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PUBLIC HEALTH AND THE TOBACCO PROBLEM: INTERNATIONAL LEGAL IMPLICATIONS FOR AFRICA

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I. INTRODUCTION

This paper seeks to argue that tobacco is a serious public health problem in Africa. It argues that despite the existence of legal instruments for the promotion of public health on the African continent, these instruments have been ineffective in addressing the growing tobacco problem. These instruments have, however, established a sound legal basis to effectively contribute to the development of a global tobacco control convention. This paper describes the development of the World Health Organization (WHO) Framework Convention on Tobacco Control[1] as a potential instrument to contain the tobacco problem in Africa. It also surveys some international legal and normative frameworks applicable to public health in Africa that support the development of the convention.

Part I of the paper discusses international and regional instruments relating to the promotion of public health in Africa. In particular, it discusses the international legal basis for the promotion of public health on the continent. It also considers some of the shortcomings associated with these instruments

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[1] The WHO World Health Assembly initiated the development of the Convention by Resolution WHA49.17 on the International Convention on Tobacco Control. *See Resolution WITA 49.17* (visited June 28, 2001) <http://tobacco.who.int/er/fctc/resolutions.html> (including all other resolutions on tobacco).

in the promotion of public health and specifically, tobacco control. Part II discusses the evidentiary basis for global tobacco control and the magnitude of the tobacco problem. It further discusses the regulatory gap in the control of tobacco, and the subsequent need for a global legal framework. In response to the threat that tobacco poses to the public health, the World Health Organization has initiated the development of a Framework Convention on Tobacco Control to be supported by several protocols.[2] A World Bank study demonstrating that state income from tobacco duties, taxes and monopolies is outweighed by the higher costs resulting from smoking and burdens of smoke-related diseases, provides a great deal of momentum for the effort.[3]

Part III surveys the development of the WHO Framework Convention on Tobacco Control, and considers its efficacy as an effective tool for tobacco control in Africa. It concludes by urging support within Africa for the convention, an instrument that it is hoped will curtail the tobacco problem and serve to promote public health, sustainable development and human rights in Africa.

II: TOBACCO AND INTERNATIONAL PUBLIC HEALTH LAW IN AFRICA

A. General

According to John Last, a renown public health expert, public health is an effort organized by society to protect, promote and restore the peoples health.[4] It combines sciences, skills and beliefs directed to the maintenance and improvement of the health of all the people through collective or social actions. The programs, services and institutions involved emphasize the prevention of disease and the health needs of the population as a whole.[5] The tobacco problem and tobacco control fall within the ambit of this broad definition. Tobacco, a causal factor of many diseases, which contains various lethal carcinogens, constitutes a significant public health problem.[6] Public

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[2] *See* World Health Assembly Resolution WHA. Res. 52.18 (2000) which envisages a framework convention to be supported by several protocols. Possible areas of protocol may include smuggling, advertisement and treatment of tobacco dependence. *See id.*

[3] *See* Prabhat Jha & Frank J. Chaloupka, CURBING THE EPIDEMIC, GOVERNMENTS AND THE ECONOMICS OF TOBACCO CONTROL 4-5, 30, 32-34.

[4] *See* JOHN M. LAST ET AL. EDS, A DICTIONARY OF EPIDEMIOLOGY 134 (Oxford Univ. Press 3d ed. 1995).

[5] *See id.* at 135.

[6] *See Tobacco Health*, WHA Res. 39.14, WHO Doc. 1/16/19 (May 15, 1986); *see Tobacco or Health*, WHA Res. 43.16, WHO Doc. 1/11/4 (May 17, 1990).

health law, a specialty encompassing the exercise of governmental powers in the interest of public health, is coextensive with the dynamic field of public health. The goals of public health necessarily rely, at least in part, on the use of public health law as a tool. Frank Grad asserts that public health law consists of a plethora of legislation having little in common but the goal of promoting public health.[7] Even though this definition refers to domestic legislation, it also applies to international legal instruments, which have some binding effect on states forcing them to promote public health. According to D.C. Jayasuriya, public health laws are mainly concerned with the good or welfare of the public at large. Individual activities or actions are regulated with the objective of preventing greater harm to a larger population. A delicate balance must be maintained between the wishes of the few who undertake or persist in behaviors or activities detrimental to health and the many whose health is thus placed in jeopardy. The laws utilize a mix of intervention modalities and strategies in the public and private sectors to achieve legislative goals. The laws and norms set standards to ensure that the overriding public interest acts as the cornerstone of public health laws.[8] International public health law encompasses concerns such as human reproduction, infectious diseases, tobacco and narcotics and food safety among others. International public health law is linked with other areas of international law such as international human rights law, environmental, trade and labor law. For the purposes of this section, I will attempt to relate tobacco control to regional instruments in Africa. I will also consider international human rights law and international trade law, particularly WTO law, which effectively control tobacco in Africa. African states are parties to these instruments. These instruments have been insufficient to address the tobacco problem particularly in developing countries with absent or weak tobacco control legislation.

It is important for Africa to support the development of the World Health Organization's Framework Convention on Tobacco Control in order to avoid the multiple burden of diseases from AIDS, tobacco and malaria. These issues involving public health and tobacco also serve as reminders that, despite their insufficiency, general international legal norms and other applicable instruments do exist in Africa. These instruments impose certain obligations and

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[7] *See* Frank P. Grad, *Public Health Law: Its Form, Function, Future, and Ethical Parameters*, 49 INT'L. DIGEST OF HEALTH LEG., 19, 21 (1998).

[8] *See* D.C. JAYASURIYA, HEALTH LAW, INTERNATIONAL AND REGIONAL PERSPECTIVES 14, B28 (1997). This book is published by Ashok Gosair & Ashish Gosair for Har-Anand Publications Pvt Ltd. and Cort-Address for Har Anard Publications Pvt Ltd is: 36A-A, Chirag Delhi, New Delhi-110017, India (on file with author).

establish basic standards relating to health in African states and provide a basis for these states' support of a convention to control tobacco.

B. African Regional Instruments

There are various instruments within Africa, mostly developed or initiated by the Organization of African Unity (OAU), which provide for the protection of health in Africa. The protection and promotion of public health is a significant objective for African states and the regional and sub-regional organizations such as the African Economic Community (AEC), the Common Market for Eastern and Southern African States, the Economic Community of West African States, the Southern African Development Community and the East African Community. The inclusion of health matters in various regional instruments by the OAU and other sub-regional organizations serves as evidence for the importance of the subject.

First and foremost, the Charter of the OAU provides that member states shall coordinate and harmonize their general policies relating to health, sanitation and nutritional, cooperation and scientific, and technical cooperation, among others.[9] One of the purposes of the OAU is to coordinate and harmonize member states' health and scientific policies.[10] The OAU maintains a specialized commission that has a mandate to deal with health matters.[11] This commission could support tobacco control as a major public health measure.

The African Charter on Human and Peoples Rights provides that every individual shall have the right to enjoy the best attainable state of physical and mental health; and States parties to that Charter are to take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.[12] Article 14 of the African Charter on the Rights and Welfare of the Child provides for:

> the right of every child to the enjoyment of the best attainable state of physical, mental and spiritual health. States parties to the Charter have undertaken measures to reduce the infant and

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[9] *See* The Organization of African Unity Charter, Sept. 13, 1963, art. II 2(d) and (e), 479 U.N.T.S. 39.

[10] *See id.*

[11] *See id.* at art. XX.

[12] *See* AFRICAN CHARTER ON HUMAN AND PEOPLES RIGHTS, art. 16 June 27, 1981, OAU Doc. CAB/LEG/67/3 rev.5, *reprinted* at 21 I.L.M 58 (1982) [hereinafter AFRICAN CHARTER] (entered into force Oct. 21, 1986).

