UN Doc. E/C.12/ARG/CO/4.

[182] Committee on the Rights of the Child, 'Concluding observation on the initial report of South Africa' (22 February 2000) UN Doc. CRC/C/15/Add.122.

CHAPTER FOUR

PROTECTION OF THE RIGHT TO HEALTH AND AN ASSESSMENT OF TOBACCO CONTROL IN ETHIOPIA

4.1 Protection of the right to health in Ethiopia

4.1.1 Constitutional protection of the right to health

The Federal Democratic Republic of Ethiopian Constitution (FDRE Constitution) guarantees human rights.[183] A certain right is considered effectively protected in a legal system when it is entrenched as a fundamental norm of the supreme constitution under the bill of rights with strict amendment requirements and enforceable by a court of law.[184]

In its substantive part, the FDRE constitution in article 41 deals with state obligation corresponding to the right to health. It provides that the state is duty bound to allocate increasing resources to provide public health.[185] The right to equal access to publicly funded social services under article 41(3) inevitably includes health services. By making cross-reference to Article 90(1) of the National Policy Principles and Objectives (NPPO) under chapter ten of the Constitution, such types of social services to be provided to people could include health services.

Further, the obligation of the state to provide rehabilitation and assistance to the physically and mentally disabled, the aged, to children who are left without parents or guardians under article 41(5) includes health services. As opposed to its title, all rights falling under the category of socio-economic rights are not clearly provided under article 41 of the FDRE Constitution. The provision is crude and it is not possible to easily identify the rights guaranteed and extent of protection afforded to them.[186] Therefore, the FDRE constitution failed to delimit the scope of socio-economic rights[187] including the right to health. Though article 41 of the FDRE constitution failed to provide specific rights with their contents, the general term employed can

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[183] Constitution of the Federal Democratic Republic of Ethiopia, Proclamation no. 1/1995 Federal Negarit Gazette Year 1 No.1 (FDRE Constitution) (article 14-44).

[184] Sisay Alemahu Yeshanew, "The justiciability of human rights in the Federal Democratic Republic of Ethiopia" (2008) 8 African Human Rights Law Journal 273.

[185] FDRE Constitution (n 183) art 41(4).

[186] Sisay Alemahu, "The constitutional protection economic and social rights in the federal democratic republic of Ethiopia" 22 (2) 2008 Journal of Ethiopian Law 135.

[187] Ibid.

help to include unlisted rights recognized by the treaties to which Ethiopia is a party.[188] The FDRE constitution also emphasized the right to health of children and women.[189]

The FDRE constitution under NPPO also deals with health particularly under its economic and social objectives.[190] Under economic objectives, the government is required to protect and promote the health, welfare and, living standard of the working population of the country.[191] Under Social objectives, the FDRE Constitution provides that policies aim at providing access to public health to the extent the country's resource permits.[192] Article 89(8) seems to provide state obligation of relatively strong and immediate than article 90(1) since the former is not explicitly limited to resources.[193] Since the NPPO in the FDRE constitution is clearer, it can be used to interpret the fundamental bill of rights section.[194]

Treaties ratified by Ethiopia also guarantee the right to health. These treaties form an integral part of the law of Ethiopia.[195] Fundamental rights and freedoms incorporated under chapter three of the constitution are required to be interpreted in a manner conforming to the principles of UDHR, international covenants on human rights, and international instruments ratified by Ethiopia.[196] Currently ICESCR, CRC, CEDAW, ACHPR, ACRWC are among treaties forming an integral part of the law of Ethiopia relevant to the right to health and are important to clarify the ambiguity of the right to health.

Since the adoption of an optional protocol on individual complaint procedures to the ICESCR, the justiciability of the right to health at the international level is not debatable. However,

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[188] Tesfaye Amare, 'Justiciability of socio economic rights in the federal democratic republic of Ethiopia', (LLM thesis, AAU 2010) 1.

[189] FDRE Constitution (n 183) article 36(1)(d) and 35(5)(a).

[190] Ibid art 89 and 90.

[191] Ibid art 89(8).

[192] Ibid art 90(1).

[193] Berihun Adugna Gebeye, 'the potential of directive principles of state policy for the judicial enforcement of socio economic rights: A comparative study of Ethiopian and India', (LLM thesis, Central European University 2015) 1.

[194] Ashenafi Eticha, 'Do the policy objectives of the FDRE constitution hinder justiciability of socio economic rights in the constitution', (LLM thesis, AAU 2017) 1.

[195] FDRE Constitution (n 183) art 9(4).

[196] Ibid art 13(2).

Ethiopia is not a party to the optional protocol. The right to health is also justiciable under the African human right system;[197] however, there are different opinions in the Ethiopian context. Principally enforceability of the right to health under the FDRE constitution was considered difficult mainly because of its general and duty oriented formulation.[198] For some the incorporation of health under NPPO in the constitution does not imply its non-justiciable nature rather NPPO serves as a complementary legal ground for its justiciability.[199] For others the incorporation of the right to health under the substantive part of the fundamental bill of rights in the FDRE constitution is the proof for its justiciability.[200] Further, others state the right to health being socio-economic right, it is not judicially enforceable; rather, they are implemented by the laws made by the legislature.[201]

It was also argued that the incorporation of health both under the substantive bill of rights part and NPPO shows the emphasis given to the right to health.[202] Hence, NPPO strengthens justiciability of the right to health, rather than making it non-justiciable.[203] Others also state that Ethiopia has to take lessons, for instance, from Ghana, whose constitution is silent on the justiciability of DPSPs; however, the Supreme Court of Ghana held that DPSPs are justiciable.[204] In practice, though frequent cases are not brought before courts concerning the right to health in

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[197] Principles (n 94), preamble para. 13.

