An International Regulatory Strategy for Global Tobacco Control

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I. INTRODUCTION

Controlling the worldwide tobacco epidemic is an extraordinary public health challenge. It is beyond scientific dispute that the use of tobacco has devastating health consequences for the user and for those exposed to environmental tobacco smoke. The exceptional public health implications of tobacco consumption, long apparent in industrialized states, are now apparent worldwide. Today, smoking is responsible for three million premature deaths per year,[1] and the annual rate of mortality from tobacco is projected to spiral to twelve million per year by the middle of the next century, with most of the increase in deaths occurring in developing countries.[2] The vast size and rapid spread of this epidemic make tobacco consumption a uniquely important public health crisis calling for national and international action.

Domestic tobacco control legislation has proven to be essential to tobacco control, yet only a limited number of countries have adopted effective regulatory measures.[3] Most industrialized states have implemented restrictive legislation, which may include banning tobacco advertising and promotion, substantially raising taxes and prices on tobacco products, and expanding restrictions on smoking in public places. Tobacco consumption has decreased or stagnated in those societies. In response, the tobacco industry has increasingly focused on penetrating and creating markets throughout Asia, Africa, Latin America, and Eastern Europe, where tobacco regulation is weak or nonexistent.

Despite growing public awareness of the global problems caused by tobacco and of the critical role of national legislation in reducing tobacco consumption and production, scholars have paid little attention to the role that international organizations, including the World Health Organization (WHO), can play in encouraging and assisting national legislation efforts. WHO is the primary multilateral organization charged with addressing the global health implications of tobacco. WHO has promoted national tobacco control legislation for over twenty-five years through its Tobacco or Health Programme, yet the organization has been unable to convince most states to adopt and effectively implement restrictive tobacco control legislation.

Recognizing the need to increase international efforts to promote national tobacco regulation, WHO is now considering, for the first time, the role that international legislation can play in furthering its Tobacco or Health Programme. In May 1995, the World Health Assembly (WHA), the legislative organ of WHO,[4] in resolution WHA48.11, requested the Director-General of WHO to report on the "feasibility of developing an international instrument

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1. Cori Vanchieri, *WHO Trying to Slow Tobacco Related Deaths in Developing Countries*, 84 J. NAT'L CANCER INST. 1689, 1689 (1992) (quoting Alan D. Lopez).

2. Kenneth E. Warner, *Tobacco Taxation as Health Policy in the Third World*, 80 AM. J. PUB. HEALTH 529, 529 (1990).

3. For an excellent discussion of the essential role of national legislation in achieving worldwide tobacco control, see generally RUTH ROEMER, LEGISLATIVE ACTION TO COMBAT THE WORLD TOBACCO EPIDEMIC (2d ed. 1993).

4. The World Health Assembly is the legislative organ of WHO and determines overall policy. WHO CONST. art. 18, *in* WORLD HEALTH ORGANIZATION, BASIC DOCUMENTS 1, 6 (40th ed. 1994) [hereinafter WHO, BASIC DOCUMENTS]. See *infra* note 144 for a discussion of WHO's administrative structure.

such as guidelines, a declaration, or an International Convention on Tobacco Control."[5]

This Article argues for an international regulatory approach that WHO can utilize to encourage international agreement and action on tobacco control. A review of the factors that constrain states from implementing effective tobacco control legislation vividly demonstrates that this global health challenge is international in origin, necessitating collaborative, multilateral action. WHO can further national codification and implementation of tobacco legislation by stimulating the development of international tobacco agreements and supportive international supervisory and financial institutions.

In light of the political factors limiting global tobacco control efforts, WHO should adopt a dynamic and incremental approach to international standard setting patterned on the international legislative techniques developed by other international organizations in a number of areas, including human rights and environmental protection. Instead of encouraging states to enact a single international instrument, as WHA48.11 suggests, WHO should gradually develop political consensus for national and international action on tobacco control, first promoting the adoption of a noncontroversial, nonlegal international instrument, and then encouraging the development of binding international agreements with sophisticated provisions for implementation and international review. By providing an ongoing diplomatic forum, WHO may, over time, heighten governmental concern about the global dangers of tobacco and may eventually transform that concern into widespread support for the adoption of cogent international norms.

An international organization's ability to affect national decisionmaking is naturally limited by a world order of independent states. Critical economic interests are at stake in the global tobacco debate. Transnational tobacco conglomerates, as well as many states, will powerfully resist the codification of international commitments to regulate tobacco. Notwithstanding these political constraints, WHO does have a degree of institutional independence to promote and guide governmental action. Recent revelations of what the tobacco industry has known and concealed about the addictive and lethal consequences of nicotine,[6] as well as sharpened interest in tobacco regulation in a number of countries, including the United States, have highlighted the issue of tobacco control worldwide. These changing global circumstances have created a unique opportunity for WHO to serve as an effective forum for the development of an international regulatory strategy, educating and motivating national leaders to rethink priorities and direct attention to controlling tobacco through a regulatory framework. The successful experience of other international organizations, including the United Nations Environmental Programme and the International Maritime Organization, in stimulating national and international action in areas fraught with political conflict[7] can guide WHO's efforts to contain the tobacco pandemic through an international

5. *An International Strategy for Tobacco Control*, WHA Res. 48.11, 48th Ass., 12th plen. mtg., Annex 1, Agenda Item 19, WHO Doc. A48/VR/12 (1995).

6. *See infra* note 19.

7. *See* discussion *infra* Part V. Examples include protection of the ozone layer and the Baltic and North Seas.

regulatory framework.

WHO, the premier authority on world health matters, has the legal capacity and public health expertise to catalyze, negotiate, and sponsor international tobacco control regulations. However, WHO has traditionally been reluctant to employ legal strategies to advance the organization's health policies. This Article argues that the time is ripe for WHO to employ international legal instruments to encourage and assist national tobacco regulation. The prospect of advancing the global struggle against tobacco through a legislative framework offers an extraordinary opportunity for WHO to reaffirm and strengthen its commitment to global public health and enhance its prestige within the world community.

This Article advocates an international regulatory strategy that WHO can use to encourage international agreement and action on tobacco control. Part II describes the tobacco pandemic, the global health implications of tobacco consumption, and the tobacco industry's penetration of new markets worldwide. Part III examines the critical role of domestic tobacco regulation in reducing tobacco prevalence and the absence of effective regulatory frameworks in most countries. This part also analyzes the international and national factors that prevent countries from adopting and implementing effective national tobacco regulation. Part IV analyzes WHO's duty to address the tobacco pandemic, the successes and limitations of its Tobacco or Health Programme, and its organizational dynamics. Part V addresses the contribution that an international regulatory framework and supporting supervisory and financial institutions can make to WHO's efforts to contain the tobacco pandemic and identifies a specific international regulatory strategy that WHO can use to promote international consensus and national action on tobacco. This Article will show that, through the development of effective international regulation and supervisory institutions, modeled on the experiences of other international organizations, WHO can have an important, albeit limited, effect on the global tobacco epidemic.

II. THE GLOBAL TOBACCO PANDEMIC

A. *Tobacco or Health*

The scientific evidence that tobacco use is among the largest worldwide causes of preventable illness and mortality is clearly established.[8] Although tobacco related disease and death occur in adulthood, tobacco has been described as a "childhood disease,"[9] since most smokers become addicted to the lethal product during childhood or adolescence.[10]

Cigarette smoking, the predominant form of tobacco use, is one of the largest causes of preventable death worldwide and is the leading cause of

8. *See infra* notes 11, 20.

9. Joseph R. DiFranza & Joe B. Tye, *Who Profits from Tobacco Sales to Children?*, 263 JAMA 2784 (1990).

10. Carine Chaix, *La Consommation Mondiale de Tabac Chez Les Jeunes*, 313 LA SANTÉ DE L'HOMME 6, 9-10 (1994).

premature death in developed countries.[11] The magnitude of the risk that cigarettes pose to human health has been widely documented since the U.S. Surgeon General's 1964 landmark report unequivocally identified smoking as a health hazard.[12] Cigarette smoking has been scientifically linked to cancer, heart disease, and pulmonary disease, among other things.[13] Smokeless tobacco, including tobacco that is sniffed or chewed, has also proven to be a threat to human health.[14]

Smoking causes untimely death and disability not only in the user, but also in those exposed to environmental tobacco smoke.[15] Nonsmokers who undergo sustained exposure to environmental tobacco smoke suffer adverse health effects; for example, they have a significantly higher rate of lung cancer[16] and heart disease[17] than do those relatively unexposed to tobacco smoke.

Despite overwhelming scientific evidence, the tobacco industry has long disputed the addictive effects and health consequences of nicotine and other

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11. WORLD HEALTH ORGANIZATION, FACTS AND FIGURES: WORLD NO-TOBACCO DAY 1 (1994) (information on May 31, 1994). *See generally* RICHARD PETO ET AL., MORTALITY FROM SMOKING IN DEVELOPED COUNTRIES 1950–2000 (1994).

12. U.S. DEP'T OF HEALTH, EDUC. & WELFARE, SMOKING AND HEALTH: REPORT OF THE ADVISORY COMMITTEE TO THE SURGEON GENERAL OF THE PUBLIC HEALTH SERVICE (1964). Periodic reports of the U.S. Surgeon General have documented the health risks of tobacco. *E.g.*, U.S. DEPARTMENT OF HEALTH, EDUC. & WELFARE, SMOKING AND HEALTH: A REPORT OF THE SURGEON GENERAL (1979); U.S. DEP'T OF HEALTH & HUMAN SERV., THE HEALTH CONSEQUENCES OF SMOKING FOR WOMEN (1980).

13. U.S. DEP'T OF HEALTH & HUMAN SERV., REDUCING THE HEALTH CONSEQUENCES OF SMOKING: 25 YEARS OF PROGRESS: A REPORT OF THE SURGEON GENERAL EXECUTIVE SUMMARY 8 (1989). The World Health Organization estimates that in populations in which smoking is widespread, tobacco smoking is responsible for 90-95% of lung cancers, 80-85% of cases of chronic bronchitis, and 20-25% of deaths from heart disease. WORLD HEALTH ORGANIZATION, *supra* note 11, at 1. In the United States, cigarettes are responsible for 87% of all lung cancer deaths and 30% of all cancer deaths. AMERICAN CANCER SOC'Y, CANCER FACTS & FIGURES—1994, at 19 (1994).

14. *See, e.g.*, U.S. DEP'T OF HEALTH, EDUC. & WELFARE, THE HEALTH CONSEQUENCES OF SMOKELESS TOBACCO. A REPORT OF THE ADVISORY COMMITTEE TO THE U.S. SURGEON GENERAL (1986); Deborah M. Winn, *Smokeless Tobacco and Cancer: The Epidemiologic Evidence*, *in* AMERICAN CANCER SOC'Y, HEALTH EFFECTS OF SMOKELESS TOBACCO 13, 13-20 (1988). Smokeless tobacco users are several times more likely to develop cancer than are nonsmokers. Winn, *supra*, at 19.

15. *See generally* NATIONAL INST. OF HEALTH, U.S. DEP'T OF HEALTH & HUMAN SERV., RESPIRATORY HEALTH EFFECTS OF PASSIVE SMOKING: LUNG CANCER AND OTHER DISORDERS: THE REPORT OF THE ENVIRONMENTAL PROTECTION AGENCY 6 (1992); U.S. DEP'T OF HEALTH & HUMAN SERV., REPORT OF THE SURGEON GENERAL, THE HEALTH CONSEQUENCES OF INVOLUNTARY SMOKING (1986) (stating environmental tobacco smoke is linked to lung cancer and respiratory ailments). Children with sustained exposure to environmental tobacco smoke are at an increased risk for a variety of medical disorders, including upper respiratory tract infections, bronchitis, pneumonia, allergic reactions, and impairment of pulmonary function. *See, e.g.*, *Committee on Substance Abuse, Tobacco-Free Environment: An Imperative for the Health of Children and Adolescents*, 93 PEDIATRICS 866, 866 (1994); Lung Cancer Risk Doubles Among Non-smokers Exposed to Tobacco Smoke During Childhood and Adolescence, 33 BLUE SHEET 14 (Sept. 12, 1990).

16. *See, e.g.*, David M. Burns, *Environmental Tobacco Smoke: The Price of Scientific Certainty*, 84 J. NAT'L CANCER INST. 1387, 1387 (1992); Elizabeth T.H. Fontham et al., *Environmental Tobacco Smoke and Lung Cancer in Nonsmoking Women*, 271 JAMA 1752, 1752-59 (1994).