> child mortality rate, to ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary healthcare, to combat disease and malnutrition within the framework of primary health care, to develop preventive health care and family life education and provision of service, to integrate basic health service programme in national development plans, and to support, through technical and financial means, the mobilization of local community resources in the development of primary healthcare for children.[13]

Article 73 of the Treaty Establishing the African Economic Community provides that member states agree to promote and increase cooperation among themselves in the field of health. To this end, they are to cooperate in developing primary healthcare.[14] Member states can also introduce or prohibit restrictions or prohibitions of certain goods affecting human health among others.[15]

Unfortunately, in its objectives under Article 4 of the AEC Treaty, the immense health problems of Africa are not mentioned. One would expect the health referenced by Article 73 also to be mentioned explicitly. The supreme organ of the AEC is the Assembly of Heads of State and Government which is responsible for the supervisory and implementation functions of the objectives. Muna Ndulo has argued that African heads of state remain devoted to the notion of state sovereignty and are unable to foster key elements that are crucial to the success of the AEC Treaty.[16] The Economic and Social Commission, which addresses health matters, is not endowed with any decision making powers. It can communicate any policies directly to the assembly but only through the mechanism of the OAU Council of Ministers, which may lead to unnecessary red tape.[17] With the looming and current

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[13] OAU Document, CAB/LEG/24.9/49 (1990).

[14] *See* Treaty Establishing the African Economic Community, June 3, 1991, 30 I.L.M. 1241 (1991) [hereinafter AEC Treaty].

[15] *See id.* art. 35. Similar provisions exist under Article 43 of the Treat establishing the Economic Community of West African States, *reprinted* at 35 I.L.M. 660 (1996).

[16] *See* Muna Ndulo, *Harmonisation of Trade Laws in the African Economic Community*, 42 INT'L & COMP. L.Q. 101, 101 (1993).

[17] Treaty establishing the African Economic Community, June 3, 1991, 30 I.L.M. 1241, art 16(c)-(e); *see also* Gino J. Naldi & Konstantinos D. Magliveras, *The African Economic Community: Emancipation for African States or Yet Another Glorious Failure?*, 24 N.C. J. INT'L L. & COM. REG. 601 (1999).

public health epidemics in Africa such as tobacco related diseases, AIDS and malaria, health matters seem to be only a secondary aspect of the treaty's role.

Article 110 of the treaty establishing the Common Market for Eastern and Southern Africa(COMESA) provides that member states agree to undertake concerted measures to cooperate in the promotion and protection of health through the control of pandemics or epidemics, communicable and vector borne diseases that might endanger the health and welfare of citizens of the Common Market, the facilitation of the movement of pharmaceuticals within the Common Market and control of their quality, the training of the manpower to deliver effective healthcare and the exchange of research, development and information on health issues.[18] Member states undertake to harmonize drug registration procedures so as to improve control of pharmaceutical standards and apply the World Health Organization Certification on the quality of pharmaceutical products dealt within international trade.[19]

These legal instruments imply that tobacco control is a health issue and should constitute a fundamental aspect of sustainable development and human rights in Africa. It deserves more attention within the OAU and among its member states. Tobacco is a looming double burden of disease in Africa when considered alongside AIDS and malaria.

Unfortunately, the implementation of OAU human rights instruments has been problematic.[20] For example, under Article 59 of the African Charter on Human and Peoples Rights, the measures taken are confidential until decided otherwise by the Assembly of Heads of State. The mandate of the African Commission on Human and Peoples Rights is limited. After investigating a reported violation of human rights, the Commission reports to the Assembly of Heads of State and governments.[21] In other words, the Commission has no

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[18] *See* The Treaty Establishing the Common Market for Eastern and Southern Africa 34 I.L.M. 908 (1995), Articles 110(1) (a), (b), (d) and (e) of the treaty (Articles 110(1)(a), (b), (d), and (e) all support foot note 18. These are the specific measure in furtherance of health).

[19] *See id.* at art. 110(2)(I).

[20] For further discussion on this, *see* Obijiofor Aginam, *Legitimate Governance in Africa, International and Domestic Legal Perspectives, Editors Edward Kofi Quashigah & Obiora Chinedu Okafor*, KLUWER L. INT'L 367, 374 (1999).

[21] *See* AFRICAN CHARTER *supra* note 12, at art. 53, 54. 9. There is also a problem of interpretation of the Banjul Charter and its Rules of Procedure. Further detailed Legal critique of this interpretation problem can be found in Richard Gittleman, *The African Charter on Human and Peoples Rights: A Legal Analysis*, 22 VA. J. INT'L L. 667 (1982). *See Interim Report on the Activities of the African Commission on Human and Peoples Rights*, Council of Ministers: Sixty-Seventh Ordinary Session (Addis Ababa, Ethiopia, 23-27 Feb. 1998) at 10, para. 22 CM/2056 (LXVII) (where the financial difficulties of the Commission were discussed). This has undermined communication between the Commission parties and other organs it has

teeth. Makau wa Mutua persuasively argues that, "[w]e cannot and should not, continue to delude ourselves that we have a human rights system. What we have is a façade, a yoke that African States have put around our necks. We must cast it off and reconstruct a system we can proudly proclaim as ours."[22]

Furthermore, the OAU Charter places special emphasis on sovereignty and non-interference in internal affairs of member states; solidarity and cooperation are present, but are not as important when considering issues such as public health. African leader Isias Afeworki has said that "[a]lthough the OAU has often championed the lofty ideals of unity, cooperation, economic development, human rights and other worthy objectives, it has failed seriously to work towards their realisation."[23] This shows that the OAU regional system may be unprepared to deal with major public health issues such as tobacco.

It is yet to be seen if the new Constitutive Act of the African Union will provide a practical framework for addressing public health concerns in Africa.[24] The Act was adopted by the member states of the Organization of African Unity in Lome, Togo on 11 July 2000. The Act shall replace the Charter of the Organization of African Unity.[25] The Act, which is comprehensive and more dynamic than the OAU Charter, has various positive provisions. Article 2 establishes an African Union.[26] One of the objectives of the African Union shall be to work with relevant international partners in the eradication of preventable diseases and the promotion of good health on the continent.[27] The Act creates an executive council composed of foreign affairs ministers or others.[28] Under Article 13, the Executive Council shall coordinate and take decisions on policies in areas of common interest to member states; health is one such area.[29] Article 14 also establishes a Specialized Technical Committee

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undermined human rights promotion protection.

[22] Makau wa Mutua, *The African Human Rights System in a Comparative Perspective, in* REVIEW OF THE AFRICAN COMMISSION ON HUMAN & PEOPLES RIGHTS 11 (1993). Also cited in E.A. Ankomah, THE AFRICAN COMMISSION ON HUMAN AND PEOPLES RIGHTS: PRACTICE AND PROCEDURES 9 (1996).

[23] J. Oloka-Onyango, *Beyond the Rhetoric: Reinvigorating the Struggle for Economic and Social Rights in Africa*, 26 CAL. W. INT'L L.J. 1. 43 (1995).

[24] *See Organization of African Unity, Constitutive Act of the African Union* (visited May 11, 2001) <http://www.oau-oua.org/lone2000/Africa%20Union%20Constitutive%20Act%20ENG.htm> (certified copies available from the Office of the OAU Legal Counsel, Addis Ababa, Ethiopia) (on file with author).

[25] *Id.* at art. 33.

[26] *Id.*

[27] *Id.* at art. 3.

[28] *Id.* at art. 10.

[29] *See Organization of African Unity, Constitutive Act of the African Union, supra* note 24.

on Health, Labour and Social Affairs which shall be responsible to the Executive Council.[30] Article 15 provides that their role is to ensure the co-ordination, follow up, evaluation and harmonization of the health programmes in Africa.[31] Article 22 creates an Economic, Social and Cultural Council which also address health matters.[32] If the OAU Constitutive Act enters into force, it could provide a more enhanced opportunities to promote health in Africa. The challenges posed by epidemics in Africa such as AIDS, malaria and tobacco related ailments should trigger a more robust and practical approach by OAU to promote health on the continent.

C. International Human Rights Law

A strong link exists between human rights and the tobacco problem. The increasing deaths resulting from tobacco consumption constitute a denial of human rights. The personal freedom of individuals to smoke, a choice which affects their own health, must be balanced against the freedom of others to live in a smoke-free environment, and the responsibility of the state to protect the public health of citizens and the expenses incurred by the State arising from tobacco use. The argument by the tobacco industry that legislation to curtail the industry restricts the right to freedom cannot be accepted.[33] In many countries, including Africa today, the tobacco industry defends smoking as an individual human right. This argument advanced by the industry depicts itself as a defender of human rights. In all countries, the government has the responsibility to protect the health of the people. Government action for the welfare of society as a whole is upheld as valid even if it runs counter to the interests of some individuals.[34] The right of states to control the tobacco industry should, therefore, take precedence over the freedom of the industry to promote its harmful product. The lethal nature and deaths arising from the industry's activities need not be overstated.[35]

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[30] *Id.*

[31] *Id.*

[32] *Id.*

[33] *See* Howard K. Jeruchimowitz, *Tobacco Advertisements and Commercial Speech Balancing: A Potential Cancer to Truthful, Non-Misleading Advertisements of Lawful Products*, 82 CORNELL L. REV. 432, at 451 (1997). The author rightly asserts that a commercial speech balancing test is that a state's interest in the health, life and safety of its citizens is a more important interest than a tobacco company's right to advertise cigarettes in that State. *See id.* at 451.