[198] AK Abebe, "Human Rights under the Ethiopian Constitution: A Descriptive Overview" (2011) 5 Mizan Law Review 54.

[199] Yitay BA, 'The critical analysis of the judicial enforceability of socio economic rights in Ethiopia', (Dissertation, University of Limpopo 2011) 1.

[200] Amsalu Darge, 'the integrated approach: A quest for enhancing the justiciability of socio-economic rights under the Ethiopian constitution', (LLM thesis, AAU 2010) 1.

[201] T Regassa, "Making Legal Sense of Human Rights: The Judicial Role in Protecting Human Rights in Ethiopia" (2010) 3 Mizan Law Review 289.

[202] Fikire Tinsae Birhane, "Justiciability of Socio-Economic Rights in Ethiopia: Exploring Conceptual Foundations and Assessing the FDRE Constitution and Judicial Perspective" (2018) 09 Beijing Law Review 322.

[203] Ibid.

[204] Abdi Jibril and Kwadwo Appiagyei-Atua, "Justiciability of Directive Principles of State Policy in Africa: The Experience of Ethiopia and Ghana" (2013) 1 Ethiopian Journal of Human Rights 1.

Ethiopia, there is nothing that affects its judicial enforceability.[205] To sum up, the right to health is effectively protected under the FDRE Constitution.

4.1.2 Legal and policy frameworks for the implementation of the right to health in Ethiopia

A. The public health proclamation

The public health proclamation stipulated that attitudinal change of society through the primary health care approach can solve most health problems of the country.[206] It also stipulates that the issuance of public health law is important for the promotion of health of the society and the creation of a healthy environment. The necessity of active participation of the society in the health sector for the implementation of the country's health policy is also clearly provided. However the proclamation is repealed by proc. No. 661/2009.

B. The Health Policy of the Transitional Government of Ethiopia

The Transitional Government Health Policy was adopted in 1993 and is still operational. Its preamble confirms that health is a prerequisite for the enjoyment of life.[207] The health policy prioritizes the prevention of disease. Moreover, it emphasizes the role of applied health research addressing major health problems. The policy gives special attention to the health needs of the family particularly women, children, and victims of man-made diseases. In its general strategies the health policy focuses on the need to strengthening health education through discouraging the acquisition of harmful habits such as cigarette smoking.[208] The priority health problems articulated in the health policy were previously implemented by the Health Sector Development Program (HSDP).[209] Currently the Health Sector Transformation Plan (HSTP) replaced it and stated Ethiopia still faces disease burdens consisting of NCDs.[210] It also stated a huge percentage

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[205] Interview with Mustafa Ahmed, Judge, Federal Supreme Court (Addis Ababa, Ethiopia, 5 March 2020).

[206] Public health proclamation, Proclamation no. 200/2000, Federal Negarit Gazette, 6th year No. 28, Addis Ababa, 9th March 2000, preamble, para. 2.

[207] Health Policy of the Transitional Government of Ethiopia (1993), preamble, para. 5.

[208] Ibid p. 14.

[209] Ministry of Health, Ethiopian Health Sector Development Programs I-IV, (2002/2003-2014/2015).

[210] Ministry of Health, Health Sector Transformation Plan 2015/2016-2019/2020 (2015), p. 12.

of NCDs are preventable through the reduction of tobacco use.[211] As such it has taken strengthening tobacco control as one of its strategic initiatives to improve the health system.[212]

4.2 The legal and policy frameworks for tobacco control in Ethiopia

4.2.1 Tobacco control as a measure to implement the right to health

The right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to underlying determinants of health which include safe and healthy working conditions and a healthy environment.[213] State parties to the ICESCR undertake to take steps to progressively realize the right to health. As per article 2(1) of the covenant all appropriate measures including legislative measures are stipulated as a means to satisfy the obligation to take steps. For the realization of the right to health legislative measures are indispensable.[214] Administrative, judicial, and educational measures are also appropriate measures.[215] The ICESCR does not stipulate specific means by which the right to health is to be implemented at the domestic legal order,[216] however, the means of implementation chosen by the state must be adequate to ensure the fulfillment of obligations under the covenant.[217]

As stated in the previous chapter tobacco production, marketing, use, and exposure to SHS is a serious threat to the enjoyment of the right to health. The obligation to protect the right to health requires state parties to prevent, treat, and control disease and generally to safeguard individuals from serious health infringements by third parties. One of the obligations imposed on states under article 12(1) of ICESCR is to take measures to discourage the use of tobacco. The state is under the duty to counteract threats to the individual right to health by third parties. Hence the adoption of adequate regulation and imposition of necessary sanction where needed is important to realize the right to health. Implementation of the right to health implies both preventive

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[211] Ibid p. 36.

[212] Ibid p. 105.

[213] General comment No. 14 (n 1) para 4.

[214] CESCR, General comment No. 3: The nature of the state parties' obligations (art. 2, para. 1, of the Covenant), (Fifth session, 1990), UN Doc. E/C 12/1999/4, para. 3.

[215] Ibid para 5 and 7.

[216] General comment No. 9 (n 108) para, 5.

[217] Ibid para 7.

actions to prevent potential violations and remedial actions where protected rights are violated.[218] It focuses on the adoption of concrete measures that could allow right holders to exercise their rights. Thus failure to take such preventive actions may amount to the violation of the right to health.

Therefore, tobacco control is one aspect of the implementation of the right to health. It is mainly because tobacco control aims at reducing externality by protecting nonsmokers from SHS. Tobacco control also provides consumers with better information about health warnings of tobacco products to improve their capacity to make healthier choices. When we see tobacco control measures, their main objective is protection of health, hence tobacco control measures are tools for the implementation of the right to health in Ethiopia.