17. Carl E. Bartecchi et al., *The Global Tobacco Epidemic*, SCI. AM., May 1995, at 44, 49 (noting in United States, of estimated 53,000 annual deaths from passive smoking, approximately 37,000 are caused by smoking related heart disease).

cigarette ingredients.[18] Recently revealed internal corporate documents show, however, that the tobacco industry has long known that nicotine is addictive and that cigarette smoking causes disease.[19]

The size of the tobacco pandemic is daunting. Smoking will have been responsible for an estimated 60 million premature deaths in developed states between 1950 and 2000, 37.8 million of the victims being between the ages of thirty-five and sixty-nine.[20] Although most of those killed by tobacco so far have been in industrialized states, the pandemic of tobacco consumption and its lethal consequences have spread rapidly in the last several decades to developing countries.

B. *Trends in Global Tobacco Consumption and Production*

In the last several decades, industrialized states have mounted aggressive public health campaigns, including tobacco control legislation, that have contributed to a dramatic decline in tobacco consumption in their populations.[21] With domestic cigarette sales stagnating, the transnational tobacco industry has successfully focused on developing and expanding new markets in Africa, Asia, Latin America, Eastern Europe, and the former Soviet Union[22] where tobacco regulation is limited.

The size and power of the tobacco industry is daunting. It is dominated by six giant American and British transnational corporations,[23] particularly British American Tobacco, Philip Morris, R.J. Reynolds, American Brands,

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18. *See, e.g.*, Kenneth E. Warner, *Tobacco Industry Scientific Advisors: Serving Society or Selling Cigarettes?*, 81 AM. J. PUB. HEALTH 839, 839 (1991). In what an industry official has characterized as a "brilliantly conceived and executed" strategy, the tobacco industry has endeavored to "creat[e] doubt about the health charge without actually denying it." *Id.*; *see also* Philip J. Hilts, *U.S. Convenes Grand Jury to Look at Tobacco Industry*, N.Y. TIMES, July 26, 1995, at A1.

19. Internal industry documents of Brown and Williamson and its parent company, British American Tobacco Industries, reveal that corporate officials have known of the addictive effect of nicotine for over thirty years through their own research studies. John Slade et al., *Nicotine and Addiction: The Brown and Williamson Documents*, 274 JAMA 225, 225 (1995). Similar evidence has been obtained against Philip Morris and R.J. Reynolds. Hilts, *supra* note 18, at A15. In July 1995, for the first time, the U.S. Justice Department convened a grand jury to investigate whether tobacco companies misrepresented the content and effects of nicotine to federal regulators. *Id.* at A1.

20. PETO ET AL., *supra* note 11, at A8. Directly or indirectly, tobacco products cause about 20% of all deaths in industrialized countries. World Health Org., *Tobacco: The Twentieth Century's Epidemic*, *in* TOBACCO ALERT, WORLD NO-TOBACCO DAY 1995 SPECIAL ISSUE 4, 4 [hereinafter *World No-Tobacco Day 1995*].

21. John P. Pierce, *Progress and Problems in International Public Health Efforts to Reduce Tobacco Usage*, 12 ANN. REV. PUB. HEALTH 383, 393-97 (1991).

22. Philip L. Shepherd, *Transnational Corporations and the International Cigarette Industry*, *in* PROFITS, PROGRESS AND POVERTY: CASE STUDIES OF INTERNATIONAL INDUSTRIES IN LATIN AMERICA 63, 79-84 (R.S. Newfarmer ed., 1985).

23. *See generally* Frederick F. Clairmonte, *World Tobacco: A Study in Conglomerate Structures*, 14 J. WORLD TRADE L. 23 (1980); Kenyon R. Stebbins, *Tobacco or Health in the Third World: A Political Economy Perspective with Emphasis on Mexico*, 17 INT'L L.J. HEALTH SERVICES 521, 524-27 (1987) [hereinafter Stebbins, *Tobacco or Health*]; Kenyon R. Stebbins, *Tobacco, Politics and Economics: Implications for Global Health*, 33 SOC. SCI. & MED. 1317, 1319-21 (1991) [hereinafter Stebbins, *Tobacco, Politics, and Economics*]; PETER R. TAYLOR, THE SMOKE RING: TOBACCO, MONEY, AND MULTINATIONAL POLITICS (1984).

Rothmans, and Imperial Brands.[24] These entities control eighty-five percent of all tobacco leaf sold on the world market[25] and are among the largest private enterprises in the world. Philip Morris, the largest tobacco company in the United States, is the largest taxpayer in America,[26] paying $12.9 billion in excise and income taxes in 1993.[27]

Confronted with stagnating sales in industrialized states, the tobacco industry began in the mid-1960s to use political pressure, financial tactics, and aggressive advertising campaigns to penetrate the markets of developing countries.[28] At the time, many countries operated closed cigarette markets and restricted sales of cigarettes to those produced by national firms.[29] Many states also used protective trade measures, including import bans, high tariffs, and import quotas,[30] to shield their national monopolies from competition and their populations from exposure to foreign tobacco.

Transnational tobacco corporations have sought and secured the help of their home governments in opening the closed tobacco markets of developing countries. Western governments have supported global tobacco exports by subsidizing domestic production of tobacco. The European Union heavily subsidizes tobacco products pursuant to its Common Agricultural Policy,[31] promoting the sale of tobacco at "giveaway prices" in Northern Africa and

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24. Philip Morris, R.J. Reynolds, and American Brands are U.S. corporations. British American Tobacco and Imperial Tobacco are based in the United Kingdom, and Rothmans is located in the United Kingdom and South America. Gregory N. Connolly, *Worldwide Expansion of Transnational Tobacco Industry*, 12 J. NAT'L CANCER INST. MONOGRAPHS 29, 30 (1992).

25. *Id.* at 30. These companies and their subsidiaries produce about 40% of the world's cigarettes. If the cigarettes manufactured by state tobacco monopolies and centrally planned economies are excluded from this calculation, these companies produce about 85% of the world's cigarettes. *Id.* Many national tobacco monopolies produce tobacco only for domestic consumption. *See* Stebbins, *Tobacco, Politics, and Economics*, *supra* note 23, at 1319. According to the Panos Institute, "[o]ver 80% of tobacco production in the South is for domestic consumption." PANOS INST., TOBACCO: THE SMOKE BLOWS SOUTH, PANOS MEDIA BRIEFING NO. 13, at 2 (Sept. 1994) [hereinafter PANOS BRIEFING]. China is the world's largest producer of tobacco and uses the vast majority of the tobacco it grows to satisfy domestic demand. *Tobacco, Politics, and Economics*, *supra* note 23, at 1320. Other major national monopolies include Japan, Indonesia, Korea, Taiwan, and Vietnam. Latin America's market was "initially composed of monopolies and national firms," while the state firms of sub-Saharan Africa are quite small, producing one percent of the world's cigarettes. Connolly, *supra* note 24, at 31.

26. Roger Rosenblatt, *How Do Tobacco Executives Live with Themselves?*, N.Y. TIMES, Mar. 20, 1994 (Magazine), at 34, 36 (describing financial and political power of U.S. tobacco conglomerates).

27. Linda Himelstein et al., *Tobacco: Does It Have a Future*, BUS. WK., July 4, 1994, at 24, 29. In the same year, R.J. Reynolds paid a total of $3.9 billion in federal excise and income taxes. *Id.* Diversification of the major American tobacco corporations in the 1980s increased the size and power of these conglomerates. Stebbins, *Tobacco or Health*, *supra* note 23, at 525-26. Philip Morris is the largest consumer products company in the world. Rosenblatt, *supra* note 26, at 36. The British tobacco companies are similarly diversified. B.A.T. Industries is not only a tobacco conglomerate, but also an insurance giant. John Tanner, *North-South: British Firm's Surge in Third World Tobacco Profits*, Inter Press Service, Mar. 11, 1993, *available in* LEXIS, News Library, Inpres File.

28. Kenyon R. Stebbins, *Transnational Tobacco Companies and Health In Underdeveloped Countries: Recommendations for Avoiding a Smoking Epidemic*, 30 SOC. SCI. & MED. 227, 228 (1990) [hereinafter Stebbins, *Transnational Tobacco Companies*].

29. Connolly, *supra* note 24, at 31.

30. *Id.*

31. EUROPEAN BUREAU FOR ACTION ON SMOKING PREVENTION, TOBACCO AND HEALTH IN THE EUROPEAN UNION 8-9 (1994) [hereinafter TOBACCO AND HEALTH IN THE EUROPEAN UNION].

Eastern Europe.[32]

The assistance of the U.S. government has been the most significant western governmental factor leading to expanded tobacco sales in developing countries. American based transnational tobacco conglomerates have enlisted the United States Trade Representative and members of the United States Congress to overcome foreign trade barriers in developing states.[33] Cigarette exports have been one of the few bright spots in the U.S. trade picture, shaving the trade deficit by $23.5 billion over the last five years.[34] Between 1986 and 1990, by threatening retaliatory trade sanctions under section 301 of the U.S. 1974 Trade Act,[35] the Reagan and Bush administrations and members of the U.S. Congress[36] successfully pressured Japan, Taiwan, and South Korea to open their closed markets to American cigarettes.[37] When Thailand resisted, the United States took the matter to the General Agreement on Tariffs and Trade (GATT), which ruled that Thailand must open its market to American cigarettes.[38] Although there has been some shift in tobacco trade policy under the Clinton administration,[39] the U.S. government still supports the U.S. tobacco companies' efforts to export tobacco products.[40]

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32. ROEMER, *supra* note 3, at 73. Tobacco production is also subsidized in other countries, including Australia and the United States. *Id.* at 72-73. In addition, for nearly 25 years, the U.S. government helped tobacco exports in the "Food for Peace Program." Stebbins, *Tobacco, Politics, and Economics*, *supra* note 23, at 1320.

33. *See infra* note 36.

34. Council on Scientific Affairs, *The Worldwide Smoking Epidemic: Tobacco Trade, Use, and Control*, 263 JAMA 3312, 3312 (1990) [hereinafter Council Report]; Myron Levin, *Targeting Foreign Smokers*, L.A. TIMES, Nov. 17, 1994, at A1, A15.

35. Trade Act of 1974, Pub. L. No. 93-618, § 301, 88 Stat. 1978, 2041 (1975) (codified as amended at 19 U.S.C. § 2411 (1988)).

36. *See, e.g.*, Judith Mackay, *U.S. Tobacco Export to the Third World: Third World War*, 12 J. NAT'L CANCER INST. MONOGRAPHS 25, 26 (1992) (describing efforts of Senator Jesse Helms to further interests of American tobacco industry in Japan). One American tobacco corporation enlisted the support of 147 members of Congress to urge the U.S. Trade Representative to use trade sanctions against Hong Kong, Ireland, Australia, and the United Kingdom if they did not remove their bans on smokeless tobacco products. Connolly, *supra* note 24, at 32.

37. *See, e.g.*, William Beaver, *The Marlboro Man Rides into the Eastern Bloc*, 88 BUS. & SOC'Y REV. 19, 20 (1994); Andrea J. Hagerman, *U.S. Tobacco Exports: The Dichotomy Between Trade and Health Policies*, 1 MINN. J. GLOBAL TRADE 175, 184-88 (1992); Paula C. Johnson, *Regulation, Remedy and Exported Tobacco Products: The Need for a Response from the United States Government*, 25 SUFFOLK U. L. REV. 1, 43-44 (1991); Fred H. Jones, *U.S. Tobacco Goes Abroad: Section 301 of the 1974 Trade Act as a Tool for Achieving Access to Foreign Tobacco Markets*, 14 N.C. J. INT'L L. & COM. REG. 439, 450-53 (1989); Stebbins, *Tobacco, Politics, and Economics*, *supra* note 23, at 1321-22; David Holley, *New "Opium War" Cuts Across the Third World*, L.A. TIMES, June 5, 1990, at H1.

38. *Thailand-Restriction on Importation of and Internal Taxes on Cigarettes*, GATT Panel Report, Nov. 7, 1990, 30 I.L.M. 1122, 1122-40 (1991); *see* ROEMER, *supra* note 3, at 76-78. Although the GATT panel ruled that Thailand must allow cigarette imports, GATT delineated policies Thailand could adopt that would apply to both domestic and imported tobacco and be consistent with GATT obligations. These national measures included ad valorem taxes, advertising bans, price restrictions, ingredient disclosures, strong warning labels, and a ban on brand name and imagery. 30 I.L.M. at 1122-40. The United States Trade Representative has threatened to refer other states to GATT for alleged discriminatory treatment of U.S. tobacco imports. *GATT Dispute Settlement Panel Report: Japanese Restraints on Imports of Manufactured Tobacco from the United States*, June 11, 1981, *available in* 1993 BDIEL AD LEXIS 39.