[34] *See* The International Covenant on Civil and Political Rights, art. 12(3), *reprinted* 6 I.L.M. 360; (1967).

[35] The World Health Organization, *Tobacco or Health: A Global Status Report*, 43-47

Human rights law stresses the protection of the populations of less developed countries. Thus, a human rights approach helps to promote public health through tobacco control in Africa. International human rights law provides for the protection and promotion of health, and most African states are parties to the UN human rights instruments with these goals.

The Constitution of the World Health Organization provides for the right to health.[36] The Constitution guarantees that "[t]he enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social conditions."[37]

African states and regional organizations have an obligation to protect or promote public health by undertaking measures to control tobacco usage or distribution. The tobacco industry in Africa is increasing its investments and more aggressively marketing its products. Article 12 of the International Covenant on Economic, Social and Cultural Rights (1966) provides that the states parties to the Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Article 12, section 2 states:

> The steps to be taken by States Parties to achieve the full realization of this right shall include those necessary for: (a) the provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child; (b) the improvement of all aspects of environmental and industrial hygiene; (c) the prevention, treatment and control of epidemic, endemic, occupational and other diseases; (d) the creation of conditions which would assure to all medical service and medical attention in the event of sickness.[38]

The Convention calls upon states to adopt special measures of protection and assistance to shield children from economic and social exploitation.[39] The ruthless targeting of children in the third world by the tobacco industry is a clear violation of international human rights law.[40] The increasing evidence of

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(1997).

[36] *See* Constitution of World Health Organization, WORLD HEALTH ORGANIZATION, BASIC DOCUMENTS (42d ed. 1999) [hereinafter Constitution].

[37] *Id.*

[38] *See id.* at art. 10(3).

[39] *See id.* at art. 10(3).

[40] *See* Lucien J. Dhooge, *Smoke Across the Waters: Tobacco Production and Exportation*

sickness and death caused by smoking and the environmental degradation arising from tobacco production are both factors that suggest the need for an increased role of international law in promoting public health in Africa.

In General Comment 6 of the United Nations (UN) Human Rights Committee, the Committee noted that the right to life has been narrowly interpreted. The expression "inherent right to life" cannot properly be understood in a restrictive manner, and the protection of this right requires that states adopt positive measures.[41] The Committee considers that it would be desirable for states parties to take all possible measures to reduce infant mortality and to increase life expectancy, especially in adopting measures to eliminate epidemics. This clearly applies to the burden of tobacco-related diseases, which has assumed the proportions of an epidemic. About 1.1 billion people smoke worldwide.[42] By 2025, the number is expected to rise to more than 1.6 billion.[43] By 2020, 7 of every 10 people killed by smoking will be in developing countries.[44] In General Comment No.14 of May 2000, the Committee on Economic, Social and Cultural Rights, states that health is a fundamental human right indispensable to the exercise of other human rights.[45] Every human being is entitled to the enjoyment of the highest standard of health conducive to living a life in dignity. The realization of the right to health may be pursued by numerous complementary approaches, such as the formulation of health policies, the implementation of health programmes developed by the World Health Organization, or the adoption of specific legal instruments. The right to health is closely related to and dependent upon the realization of other human rights such as rights to food, education, human dignity, life and access to information. The Committee stated that the drafting history and express wording of Article 12(2) acknowledge that the right to

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as International Human Rights Violations, 22 FORDHAM INT'L L.J. 355, 439, 440 (1998).

[41] *See General Comment 6 of the Human Rights Committee on the Right to Life in Article 6 of the UN Covenant on Civil and Political Rights* (visited on May 11, 2001) <http://www.unhchr.ch/tbs/doc>. Also available at UN High Commissioner for Human Rights Office, Geneva.

[42] *See* PROBHAT JHA & FRANK CHALOUPKA, TOBACCO CONTROL IN DEVELOPING COUNTRIES 11 (2000).

[43] *Id.*

[44] *See* PRABHAT JHA & FRANK J. CHALOUPKA, CURBING THE EPIDEMIC, GOVERNMENTS AND THE ECONOMICS OF TOBACCO CONTROL 1-2 (1999).

[45] *See* CESB, Doc. E/C.12/2000/4/ (containing general comment 14, on the Right to The Highest Attainable Standard of Health Committee on Economic Social and Cultural Rights, 22d Sess., Geneva, 25 April B 12 May 2000) (available at <http://www.unhchr.ch/tbs/doc.nsf/MasterFrameView/>).

health[46] embraces a wide range of socio-economic factors that promote conditions where people can lead a healthy life. This also extends to the underlying determinants of health such as nutrition, safe and healthy working conditions and the environment. The Committee gave a wider definition of health that takes account of recent diseases such as HIV/AIDS and cancer.[47]

The prevention, treatment, and control of epidemic, endemic, occupational and other diseases require the establishment of prevention and education programmes for behaviour related health concerns. Tobacco is an example. The control of diseases refers to states', individual and joint efforts, *inter alia*, to make available relevant technologies to use and improve epidemiological surveillance and data collection and to implement or enhance other strategies of disease control.

Gostin and Lazzarini have described the minimum content of the right to health:

> The State would have a responsibility, within the limits of its available resources, to intervene to prevent or reduce serious threats to the health of individuals or populations. The responsibility to intervene or regulate applies to both governmental services and private enterprises. A government violates the right to health when, for example, it knowingly allows government entities and private companies within its jurisdiction to expose its people to health threats.

This situation evidently applies to the tobacco problem. In the case of tobacco, all states are urged to ensure that public health infrastructures are developed to contain the epidemic and that the marketing of tobacco is regulated.[48] However, since the right to health is an economic, cultural and social right, inextricably linked to economic development, incomplete and ineffective public health infrastructures constitute serious impediments to tobacco control in Africa.

Article 24 of the Convention on the Rights of the Child (1989) provides that "States Parties recognise the right of the child to the enjoyment of the highest attainable standard of health and to facilities for rehabilitation of health."[49]

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[46] *See* CESCR, General Comment 14, Doc. E/C.12/2000/4 (2000).

[47] *Id.*

[48] The WHO World Health Assembly has passed various resolutions that affirm this. *See* WHA Res. 43.16 (1990); WHA Res. 42.19 (1989), WHA 41.25 (1988) (available online at <http://tobacco.who.int/er/fctc/resolutions.html> as of February 2001).

[49] Convention on the Rights of the Child, Ga. Res. 44/25, U.N., 44 U.N. GAOR, Supp. No.

States parties shall take appropriate measures; to diminish infant and child mortality; to ensure the provision of necessary medical assistance and healthcare to all children with emphasis on the development of primary healthcare; to combat disease and malnutrition, including within the framework of primary healthcare, taking into consideration the dangers and risks of environmental pollution; to ensure that parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health, the advantages of hygiene and environmental sanitation and the prevention of accidents; and to develop preventive health care and guidance for parents. States parties undertake to promote and encourage international co-operation with a view to progressively achieving the full realisation of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.[50]

Although the Convention on the Rights of the Child does not contain any explicit right to protection from the harms of tobacco, interpretation of the Convention by the Committee on the Rights of the Child and state practice demonstrates that tobacco is a human rights issue.[51] The Committee has thus identified the issue of tobacco consumption as within the scope of the Convention. Under the reporting guidelines established by the Committee, states are requested to provide information on legislative and other measures taken to prevent the children's use of alcohol, tobacco and other substances which may be detrimental to their health, and are available with or without restrictions to adults, and on any evaluation made of the effectiveness of such measures, with the data on use of such substances by children.[52]

The Convention on the Elimination of All Forms of Discrimination Against Women also makes provision for the protection of the health of women.[53] The Convention makes a provision for health education and information for women and their families.[54] It provides for the right to protection of health and to safety in working conditions.[55] Legislation relating to matters covered in this

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149 at 165, U.N. Doc. A/44/736 (1989) (entered into force Sept. 2, 1990).