4.2.2 Introductory remarks on tobacco control in Ethiopia

Controlling tobacco production was thought to be introduced during the era of empress Zewditu by the tobacco Regie regulation in 1928.[219] Since then various laws were enacted with the main objective of strengthening economic earnings by monopolizing tobacco business rather than protecting the public health.[220] Even proclamation 661/2009[221] did not recognize the public health dimension of tobacco as it did not regulate prohibited places to smoke. However, its implementation regulation no. 299/2013 provided "no person may smoke tobacco in a place for a public gathering or use."[222] Although such regulation is the first law in the Ethiopian history of tobacco control to prohibit smoking at public places, the permission of smoking designated area under article 36(3) raises questions as to the place given to public health.

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[218] Economic and Social Council, Report of the High Commissioner for Human Rights on Implementation of Economic, Social and Cultural Rights (2009), UN Doc. E/2009/90, p. 8.

[219] Edilu Shona, "Banning smoking in public places under Ethiopian legal framework: some evidence from Hawassa city" (2017) Beijing law review 535.

[220] Ibid.

[221] Proclamation No. 661/2009, A proclamation to provide for food, medicine, and health care administration and control, Federal Negarit Gazette, 16th Year No. 9, Addis Ababa, 13th January 2010.

[222] Regulation no. 299/2013, Council of ministers regulation to provide for food, medicine, and health care administration and control, Federal Negarit Gazette, 20th Year No. 11, Addis Ababa 24th January 2014, article 36(1).

Ethiopia's commitment to tobacco control became clear with its ratification of the WHO FCTC.[223] Later, a directive was enacted by the FMHACA to enhance the implementation of the Convention.[224] Though the directive prohibits smoking at indoor and outdoor public places including public conveyances,[225] it still permits smoking designated areas.[226] To sum up, the history of tobacco control efforts in Ethiopia shows the states the most intent to monopolize the tobacco industry for the purpose of maximizing the government's financial benefit rather than safeguarding the public from the dangers of the tobacco epidemic.

4.2.3 The current tobacco control regimes

4.2.3.1 The WHO FCTC

Ethiopia signed the WHO FCTC in 2004 and ratified it in 2014. The convention, being the international treaty ratified by Ethiopia, became part and parcel of the law of Ethiopia. Hence, it is considered legislation in Ethiopia important for tobacco control. Parts of the Convention are almost similar to the proclamation discussed below.

4.2.3.2 Proclamation no. 1112/2019

The main domestic instrument governing tobacco control in Ethiopia is proclamation no. 1112/2019.[227] It seems comprehensive in the protection of public health. The preamble of the proclamation clearly stipulates the necessity of preventing and controlling the health of the public from the devastating health consequences of tobacco products.[228] It requires a special license for those who manufacture, import, wholesale or distribute any tobacco product.[229] It also prohibits manufacturing, wholesale, distribution, selling, or offering for sale or trade in any electronic nicotine delivery system or other related cigarette resembling technology products.[230]

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[223] Proclamation No. 822/2014, Proclamation to ratify the world health organization framework convention on tobacco control, Federal Negarit Gazette, 20th Year No. 16, Addis Ababa, 17th February 2014.

[224] Ethiopian food, medicine, and health care administration and control authority, Tobacco Control Directive No 28/2015.

[225] Ibid art 14(1-4).

[226] Ibid art 15.

[227] Proclamation no. 1112/2019, A proclamation to provide for food and medicine administration, Federal Negarit Gazette, 25th year No. 39, Addis Ababa, 28th February 2019.

[228] Ibid preamble, para. 5.

[229] Ibid article 46(1).

[230] Ibid art 46(2).

It further obliges tobacco growers and manufacturers to prevent and control potential harms caused on the health of employees.[231] Mechanisms of tobacco control under the proclamation are both non-price and tax measures.

4.2.3.2.1 Non-price measures

A. Regulation of tobacco product contents

The proclamation prohibits the manufacturing, importing, wholesale, selling, or offering to sell tobacco products containing prohibited ingredients.[232] Accordingly, it is prohibited to manufacture, import, and wholesale, distribute, sell, or offer for sale any tobacco product that has a characterizing flavor, whether or not the product packaging indicates that or not. In addition, tobacco products that contain one or more additives with properties associated or likely to be associated with energy or vitality, health benefits, or reduced health risk such as amino acids are prohibited.

B. **Prohibition of Tobacco use at public places**

Smoking or using tobacco products in any part of all indoor workplaces, all indoor public places, on all means of public transport, and in all common areas within condominium housing is prohibited.[233] Further, smoking or tobacco use in any outdoor space within **ten meters** under public places and government institutions is also prohibited.

C. Controls on sales of tobacco products

Firstly, it is prohibited to sell tobacco products to and by any person under the age of 21.[234] It is also prohibited to sell tobacco products in the places where smoking and using tobacco products is prohibited and within a hundred meters of the premises of health institutions, schools, and youth centers. Further, sell or arrangements for tobacco products to be sold where the purchaser and seller are not in the same physical location is prohibited.[235] Tobacco products may only be sold in intact packages containing 20 sticks or consisting specified weight. Moreover, the

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[231] Ibid art 46(3).

[232] Ibid art 47(1).

[233] Ibid art 48(1).

[234] Ibid art 49(1).

[235] Ibid art 49(3).

manufacturing, importation, storing, wholesale, distribution, selling, or offering to sell any shisha products are prohibited.[236]

D. The Prohibition of tobacco product promotion

All direct and indirect tobacco product advertising, promotion, and sponsorship is prohibited.[237] Even in retail shops tobacco products are required to be placed behind or under the counter to avoid customers from easily grasping the product.