39. Kate Nagy, *Farming Tobacco Overseas: International Trade of U.S. Tobacco*, 86 J. NAT'L CANCER INST. 417 (1994).

40. *See, e.g.*, *U.S. Trade and Health Goals Called at Odds in Cigarette Exports*, 10 INT'L TRADE REP. 59, 59 (1993) (U.S. Trade Representative follows aggressive tobacco export stance, while U.S. Department of Health and Human Services supports Asian anti-smoking groups and programs).

The tobacco industry has also employed financial tactics to enter and dominate closed tobacco markets in the last several decades, providing cash hungry governments with lucrative financial incentives such as joint ventures and licensing agreements.[41] Such devices have been particularly effective in enabling the tobacco industry to penetrate national monopolies or compete independently in Eastern Europe and the former states of the Soviet Union,[42] where American and European based transnationals have committed more than $1.5 billion to build or retool cigarette plants throughout the region.[43] In other developing states, the tobacco industry has focused on dominating or acquiring domestic tobacco enterprises. This has resulted in the "virtual disappearance" of independent tobacco operations in developing countries.[44]

Transnational tobacco conglomerates have also made tremendous inroads into the markets of Asia, Africa, Latin America, and Eastern Europe through aggressive advertising and promotion. While national firms and state monopolies did little to advertise their products,[45] transnational tobacco conglomerates introduced cigarette advertising and promotion on a massive scale in these states.[46] Tobacco advertising and promotion campaigns in developing states target the youth, particularly young women.[47] Women in these countries represent a tantalizing market for the tobacco industry. An average of only 8% of women in developing states currently smoke, compared to 21% in industrialized countries.[48] In most countries, where public

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41. Connolly, *supra* note 24, at 31. Under licensing agreements, local brands are marketed and manufactured under the auspices of foreign countries. Kenyon R. Stebbins, *Making a Killing South of the Border: Transnational Cigarette Companies in Mexico and Guatemala*, 38 SOC. SCI. & MED. 105, 106 (1991). Setting up local factories has enabled tobacco conglomerates to "compete with national production, to undermine the monopolies and to reinforce market penetration by creating economic dependence on tobacco." World Health Org., *The Tobacco Industry: Strategies and Prospects*, *in* TOBACCO ALERT, WORLD NO-TOBACCO DAY 1994, at 6, 6.

42. Philip Morris and R.J. Reynolds have entered into 14 joint ventures with state tobacco companies. Philip Morris is involved in nine joint ventures in Eastern Europe and is investing $80-$100 million in a new plant in St. Petersburg, Russia. R.J. Reynolds is involved in five joint ventures and owns three plants outright for a total investment of $300 million since 1992. Wayne Hearn, *Emptying the World's Ash Trays: International Medical Community May Support Smoking Cessation Policy*, 37 AM. MED. NEWS 19 (1994).

43. Levin, *supra* note 34, at A15.

44. Stebbins, *Transnational Tobacco Companies*, *supra* note 28, at 229.

45. Nagy, *supra* note 39, at 417.

46. WORLD HEALTH ORG., SPONSORSHIP OF CULTURAL AND SPORTS ACTIVITIES 1-3 (1994); Connolly, *supra* note 24, at 33; *see also* Ronald M. Davis, *Slowing the March of the Marlboro Man*, 309 BRIT. MED. J. 889 (1994) (describing promotional tactics used by tobacco industry in developing and newly industrializing states). Transnational conglomerates spend approximately a quarter of a billion dollars a year giving away free cigarettes throughout the world. Beaver, *supra* note 37, at 22.

47. *See* BOBBIE JACOBSON, BEATING THE LADY KILLERS: WOMEN AND SMOKING 32 (1986); WORLD HEALTH ORG., WOMEN AND TOBACCO 2-3 (1992); Alvin Winder et al., Gender Differences in Smoking Prevalence in Asia: Implications for Public Health, Paper presented at the 9th World Conference on Tobacco or Health, Paris, France 3 (Oct. 1994) (on file with author). For discussion of the efforts of the tobacco industry to nurture a market for cigarettes among young women in Japan, see Miki Tanikawa, *Smoking Lures Women in Japan*, N.Y. TIMES, July 19, 1995, at C3.

48. World Health Org., *Women Who Smoke Like Men Face the Same Risks as Men*, Press Release WHO/55 (July 17, 1995); *see also* Mackay, *supra* note 36, at 25 (citing statistics that only 5% of women in developing areas smoke and arguing manufacturers actively seek to increase this number). The threat that tobacco now poses to women's health worldwide was specifically identified at the Fourth World Conference on Women. REPORT OF THE FOURTH WORLD CONFERENCE ON WOMEN, Beijing, China, Sept. 4-15, 1995, art. 107(o) [hereinafter REPORT OF THE FOURTH WORLD CONFERENCE ON WOMEN]. The conference resolutions stressed the need to create awareness of the impact of the pandemic and to develop

knowledge of the dangers of cigarette consumption is limited[49] and tobacco control regulation is weak or nonexistent,[50] the marketing efforts of transnational corporations have been remarkably successful.

The evidence of this success is staggering. Worldwide cigarette consumption has increased 75% in the last few decades.[51] American cigarette exports alone have more than trebled in the last ten years.[52] In this decade, tobacco consumption is expected to fall by 17% in developed states and to rise by 12% in developing countries and Eastern Europe.[53] Although there are wide differences among countries, regional generalizations about increasing tobacco consumption are possible.

Tobacco exports and sales have dramatically accelerated in Asia since the mid-1980s, when Japan, Taiwan, South Korea, and Thailand, all with national tobacco monopolies, responded to pressure from the Reagan and Bush administrations by opening their markets to American firms. Between 1985 and 1989, exports of American tobacco to the region doubled.[54] With Japan, China, and South Korea in the lead, Asia now has the highest total cigarette consumption in the world.[55] China, where 70% of men aged twenty-five or older smoke,[56] is currently the transnational tobacco companies' most coveted target.[57] According to WHO, the Asian cigarette market will grow by 30% this decade, with most of the increase going to transnational tobacco conglomerates.[58]

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regulatory and educational measures to reduce smoking. *Id.*

49. In the Philippines, for example, where nearly two-thirds of the men and one-fifth of the women smoke, a survey by the British journal *Tobacco Control* found that 57% of the respondents did not know that cigarettes cause cancer. Levin, *supra* note 34, at A15. Health warnings on cigarette packages are often not required; even where required, they are frequently ineffective because of widespread illiteracy. Stebbins, *Tobacco, Politics, and Economics*, *supra* note 23, at 529. In addition, many consumers in developing states purchase their cigarettes from vendors one at a time and never see a health warning on a package. *Id.* The United States does not require that cigarettes for export carry health warnings or a statement of tar and nicotine. Council Report, *supra* note 34, at 3318.

50. *See infra* Part III.A.

51. Council Report, *supra* note 34, at 3312-13.

52. According to one study, cigarette exports have jumped from 67.1 billion cigarettes in 1984 to an estimated 207.5 billion cigarettes in 1994. Levin, *supra* note 34, at A1. As a result of the phenomenal growth in exports, U.S. tobacco manufacturers actually increased production of cigarettes, despite declining sales at home. Stebbins, *Tobacco or Health*, *supra* note 23, at 52.

53. Davis, *supra* note 46, at 889.

54. Beaver, *supra* note 37, at 20.

55. Robert Evans, *Third World, Women Boost Smoking Death Forecasts*, Reuters BC Cycle, May 30, 1994. In the Western Pacific Region, surveys by WHO indicate that more than 60% of men smoke in Cambodia, South Korea, Fiji, Kiribati, the Philippines, Papua New Guinea, and Tonga. World Health Org., *Tobacco or Health Situation in the Western Pacific Region*, *in* TOBACCO ALERT, Apr. 1993, 2, 2. In WHO's Southeast Asia Region, which includes India, Korea, Sri Lanka, Thailand, and Nepal, manufactured cigarette consumption is estimated to have increased by 60% between 1963 and 1990. World Health Org., *Tobacco or Health in South-East Asia*, *in* TOBACCO ALERT, Jan. 1993, at 8, 8.

56. Sally Wagern & Rose Mary Romano, *Tobacco and the Developing World: An Old Threat Poses Even Bigger Problems*, 86 J. NAT'L CANCER INST. 1752 (1994). On the activities of foreign tobacco firms and the predicted health consequences of the smoking epidemic in China, see Jing Je Yu et al., *A Comparison of Smoking Patterns in the People's Republic of China with the United States: An Impending Health Catastrophe in the Middle Kingdom*, 264 JAMA 1575 (1990).

57. *See, e.g.*, Judith Mackay, *Battlefield for the Tobacco War*, 261 JAMA 28 (1990). There are 300 million smokers in China, more people than the entire population of the United States. Philip Shenon, *Asia's Having One Huge Nicotine Fit*, N.Y. TIMES, May 15, 1994, sec. 4, at 1.

58. Shenon, *supra* note 57, sec. 4, at 1.

In Eastern Europe and the former Soviet Union, the transnational conglomerates moved in swiftly after the collapse of communism and successfully developed a market for "western" brands.[59] Although American cigarettes have been available in Eastern Europe for many years, the fall of communism has provided profitable opportunities to acquire state-run plants, to build new manufacturing facilities, and to advertise tobacco, a practice that was severely restricted under old socialist regimes.[60] Although there are large differences across the region, smoking prevalence is high and growing throughout Eastern Europe and the former Soviet Union.[61] In Russia, approximately 50% of the men and 25% of the women now smoke.[62]

In Latin America and the Caribbean, the tobacco industry is now dominated by transnational tobacco conglomerates.[63] A 1992 report by the U.S. Surgeon General found that the median smoking prevalence in Latin America and the Caribbean is 37% for men and 20% for women.

Although tobacco consumption is still comparatively low in Africa,[64] it is growing steadily and rapidly.[65] The Food and Agricultural Organization (FAO) predicts that, with projected demographic and socioeconomic changes, the level of tobacco consumption in Africa will become one of the highest in the world unless national policies are introduced to counter the trend.[66]

The enormous growth in smoking throughout the world in recent years has increased the global risk of tobacco related diseases at an alarming rate. In Asia and Latin America, the number of people smoking is now growing 7% faster than the general population; in Africa, the figure is 18%.[67] The

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59. According to the former Director of the Office on Smoking and Health, "[w]hen the Berlin Wall fell, the multinational tobacco corporations were among the first to rush in and exploit the new Eastern European markets. . . ." Nagy, *supra* note 39, at 417; *see also* Jane Perlez, *R.J. Reynolds Woos Polish Smokers*, N.Y. TIMES, June 6, 1994, at D1 (stating tobacco conglomerates have purchased plants in Hungary, the Czech Republic, Ukraine, and Russia).

60. Beaver, *supra* note 37, at 21.

61. *See generally* Tom Reynolds, *Smoking Deaths Soar in Central and Eastern Europe*, 87 J. NAT'L CANCER INST. 1348 (1995). According to David Simpson of the International Agency on Tobacco and Health, "[c]igarette companies are going into countries that are very vulnerable to their infiltration . . . . Smoking prevalence is very high. Unlike, say, an African country, where tobacco companies have to introduce the habit in order to create a market, to say the post-Communist market was ready and waiting for them is an understatement." *Id.* at 2348; *see also* World Health Org., *Tobacco or Health in Six Countries of Central and Eastern Europe: Reports of WHO Tobacco or Health Missions*, *in* TOBACCO ALERT, July 1993, at 9, 9-10.

62. Hearn, *supra* note 42, at 19. Throughout the region, tobacco conglomerates have nurtured a budding market of female smokers. WHO reports that in Eastern Europe smoking has increased among women aged 25 to 34 from 6% to over 15%. Senthil Ratnasabapathy, *Health — Women: Western Tobacco Advertising Blitz Hits East Europe*, Inter Press Service, Feb. 24, 1994, *available in* LEXIS, News Library, Inpres File.

63. World Health Org., *Tobacco or Health: Status in the Americas, World Health Organization*, *in* TOBACCO ALERT, July 1992, at 4, 4.

64. World Health Org., *Tobacco Use in Africa and Future Health Consequences*, *in* TOBACCO ALERT, Apr. 1994, at 2, 2.

65. Derek Yach, *The Impact of Smoking in Developing Countries with Special Reference to Africa*, 16 INT'L J. HEALTH SERVICES 279, 283-86 (1986).