[50] See Article 24 of the Convention (*reprinted at* 28 I.L.M. 1448 (1989)).

[51] *See, e.g.*, Committee on the Rights of the Child Report, 20th Sess., UN Committee on the Rights of the Child, UN Doc. CRC/C/84 (1999) (available at <http://www.unhchr.ch/tbs/doc.nsf> as of May 10, 2001).

[52] *See* Committee on the Rights of the Child Reporting Guidelines, 14th Sess., UN Doc. CRC/C/58 (1996) (available at <http://www.unhchr.ch/tbs/doc.rsf> as of May 10, 2001).

[53] *See* Convention on the Elimination of All Forms of Discrimination Against Women, Dec. 18, 1979, G.A. Res. 34/180, U.N. GAOR, 34th Sess. UN. Doc. A/34/830 [1979] (these are general provisions relating to discrimination against women, no mention of "health.").

[54] *Id.*, at art. 10(h).

[55] *Id.*, at art. 11.

article shall be reviewed periodically in the light of scientific knowledge and revised accordingly. Recent research in many parts of Africa has shown that the tobacco industry is increasingly targeting children and women.[56] Indeed the UN Committee on the Elimination of Discrimination Against Women included women's health throughout their life cycle in General Recommendation 24. It has stressed increased expenditure for women's health services.

Many of these international human rights standards can be found in the various constitutions and legislation of African states.[57] African countries usually complain of an inability to implement these rights due to a lack of funds. Recognizing the need for financial support, the prohibition of advertisement, increased taxes on tobacco sales and mass education on the dangers of tobacco will be less costly to implement.[58]

Human rights law has increasingly placed responsibility on states to control non-state actors.[59] International law reaches private conduct by means of state responsibility to prevent or punish such conduct or, in some cases by the imposition of direct individual responsibility. State responsibility may also arise from the official act of condoning or acquiescing in abuses committed by private actors.[60] Indeed, evolving human rights jurisprudence interprets the treaty obligation to ensure the enjoyment of rights as requiring the exercise of due diligence to prevent or respond to violations committed by private actors.[61] Thus, a state's obligation to protect and promote economic and social rights includes the obligation to prevent non-state actors such as tobacco companies, advertising agencies and sports activities from promoting tobacco products

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[56] Emster V et al., *Women and Tobacco: Moving from Policy to Action*, BULLETIN OF THE WORLD HEALTH ORGANIZATION 891, 893 (2000).

[57] Chapter III of Constitution of Uganda makes a similar provision. Republic of Uganda, Constitution of the Republic of Uganda (1995) (printed by Uganda Printing and Publishing Corporation, P.O. Box 33, Entebpe Uganda).

[58] *See* The Report of the Second Working Group of the WHO Framework Convention on Tobacco Control April 26, 2000, Document A/FCTC/WG2/5 WHO Working Group on the WHO Framework Convention on Tobacco Control, 2d Session at 8-10. The report lists these technical elements as possible draft elements for the Convention. These can be accessed at the WHO website: (<http://www.who.int/wha-1998/Tobacco/second/Sarglais.htm>).

[59] *See* Janelle M. Diller & David A. Levy, *Child Labour, Trade and Investment: Towards the Harmonization of International Law*, 91 AM. J. INT'L L. 663, 668 (1997).

[60] Article 2(e) and (f) of CEAFDAW reflects this changing face on international law. Convertion or the Elimination of all Forms of Discrimination Against Women, Dec. 18, 1979, Art. 2(e), (f), 1249 UNTS 13. Under these provisions, it is the responsibility of states to take appropriate measures to eliminate discrimination against women by any person, organization or enterprise. These could be through legislation, or abolishing existing laws or regulations. *See* CEAFDAW, *supra* note 53, at art. 2(e) and (f).

[61] *See* OSCAR SCHACHTER, INTERNATIONAL LAW IN THEORY AND PRACTICE 341 (1991).

which kill. Holding tobacco companies accountable for misleading advertisements, targeting minors and the use of child labor in the industry is supported by international human rights law.

Most of the instruments emphasize protecting the health of youth and mothers, health information and education. These human rights instruments such as the International Covenant on Economic, Social and Cultural Rights and the Convention on the Rights of the Child, provide for preventive/primary healthcare and for the treatment of disease. Since African states are parties to these treaties, they have a duty to protect public health by controlling tobacco in Africa.

Despite this, some commentators argue that the scope of the human right to health remains subject to controversial debate. This may undermine the implementation of this right. The presence of health in international human rights law has not guaranteed the protection of health in Africa.

To borrow the words of Dr. Jonathan Mann, late professor of Harvard University and director of UNAIDS:

> The recent discovery of inextricable linkages between human rights and health is one of the great advances in the history of health and society. The major reasons for preventable illness, disability and premature death around the world are caused as much by societal discrimination, inequity, and injustice as by viruses or parasites.[62]

D. The World Trade Organization Law

The agreements of the World Trade Organization (WTO) relate to the protection of human health. Relevant General Agreement of Trade & Tariffs (GATT) covenants that apply include Agreement on Trade in Goods, the Agreement on the Application of Sanitary and Phytosanitary Measures, Agreement on Technical Barriers to Trade, Agreement on Agriculture, Agreement on Trade Related Aspects of Intellectual Property (TRIPS) and Agreement on Import Licensing Procedures.[63] The legal framework of the World Trade Organization appears to allow the possibility of tobacco control.

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[62] Mark E. Wojcik, *Tribute: On the Sudden Loss of a Human Rights Activist: A Tribute to Dr. Jonathan Mann's Use of International Human Rights Law in the Global Battle Against AIDS*, 32 J. MARSHALL L. REV. 129 (1998) [emphasis mine].

[63] *See* WORLD TRADE ORGANIZATION, THE RESULTS OF THE URUGUAY ROUND OF MULTILATERAL TRADE NEGOTIATIONS: THE LEGAL TEXTS, 20, 69, 138, 39, 365, 255, 519 (respectively) (1994).

Article XX of the General Agreement on Tariffs and Trade, provides *inter alia*, that:

> Subject to the requirement that such measures are not applied in a manner which would constitute a means of arbitrary or unjustifiable discrimination between countries where the same conditions prevail, or a disguised restriction on international trade, nothing in this Agreement shall be construed to prevent the adoption or enforcement by any contracting party of measures, necessary to protect human, animal, or plant life or health, relating to the conservation of exhaustible natural resources if such measures are made effective in conjunction with restrictions on domestic production or consumption.[64]

This means that WTO member states can adopt health protection measures such as that for tobacco control. The measures will be valid provided they are not arbitrary, discriminative or are a disguised restriction to trade.

The GATT recognizes that free trade is not the only policy goal for nations. Thus, it has many exceptions that give equal or greater weight to other policy goals such as security and sustainable development, which includes health, environment and labour matters.[65] The WTO Secretariat has been notified of agreements aimed at protecting human health that required certain products to be subject to import or export restrictions, such as the Basel Convention on the Control of Transboundary Movements of Hazardous Waste and their Disposal.[66] The notification of restrictions of trade under these conventions is based on the health exception under Article XX. This article justifies tobacco control for health reasons. Furthermore, some GATT jurisprudence directly relevant to the issue of tobacco control exists.

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[64] *Id.* at 591.

[65] Articles XX and XXI of GATT make explicit provisions for these exceptions which show the existence of other policy goals. The WTO Working Group on the Environment which has met regularly especially from 1991 and its task, to examine upon request specific matters relevant to trade policy aspects of measures to control pollution and protect the human environment.

[66] JACKSON & DAVEY, LEGAL PROBLEMS OF INTERNATIONAL ECONOMIC RELATIONS 560-61 (3d ed. 1995).