E. Health warning, packaging and labeling of tobacco products

The packaging of any tobacco product is required to contain rotating health warnings and messages displaying no less than 70% of the front and backside of each principal area of its packaging and labeling.[238] Any misleading statement or presentation on the packaging or labeling of the tobacco product with the likely effect of creating an erroneous impression about the product (e.g. characteristics, health effects etc.….) is prohibited.[239]

4.2.3.2.2 Tax measures

Tobacco taxation is important both as a source of government revenue and reducing the consumption of tobacco products by making them unaffordable. Accordingly, proclamation No 1186/2012[240] was enacted to levy an excise tax on some goods in which tobacco products are included. As such tobacco products will be subject to more than 30% excise tax. Hence, the price of tobacco products has somehow increased. The WHO suggests countries to impose a 70% excise tax on tobacco selling price however this is not true in Ethiopia. The increment of taxes on tobacco products may increase illicit tobacco trade. Despite such fears studies conducted by the World Bank group shows the main reason for illegal tobacco trades is not increment of tobacco

[236] Ibid art 49(5).

[237] Ibid art 61(1).

[238] Ibid art 57(2)/

[239] Ibid art 57(3 and 4)/

[240] Proclamation No. 1186/2012, Excise tax proclamation (2012).

tax rather it is non price factors like weak regulatory framework and poor governance.[241] Thus strong and coordinated systems to control illegal trades are important.

4.2.3.3 The trade competition and consumer protection proclamation no. 813/2013

Proclamation No 813/2013 prohibits the production of goods that affect human health and to ensure their safety and suitability to human health.[242] The role of this law in regulating tobacco products cannot be ignored because tobacco products can be included under article 2(1) of the proclamation which defines goods. The proclamation prohibits any activity by business-person to make available for sale or selling goods which are dangerous to human health.[243] Most importantly, consumers have the right to claim compensation for the damages they may suffer as a result of using the goods.[244]

4.2.3.4 The National Tobacco Control Strategic Plan

The National Tobacco Control Coordinating Committee developed the National Tobacco Control Strategic Plan.[245] This is a multi-sectoral plan with the primary vision of creating tobacco-free Ethiopia. It encompasses nine strategic objectives and twenty-three strategies that are imperative in achieving the objective of FCTC on demand and supply reduction. The strategic plan has set the target of reducing the existing tobacco prevalence by 15% at the end of 2020.[246] The overall goal of the plan is to eliminate tobacco-associated deaths, disease, and disability in the country.

The above discussed laws had the following strengths and weaknesses. The requirement of 70% of the packaging of the tobacco product to display health warnings is among the strengths of proc. 1112/2019.[247] Hence, it is stronger than the FCTC which only requires 50%.[248] Secondly,

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[241] The World Bank, "Confronting Illicit Tobacco Trade : A Global Review of Country Experiences" (*documents.worldbank.org*, January 1, 2019) 1 http://documents.worldbank.org/curated/en/677451548260528135/Confronting-Illicit-Tobacco-Trade-a-Global-Review-of-Country-Experiences. Accessed April 16, 2020.

[242] Proclamation No. 813/2013, trade competition and consumer protection proclamation, Federal Negarit Gazeta, 20th year No. 28 Addis Ababa, 21st March 2014, preamble para 2 and 3

[243] Ibid art 22(10).

[244] Ibid art 14(5).

[245] Ethiopian food, medicine, and health care administration and control authority, Tobacco control strategic plan (2010-2012).

[246] Ibid p 3.

[247] Proclamation no. 1112/2019 (n 227) art 57(2).

the proclamation outlawed the exception to the prohibition of smoking in public places.[249] Previously smoking at public places was prohibited it was however, exceptionally permitted at smoking designed areas.[250] The permission of smoking at designated areas serves no purpose rather it is against the rationale behind the prohibition of smoking at public places. The regulation to be issued to the proclamation no. 1112/2019 should however, avoid providing for smoking designated areas. Thirdly, unlike the previous laws, it explicitly governs shisha as one of the tobacco products and prohibits its manufacturing, importing, storing, and wholesale, selling, or offering for sale.[251]

All the above laws, however, do not explicitly govern the protection of women and children from passive smoking at home. The only countrywide tobacco use research conducted in 2016 shows 9.9% (6.3 million) non-smokers were exposed to passive smoke at home in which children and women could be vulnerable. That is why it should be given policy priority and be included under the law since none of the laws protects exposure to SHS at home. Hence either indoor public places should be interpreted broadly to include smoking at homes or smoking at home should be explicitly prohibited.

4.3 Institutional protections for tobacco control in Ethiopia

Though every organ of government has to eliminate the prevailing danger of the tobacco epidemic, there are however principal actors in the tobacco control. The first institution in this regard is the Ministry of Health (MOH) which is generally empowered to formulate the country's HSDP, follow up and elevate its implementation,[252] unequivocally includes tobacco control. The mandates of MOH which are imperative to tobacco control include providing appropriate support to promote research activities intended to provide solutions for the country's

[248] FCTC (n 120), article 11 (1) (b) (iv).

[249] Proclamation no. 1112/2019 (n 227) art 70(3).

[250] Regulation No. 299/2013 (n 222) art 36(3).

[251] Proc. No 1112/2019 (n 227) article 49(5).