66. Derek Yach, *Tobacco in Africa*, WORLD HEALTH F., Jan. 1996, at 1, 4.

67. Reported by the head of WHO's Tobacco or Health program. Simon Chapman, *Fiddling While Tobacco Burns: Sixth World Conference on Smoking and Health, Tokyo, 9-12 November 1987*, 296 BRIT. MED. J. 39, 39-40 (1988). Urbanization and economic growth are associated with increased tobacco use, contributing to an epidemiological transition. The major causes of death are shifting from communicable and infectious diseases to chronic diseases more typical of industrialized states. *See, e.g.*, Dean T. Jamison

already high prevalence of smoking in developing countries is likely to rise further as economic development makes tobacco more affordable.[68] WHO predicts that if the current trend in developing countries persists over the next thirty years, seven million inhabitants of developing countries will die annually from smoking related diseases,[69] accounting for 70% of tobacco related deaths worldwide.[70] Hence, within the next thirty years, smoking will be not only the leading cause of premature mortality in developed states, but also the leading cause of premature death worldwide.[71]

III. NATIONAL LEGISLATIVE ACTION TO COMBAT TOBACCO: THE INTERDEPENDENCE OF GLOBAL TOBACCO CONTROL EFFORTS

A. *The Role of Legislation in National Tobacco Control Efforts*

Domestic regulation has proven to be an essential mechanism of tobacco control.[72] Few countries, however, have managed to adopt comprehensive regulatory approaches to tobacco control. A review of the history of tobacco control in countries that have effectively reduced tobacco exposure in their populations shows that there are a number of broad regulatory strategies that countries worldwide can use to reduce tobacco prevalence, despite divergent cultural, social, economic, and health conditions.[73] This section reviews the role of legislation in a comprehensive national antitobacco campaign and describes specific regulatory strategies that have been and can be adopted by states to control tobacco prevalence in their societies.

There is considerable evidence that public health regulation can affect tobacco use. Most industrialized countries have developed a strong regulatory policy on tobacco that has dramatically reduced tobacco prevalence in these societies. Canada, for instance, has been among the world leaders in deterring tobacco consumption[74] through a variety of stringent national legislative measures.[75] Western European countries have enacted a variety of measures

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& W. Henry Mosley, *Disease Control Priorities in Developing Countries: Health Policy Response to Epidemiological Change*, 81 AM. J. PUB. HEALTH 15, 18 (1991).

68. *See World No-Tobacco Day 1995*, *supra* note 20, at 5; Jamison & Mosley, *supra* note 67, at 17-18.

69. Andrew A. Skolnick, *Experts at Buenos Aires Conference Predict Pandemic of Tobacco Deaths*, 267 JAMA 3255, 3255 (1992).

70. World Health Org., *World No-Tobacco Day 1994: Over One Billion Smokers in the World*, WHO Press Release WHO/44 (May 30, 1944).

71. Skolnick, *supra* note 69, at 3255.

72. For an excellent and exhaustive study of national tobacco regulation worldwide, see generally ROEMER, *supra* note 3.

73. The resolutions of the Fourth World Conference on Women called upon states to adopt tobacco regulating measures as an important component of health promotion and disease prevention worldwide. REPORT OF THE FOURTH WORLD CONFERENCE ON WOMEN, *supra* note 48, art. 107(o).

74. Between 1981 and 1994, the prevalence of tobacco smoking in Canada declined from 38% to 31%. HEALTH CANADA, SURVEY ON SMOKING IN CANADA 1 (1994) (on file with author); *see also* HEALTH CANADA, A GUIDE FOR TRACKING PROGRESS FOR THE OBJECTIVES OF THE NATIONAL STRATEGY TO REDUCE TOBACCO USE IN CANADA (1994) (on file with author).

75. By statute, Canadian and provincial taxes on cigarettes are about 76.5% of the total price paid by consumers — a figure somewhat higher than that in Western European states and much higher than that in the United States. Robert Kagen & Daniel Vogel, *The Politics of Smoking Regulation: Canada, France, the United States*, *in* SMOKING POLICY: LAW, POLITICS, AND CULTURE 22, 28 (Robert L. Rabin &

to combat smoking,[76] and the European Economic Community has furthered cooperation among governments on strong regulatory measures to reduce tobacco consumption throughout the region.[77]

Since there are a number of diverse determinants of smoking behavior,[78] legislation alone cannot contain the smoking epidemic. However, according to Professor Ruth Roemer, domestic regulation of tobacco has proven to be a critical element in national tobacco control efforts for the following reasons:

> Legislation can express government policy on the production, promotion and use of tobacco; emphasize the government's commitment to combating smoking by allocating governmental resources to effective anti-tobacco programmes; launch governmental and voluntary antismoking activities; encourage smokers to stop smoking and dissuade potential smokers, particularly young people, from starting to smoke; protect the right of nonsmokers to be free from involuntary or passive smoking; and contribute to a climate of opinion and social pressure in which smoking is unacceptable.[79]

There is a consensus within the public health community that the most effective way to reduce tobacco prevalence is to use as many regulatory strategies as possible.[80] The next section briefly reviews the global evidence for the effectiveness of five critical regulatory measures that can be and have been adopted by states worldwide to reduce tobacco prevalence in their societies.

1. *Fiscal Measures*

Perhaps the most important tobacco control measures are domestic fiscal regulations that discourage both the use and the production of tobacco.[81] One

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Stephen D. Sugarman eds., 1993). In February 1994, the Canadian government launched the Tobacco Demand Reduction Strategy. The strategy, designed to enhance Canada's tobacco control efforts, is a three year initiative funded by a health promotion surtax (CAN$60 million annually) on tobacco manufacturing profits. HEALTH CANADA, TOBACCO DEMAND REDUCTION STRATEGY: AN UPDATE 1 (1994) (on file with author). The Canadian government's regulatory effort to restrict severely tobacco advertising and promotion, however, was recently ruled unconstitutional by the Canadian Supreme Court. RJR-MacDonald, Inc. v. Attorney Gen. of Can., 100 C.C.C.3d 449 (1995).

76. *See* Marc Danzon & Tapani Piha, *Europe and Smoking*, *in* WORLD HEALTH, Nov. 1991, at 18; *see also* TOBACCO AND HEALTH IN THE EUROPEAN UNION, *supra* note 31 (providing country by country analysis of tobacco control legislation in Europe); Annie J. Sasco et al., International Agency for the Research on Cancer, *Comparative Study of Anti-smoking Legislation in Countries of the European Economic Community*, IARC Technical Report No. 8 (1992) (same).

77. *See, e.g.*, TOBACCO AND HEALTH IN THE EUROPEAN UNION, *supra* note 31, at 1-10. Directives of the Council of the European Communities have provided for the harmonization of laws, regulations, and administrative provisions of member states concerning bans on television advertising, bans on certain oral tobacco products, the taxation of tobacco products, the tar content of cigarettes, the labeling of tobacco products, and the restriction of smoking in public places. *Id.* at 6-7.

78. *See, e.g.*, Chen Minzhang, *Smoking in China*, 16 WORLD HEALTH F. 10 (1995); Ruth Roemer, Legislation to Combat the Tobacco Epidemic and the African Countries, Paper Presented at the All Africa Conference on Tobacco and Health, Harare, Zimbabwe, 4-5 (Nov. 16, 1993) (on file with author) [hereinafter Tobacco Legislation in Africa]. A comprehensive tobacco control program includes restrictive regulation, "preventive action, public information, education programs, and smoking cessation interventions." Tobacco Legislation in Africa, *supra*, at 5.

79. 2 WORLD HEALTH ORG., SMOKE-FREE EUROPE: LEGISLATIVE STRATEGIES FOR A SMOKE-FREE EUROPE, at 1-2 (1987) [hereinafter 2 SMOKE-FREE EUROPE].

80. *E.g.*, Pierce, *supra* note 21, at 396.

81. *See, e.g.*, Ruth Roemer, *Legislation to Control Smoking: Leverage for Effective Policy*, 9 CANCER DETECTION & PREVENTION 99, 105 (1986) [hereinafter Roemer, *Leverage for Effective Policy*].

type of effective regulation is taxation. Many studies in industrialized states, as well as the few studies conducted in developing states, have found an inverse correlation between cigarette prices and consumption,[82] particularly among the young.[83] Other critical economic legislation that countries have adopted focuses on decreasing the profitability of tobacco production. These strategies include crop substitution programs and eliminating subsidies for tobacco production.[84]

2. *Regulation of Advertising and Promotion*

Advertising and promotion are the tobacco industry's most powerful weapons in its campaign to increase tobacco consumption.[85] The goals of advertising, promotion, and packaging are to increase consumption, particularly among the young; to encourage smokers to continue smoking; and to create an atmosphere in which smoking is socially acceptable.[86] Advertising is effective, particularly among children,[87] and the growing popularity of tobacco use among the youth of developing and newly industrialized states — where advertising restrictions are scarce — heightens concern about its use.[88]

Advertising regulations are now the world's most common type of antismoking legislation.[89] Twenty-seven countries now prohibit virtually all tobacco advertising, and a total of seventy-seven control either its content or

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82. Tax increases can apply to all cigarettes equally, or legislators can differentiate by imposing higher taxes on cigarettes with higher tar and nicotine content. Between 1978 and 1981, the United Kingdom successfully imposed a cigarette tax on high tar and nicotine cigarettes to reduce consumption. *See, e.g.*, ROEMER, *supra* note 3, at 94.

83. *See, e.g.*, Pierce, *supra* note 21, at 394. Although cigarette demand among adult smokers is fairly price inelastic, young smokers are very responsive to changes in the price of cigarettes. Studies in the United States have found that a 10% increase in price produces a 14% decrease in tobacco consumption among teenagers. ROEMER, *supra* note 3, at 86 (citing Kenneth E. Warner, *Cigarette Taxation: Doing Good by Doing Well*, 5 J. PUB. HEALTH POL'Y 312, 312 (1984)). Existing studies suggest that tobacco consumption in less developed countries may be even more sensitive to price increases than in developed states. ROEMER, *supra* note 3, at 88; Warner, *supra* note 2, at 529.

84. *See, e.g.*, 2 SMOKE-FREE EUROPE, *supra* note 79, at 21.

85. Tobacco Legislation in Africa, *supra* note 78, at 6. The sheer size of worldwide tobacco advertising demonstrates its importance to the tobacco industry. Annually, $4 billion is spent on advertising and promotion, making tobacco the world's most heavily advertised product. Stebbins, *Tobacco or Health*, *supra* note 23, at 528.

86. *See, e.g.*, ROEMER, *supra* note 3, at 24-26; Gilbert J. Botvin et al., *Smoking Behavior of Adolescents Exposed to Cigarette Advertising*, 108 PUB. HEALTH REP. 217 (1993).

87. According to the U.S. Center for Disease Control, advertising directly influences brand awareness and attitudes about smoking among adolescents. Adolescents generally smoke the most heavily advertised brands. *Trends in Smoking Initiation Among Adolescents and Young Adults-United States, 1980-1989*, 274 JAMA 528, 529 (1995). However, a few commentators question the connection between tobacco advertising and tobacco consumption. *See, e.g.*, Jean J. Boddewyn, *Cigarette Advertising Bans and Smoking: The Flawed Policy Connection*, 13 INT'L J. ADVERTISING 331 (1994).

88. For instance, the World Health Organization calls upon states not only to ban direct advertisement in the printed media, on billboards and television, and through promotion, but also to ban indirect advertising such as sponsorship of sporting events and the association of tobacco with other products. *See, e.g.*, Roemer, *Leverage for Effective Policy*, *supra* note 81, at 100-03. Forms of indirect promotion proliferate as the tobacco industry seeks to evade advertising restrictions. *See, e.g.*, 2 SMOKE-FREE EUROPE, *supra* note 79, at 6.