E. The Thai Cigarette Case

The Thai Cigarette case concerned prohibitions on the import and export of tobacco and tobacco products by Thailand.[67] Thailand sought to justify the trade prohibitions under Article XX (b) of the GATT on the grounds that Thailand had adopted measures to control smoking that could only be effective if cigarette imports were prohibited and because chemicals and other additives contained in US cigarettes might make them more harmful than Thai cigarettes.[68]

The GATT panel held and accepted that:

> Smoking constituted a serious risk to health and that measures designed to reduce the consumption of cigarettes fell within the scope of Article XX (b) of the GATT. It meant that the measures to protect human health can be applied if necessary to achieve health policy objectives. On the basis of recommendations adopted in resolutions of the forty-third Assembly of the World Health Organization in 1990, the Panel held that other measures consistent with the GATT were reasonably available to Thailand to control the quality and quantity of cigarettes smoked, including non-discriminatory regulations. These must be implemented on a national treatment basis (such as requiring disclosure of ingredients), a ban on unhealthy substances, and a ban on advertising and information campaigns. These could achieve Thailand's health policy goals.[69]

In fact GATT upheld the advertising ban, stating that various tobacco control measures could be applied both to domestic and imported tobacco and remain consistent with GATT.[70] The case could imply that member states of GATT can adopt strong tobacco control legislation provided that the measures are aimed at protecting health and do not discriminate between domestic and imported tobacco. Therefore, it would be possible to design stringent tobacco control measures to alleviate tobacco control deaths without violating the

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[67] Thailand-Restrictions on Importation of and Internal Taxes on Cigarettes, Report of the Panel, B.I.S.D. 36S/392 (1990) [hereinafter Thai Cigarette Case].

[68] *Id.*, ¶ 1A.

[69] *Id.* See generally ¶ 77.

[70] Thai Cigarette Case, *supra* note 67, ¶ 75, 77.

GATT commitment. The Panel provided a general mechanism for tightening tobacco control without breaking WTO rules. For example, following the decision, Thailand maintained its advertising ban and has upheld other strict measures to control tobacco use.[71] The Thai Cigarettes case highlights public health concerns which will increasingly be reflected in WTO's international trade goals. Thailand's response in adopting and enforcing strong multifaceted restrictive legislation is a model of what countries can do when faced with invasion by multinational companies and their advertising.[72] This case demonstrates one way in which African states could resist the tobacco industry and undertake tobacco control measures under the WTO exceptions under Article XX.[73]

The Agreement on Technical Barriers to Trade ensures that technical regulations and standards such as packaging labelling, and marketing are not adopted or applied in a way that creates unnecessary obstacles to trade.[74] The Agreement provides for use of labels on products such as tobacco.[75] It allows restrictive technical regulations, as an exception necessary to the protection of human health.[76] The scientific evidence on the harm caused by tobacco is well established.[77] This supports the concept of tobacco control achieved by the restriction of tobacco advertising, packaging and labelling, as well as the regulation of nicotine levels in cigarettes.

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[71] Ruth Roemer, *Legislative Action to Combat the World Tobacco Epidemic*, 2 WHO GENEVA 78 (1993).

[72] *See id.*

[73] *See Tuna-Dolphin Case*, GATT Document. DS21/R, 3 September 1991 (30 I.L.M.) (1991) 1594; and *Shrimp Turtle Case* (United States B Import Prohibition of Certain Shrimp and Shrimp Products, Oct. 12, 1998, 38 I.L.M. 118 (1999)) both of which laid down the conditions for the application of Article XX and even endorsed the importance of objectives such as sustainable development.

[74] Article 2.1 of Agreement on Technical Barriers to Trade, WORLD TRADE ORGANIZATION, *supra* note 63.

[75] *Id.*, at art. 1.3.

[76] *Id.*, at art. 2.2 and 5.7. *See also* THE URUGUAY ROUND RESULTS: A EUROPEAN LAWYERS PERSPECTIVE 311 (Jacques H.J. Bourgeois et al., European Inter-University Press) (1995).

[77] *See generally The Health Consequences of Smoking*, (available from US Department of Health Education and Welfare, Public Health Service, Health Services and Mental Health Administration, US Government Printing Office, Washington, D.C., 20402); *The Health Consequences of Smoking for Women, a Report of the Surgeon General* (available from 1980 US Department of Health and Human Services, Public Health Service, Office of the Assistant Secretary for Health Office on Smoking and Health, Rockville, Maryland 20857). Surgeon General's Reports on scientific evidence of smoking and health are also available online and can be located at <http://www.cdc.gov/tobacco/sgrpage.htm>. These volumes detail the scientific link between cigarette smoking and human deaths.

The Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS) provides minimum standards for governing the use of intellectual property, including medical technologies and pharmaceuticals.[78] It guarantees product and process patent protection.[79] TRIPS contains provisions to protect human health in relation to patents.[80] There is a wider exception relating to protection of public health in the formulation of laws in conformity with intellectual property rights.[81] Article 8 (1) provides that Members may, in formulating or amending their laws and regulations, adopt measures necessary to protect public health and nutrition and to promote the public interest in sectors of vital importance to their socio-economic and technological development, provided that such measures are consistent with the provisions of this agreement.[82] The South African tobacco controls involving health warnings of twenty-five percent of the packet fall under this category and these have not been challenged under TRIPS.[83] Unfortunately, few African states have enacted legislation for more stringent health warnings comparable to that of South Africa.

While health protection is an aspect of WTO law, the sovereign right to restrict trade for public health reasons is subject to scientific and other disciplines to ensure that health protection measures do not unnecessarily restrict trade. One move forward in these arguments has been the push for further multilateral cooperation in the areas that have a bearing on international trade such as the environment and health.[84] This means that a convention to control tobacco will be compatible with the legal regime of the World Trade Organization.

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[78] *See* Agreement on Trade-Related Aspects of Intellectual Property Rights, Apr. 15, 1994, LEGAL INSTRUMENTS-RESULTS OF THE URUGUAY ROUND, art. 15, 25, 27, 1995 W.T.O. 370.

[79] *Id.*

[80] Article 8(1).

[81] *Id.* See also Article 27 of TRIPS provides that Members may exclude from patentability inventions and prevent within their territory the commercial exploitation of what is necessary to protect human life and health or to avoid serious prejudice to the environment.

[82] *Id.*

[83] The South African Tobacco Products Control Act, Act No. 12 (1999), available in REPUBLIC OF SOUTH AFRICA, GOVERNMENT GAZETTE (Cape Town), April 23, 1999. To date, the Act is unchallenged in Courts.

[84] *See Beef Hormones Case* (United States and Canada v. European Union); *see also* WTO Appellate Body Reports on Measures Concerning Meat and Meat Products, WTO Doc. WT/DS26/AB/R (Jan. 16, 1998). This has been the position in several WTO position papers on the subject of Trade and Environment.

II. TOBACCO AS A PUBLIC HEALTH PROBLEM

A. Tobacco Problem and Burden of Disease: A Double Jeopardy

It is now widely accepted that tobacco related diseases are a major global public health disaster.[85] The developing world, including Africa, will face the epidemic in the same way they have been confronted with other pandemics such as AIDS.[86] It is now settled that currently tobacco kills 4 million people a year globally.[87] If current trends remain constant, there will be 10 million deaths yearly from tobacco related diseases by 2030.[88] Seventy percent of these deaths will occur in low and middle income countries.[89] There are over 1.2 billion smokers in the world today with seventy-five percent of these residing in developing countries.[90] It is projected that this number will continue to increase because of the following factors: increase in the third world population; increased smoking prevalence in urban areas; probable increase in smoking rates by women due to marketing strategies; intensive and ruthless marketing by transnational tobacco companies; and poor and weak knowledge of health risks in many populations and poor funding for tobacco control programmes.[91] These factors are even more prevalent in Africa. It is now scientifically proven that tobacco is responsible for over twenty-five different diseases, including cancer.[92] The U.S. Surgeon General has called cigarette smoking "an important public health issue of our time."[93] Cigarettes kill when used as intended and there is no known level of safe consumption.[94] The recent Minnesota tobacco litigation resulted in document discovery.[95] It showed how the industry distorted scientific records, well aware that smoking

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[85] WHO, The World Health Report, 1999, WHO (1999) at 65.

[86] *Id.*

[87] *See* Probhat Jha & Frank Chalovpka, *supra* note 42, at 25-29. *See also Peto Lopez et al.*, MORTALITY FROM SMOKING IN DEVELOPED COUNTRIES 1950-2000 (Oxford Univ. Press) (1994).

[88] *Id.*

[89] *Id.*

[90] *Id.*

[91] CURBING THE EPIDEMIC, GOVERNMENT AND THE ECONOMICS OF TOBACCO CONTROL 13-20, 22-23.