[252] Proclamation 916/2015, Definition of Powers and Duties of the Executive Organs of the Federal Democratic Republic of Ethiopia, Federal Negarit Gazette, 22nd issue No. 12, Addis Ababa, 9th December 2015, art 33(1).

health problems, ensuring the proper execution of food, medicine, and health care regulatory functions and expanding health education through various appropriate means.[253]

The Ethiopian FMHACA was established with the primary objective of protecting the health of consumers,[254] though tobacco was not explicitly stated as its mandate under the initial law that established the institution. Later on FMHACA was empowered to undertake all acts necessary for the implementation of the WHO FCTC.[255] Hence it is the main government organ in Ethiopia currently empowered to monitor the enforcement of the tobacco control regime. It is currently called EFDA.

Ethiopian Public Health Institute (EPHI) is also vital for tobacco control.[256] One of the powers of the institute is to undertake research on health system and related issues vital for health promotion and disease prevention.[257] Since tobacco is among the main cause of diseases mainly NCDs, the institute can contribute significantly to controlling tobacco by conducting researches on the tobacco epidemic.

Though the above listed institutions are primarily duty bound in developing effective tobacco control, the role of other sectors should not be overlooked. Particularly the Ministry of Culture and Tourism, the Ministry of Women and Children Affairs, the role of media and NGOs should not be ignored. Hence, strong coordination and cooperation are necessary among all government organs to have an effective tobacco control system.

4.4 Consequences of violating tobacco control laws in Ethiopia

4.4.1 Administrative measures

Administrative measures are one of the consequences of violating tobacco control legislation in Ethiopia.[258] The administrative measures that can be imposed range from written warning[259] up

[253] Ibid art 33(11-13).

[254] Regulation No. 189/2010, Ethiopian Food, Medicine and health Care Administration and Control Authority establishment council of ministers regulation, art 4.

[255] Proclamation no. 822/2014 (n 223) art 3.

[256] Regulation no. 301/2013, Ethiopian Public Health Institute establishment Council of Ministers' regulation (2014), art 5(1).

[257] Ibid art 6(4).

[258] Proclamation no. 1112/2019 (n 227) art 65(1).

to the revocation of license[260] depending on the severity of the non-compliance. Where persons doing business concerning tobacco products are criminally convicted for the acts related to such work they may be banned from doing such business.[261] Further, the executive organ can impose civil penalties independently or together with other administrative measures.[262]

Practically, though many works remain to be done, the EFDA started taking initial administrative measures. According to an interview with W/ro Asnakech Alemu at the EFDA, over 7000 business-person in Addis Ababa were warned in writing until 11 March 2020 for violating tobacco control laws.[263]

4.4.2 Criminal liability

Manufacturing, importing, wholesale, sale in the retail, providing or distributing for use by the public tobacco products without license or with falsified document entails criminal responsibility.[264] The violation of the prohibition related to the promotion of tobacco products,[265] selling and smoking or using tobacco products at prohibited public places entails criminal punishment.[266] However, the punishment provided both for the selling or using tobacco products at prohibited places does not seem enough to deter the individuals.

Violating the requirement to post the "no smoking" notice with its corresponding sign or failure to take the required measures when there is smoking or tobacco use there entails criminal responsibility.[267] Furthermore, manufacturing, importing, wholesale, distribution, storing, or in any way selling tobacco products which are illicit or shisha entails criminal punishment.[268] However, the FDRE criminal code of 2004 does not cover the sale or distribution of shisha

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[259] Ibid art 65(2).

[260] Ibid art 65(3).

[261] Ibid art 65(9).

[262] Ibid art 65(10).

[263] Interview with Asnakech Alemu, product safety directorate director, Ethiopian Food and Drug Authority (Addis Ababa, Ethiopia, 11 March 2020).

[264] Proclamation 1112/2019 (n 227) art 67(4).

[265] Ibid art 67(18&19.

[266] Ibid art 67(20).

[267] Ibid art 67(22).

[268] Ibid art 67(23).

products. Selling, furnishing, or in any way giving tobacco products to a person under the age of 21 entails criminal punishment as per article 67(24). Violation of the tobacco control provisions which prohibit tobacco industry interference also results in criminal responsibility.[269] In the case where the crimes are committed by a legal entity, the court may order suspension, dissolution, or closure of the entity as may be appropriate.[270] Enforcing criminal law provisions is vital for strengthening the right to health by deterring future perpetrators.

4.5 Major challenges of enforcing tobacco control laws in Ethiopia

4.5.1 Resource scarcity

The provisions of the FCTC are very broad, hence its effective implementation requires huge resources which are challenging to mobilize for developing countries like Ethiopia. In controlling tobacco products one of the tasks to be performed by the EFDA is checking whether the product has prohibited additives and flavors. However, since tobacco products include thousands of chemicals in it such checkup is not available in Ethiopia because its highest technology requirement is not available to Ethiopia.[271] As such the only thing which is done in relation to additives is checking whether the product has flavors or not.[272] As per one of the key informant at EFDA:

For countries like Ethiopia it is difficult to allocate huge and sufficient resources to all sectors as necessary. This is mainly because there is an issue of prioritization in the government policy where states most of the time prioritizes some issues from others. In our case concerning health government prioritizes food and medicines administration and control than tobacco. Nowadays in Ethiopia unlike medicines, there is no separate laboratory to check whether a given tobacco product included prohibited additives or not. Hence the resource allocated to tobacco control is not enough and sufficient to effectively enforce tobacco control laws in Ethiopia.[273]

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[269] Ibid art 67(25).

[270] Ibid art 67(26).

[271] Interview with Asnakech (n 263).

[272] Ibid.

[273] Ibid.

Further, as per one of the key informants at the MOH there is no separate budget to tobacco control; however, it will take the parcel from the budget allocated to NCDs.[274] Although the resource allocated is not adequate to implement tobacco control laws, what they are doing is just working with the available resources. Hence resource constraint is one of the challenges in the implementation of tobacco control laws in Ethiopia.