89. *E.g.*, ROEMER, *supra* note 3, at 32-43.

its timing.[90]

The tobacco industry, however, has vehemently and sometimes successfully attacked such regulations as violations of the industry's freedom of expression. As commercial speech, tobacco advertising enjoys some constitutional or statutory protection in a number of countries.[91] In September 1995, for example, the Canadian Supreme Court struck down the Canadian Tobacco Products Control Act,[92] which banned virtually all advertisement of tobacco products,[93] as an unconstitutional infringement of freedom of expression.[94] The Court's decision was widely considered a stunning setback to global public health forces, since the Tobacco Products Control Act was regarded as a model for legislation in other countries.[95]

3. *Regulation of Smoking in Public Places and Workplaces*

Regulation of smoking in public places and workplaces serves a number of functions in comprehensive national campaigns to reduce tobacco use.[96] First, regulating smoking in these locations protects the rights and health of nonsmokers.[97] Second, such legislation effectively discourages smoking by

90. *Id.* at 250. *See generally* Ross D. Petty, *Advertising Law and Social Issues: The Global Perspective*, 17 SUFFOLK TRANSNAT'L L.J. 309, 341-44 (1994) (comparing different countries' approaches to advertising regulation). The stringency of tobacco advertising regulation varies among states. The minimum approach prohibits advertising on television and radio, while more stringent approaches range from restricting the content and format of advertising in printed media and on billboards to total bans on advertising. 2 SMOKE-FREE EUROPE, *supra* note 79, at 3, 6.

91. Alan T. Shao & John S. Hill, *Global Television Advertising Restrictions: The Case of Socially Sensitive Production*, 13 INT'L J. ADVERTISING 347 (1994); Paul Robbennolt, Comment, *Not Just Smoke and Mirrors: Free Expression and EC Restrictions on Tobacco and Alcohol Advertising*, 1992 U. CHI. LEGAL F. 419, 420, 434. In the European Union, all television tobacco advertising has been banned. Shao & Hill, *supra*, at 349. No political consensus has been achieved on a European Commission proposal calling for a ban on all direct and indirect advertising of tobacco. *See* Note, *Tobacco Proves Addictive: The European Community's Stalled Proposal to Ban Tobacco Advertising*, 26 VAND. J. TRANSNAT'L L. 149 (1993) [hereinafter *Tobacco Proves Addictive*]. Some legal authorities in the United States argue that broad tobacco advertising bans would be consistent with the First Amendment of the United States Constitution. *See, e.g.*, Lawrence O. Gostin & Allan M. Brandt, *Criteria for Evaluating a Ban on the Advertisement of Cigarettes: Balancing Public Health Benefits with Constitutional Burdens*, 269 JAMA 904, 905 (1993).

92. Tobacco Products Control Act of June 28, 1988, ch. 20, [1988] 1 S.C. 393 (Can.).

93. *See, e.g.*, Kagen & Vogel, *supra* note 75, at 28-30. In particular, the Act banned all cigarette advertising and promotion in newspapers and magazines. *Id.*

94. RJR-MacDonald, Inc. v. Attorney Gen. of Can., 100 C.C.C.3d 449 (1995). The Court ruled that limited restrictions on tobacco ads were permissible under the Canadian Charter of Rights and Freedoms, but that a comprehensive ban on advertising would improperly prohibit tobacco manufacturers from communicating with consumers about a legal product. *Id.*

95. *See, e.g.*, *Canada Voids All-out Ban on Tobacco Products*, N.Y. TIMES, Sept. 22, 1995, at A6.

96. *See, e.g.*, Roemer, *Leverage for Effective Policy*, *supra* note 81, at 106-08. For analysis of national regulation of smoking in public places and work sites, see, e.g., ROEMER, *supra* note 3, at 97-116; R. Masironi & H. Geizerova, World Health Org., *Smoke-Free Public Places: A World Overview*, WHO Doc. WHO/TOH/CLH/90.3 (1990); *see also* Maria Oknoska, *Legal Aspects of Passive Smoking: An Annotated Bibliography*, 86 LAW LIBR. J. 445 (1994) (highlighting public concerns and legal strategies relating to second-hand smoke).

97. *See supra* notes 15-17 and accompanying text (describing health consequences of environmental tobacco smoke).

contributing to an atmosphere in which smoking is socially unacceptable.[98]

At least ninety states have legislation regulating smoking in public places, and subnational legislation is also commonplace, although the regulations' extensiveness varies widely.[99] In addition, there has been increased public support for national regulation of smoking in workplaces in the last decade; about forty states have legislated such restrictions,[100] but the comprehensiveness varies considerably across countries.[101]

4. *Discouraging Tobacco Consumption by Young People*

Because most smokers start in their teenage years,[102] legislation addressing the forces that encourage children to use tobacco has proven critical in national public health campaigns aimed at reducing the morbidity and mortality associated with tobacco use.[103] Some forty-two countries have enacted such legislation.[104]

Tobacco regulation in the United States is weak compared to that in other industrialized states.[105] Recent initiatives at the federal level, however, reflect expanding public support for regulations to discourage young people from smoking. In August 1995, the Clinton administration proposed a number of federal measures to reduce the number of American children who become addicted to nicotine.[106] The proposed regulations involve measures to reduce

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98. According to WHO, "by expressing the social norm of a non-smoking environment, [such regulation] activates peer pressure and so exercises an influence that exceeds the specific terms of the legislation." 2 SMOKE-FREE EUROPE, *supra* note 79, at 25.

99. ROEMER, *supra* note 3, at 97-100. Smoking is most commonly banned in government buildings, hospitals and health centers, educational institutions, nurseries, public transportation, and indoor public places (including theaters, cinemas, libraries, museums, elevators, restaurants, and sports arenas). *Id.* at 100, 111-12.

100. World Health Org., *Tobacco-free Workplaces and the Law, World No-Tobacco Day 1992* Press Summary (May 31, 1992).

101. In addition, some countries restrict tobacco smoking where it creates an increased risk of disability or disease, such as where hazardous materials are used or pregnant women work. ROEMER, *supra* note 3, at 112. Tobacco smoke can increase the risk associated with hazardous material in the workplace, in some cases causing a highly elevated risk of disease. WORLD HEALTH ORG., FACT SHEET: WORLD NO-TOBACCO DAY MAY 31, 1992; *see also* WORLD HEALTH ORG., Office of Occupational Health, and Tobacco or Health Programme, *The Interaction of Smoking and Workplace Hazards: Risks to Health*, WHO Doc. WHO/OCH/TOH/92.1 (1992).

102. *See supra* text accompanying notes 9-10.

103. David A. Kessler, *Nicotine Addiction in Young People*, 333 NEW ENG. J. MED. 186 (1995).

104. ROEMER, *supra* note 3, at 251. National legislation aimed at reducing smoking by the young takes a variety of forms: (1) prohibiting sales of tobacco products to minors; (2) banning or restricting tobacco vending machines; (3) banning smoking in educational institutions and other places frequented by minors, including rock concerts and sporting events; (4) prohibiting distribution of free cigarette samples; (5) restricting sales of smokeless tobacco products; and (6) prohibiting cigarette advertising and sponsorship of sports events and rock shows. *Id.* at 120. For a global analysis of restrictions on tobacco use by minors, see *id.* at 117-28; 2 SMOKE-FREE EUROPE, *supra* note 79, at 33-43.

105. *See, e.g.*, Bartecchi et al., *supra* note 17, at 47; Kagen & Vogel, *supra* note 75, at 27. Despite laws in all states regulating tobacco sales to minors, American children can easily buy cigarettes and other tobacco products. U.S. DEP'T OF HEALTH & HUMAN SERV., HHS FACT SHEET, CHILDREN AND TOBACCO: THE PROBLEM (Aug. 10, 1995).

106. Regulations Restricting the Sale and Distribution of Cigarettes and Smokeless Tobacco Products to Protect Children and Adolescents, 60 Fed. Reg. 41,134 (1995) (to be codified at 21 C.F.R. §§ 801, 803, 804, 897) (proposed Aug. 11, 1995). In July 1995, the U.S. Food and Drug Administration (FDA) concluded for the first time that nicotine is a drug that should be regulated by the agency. *See* Philip J.

children's *access* to cigarettes, such as requiring age verification and face to face sales and eliminating mail order sales, vending machines, free samples, and self-service displays. The proposed regulations also include measures to reduce the *appeal* of cigarettes to children, such as banning outdoor advertising within one thousand feet of schools and playgrounds; restricting all billboard and other outside advertising to black and white text; prohibiting the sale or distribution of products that carry cigarette or smokeless tobacco product brand names or logos; prohibiting brand name sponsorship of sporting and entertainment events; and requiring the industry to fund ($150 million annually) a public health campaign to prevent children from smoking.[107]

5. *Mandatory Health Education*

"Countries that have achieved a significant reduction in smoking . . . have introduced strong educational programs" on the dangers of smoking.[108] Educational programs on tobacco vary among countries and include educational programs in schools, public campaigns on smoking cessation, and other programs mandated by general statutory requirements for public information and health education on smoking.[109]

Mandatory health warnings on cigarette packages and tobacco advertising are another way to inform the public about the health consequences of smoking. At least seventy-seven countries now require health warnings on cigarettes, although in most of them the requisite warning labels are too weak or too familiar to be effective in discouraging tobacco consumption.[110] In addition, a number of tobacco exporting states, including the United States, exempt exported cigarettes from regulations on labeling and tar content.[111]

B. *The Limitations of Unilateral Approaches to Tobacco Control: The International Origins and Global Repercussions of the Tobacco Pandemic*

Although a number of countries have significantly reduced the prevalence of tobacco use through comprehensive legislation, tobacco regulation remains weak or nonexistent in most countries, especially developing states, newly

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Hilts, *Tobacco Held to Be a Drug That Must Be Regulated*, N.Y. TIMES, July 13, 1995, at A18. The Clinton Administration's proposal authorized the FDA to begin the process of declaring nicotine an addictive drug. Philip J. Hilts, *Clinton to Seek New Restrictions on Young Smokers*, N.Y. TIMES, Aug. 10, 1995, at A1.

107. U.S. DEP'T OF HEALTH & HUMAN SERV., HHS FACT SHEET, CHILDREN AND TOBACCO: THE PROPOSAL (Aug. 10, 1995). For a discussion of smoking trends among American adolescents, see, e.g., *Trends in Smoking Initiation Among Adolescent and Young Adults-United States, 1980-1989*, *supra* note 87, at 528; Michael Janofsky, *25-Year Decline of Smoking Seems to Be Ending*, N.Y. TIMES, Dec. 19, 1993, at A24.

108. *See, e.g.*, Roemer, *Leverage for Effective Policy*, *supra* note 81, at 108. While effective health education can exist without legislation, Professor Roemer has noted that the "enactment of legislation making health education on smoking compulsory expresses government policy and ensures effective implementation of educational programmes." ROEMER, *supra* note 3, at 129.

109. ROEMER, *supra* note 3, at 130. "Most countries have educational programs on the hazards of smoking, but not all of them have enacted legislation making health education on tobacco mandatory, and even fewer have legislation that allocates funds to such programs." *Id.* at 129.

110. Tobacco Legislation in Africa, *supra* note 78, at 9.

111. Bartecchi et al., *supra* note 17, at 51.

industrializing states, and the formerly socialist states of Eastern Europe. By 1993 only two African states, one Southeast Asian state, and two Eastern Mediterranean countries had instituted regulatory efforts to prevent young people from smoking.[112] Although nineteen countries in the Americas, seven African countries, and five Southeast Asian states have instituted partial legislative restraints on tobacco advertising,[113] governments often fail to enforce these regulations,[114] or the tobacco industry finds ways to circumvent them.[115] This absence of effective domestic regulation has created a lucrative opportunity for transnational tobacco industries to target such countries. This section analyzes the global and domestic obstacles to adequate national tobacco regulation. Because these barriers restrict the ability of each nation unilaterally to control tobacco consumption and production within its borders, it is urgent to forge international consensus and take multilateral action.

National actors who want to reduce tobacco's domestic impact face powerful internal political and economic resistance to effective domestic regulation. Tobacco production and consumption have a superficial economic appeal for many poorer countries. Over one hundred twenty states produce tobacco,[116] and domestic consumption generates substantial tax revenue for many governments.[117]

The assumption that tobacco production and sales necessarily benefit national economies, however, must be questioned.[118] The true or social costs of tobacco production and consumption include the costs of environmental pollution,[119] deforestation,[120] and most important, tobacco related mortality

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112. ROEMER, *supra* note 3, at 251.

113. *Id.* at 250.

114. *See, e.g.*, Levin, *supra* note 34, at A15 (describing how in many states of former Soviet Bloc advertising regulations have "proved toothless or left loopholes that companies have been happy to exploit").

115. *See, e.g.*, ROEMER, *supra* note 3, at 42 (describing ineffectiveness of partial bans since they permit tobacco industry to shift resources to other areas); Ramon Isberto, *Asia-Health: More Fire and Smoke in Tobacco War*, Inter Press Service, May 6, 1994, *available in* LEXIS, Newa Library, Inpres File (describing how transnational tobacco conglomerates skirt advertising bans in Asia through indirect advertising of brand names and logos on other products).