[92] SURGEON GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *supra* note 77.

[93] *Id.*

[94] *Id.*

[95] Michael V. Ciresi et al., *Decades of Deceit: Document Discovery in the Minnesota Tobacco Litigation*, 25 WM. MITCHELL L. REV. 477, 489 (1999).

causes disease.[96] It also demonstrated how an industry that is international in character could escape accountability to the detriment of public health.[97]

It is now established that the tobacco industry has abandoned the highly regulated markets in Europe and North America to the third world. Africa is a prime target for these industries due to the lax or absence of legislation or policies to control tobacco. It does not have the sophisticated public health and regulatory systems that are increasingly making the lives of tobacco companies in developed countries difficult. In addition, Western packaged cigarettes are viewed as Western cultural products and an enjoyment of Western culture.[98] This perception has been accelerated by the dramatic turn by developing countries toward free-market economies. As summed up by David Fidler, Western tobacco companies succeeded in riding the waves of international trade law, liberal triumphalism and globalizing Western culture in penetrating the markets and lungs of millions of people in the developing world.[99] In the 1999 World Health Report, the World Health Organization stated that, despite the success in health achieved globally during the 20th century, the balance sheet is tainted by the avoidable burden of disease and malnutrition that the world's disadvantaged populations continue to bear.[100] While the WHO and other international organizations have tried to reduce the health gap between developed and developing countries, there is much evidence that a gap of daunting, and in some cases, worsening proportions remains.

The WHO has declared that populations in developing countries now face not only continued threats from infectious disease but also growing epidemics of non-communicable ailments particularly those related to the lung and heart. Tobacco is a major cause of these diseases. The globalization of the industry has thus had adverse health effects in Africa. Experts have identified the phenomenon of globalization of public health under which states are losing the ability to protect the health of their citizens from disease threats.[101]

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[96] *See id.* at 490-92.

[97] *Id.* at 477, 565.

[98] *See* Ross Hammond, *Tobacco Advertising & Promotion: The Need for a Coordinated Global Response* (visited Sept. 13, 2000) <http://tobacco.who.int/en/fctc/delhi/ROSS2000X.doc> (presented at a World Health Organization International Conference on Global Tobacco Control Law: Towards a WHO Framework Convention on Tobacco Control, 7-9 January 2000, New Delhi, India).

[99] David P. Fidler, *Neither Science Nor Shamans: Globalization of Markets and Health in the Developing World*, 7 IND. J. GLOBAL LEGAL STUD. 1, 201 (1999).

[100] *See* World Health Organization, The World Health Report, 1999, Making a Difference, WHO Geneva 13 (1999).

[101] *See generally* Derek Yach & Douglas Bettcher, *The Globalization of Public Health, I: Threats and Opportunities*, 88 AM. J. PUB. HEALTH 735 (1998); Derek Yach & Douglas

B. Africa: A Lacuna in Tobacco Control Measures at the National Level

In Africa, tobacco control seems to be a problem for governments for two paradoxical reasons: tobacco is a major health hazard as well as an important economic commodity. If tobacco were not harmful to health, there would be no reason to control its use. The dilemma for African governments is how to deal with a highly addictive and lethal product which sits in a regulatory "no person's land."[102] It is neither a drug nor a food product for regulatory purposes and, thus remains a legal product.[103] Given this conflict of interest between health and corporate wealth, public policy on tobacco continues to be ad-hoc, with no meaningful legislation to control tobacco in Africa. Only South Africa may be said to have strong tobacco control legislation.[104] Most African countries have weak or non-existent laws to control the increasing tobacco problem. This is a serious legal lacuna that needs to be addressed transnationally in the face of a problem that has international dimensions.

In March of 1999, the South African Parliament amended the Tobacco Products Control Act.[105] The main purpose was to reduce the pressure on young people to begin smoking, to protect the constitutional right of the non-smoking majority to a smoke free environment and to attempt to reduce the harmfulness of cigarettes for those who cannot quit smoking. The new act prohibits all tobacco advertising, sponsorship and promotion. It also forbids smoking in all enclosed areas and work places, except some restricted areas. The act also regulates the permissible levels of tar and nicotine in cigarettes. The sale of cigarettes to children is also controlled.[106]

These stringent advertising restrictions have made it difficult for foreign tobacco companies to penetrate the South African market. To date, the presumed loss of jobs due to stringent laws has not been proven to have

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Bettcher, *The Globalization of Public Health, II: The convergence of Self Interest and Altruism*, 88 AM. J. PUB. HEALTH 738 (1998); David P. Fidler, *The Globalization of Public Health: Emerging Infectious Diseases and International Relations*, 5 IND. J. GLOBAL LEGAL STUD. 11, 12 (1997).

[102] *See* Cass R. Sunstein, *Regulations: Is Tobacco a Drug? Administrative Agencies as Common Law Courts*, 47 DUKE L.J. 1013, 1014 (1998).

[103] *Id.* at 1019.

[104] This was expressed by the award by WHO of the Important WHO Health Award for Work on Tobacco Control to Dr. Nkozasara Dhlamini Zuma, Health Minister of South Africa. *See* WHO Press Release WHA/2, 17th May 1999. This press release can be accessed at <http://www.who.int/inf-pr-1999/en/pr99_wha2.html> (visited April 29, 2001).

[105] *See* Tobacco Products Control Act, Act No.12 (1999), *available in* REPUBLIC OF SOUTH AFRICA, GOVERNMENT GAZETTE (Cape Town), April 23, 1999.

[106] *Id.*

occurred.[107] The ban on tobacco advertising is not unconstitutional, and based on the promotion of the common good.

However, Africa remains a continent on which the tobacco epidemic could potentially undermine sustainable development and where tobacco could become a mass killer. The absence of viable domestic legislation is a strong factor for states to support the development of the WHO Framework Convention on Tobacco Control as a vehicle for protecting public health in Africa. Through the convention, an international solidarity and support for the quest for alternative livelihoods could be sought while avoiding another burden of disease in Africa. It could also address the transnational nature of the tobacco problem in Africa. Peter Mutharika discussed cultural disunity, good governance, political instability and economic stagnation as possible areas where international law can make a new contribution in Africa in the Twenty-First century.[108] To the aforementioned list, we could add the role of international law in the promotion of public health in Africa. A global tobacco control convention is a central and positive aspect of this feature. Against this broad background, it is now possible to turn to a critical examination of the WHO Framework Convention on Tobacco Control itself.

III. WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL

A. The WHO Constitution

The World Health Organization is in the advanced stages of facilitating the development of an International Convention on Tobacco Control.[109] The objective is to establish and agree on international responses to achieve a reduction in tobacco use in order to promote the public health, social and

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[107] *See* Yussuf Saloojee & Elif Dagli, Tobacco Industry tactics for resisting public policy on Health, Bulletin of the World Health Organization 78, 902, 905 (2000).

[108] *See* generally Peter Mutharika, *The Role of International Law in the Twenty-First Century: An African Perspective*, 18 FORDHAM INT'L L.J. 1706 (1995).

[109] The actual negotiation of the Convention commences from October 16 to 21, 2000 when the first meeting of the Intergovernmental Negotiating Body commences in Geneva. The process has been based on Article 19 of the WHO Constitution, which empowers the Organization to develop treaties to promote health. Resolutions WHA52.18 and WHA53.16 have set the negotiations on track. For example, it established a Working Group and an Intergovernmental Negotiating Body to develop the Convention. These also address the participation of Observers in the treaty making process. The two Resolutions accessed at <http://tobacoo.who.int/en/fctc/resolutions.html> (visited May 29, 2001). *See generally* in World Health Organization, Tobacco Free Initiative, The Framework Convention on Tobacco Control. A Primes, WHO Document WHO/NCD/TFI/99.8 Rev. 3 at 203 (2000).

economic consequences of tobacco consumption, and to provide a mechanism for implementing such responses through the engagement of parties.[110] WHO is legally empowered to develop conventions.[111] The development of a tobacco control convention is legally derived from the WHO Constitution, which applies to all members including developing. However, this is the first time that the WHO is activating its constitution to develop this treaty. Article 19 of the Constitution states that the Health Assembly has authority to adopt conventions or agreements with respect to any matter within the competence of the Organization. A two-thirds vote of the Health Assembly shall bind a member when accepted by it in accordance with its constitutional processes. It is important to note that Article 2 of the Constitution endows the WHO with several functions that directly or indirectly require the application of legal principles. These include, "to act as a directing and co-ordinating authority on international health work, to propose conventions, agreements, and regulations . . . consistent with its objective, and to develop, establish, and promote international standards with respect to food, biological pharmaceutical and consumer products." Thus, the development of a WHO convention on tobacco control is legally mandated because it is based directly on the WHO Constitution. This Constitution governs actions of the organization and has a binding or persuasive effect on states that are members of the WHO. In addition, the WHO World Health Assembly has passed various resolutions since 1970 urging states to combat smoking epidemics among others using legislative means. These resolutions have accumulated a body of soft law that has strengthened the need for a global instrument for tobacco control.[112]

This sound legal basis has enabled the WHO to exercise its mandate to protect public health through the development of an International Legal Instrument.