4.5.2 Interference of the tobacco industry

Currently the role of the government concerning tobacco is limited to regulation of the tobacco products because the business is monopolized by private sector. As per the key informant in the EFDA, the tobacco industry in Ethiopia highly interferes with the effective control of tobacco products.[275] As such tobacco industry tackles the enactment of strong tobacco control laws and enforcement of laws adopted. This is done by various mechanisms among which publication or sponsoring the publication of fraud and wrong researches on the number of tobacco product users and illegal trade in Ethiopia are apparent.[276] As per the informant, EFDA is trying to avoid such challenges; however, the industry equally come up with new sort of obstacles which contributes to the delay of implementing tobacco control laws. Thus, the tobacco industry is considered as a threat to tobacco control in Ethiopia.[277]

4.5.3 Lack of legal synchronization

Before and after the enactment of the proclamation 1112/2019 by the federal government, there was no similar tobacco regulating comprehensive law in the regional states of Ethiopia. As per the words of the key informant at EFDA, even the federal government had prepared model tobacco control law and delivered to regional states; however, none of them had come up with their respective tobacco control laws.[278] Although there is a huge opportunity where regional states can provide better protection of public health by enacting tobacco control laws even stronger than the federal law as they are autonomous, through their failure they are unsuccessful

[274] Interview with Dr. Muse G/Michael, Tobacco control representative, Disease Prevention and Control Directorate, Ministry of Health (Addis Ababa, Ethiopia, 27 February 2020).

[275] Interview with Asnakech (n 263).

[276] Ibid.

[277] Ibid.

[278] Ibid.

to protect non-smokers from the dreadful effects of tobacco product. Even at the federal level regulation relevant to the implementation of the proclamation is not enacted yet.

4.5.4 Illicit trade in tobacco products

Around 45% of tobacco products are imported to Ethiopia through contraband traders.[279] According to Dr. Eyob Tekalign (Ministry of Finance) during the discussion on the draft Excise Tax Proc. No. 1186/2012, the current focus of the government is fighting the increasing contraband tobacco product trade in the country.[280] Contraband tobacco trades are a double burden to the state: evading tax and endangering the public health. Hence, until tobacco smuggling is effectively controlled in Ethiopia, it will continue to be a barrier to the effective enforcement of tobacco control laws.

4.5.5 Loose cooperation and coordination among government institutions

The effective implementation of tobacco control laws requires multi-sectoral tasks. Enforcement of tobacco control legislation in Ethiopia requires strong cooperation among all government sectors.[281] For instance, tobacco advertisement is prohibited under Ethiopian laws. However, when we see most Ethiopian films they advertise tobacco indirectly by smoking in the films. Although the EFDA has the general mandate of enforcing tobacco control laws, in this specific scenario the Ministry of Culture and Tourism should censor films that could preach risky behaviors to the general community, since the movies had the great opportunity of shaping human behaviors. According to Asnakech Alemu, the EFDA is trying to overcome those misconceptions by conducting dialogues with several sectors of the FDRE government.[282] However, weak coordination persists.

4.5.6 Complex nature of the work

The works related to the full enforcement of tobacco control laws are very complex.[283] Most of the works on the tobacco control are to be conducted on the behavior of the community and the

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[279] "Successive Tax Increase in Store for Tobacco Products – Ethiopian Monitor" https://ethiopianmonitor.com/2020/01/03/successive-tax-increase-in-store-for-tobacco-products/ accessed April 16, 2020.

[280] Ibid.

[281] Interview with Asnakech (n 263)

[282] Ibid.

[283] Ibid.

existing several individual behaviors in the community make the work challenging. For instance, production, sale, distribution, or using tobacco products with flavor including shisha is clearly prohibited. However, the reality in the community shows as if the product is legally permitted.[284] People who use or facilitate the use of such products are those who are addicted to it worsens the problem. Some rightly stated that tobacco control becomes complex because of the absence of a comprehensive study on the issue.[285] The full enforcement of tobacco control laws requires time.[286] This is mainly because the enforcement of tobacco control laws needs multifaceted tasks and the creation of appropriate systems necessary to change societal behaviors. Unlike the prohibition under the laws, cigarettes still continue to be sold in pieces in retail shops, and enforcing smoking bans at some public places still remains challenging.[287] Enforcing tobacco control laws may need time to some extent, however, the government must be committed to enforcing obligations of immediate effect.

4.5.7 Shortage of professionals and experts

The EFDA faces the challenge of limited technical experts on product safety and legal experts on tobacco control.[288] There are only 5-6 product safety experts and scant legal experts in the institution until 25 February 2020.[289] What aggravates the problem is that only such staff members perform the overall tobacco control measures in the federal government whose task is considered complex as stated above. The problem is countrywide because even at the regional state level beyond the absence of tobacco control laws the regional health bureaus have weak performance in tobacco control.[290]

4.5.8 Lack of Awareness

Awareness creation on the health impacts of tobacco and prevailing tobacco control laws had been made to major stakeholders including different government organs (both at federal and

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[284] Ibid.

[285] Interview with Nuriya Yusuf, Women, Child, and Youth Directorate, Ethiopian Public Health Institute (Addis Ababa, Ethiopia, 3 March 2020).

[286] Interview with Asnakech (n 263).

[287] Ibid.

[288] Interview with Freselam Yosef, legal expert, Ethiopian Food and Drug Authority (Addis Ababa, Ethiopia, 25 February 2020).

[289] Ibid.

[290] Ibid.

regional states), media, civil societies, owners of hotels, bars, and restaurants, etc. However, additional work has to be done concerning teaching the community about the health impact of tobacco (health education).[291] Awareness about the danger of tobacco can contribute to the cessation of smoking. Public education is imperative because graphic health warnings may not teach the illiterate; and media campaigns on tobacco may not influence all inhabitants since all community members do not have equal access to media. Hence beyond the requirement of graphic health warnings on the tobacco packaging and media campaigns, it is important to initiate community-based teaching on the health effects of tobacco consumptions.