116. Melanie Powell, *The Health Policy Implications of International Trade in Alcohol and Tobacco Products*, 84 BRIT. J. ADDICTION 1151, 1152 (1989).

117. Many developing states have highly regressive cigarette taxes that are often the single largest source of a state's internal revenue, providing up to 15% of its total tax revenue. Stebbins, *Tobacco or Health*, *supra* note 23, at 528. To many developing countries, tobacco seems to offer a "lifebelt," providing "jobs, revenue, exports, foreign exchange, education, training and prosperity." TAYLOR, *supra* note 23, at 242. Consequently, tobacco production has generated a bond between developing states and the tobacco industry. *See id.* at 261-73.

118. *See, e.g.*, WHO Regional Office for Europe, *Report on a WHO Seminar: The Economics of a Tobacco-Free Society*, WHO Doc. EUR/ICP/TOH 018(C), at 4 (1993).

119. The cultivation of tobacco contributes to soil erosion, and pesticides applied to tobacco fields contaminate water supplies. PANOS BRIEFING, *supra* note 25, at 9-10.

120. About half of the tobacco planters in developing states burn large sections of tropical forest and planted forests to process tobacco leaves. *Id.* at 6; Chapman, *supra* note 67, at 40. According to one commentator, "the tobacco-caused deforestation problem is of major proportions in particular parts of the developing world, most notably in Malawi, and in parts of Brazil (Rio del Sol), Zimbabwe, Uganda, Tanzania, and Kenya. The situation in China and in other tobacco-growing parts of Asia remains unknown, although ominous." Simon Chapman, *Tobacco and Deforestation in the Developing World*, 3 TOBACCO CONTROL 191, 193 (1994). Processing tobacco causes substantial ecological damage. *See* PANOS BRIEFING, *supra* note 25, at 6.

and morbidity. For example, the direct and indirect medical costs to American society for tobacco induced morbidity and mortality were estimated at $53 billion in 1984 alone.[121] Hence, tobacco production and promotion are not as economically profitable for developing states as typically assumed. In many states, the expansion of domestic tobacco consumption and production has been based upon misguided notions of short term fiscal gains that have overshadowed the long term costs to health, the environment, and development.

Although an increasing number of states may now recognize the threat that tobacco poses to their societies, countries desiring to reduce domestic tobacco prevalence through legislation contend with competing demands for limited national resources. For the public health sectors of many developing states, overwhelmed by infectious and communicable diseases,[122] tobacco control represents an emerging and much neglected health sector exigency.[123] In addition, many poor states do not have an adequate legislative foundation upon which to build public health strategies, including legislative action to control tobacco.[124]

Though national factors are significant, the factors that restrict the ability of countries to combat effectively the tobacco pandemic are primarily international. The transnational tobacco industry has dramatically advanced the worldwide smoking epidemic by influencing a number of factors that have increased global sales and consumption of tobacco products. Aggressive advertising by multinational conglomerates and the targeting of susceptible populations, including women and the young, increase domestic demand throughout the developing world. Transnational tobacco companies have focused not only on gaining entry into closed national markets throughout the world, but also on blocking the imposition of national regulations that restrict the advertising or sale of cigarettes.[125] In addition, political pressure by the major western tobacco exporting states, particularly the United States, has forced open markets and expanded advertising[126] in importing countries.

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121. Stebbins, *Tobacco, Politics, and Economics*, *supra* note 23, at 1318.

122. *See, e.g.*, Allyn L. Taylor, *Making the World Health Organization Work: A Legal Framework for Universal Access to the Conditions for Health*, 18 AM. J. L. & MED. 301, 304-09 (1992) (describing how public health sectors of many developing states have been overcome by infectious diseases, including cholera, malaria, tuberculosis, and HIV/AIDS).

123. *See generally* Jamison & Mosley, *supra* note 67.

124. *See, e.g.*, E. Najera et al., *Health for All as a Strategy and the Role of Health Legislation: Some Issues and Views*, 37 INT'L DIG. HEALTH LEGIS. 362, 363 (1986) ("[F]ew countries . . . have expressly enacted legislation or legally binding regulatory instruments on which to base their activities to ensure the protection and care of the health of their peoples.").

125. The history of national tobacco control efforts worldwide indicates that countries attempting to domestically regulate tobacco "can expect a coordinated and intensive confrontation with the international tobacco industry." Judith M. Mackay, *Tobacco Control-Action and Obstacles*, 15 CANCER DETECTION & PREVENTION 429, 431 (1991).

126. The U.S. trade policy has not only sought to lift trade barriers, but has also aimed at "forcing [countries] to remove [advertising and marketing] restrictions they had imposed on themselves so that American cigarettes could gain entree." *U.S. Government Trade Policy Is Exporting America's Cigarette and Lung Cancer Epidemic Abroad - NCAB [National Cancer Advisory Board] Told*, 31 THE BLUE SHEET 5 (Dec. 14, 1988) (citing Kenneth Warner, Chair of the Department of Public Health Policy and Administration at the University of Wisconsin); *see also* Levin, *supra* note 34, at A15 (describing how trade officials, at insistence of industry, have pressured Japan, South Korea, Thailand, and Taiwan to open their markets to U.S. tobacco and allow firms to advertise their cigarettes). A 1990 report from the U.S.

Western pressure has also led to a number of changes in developing and newly industrializing countries that have reduced the price and increased the demand for cigarettes.[127] In many of the poorer states, aggressive tobacco promotion by the tobacco industry and western states simply overwhelms underfunded national tobacco control efforts.[128]

The potential profits of international trade in tobacco have also induced many cash hungry governments to expand domestic production of tobacco and to place less emphasis on public health. Many of the one hundred twenty tobacco producing countries look to expand domestic production of raw tobacco for export to provide much needed foreign exchange.[129] However, few countries reap significant financial gains from tobacco exports.[130] Most developing countries do not export tobacco, but rather produce it for domestic use.[131] Among developing states that export tobacco, with the exception of Malawi[132] and Zimbabwe,[133] the crop provides only a negligible part of foreign exchange earnings.[134] The transnational tobacco conglomerates' virtual monopoly over tobacco exports thus thwarts developing countries' attempts to earn significant national income from exporting tobacco.

General Accounting Office documents that the U.S. government and transnational cigarette companies have resisted efforts to restrict marketing of U.S. tobacco in newly opened markets in Asia. Prakit Vateesatokit, *Letter from Bangkok: The Latest Victims of Tobacco Trade Sanctions*, 264 JAMA 1522, 1524 (1990) (citing U.S. GEN. ACCOUNTING OFFICE, TRADE AND HEALTH ISSUES: REPORT TO CONGRESSIONAL REQUESTERS, Pub. GAO/NSAID 90-190 (1990)).

127. Council Report, *supra* note 34, at 3312. Increases in tobacco import quotas, lower tariffs on tobacco products, and the proliferation of new foreign brands increase the supply of cigarettes, lead to lower retail cigarette prices, and increase demand. *Id.*

128. Stebbins, *Tobacco or Health*, *supra* note 23, at 527.

129. For example, foreign exchange earnings from raw tobacco account for over 50% of all agricultural export earnings in Malawi and Zimbabwe, and for about 10% in India, Paraguay, and South Korea. *Health: U.N. Renews Attack on Killer Tobacco Mindful of Poor*, Inter Press Service, July 18, 1994 *available in* LEXIS, News Library, Inpres File. By 1977, developing states accounted for 60% of world tobacco output. *Id.* Hard currency investment by transnational tobacco corporations in cigarette plants in many countries, including those in central and eastern Europe, has also encouraged cash hungry countries to place less emphasis on controlling the smoking epidemic. *See supra* notes 39-43 and accompanying text. Bribes and kickbacks to officials are also "not unusual." Stebbins, *Tobacco or Health*, *supra* note 23, at 527.

130. Declining tobacco consumption in industrialized states and domestic content requirements have lessened the profitability of tobacco exports. For example, recent U.S. legislation requiring American made cigarettes to contain no more than 25% imported tobacco has further depressed imports from developing states. *Tobacco Industry Concerned About Domestic Content Law's Requirements*, 11 INT'L TRADE REP. 465, 465 (1994); John Stackhouse, *Tobacco: Third World Windfall and a Deadly Dilemma*, HOUSTON CHRON., Sept. 4, 1994, at A25.

131. *See* discussion *supra* note 25.

132. Malawi accounts for 33% of world tobacco production. Gumisai Mutume, *Southern Africa-Commodities: Save Tobacco, Save Our Economies*, Inter Press Service, Aug. 3, 1994 *available in* LEXIS, News Library, Inpres File. Tobacco accounts for 80% of Malawian exports. *Zimbabwe: Tobacco's Struggle for Survival*, AFR. ECON. DIG., Reuter Textline, Aug. 15, 1994, *available in* LEXIS, World Library, Txtlne File.

133. The tobacco industry has an important place in the Zimbabwean economy and is one of the country's largest employers. Mutume, *supra* note 132. Exports of tobacco bring Zimbabwe $414 million per year — almost 30% of all export earnings — and constitute the single most important source of foreign exchange. *Id.*

134. PANOS BRIEFING, *supra* note 25, at 1. In Africa, Malawi and Zimbabwe collect 94% of the continent's export earnings of tobacco, and the remainder of tobacco trading states, taken together, run a trade deficit in tobacco. Simon Chapman et al., *All Africa Conference on Tobacco Control*, 308 BRIT. MED. J. 189, 190 (1994). For these countries, therefore, the tobacco trade produces a net loss of foreign exchange. *Id.*

The tobacco epidemic has worldwide repercussions, not only for developing nations and the states of eastern Europe and the former Soviet Union where smoking is now widespread, but in industrialized countries as well. These repercussions restrict the ability of all nations to combat the epidemic effectively.[135] Philip Morris and R.J. Reynolds earned $3 billion from foreign sales of tobacco in 1993 alone; some transnational conglomerates now reportedly make up to 60% of their profits from sales in developing states.[136] These profits are arguably being used "to attempt to maintain the current levels of consumption in developed countries by targeting some vulnerable groups including young people and ethnic minorities"[137] through advertising.

The tremendous global profits of the American and British tobacco conglomerates may also be diverted to maintain consumption patterns in industrialized states by financing costly efforts to oppose stringent tobacco control laws. According to the Advocacy Institute, a Washington antismoking group, legal fees incurred by American tobacco corporations in efforts to repeal or prevent the imposition of tobacco control laws and in defending lawsuits could be as much as $600 million annually in the United States.[138] In addition, tobacco conglomerates regularly support state and federal political candidates with large donations.[139] Such contributions, among other things, make the tobacco lobby "one of the most influential forces in the government."[140]

The global spread of the international communications media has contributed to the ever increasing urgency and interdependence of global tobacco control efforts. Foreign newspapers and magazines and new mass communications media, such as cable and satellite television, restrict the ability of individual countries to regulate tobacco promotion and advertisement within their sovereign borders. Countries that have sought to restrict or ban advertising have already experienced the problem of direct and indirect advertising "overspill" from other states.[141] For example, even countries with virtually total bans on tobacco advertising generally tolerate it in foreign newspapers and magazines.[142] Tobacco advertising on cable and satellite

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135. Chapman, *supra* note 67, at 40.

136. Himelstein et al., *supra* note 27, at 25.

137. *Id.*

138. *Id.*

139. For example, in the United States, the tobacco companies donated $5.6 million in federal contributions during the 1992 election. *Id.* According to *Business Week*, tobacco lobbyists are also "out in force" in states such as Maryland, California, and Massachusetts, where antismoking sentiment is high. *Id.* For example, in the wake of proposed new federal regulations by the Clinton Administration to regulate nicotine and tobacco marketing to children, the tobacco industry pumped more than $1.5 million into national Republican party treasuries in the first half of 1995, a figure equal to five times the amount contributed during the same period in 1994. Jane Fritsch, *Tobacco Companies Pump Cash into Republican Party Coffers*, N.Y. TIMES, Sept. 13, 1995, at A1.

140. Bartecchi et al., *supra* note 17, at 48. "In 1989 it was reported that over a two year period, 420 of 535 congressional representatives and 87 of 100 senators accepted tobacco campaign contributions . . . ." *Id.*

141. *See, e.g.*, 1 REGIONAL OFFICE FOR EUROPE COPENHAGEN, WORLD HEALTH ORG., IT CAN BE DONE: A SMOKE-FREE EUROPE 34 (1990) [hereinafter 1 SMOKE-FREE EUROPE].