B. Rationale for a Convention to Control Tobacco

While national programmes offer direct means of combating the epidemic caused by tobacco, an international strategy becomes imperative. This is

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[110] Chair's text of a framework convention on tobacco control, WHO Doc. A/FCTC/1Nb2/2, Intergovernmental Negotiating Body or the Framework Convention or Tobacco Control, Second Session, at 1.

[111] *See* Constitution, *supra* note 36, at 7.

[112] While soft law such as WHO Resolutions spell rules of conduct that may not be legally binding, they clearly have an impact on international relations and may later harden into treaties. *See* D.J. HARRIS, CASES AND MATERIALS ON INTERNATIONAL LAW 64-65 (5th ed. 1998) (explaining the role of soft law in the development of international law).

because tobacco industry tactics have been extremely elusive and are able to subvert national tobacco controls. The industry transcends national frontiers and international regulation offers a stronger tool to avert the tobacco problem. Another reason is that most health problems traverse national boundaries. This compels the use of multilateral initiatives to tackle transboundary health issues. International action creates a vehicle for concerted action towards containing the ever rising statistics of tobacco related deaths today. Dr. Gro Harlem Brundtland, WHO Director General, stated that tobacco control cannot succeed solely through the efforts of individual governments, national NGOs, and media advocates. We need an international response to an international problem.[113]

The Convention is the central strategy in the fight against tobacco. The Convention's creation and implementation depends upon continuous political support of national governments, global institutions and civil society. The multilateral treaty remains the best medium currently available for imposing precise and detailed binding rules of precision and detail in the new areas into which international law and concern is expanding, and for codifying, clarifying and supplementing the customary law in familiar settings.[114] Protection of public health by controlling tobacco is an area where international law is crucial for addressing the multilateral nature of the problem.

The framework approach of using both a framework convention and protocols is the most feasible option for global tobacco control. By dividing the negotiation of separate issues into individual agreements rather than resolving all substantive issues in one instrument, the framework renders global tobacco control more politically acceptable, creates a forum for cooperation and negotiation for implementing detailed protocols. Furthermore, it offers a model for a continuous and dynamic process of law making.[115] In the case of tobacco control, there are conflicting political interests between the objectives of health promotion and the economic benefits associated with tobacco growth. Moreover, information gaps due to the lack of consensus on certain issues of tobacco control, such as testing methods, necessitate this

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[113] *See* Dr. Gro Harlem Brundtland, Remarks at the Seminar on Tobacco Industry Disclosures Geneva (Oct. 20, 1998) (transcript available at <http:www.who.int/director-general_general/speeches/1998/english/19981020-tfi.html (visited June 2, 2001)).

[114] HARRIS, *supra* note 112, at 765.

[115] *See* World Health Organization, Tobacco Free Initiative, *The Framework/Convention/Protocol Approach*, Framework Convention on Tobacco Control, Technical Briefing Series, Paper 1, WHO Document WHO/NCD/TFI/99.1, WHO 1999 (available at <http://whqlibdoc.who.int/itq/1999/WHO_NCD_TFL_99.1.PDF> (visited June 1, 2001)).

approach. In these instances, a framework approach will permit instruments to be drawn up for those issues upon which some consensus exists. It will provide a forum for discussion and the co-ordination of information gathering and evaluation relating to those issues not yet resolved.[116]

C. Resolutions on the Framework Convention on Tobacco Control

1. Resolutions WHA49.17 and EB103.R11

The idea to develop a global tobacco control treaty has been incubating since 1975.[117] Gaining momentum in the 1990's the Forty-Ninth World Conference on Tobacco or Health in 1996 endorsed the idea.[118] In Resolution WHA49.17, the World Health Assembly requested the Director General of WHO to initiate the development of a Framework Convention in accordance with Article 19 of the WHO Constitution.[119] In December 1998, the WHO Executive Board adopted a resolution charting the course of developing the Convention.[120] The resolution suggested two key decisions for the 52nd World Health Assembly: first, to establish a Working Group on the Framework Convention on Tobacco Control, open to all member states; second, it urged the Assembly to establish an intergovernmental negotiating body open to all member states, which should serve to draft and negotiate the proposed WHO Framework Convention on Tobacco Control.

The World Health Assembly's adoption of the resolution opened pre-negotiations for the convention. Formal negotiations of the Convention and its protocols began with the first meeting of the intergovernmental negotiating body from 16 to 21 of October 2000. Additionally, a public hearing was held from 12 to 13 October to enable all interested parties in the Framework Convention on Tobacco Control to express their views. This ranged from public health NGOs to tobacco companies. Under the current schedule, the

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[116] Eric Le Gresley, *Options for the Preparation of an International Framework Convention and Related Protocols for Tobacco Control: Public Health and International Law Considerations*, WHO/MSA/PSA/97.9 (1997) (visited May 25, 2001) <http://www.who.int/toh/library/wholechdoc.htm>.

[117] Executive Board Resolution EB103.R11, WHO Executive Board Document EB103/5 (visited April 30, 2001) <http://www.who.int/gb/eb103/ee5.pdf>.

[118] See William Onzivu, International Legal and Policy Framework for WHO Framework Convention on Tobacco Control, 6 (visited June 13, 2001) <http://tobacco.who.int/er/fctc/delhi/ONZIVU2000X.doc>.

[119] *Id.*

[120] *Id.*

Framework Convention and its related protocols will be ready for adoption by the year 2003.[121] The last working group attracted over 140 member states of the WHO. The progress of treaty making will depend upon the political will and the sustained commitment of states determined to protect public health from the tobacco pandemic. The interests of governments are paramount in treaty making. States must perform these acts in good faith.[122] As was stated by Judge Gros in the WHO Agreement Case, "in the absence of a super State, each international organisation has only the competence which has been conferred on it by the States which founded it, and its powers are strictly limited to whatever is necessary to perform the functions which its constitutive charter has defined."[123] Thus, the competence of the WHO is that which is attributed to it by states. Specialized agencies of the UN have special competence which they have received from member states for well-defined tasks.[124] Ministries such as Foreign Affairs, Justice, Finance and Foreign Trade, Environment, Education, Agriculture and Labour may be involved in the process. The role of WHO involves facilitating the treaty-making process by promoting the participation of the least developed countries in the treaty-making process and providing technical support to member states to advance the adoption of the convention.[125]

Technical standards on tobacco control are being established and maintained by the WHO. The work of the WHO in this field requires compliance from member states such as annual reports on steps taken to promote public health.[126] In WHA Resolution WHA49.17, member states recognized the unique capacity of WHO to serve as a platform for the adoption of the Convention.

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[121] Towards a WHO Framework Convention on Tobacco Control, WHO DOC. EB103.R11 (29 January 1999) (outlining projected activities for controlling tobacco).

[122] Vienna Convention on the Law of Treaties, U.N. GAOR Int. L. Comm'n, 32nd Sess, 10th mtg. At § 26, U.N. Doc. A/Conf39/28, UKTS 58, 8 ILM 679 (1980) (providing that a treaty must be performed in good faith).

[123] Interpretation of the Agreement of 25 March 1951 Between the WHO and Egypt, 1980 ICJ 73, 103 (Dec. 20) (advisory opinion).

[124] *Id.*

[125] *See* WHA Res. 52-18 *supra* note 109, at ¶ 3(A), (5).