4.6 Ethiopia's tobacco control efforts before selected international treaty bodies

Concluding observations which are the outcome of state reports are significant for the improvement of domestic implementation of human rights,[292] because they are made after careful consideration of cases.[293] It serves direct public attention to gaps and specify particular activities to improve implementation,[294] and has both retrospective and prospective effects.[295] Identifying legislative and policy gaps is their basic importance which in turn helps as a vehicle for the formulation of new laws and policies.[296] Ethiopia is considered to have a mixed approach of reporting status, excellent under CRC, fair under CEDAW, and very poor under other treaties like ICESCR.[297] Previously, the Ministry of Foreign Affairs (MOFA) was mandated for the

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[291] Interview with Dr. Muse (n 274).

[292] Anteneh Geremewu, "Domestic implications of concluding observations of the Committee on the Rights of the Child: the case of Ethiopia (2016) 5 Haramaya Law Review 34.

[293] Kerstin Mechlem, "Treaty Bodies and the Interpretation of Human Rights" (2009) 42 Vanderbilt Journal of Transnational Law 923.

[294] Anne F. Bayefsky, The UN human rights treaty system: universality at the crossroads (2001) p. 66. Available at https://pdfs.semanticscholar.org/d572/04555e547409baec70678d454a67cd58885c.pdf. last accessed on April 11, 2020.

[295] Geremewu (n 292).

[296] Fasil Mulatu and Rakeb Messele, Impact assessment report on the draft national child policy of Ethiopia (Addis Ababa University, Center for Human Rights 2014) 13.

[297] Eva Brems, "Ethiopia before the United Nations treaty monitoring bodies" (2007) 20 Africa focus 53.

preparation and submission of state reports.[298] However, currently, the Federal Attorney General (FAG) performs such a task.[299]

Ethiopia's experience of review of tobacco control measures before treaty bodies is limited. So far, Ethiopia had submitted four reports to the Committee on Rights of the Child; however, only the combined fourth and fifth periodic report (2012) tried to deal with tobacco. The report stated the country had implemented various programs to minimize the multidimensional consequences of tobacco;[300] however, it admitted the existence of increasing premises where illicit drugs are sold.[301] Nevertheless, no recommendation important to tobacco control was given.

The only report submitted by Ethiopia to the CESCR in 2009 which constituted combined initial, second, and third periodic reports has not dealt with the tobacco problem clearly though it tried to show measures taken to prevent and control NCDs.[302] Ethiopia had submitted four reports to the CEDAW; however, none of the reports dealt with the tobacco problem. The report submitted to CEDAW Committee in 2017 should have considered the tobacco problem because it is the first state report submitted to treaty bodies after the ratification of FCTC and GATS conducted in Ethiopia in 2016 shows the number of people exposed to SHS at home where women are easily vulnerable. Hence, the forthcoming state reports to treaty bodies must explicitly show the measures taken to protect the public from the tobacco epidemic.

4.7 Ethiopia's status of UPR in light of tobacco control

The Human Rights Council (HRC) requires the later UPR reviews to focus on the implementation of the former outcome reports,[303] because the implementation of the former UPR recommendations is significant for the effective protection of the human rights. The fruitfulness

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[298] Proc. 916/2015 (n 252), article 15(4).

[299] Proclamation No. 943/2016, Federal Attorney General establishment proclamation, Federal Negarit Gazette, 22nd Year No. 62 ADDIS ABABA, 2nd May 2016, article 6(8)(e).

[300] Committee on the Rights of the Child, Combined fourth and fifth periodic report of Ethiopia (2012) UN Doc. CRC/C/ETH/4-5, para 214.

[301] Ibid para 214-216.

[302] CESCR, Combined initial, second and third periodic reports by Ethiopia (28 July 2009) UN Doc. E/C.12/ETH/1-3, para 308.

[303] United Nations Human Rights Council: Institution-Building of the United Nations human right council, Resolution 5/ 1 of 18 June 2007 (HRC resolution 5/1), para 34.

of UPR needs the meaningful engagement of relevant stakeholders at the national level including Civil Society Organizations (CSOs) and NHRIs.[304] The key purpose of UPR is to bring the improvement of human rights situations in a country.[305] However, its state-driven nature may cause unnecessary politicization and hence weaken the credibility of the council.[306] Whether for UPR or other treaty monitoring body, strong national institution to submit reports on time and enforcing its outcome is required.[307] Accordingly, many states have developed a new type of government structure known as the National Mechanism for Reporting and Follow up (NMRF) for such purpose.[308]

Ethiopia had submitted three UPR reports to HRC where CSOs had participated in the consultation organized for the reports.[309] Overall review of the three UPR reports made by Ethiopia to HRC reveals neither of them reflects tobacco control. Why the organ preparing and submitting the UPR neglects this challenging public health disaster is not clear. During the submission of the reports, the government was a major shareholder in the tobacco industry. Such a fact may create serious questions as to how to effectively control tobacco while participating in the business. However, if there were alternative reports submitted such gaps could have been filled because the experience of Argentina, for instance, shows alternative reports can play a significant role for the state to improve its tobacco control measures.[310]

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[304] Jose Parra, "Beyond the procedure: The universal periodic review as a catalyst for public debate on human rights, (2006) p 11-12.

[305] HRC resolution 5/1 (n 303), para 4(a).

[306] Katherine Short, "From Commission to Council: has the United Nations succeeded in creating a credible human rights body?" (2008) International Journal on Human Rights 147.