142. Telephone Interview with Ruth Roemer, Adjunct Professor of Health Law, *UCLA School of Public Health* (Aug. 14, 1995).

television is cause for even greater concern because it restricts the ability of countries to control even direct advertising that is broadcast from abroad.[143] With the global proliferation of new mass communications media and the rapid rise of international travel, advertising "overspill" is likely to become even more widespread. Direct and indirect tobacco advertising and promotion transcend national boundaries; they can no longer be regarded as purely matters of domestic concern. Given the global integration of tobacco industry finance and the global repercussions of tobacco advertising and promotion, there is an inherent conflict between western tobacco exporting states' twin policy goals of promoting tobacco exports and discouraging domestic smoking.

The tobacco pandemic vividly demonstrates the ever increasing interdependence of national efforts to protect public health. This global health challenge is international in origin, has international repercussions, and necessitates collaborative, multilateral action to encourage and assist countries in the development and implementation of effective domestic regulatory programs. In addition, the speed with which tobacco use has become a worldwide epidemic demonstrates the urgency of prompt and effective national and international action. Although the tobacco pandemic poses serious challenges to national and international decisionmakers, it also offers an opportunity for unprecedented international cooperation to protect global health.

IV. WHO AND AN INTERNATIONAL STRATEGY FOR TOBACCO CONTROL

A. *The World Health Organization and the Tobacco or Health Programme*

The World Health Organization,[144] established in 1946,[145] is the primary specialized agency charged with improving global health conditions. With six regional offices, more than one hundred ninety member states, and an annual regular budget exceeding $800 million per year, WHO is the largest international health agency and one of the largest specialized agencies in the United Nations. Most observers have customarily viewed WHO primarily as an effective medical, technical organization.[146] In its traditional activities,

143. *See, e.g.*, 1 SMOKE-FREE EUROPE, *supra* note 141, at 34.

144. WHO has a complicated, decentralized structure, with central headquarters in Geneva, six regional offices, and many country and field offices. PAUL F. BASCH, TEXTBOOK OF INTERNATIONAL HEALTH 342 (1990). At the global headquarters, the World Health Assembly determines overall policy of the organization. WHO CONST. *supra* note 4, art. 18,. The Executive Board, which consists of 32 technically qualified individuals, is responsible for giving effect to the policies of the Assembly. *Id.* arts. 24, 28. The Secretariat consists of the Director-General and a technical and administrative staff. *Id.* art. 30. The Director-General, nominated by the Executive Board, is WHO's chief technical and administrative officer. *Id.* art. 31.

145. Representatives of 61 states signed the WHO Constitution on July 22, 1946, at the International Health Conference held in New York City from June 19 to July 22, 1946; the Constitution became effective on April 7, 1948. WHO, BASIC DOCUMENTS, *supra* note 4, at 1 n.1.

146. WHO regularly formulates and adopts technical recommendations that command respect because of WHO's reputation for technical expertise. *See* HAROLD K. JACOBSON, NETWORKS OF INTERDEPENDENCE: INTERNATIONAL ORGANIZATIONS AND THE GLOBAL POLITICAL SYSTEM 319 (2d ed. 1984).

WHO has been described as one of the "most valuable" agencies of the United Nations system.[147]

Although WHO is not the only international agency involved in health matters,[148] the United Nations Charter and WHO's constitution endow WHO with the duty to provide global leadership in international health in general. The structure of the relationship between the United Nations and WHO is grounded in the United Nations Charter,[149] particularly in those sections that describe the objectives of the United Nations. Article 55 of the United Nations Charter describes the goals that the United Nations has pledged to promote among its members, including "solutions of international economic, social, health and related problems."[150]

The U.N. General Assembly has overlapping jurisdiction within the field of health[151] and the legal authority to address the global problems of tobacco control. However, as the specialized agency with the primary constitutional directive of acting as the "directing and co-ordinating authority on international health work,"[152] WHO bears the cardinal responsibility for implementing the aims of the U.N. Charter with respect to health. Furthermore, article 1 of WHO's constitution proclaims that the organization's fundamental objective is the "attainment by all peoples of the highest possible level of health."[153]

WHO and its regional offices have played a critical role in establishing the scientific foundation for global action against tobacco[154] and in encouraging and assisting countries to develop domestic regulatory frameworks for tobacco control. Since 1970, the World Health Assembly has also enacted a number of resolutions emphasizing WHO's priorities in tobacco control, including urging countries to adopt specific strategies for tobacco

147. DOUGLAS WILLIAMS, THE SPECIALIZED AGENCIES AND THE UNITED NATIONS 34 (1995).

148. *See, e.g.*, BASCH, *supra* note 144, at 326-53 (describing organizations working in international health).

149. U.N. CHARTER arts. 1, ¶ 3; 55-59; 63-64.

150. *Id.* art. 55(b).

151. *See, e.g.*, THEODOR MERON, HUMAN RIGHTS LAW-MAKING IN THE UNITED NATIONS 259-60 (1986). Acting within the framework of the United Nations Charter, the General Assembly has the legal capacity to study and discuss the international problems of tobacco and to promulgate nonbinding recommendations designed to promote global tobacco control efforts. Article 13, ¶ 1(b) of the U.N. Charter commands the General Assembly to "initiate studies and make recommendations . . . promoting international cooperation in the . . . health [field]." In addition, the General Assembly has the legal capacity to provide a forum for the negotiation of a multilateral tobacco control agreement that establishes law for the parties to the instrument. U.N. CHARTER art. 13, ¶ 1(b). Article 13, ¶ 1(a) of the U.N. Charter empowers the General Assembly to "initiate studies and make recommendations . . . encouraging the progressive development of international law and its codification . . . ." U.N. CHARTER art. 13, ¶ 1(a). Although the General Assembly lacks express legislative powers, it has discharged its obligation to encourage the "progressive development of international law and its codification" by acting as a facilitator for the creation of international legislative rules through the traditional treatymaking process. *Id. See generally* Robert E. Riggs, *The United Nations and the Politics of Law*, *in* POLITICS IN THE UNITED NATIONS SYSTEM 41, 43-46 (Lawrence S. Finkelstein ed., 1988). Like other specialized agencies, WHO has only a treaty relationship with the United Nations. *See* U.N. CHARTER art. 57; *see also Agreement Between the United Nations and the World Health Organization*, *in* WHO, BASIC DOCUMENTS, *supra* note 4, at 41.

152. WHO CONST., *supra* note 4, art. 2(a).

153. *Id.* art. 1.

154. *See* ROEMER, *supra* note 3, at 3.

control and strengthening WHO's collaboration on tobacco with member states, other United Nations organizations, and nongovernmental organizations.[155] In 1990, WHO established the Tobacco or Health Programme as a separate entity within WHO[156] in order to strengthen tobacco control efforts. The key component of WHO's Programme involves collaborating with member states to formulate policies and strategies for national tobacco control programs[157] and providing technical advice and support for national tobacco regulation.

Despite the operational accomplishments of WHO's global tobacco campaign in the last twenty-five years, the organization acknowledges that it has been unable to develop or sustain national commitment to domestic tobacco regulation. Comprehensive national tobacco control policies that meet all or nearly all of WHO's recommendations exist, WHO concedes, in "only a very few countries."[158]

Recognizing the need to strengthen international efforts to promote national tobacco control activities, WHO is considering the role that international legal instruments can play in its tobacco control strategies. In October 1994, the Ninth World Conference on Tobacco or Health adopted a resolution urging national governments and WHO to prepare and realize an international convention on tobacco control to be adopted by the United Nations.[159] In May 1995, the World Health Assembly responded to the

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155. *See, e.g., WHO Programme on Tobacco or Health*, Exec. Bd. 89th Sess., Prov. Agenda Item 24.1, at 3-4, WHO Doc. EB89/INF.DOC./5 (1991); WHA Res. 42.19, 42nd World Health Assembly, WHO Doc. WHA42/1989/REC/1 (1989), *compiled in* 3 WORLD HEALTH ORG., HANDBOOK OF RESOLUTIONS AND DECISIONS OF THE WORLD HEALTH ASSEMBLY AND THE EXECUTIVE BOARD: 1985-1992, at 55 (3d ed. 1993) [hereinafter WHO, HANDBOOK]; WHA Res. 44.26, 44th World Health Assembly, WHO Doc. WHA44/1991/REC/1 115 (1991), *compiled in* WHO, HANDBOOK, *supra*, at 56-57. In 1986, the World Health Assembly launched a global public health approach to tobacco control, urging countries to adopt a comprehensive approach to tobacco control, including the critical regulatory measures, detailed in Part III above. *See* WHA Res. 39.14, 39th World Health Assembly, *compiled in* WHO, HANDBOOK, *supra*, at 53-54.

For a review of WHO's cooperation with intergovernmental and nongovernmental organizations on tobacco control efforts, see *WHO Programme on Tobacco or Health: Implementation of Resolutions WHA42.19, WHA43.16 and WHA45.20*, Report by the Director General, 46th World Health Assembly, Prov. Agenda Item 19, WHO Doc. A46/10 (1993). At the end of 1993, a focal point on multisectoral collaboration was designated within the United Nations Conference on Trade and Development (UNCTAD) to promote and strengthen tobacco control strategies. *See, e.g., Coordination Questions: Multisectoral Collaboration on Tobacco or Health: Progress Made in the Implementation of Multisectoral Collaboration on Tobacco or Health: Report of the Secretary General*, Prov. Agenda Item 9(c), at 3, ECOSOC Doc. E/1995/67 (1995) [hereinafter *Multisectoral Collaboration on Tobacco*]. For a description of activities of intergovernmental organizations and nongovernmental organizations in tobacco control, see *id.* at 9-12 and *Draft Addendum to Report of the Secretary-General on Multisectoral Collaboration on Tobacco or Health* (E/1995/67), ECOSOC Doc. E/1995/67/Add.1 (1995).

156. *See, e.g.*, C. Chollat-Traquet, *Tobacco or Health: A WHO Programme*, 28 EUR. J. CANCER, 311 (1992). In May 1994, the Tobacco or Health Programme was relocated to the WHO's Programme on Substance Abuse. World Health Org., *Tobacco or Health Report by the Director General*, Exec. Bd. 95th Sess., Prov. Agenda Item 12, at 2, WHO Doc. EB95/27 (1994).

157. *See, e.g.*, WHO Doc. EB89/INF.DOC./5, *supra* note 155, at 5.

158. WHO Doc. EB95/27, *supra* note 156, at 4.

159. Resolutions of the Ninth World Conference on Tobacco or Health, art. 4(b), *reprinted in Multisectoral Collaboration on Tobacco*, *supra* note 155, annex II. For a background proposal for a global regulatory approach to tobacco control, see Allyn L. Taylor, International Legislation to Combat the Tobacco Pandemic, Paper Presented at the Ninth World Conference on Tobacco or Health, Paris, France (1994) (on file with author).

Conference's call for an international tobacco strategy. In resolution WHA48.11, the World Health Assembly began formal consideration of alternative international regulatory approaches to tobacco control. Resolution WHA48.11 called upon the Director-General of WHO to report to the May 1996 Assembly on the "feasibility of developing an international instrument such as guidelines, a declaration, or an International Convention on Tobacco Control to be adopted by the United Nations."[160]

B. *The Role of WHO in an International Strategy for Tobacco Control*

As the premier authority on world health matters, WHO has a unique opportunity to propel an international strategy for tobacco control, promoting and guiding government action on multilateral tobacco control instruments that detail national obligations of states to protect the health of their populations. WHO has the legal authority and public health expertise to serve as the platform for the development of an international regulatory approach to tobacco control. The question is whether WHO has the organizational capacity to do so.

WHO has traditionally eschewed the use of international legislative strategies to promote its health policies. There are several possible explanations for this attitude. An organization's behavior is shaped by many aspects of its external and internal environment. In addition to membership,[161] these aspects include its processes, structures, and key personnel.[162] An organization's behavior also reflects its culture — the pattern of basic assumptions existing within the organization.

WHO's traditional conservatism regarding the use of legal institutions reflects the cultural predispositions of the organization.[163] Historically, the medical professionals who constitute the key leadership of the organization have seemed to share a common understanding that efforts to achieve the organization's health goals should not include a legal component. WHO has encouraged the formulation of binding standards only in two very limited and traditional areas of international public health regulation;[164] moreover, WHO officials have acknowledged that the organization's lawmaking efforts in these

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160. WHA Res. 48.11, *supra* note 5, at 1.