[126] *See* Constitution, *supra* note 36, at art. 61-65. *See, e.g.*, C.F. AMERASINGHE, PRINCIPLES OF THE INSTITUTIONAL LAW OF INTERNATIONAL ORGANIZATIONS 200-01 (1996).

2. Resolutions WHA52.18 and WHA53.16

Resolution WHA52.18 established an inter-governmental negotiating body for the convention, which is open to all member states.[127] The negotiating body's role is to draft and negotiate the proposed WHO framework[128] for the Convention on Tobacco Control and possible protocols. The Resolution also established a working group on the Convention open to all member states in order to prepare the work of the inter-governmental negotiating body. The working group prepared a catalogue of draft elements and submitted a report to the Fifty-Third World Health Assembly.

The Resolution urged member states to give high priority to accelerating work on the development of the Convention and possible related protocols, to provide resources and co-operation necessary to accelerate the work, to promote intergovernmental consultations to address specific issues, for example, public health matters and other technical matters relating to negotiation of the proposed Convention and possible related protocols.[129] Additionally, the resolution encouraged member states to establish, where appropriate, relevant structures such as national commissions and mechanisms to examine the implications of a Framework Convention on Tobacco Control within the context of health and economic issues, especially its effects on the economy of agriculturally dependent states, to facilitate and support the participation of non governmental organizations, recognizing the need for multi-sectoral representation.[130] The resolution urged the Director General, among others, to facilitate the participation of the least developed countries in the work of the working group, in intergovernmental technical consultations, and in the inter-governmental negotiating body.[131]

Resolution WHA53.16 of 20 May 2000 stated that the proposed draft elements for a framework convention established a sound basis for initiating the negotiations by the Intergovernmental Negotiating Body and called upon the Negotiating Body to commence its negotiations with an initial focus on the draft framework convention, without prejudice to future discussions on possible related protocols, and to examine the question of an extended participation as observers of NGOs according to criteria to be established by the body.[132]

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[127] *See* WHA Res. 52.18, *supra* note 125, at ¶ 1(1).
[128] *Id.*
[129] *Id.* at ¶ 2(1).
[130] *See id.* at ¶ 2(5).
[131] *See id.* at ¶ 3(5).
[132] *See* WHA Res. 53.16, *supra* note 126, at ¶ 4(4).

It should be noted that the right of the WHO Health Assembly to make resolutions derives from the WHO Constitution. Under Articles 21 and 23 of the WHO Constitution, the Health Assembly has authority to make recommendations to Members with respect to any matter within the competence of the Organization.[133] These regulations come into force for all Members after due notice has been given of their adoption by the Health Assembly except for such Members as may notify the Director-General of rejection or reservations within the period stated in the notice. These resolutions are soft law, intended to have binding effects creating obligations and rights, even though there may be a possibility of opting out. These are operational acts of the WHO which have a binding effect.[134]

D. Possible Areas of Negotiation

There are several issues likely to be the focus of the negotiations.[135] Possible harmonization of prices and taxes on tobacco products at the international level is necessary to avoid excessive price differences among neighboring countries. Increased cigarette smuggling across borders has increased smoking and poses a serious threat to public health. This requires strict control. Control of duty-free tobacco products will reduce consumption because tax free sale increases the availability of cheap cigarettes. Much of this is smuggled.[136] Advertising and trade in tobacco on the Internet are of international importance, as the Internet transcends national frontiers and bypasses national law. Thus, children may need to be protected from sales of cigarettes through the Internet. Furthermore, inaccurate and different test methods for tobacco ingredients in different countries call for internationally accepted methods that provide consumers with meaningful measures of what they expect to obtain from these products. An agreement on the elements of package design at the international level will improve trade relations that are consonant with the promotion of public health. There is environmental damage

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[133] See Constitution, *supra* note 36, at 7.

[134] *See* Constitution *supra* note 36, at 7. Under Article 19, conventions or agreements come into force when accepted by a WHO member. *See id.* Under Article 20, members shall notify the Director General of WHO on actions taken pursuant to a convention or agreement. *See id.*

[135] *See also* Provisional Texts of Proposed Draft Elements for a WHO Framework Convention on Tobacco Control with Comments of the Working Group. Document A53/12 of the 53rd World Health Assembly. *See also Improving Public Health Through an International Framework Convention on Tobacco Control*, Framework Convention on Tobacco Control, Technical Briefing Series, Paper 2, TFI-WHO, Doc. WHO/NCD/TFI/99.2 (1999).

[136] *Improving Public Health, id.* at 21.

such as deforestation resulting from the activities of the tobacco industry.[137] Information sharing should include standardized approaches to facilitate global monitoring of the tobacco epidemic and evaluation of the effectiveness of policies to combat it may be included. These and other areas may be addressed in a protocol.[138] In the various resolutions of the World Health Assembly on tobacco, there was broad agreement that it is difficult to thwart tobacco and its public health impact in isolation. This is especially so in developing countries.

It is also an acceptable norm by the international community that treaty law has an important role of enhancing the technical capability of states to address certain pertinent issues affecting them.[139] The WHO Framework Convention on Tobacco Control will boost the technical capacity of states to counter the tobacco problem.

IV. CONCLUSION

The Framework Convention on Tobacco Control will be an international legal instrument that will circumscribe the global spread of tobacco and tobacco-derived products. Other potential public health benefits of the Convention include mobilization of global and national technical and financial support for tobacco control and raising awareness, nationally and internation-

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[137] *See* Helmut Geist, *How Tobacco Farming Contributes to Tropical Deforastation, in* THE ECONOMICS OF TOBACCO CONTROL: TOWARDS AN OPTIMAL POLICY MIX 232 (Iraj Abedian ed. 1998).

[138] The World Health Assembly called upon the Intergovernmental Negotiating Body to commence its negotiations with an initial focus on the draft framework convention, without prejudice to future discussions on possible related protocols. Possible subjects of a protocols could include Testing and reporting of ingredients, product regulation, Industry regulation, agricultural policies, treatment of tobacco dependence, Environmental tobacco smoke, Health Education and Research, Information exchange, Duty free sales, Tobacco taxes/price and smuggling. According to Work Group Report on the WHO Framework Convention on Tobacco Control, WHO document A/FCTC/WG2/5, 13 B 14, *see also* WHA Res. 53.16, *supra* note 109, at ¶ 4(2) (2000).

[139] *E.g.*, PATRICIA W. BIRNIE & ALAN E. BOYLE, BASIC DOCUMENTS ON INTERNATIONAL LAW AND THE ENVIRONMENT 211 (1995). Article 10 of the Montreal Protocol on Substances that deplete the Ozone Layer provides for the provision of technical and financial cooperation including the transfer of technology, *id.* at 390. Articles 20, 21 and 25 of the Convention on Biological Diversity make provisions for financial and technical support for parties especially developing countries, *id.* at 252. Articles 4, 12, 11 and 21 of the United Nations Framework Convention on Climate Change provide for technical and financial support for countries to fulfil their obligations under the Convention, *id.* at 513. Article 21 of the United Nations Convention to Combat Desertification in Those Countries Experiencing Serious Drought or Desertification Particularly in Africa provides for a mechanism for technical support for the parties.

ally for a strengthened tobacco control action. The protocols to the Framework Convention will serve as a comprehensive tobacco control action as agreed norms are translated into national legislation and action. These may address, for example, commitments on information exchange on tobacco, research, smuggling and taxation, advertisement and children.

The development and future implementation of the WHO Framework Convention on Tobacco Control is an instrument that deserves the full support of African states and the international community, who are indeed members of the World Health Organization. It is an instrument that will promote public health through tobacco control. International public health law obliges African states and regional organizations to promote public health in Africa. Tobacco control and protection of public health will promote sustainable development in Africa. The need is for the OAU and African states to take practical steps to support the Convention. Political support in this regard is crucial. African states need to establish Multisectoral National Institutions for tobacco control.

African governments, NGOs and civil society must rise to the enormous health challenges posed by tobacco to avoid a double edged inequitable disease burden on populations in Africa. Already, the burden of such communicable diseases as malaria, TB and HIV/AIDS are high. Combined with diseases such as cancer and heart diseases that results from tobacco, the dawn of the Twenty-First century promises doom for populations in Africa. Needless to say that this avoidable double-edged burden of disease will plunge Africa deeper in the abyss of underdevelopment and persistent poverty.