[307] Mizanie A. Tadesse, "Ethiopia and the universal periodic review Mechanism: A critical reflection", (2016-2017) 28 Journal of Ethiopian Law 23.

[308] UN OHCHR, National mechanisms for reporting and follow-up: A practical guide to effective state engagement with international human rights mechanisms, (2016), p.1

[309] Eyob Awgchew, "The universal periodic review mechanism: Trend, challenge and prospect for enforcement of human rights in Ethiopia", (LLM thesis, AAU 2019) 1.

[310] United Nations Human Rights Council, parallel report to the Universal Periodic Review of the government of Argentina (2017).

4.8 Review of tobacco control efforts and ways forward

Ethiopia had made various legal and institutional efforts to control tobacco; however, overall evaluation could signify that a lot of things are remaining to be done. Hence, the effective observance of tripartite duties corresponding to the recognition of the right to health by Ethiopia remains questionable since there are still various challenges of effectively enforcing tobacco control laws. The problem is not with the laws but with their implementation. In the absence of effective tobacco control, government revenues collected from tobacco will be utilized to curing tobacco illness. A plausible way forward is drying the source of the illness by effectively controlling the product including by taking strong measures on the illicit trafficking of tobacco products. A high increment of tax on the tobacco products is the best way for discouraging its use and initiation of smoking by the youth. Further cooperating with and strengthening **NGOs** like Mathiwos Wondu Ethiopian cancer society is also imperative in rehabilitating those subjected to tobacco-related diseases like cancer. To sum up it is hardly possible to conclude that Ethiopia has observed its obligations implied by the right to health by effectively enforcing tobacco control laws. The best way forward is to continue the commenced positive efforts and taking effective and timely measures on the prevailing barriers to tobacco control.

CHAPTER FIVE

CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion

The recognition of the right to the highest attainable standard of physical and mental health entails a tripartite set of state obligations to respect, protect, and fulfill. The right to health is explicitly recognized under several international regional and national legal instruments. As a party to several international and African human rights treaties guaranteeing the right to health, Ethiopia has undertaken the obligation to adopt legal and policy measures in order to effectively enforce the right to health.

Despite the recognition of the right to health under several legal documents, tobacco had been a serious threat to the effective enjoyment of the right to health. As a response to such a problem, WHO FCTC was adopted. Besides ratifying the FCTC, there are several domestic legal and policy frameworks adopted to control the tobacco-related epidemic in Ethiopia. Among others, laws controlling the contents of a tobacco product to be manufactured and prohibiting the use of tobacco products at public places have been enacted. Institutional frameworks are also established.

Despite such legal, policy, and institutional frameworks, tobacco is becoming a serious public health threat in Ethiopia mainly because of the failure to effectively implement tobacco control laws. The interference of the tobacco industry, scarcity of resources, lack of legal harmonization; and the existence of illegal tobacco trade remain the main barriers. The lack of coordination and cooperation among government sectors is also among the main challenges.

Although administrative measures and criminal penalties are provided for the violation of the tobacco control laws, the enforcement remains at the infant stage. Unless the government fully focuses on the effective enforcement of existing tobacco control laws, tobacco will continue to be a threat to public health, implying Ethiopia's failure to implement the right to health. Further, though tobacco had been a clear human right concern, the state reporting practice to treaty bodies as well as its universal periodic review status neglects the danger of tobacco to the realization of the right to health. To sum up, the current tobacco control laws of Ethiopia to some extent

provides a good opportunity for the protection of the right to health, but their weak practical enforcement remains a barrier to the realization of the right to health.

5.2 Recommendations

To address legal and institutional problems to the effective enforcement of tobacco control laws in Ethiopia, I recommend the following.

- ✓ Effective coordination and cooperation among the government institutions concerned with tobacco control should be strengthened.
- ✓ Measures for legal harmonization must be taken particularly implementation regulation for the proclamation no. 1112/2019 must be enacted.
- ✓ The government must pay a strong commitment to enforcing the clearly articulated tobacco control laws and policies. Particularly administrative and criminal law provisions of the tobacco control laws should be enforced effectively.
- ✓ Ethiopia needs to develop practice of reporting the measures taken on tobacco control and challenges thereto to the international human right monitoring mechanisms.
- ✓ Excise tax on tobacco products needs to be highest and must be increased through time taking into account economic growth and inflation. The revenues collected from tobacco products also need to be used in the rehabilitation centers for tobacco-related diseases.
- ✓ Indirect advertising of tobacco products needs to be banned in practice, particularly by taking measures especially on films that indirectly advertise tobacco products by smoking in the films.
- ✓ Information campaigns need to be strengthened particularly community-based teaching on the health impact of tobacco products and the prohibitions related to tobacco needs to be commenced. The role played by the media and NGOs in creating awareness on tobacco-related health education must be strengthened.
- ✓ Ethiopia needs to ratify the WHO Protocol to Eliminate Illicit Trade in Tobacco Products and enforce it.
- ✓ Ethiopian tobacco control laws need to prohibit smoking at homes. As long as smoking is causing harm to others, why the government should not ban smoking at home? For the better protection of the rights to health of women and children it is vital to prohibit smoking at homes.

- ✓ While controlling tobacco product marketing and consumption, at the same time it is important to start smoking cessation measures to help addicted smokers to quit smoking for the betterment of their health and members of their families.
- ✓ The federal government budget on the health sector needs to be increased through time to effectively enforce the tobacco control problems. This could be important to fill human resource gaps in the tobacco control efforts by recruiting the necessary staff to the relevant posts.
- ✓ Further research has to be conducted in the area to fill the existing tobacco control-related legal and institutional gaps.

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