161. WHO's reluctance to develop public health law reflects, at some level, its members' goals and policies. The behavior of public international organizations traditionally has been understood exclusively as the reflection of the interest of their dominant coalitions or key financial members. ERNST B. HAAS, WHEN KNOWLEDGE IS POWER: THREE MODELS OF CHANGE IN INTERNATIONAL ORGANIZATIONS 57-58 (1990); *see also* Taylor, *supra* note 122, at 339-40 (describing financial and structural constraints limiting WHO's autonomy to implement independent decisions).

162. Factors that may affect the behavior of international organizations include ideology, voting, representation, secretariat autonomy, the status of outside experts, leadership, political goals, and institutionalization. HAAS, *supra* note 161, at 89-92.

163. Taylor, *supra* note 122, at 343; *see* Jay M. Shafritz & J. Steven Ott, *The Organization Culture School*, *in* CLASSICS OF ORGANIZATION THEORY 373, 374, 378 (Jay M. Shafritz & J. Steven Ott eds., 2d rev. ed. 1987). "Culture" has been defined as a "deeper level of basic assumptions and beliefs that are shared by members of an organization, that operate unconsciously, and that define in a basic 'taken-for-granted' fashion an organization's view of itself and its environment." Edgar Schien, *Defining Organization Culture*, in CLASSICS OF ORGANIZATION THEORY, *supra*, at 381, 384.

164. These are Nomenclature Regulations and International Health Regulations. S.S. FLUSS & F. GUTTERIDGE, WORLD HEALTH ORGANIZATION 15-19 (1993).

areas have been a "failure."[165] Senior health legislation officials at WHO have commented that this disposition to avoid legal strategies represents a "reluctance within the organization to indulge in what might be termed the 'making of official science,' a reluctance shared with its forbears."[166]

WHO's conservative culture is clearly among the most significant factors contributing to the organization's past avoidance of legal strategies. Accordingly, WHO may not be able to transcend its conservative anti-law culture and to foster a legislative foundation for tobacco control. A strong organizational culture can dominate the organization's behavior and constrain it from making needed changes. Nonetheless, an organization's culture can evolve and develop.[167] Crisis is the greatest stimulus of change in international organizations.[168] More precisely, organizational evolution is triggered not by crisis itself, but by the organizational leaders' perceptions of the circumstances.[169] If the leaders do not perceive traditional solutions as capable of resolving the crisis, then they may employ innovative approaches.

The growing urgency and complexity of the tobacco pandemic have inspired WHO's leaders to consider adopting innovative legal strategies. Patterns of organizational behavior that contradict WHO's traditional culture are beginning to emerge. For example, resolution WHA48.11's call for considering international legal instruments to promote WHO's health policies is clearly contrary to WHO's traditional practice. Of course, it remains to be seen whether WHA48.11 represents a step toward genuine organizational evolution or adaptation[170] of WHO's conservative anti-law culture, or merely a temporary and inconsequential deviation from established procedures.[171] Nevertheless, WHO's unconventional consideration of the role that international law and institutions can play in promoting world public health protection policies suggests that WHO's leaders may be rethinking and expanding the organization's traditional scientific, technical approaches to international health.

Current challenges facing WHO indicate that the time may be ripe for the

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165. S.S. Fluss & Frank Gutteridge, *Some Contributions of the World Health Organization to Legislation, in* ISSUES IN CONTEMPORARY INTERNATIONAL HEALTH 35, 41 (Thomas A. Lambo & Stacey B. Day eds., 1990).

166. *Id.* at 42.

167. *See, e.g.*, HAAS, *supra* note 161, at 17-49.

168. *See generally* Rosabeth Moss Kanter, *The Architecture of Culture and Strategy Change, in* CLASSIC READINGS IN ORGANIZATIONAL BEHAVIOR 615, 626 (J. Steven Ott ed., 1989) (discussing galvanizing events).

169. *Id.* at 617.

170. According to Ernst B. Haas, organizational adaptation, as opposed to evolution, is marked by small, incremental growth. "Adaptation is incremental adjustment, muddling through . . . . Because ultimate ends are not questioned, the change in behavior takes the form of a search for more adequate means to meet the new demands." HAAS, *supra* note 161, at 34. Nevertheless, adaptation can result in the successful application of new practices.

171. Although unconventional, WHA48.11 falls far short of being concrete evidence of organizational evolution. As Ernst B. Haas has noted, mere ad hoc or episodic use of innovation does not amount to effective institutionalization of new practices. "Successful institutionalization takes place only when [such innovations] are consistently used and fully integrated into the regular decision-making process." *Id.* at 86. At best, WHA48.11 does not even reflect such an ad hoc use of innovative behavior. It is a call to consider the role that international legislative efforts can play in global tobacco control efforts and thus falls far short of even an endorsement of an international legislative framework.

evolution of the organization's conservative anti-law culture. The growing complexities of responding to the international burden of disease are testing the organization's capacity to maintain its reputation as the foremost authority on international health. Yet, these challenges have also created an extraordinary opportunity for the leaders of WHO to reshape the way in which the organization thinks and acts.

However, WHA does not cast WHO as the platform for an international convention on tobacco control. WHA suggests instead that such an instrument should be generated under the United Nations' auspices.[172] While the United Nations has the authority to steer the massive effort needed to create an international strategy on tobacco control, the efficiency and perhaps the existence of such a strategy may be severely compromised if WHO neglects to assume the primary responsibility for such global efforts. WHO has the principal responsibility, and the legal and technical capacity, to lead the development of an international regulatory framework, initiate discussion among member states, and facilitate the setting of international standards for global tobacco control. In contrast, the General Assembly lacks both the expertise and the time[173] necessary to facilitate the negotiation and supervise the implementation of complex tobacco control standards.[174] Hence, despite WHO's oft-noted bureaucratic inefficiencies,[175] the organization's public health expertise is essential to forging an international political consensus for public health protection, generating complex, technical norms on tobacco control, and assisting states to implement such norms.

Advancing the global struggle against the tobacco crisis through a legislative framework presents an extraordinary opportunity for WHO to reaffirm and strengthen its commitment to global public health and to enhance its prestige within the international community. WHO must develop from a biomedical, technical organization into an institution with the capacity to use innovative strategies, including legislation, if it is to provide leadership on a regulatory strategy for tobacco and for global public health matters generally.

V. AN INTERNATIONAL REGULATORY STRATEGY FOR TOBACCO CONTROL

The development and implementation of international public health law

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172. *See supra* note 151.

173. *See, e.g.*, MERON, *supra* note 151, at 265; *see also* G.M. DANILENKO, LAW-MAKING IN THE INTERNATIONAL COMMUNITY 266-77 (describing factors involved in choice of lawmaking arenas). Although a variety of considerations are theoretically appropriate to the choice of lawmaking forums, Danilenko notes that "experience demonstrates that the actual impact of these concepts depends on the configuration of effective power in a given area of relations." *Id.* at 272.

174. The General Assembly does, of course, have the authority to involve WHO in the development of a U.N. international strategy on tobacco control as well as in the drafting and implementation of an international convention sponsored under U.N. auspices. However, given the frequent absence of effective interagency coordination in the United Nations' system, WHO's critical role in this process may be drastically and unwisely curtailed if the health agency abandons its critical leadership role in the global struggle against tobacco. In recent years, specialized agencies have increasingly complained that the General Assembly is "legislating more and more, and in ever greater detail" in fields that "are clearly the responsibility" of one of the specialized agencies. MERON, *supra* note 151, at 260 (citing UNESCO Doc. 110/EX/19, para. 67 (1980)).

175. *See, e.g.*, Fiona Godlee, *WHO at Country Level - A Little Impact, No Strategy; World Health Organization*, 309 Brit. Med. J. 1636 (1994).

to promote national action on tobacco control can contribute critically to WHO's campaign for a smoke free world. Encouraging states to develop binding and specific international legal commitments to control tobacco may powerfully influence states to rethink priorities and redirect resources to combatting the tobacco epidemic through a national regulatory framework. Although an international regulatory strategy on tobacco may face political opposition from the tobacco industry and some states, the ability of other international organizations[176] to encourage states to adopt cogent international standards on issues fraught with political conflict indicates that WHO may have the authority to promote and guide governmental action by serving as a platform for the codification of international law.

The successful international standard setting efforts of other international organizations can serve as a precedent, model, and guide in WHO's efforts to achieve international action on tobacco control. The establishment of other international organizations as centers for policy debate and international codification regarding controversial issues suggests that international organizations, including WHO, may have a degree of independence adequate to promote and guide governmental action and achieve bargains and compromises on politically charged issues, including tobacco control.

Of course, tobacco is a divisive political issue. Accordingly, there is good reason for skepticism about the ability of WHO to alter state behavior and to encourage the codification and implementation of effective international tobacco control instruments. The ability of an international organization to influence national decisionmaking is limited in a world order dominated by independent states.[177] States are generally reluctant to sacrifice any autonomy to international organizations.[178] The one hundred twenty tobacco producing nations may be disinclined to support the development of an international regulatory approach to tobacco control, and powerful tobacco exporting countries, including the United States and Great Britain, may

176. These organizations include the United Nations Environmental Programme (UNEP), the International Maritime Organization (IMO), and the International Labour Organization (ILO).

177. *See, e.g.*, WILLIAMS, *supra* note 147, at 29.

178. *See, e.g.*, HAAS, *supra* note 161, at 55-61. WHO's efforts to develop international public health law on tobacco control may face jurisprudential objections. In the latter half of this century, international law has moved away from a traditional vision of an international society of sovereign states with supreme authority over their respective territories. In particular, the need of states to cooperate in order to solve essential problems in a number of realms, including human rights and environmental protection, has precipitated the gradual erosion of the traditional concept of state sovereignty. Environmental protection and the treatment by a state of its own nationals have become subjects of international concern and action as states have created binding international legal standards. *See, e.g.*, A.A. Cancado Trindade, *The Contribution of International Human Rights Law to Environmental Protection, with Special Reference to Global Environmental Change*, *in* ENVIRONMENTAL CHANGE AND INTERNATIONAL LAW 244, 245-50 (Edith Brown Weiss ed., 1992) [hereinafter ENVIRONMENTAL CHANGE]; Jonathan I. Charney, *Universal International Law*, 87 AM. J. INT'L L. 529 (1993); *see also* LOUIS HENKIN, HOW NATIONS BEHAVE 228-39 (1979) (analyzing development of international human rights law). In contrast to the evolution of international cooperation and the harmonization of state behavior in human rights, environmental protection, and other realms of global concern, decisionmaking in international public health is still steeped in the statist model of international law. International cooperation in public health law is functionalist and restricted to limited, technical concerns. Although the international community's ability to combat the tobacco pandemic depends upon international cooperation facilitated by effective international institutions to guide governmental behavior, states may not yet acknowledge that multilateral action is necessary to protect global public health.

strongly oppose any international regulation that threatens tobacco exports.[179] Furthermore, the transnational tobacco conglomerates, which have tenaciously opposed the development of national tobacco control regulations, will wield their considerable economic and political power to obstruct any international legislation on tobacco control.

Yet the politics of global tobacco control are not clear cut. Recent revelations that the tobacco industry has long possessed and concealed knowledge about the addictive qualities of nicotine, as well as sharpened interest in national tobacco regulation in some states, including the United States, have highlighted the issues of tobacco control worldwide and created a critical opportunity for WHO to serve as an effective forum for the protection of global public health. Notwithstanding opposing forces, therefore, WHO can achieve progress in global tobacco control by initiating, sponsoring, and coordinating international tobacco negotiations.

Given the modest level of current global commitment to tobacco regulation, WHO should adopt a measured, gradual approach to international standard setting to achieve global consensus. Instead of encouraging states to codify a single instrument, as suggested in WHA48.11,[180] WHO should develop political consensus for international action on tobacco control over time, first promoting global support for the adoption of a noncontroversial, nonbinding instrument and then progressively encouraging the adoption of binding legal commitments of increased scope and strength.[181]

This dynamic and continuous model of international standard setting has been used frequently and sometimes effectively by other international organizations and can serve as a precedent for WHO. International law has developed in this manner in fields as diverse as the international protection of human rights[182] and the status of outer space.[183] Perhaps the most

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179. Great Britain, for example, obstructed a proposed European Community Directive to ban virtually all tobacco advertisement within the European Community. *Tobacco Proves Addictive*, *supra* note 91, at 152, 155.

180. WHA Res. 48.11, *supra* note 5, at 3(1).

181. An alternative international regulatory approach to tobacco control is the development of international instruments directly addressing the responsibilities of transnational tobacco corporations. However, as neither states nor public international organizations, multinational corporations are not traditional subjects of international law. *See* RESTATEMENT (THIRD) OF FOREIGN RELATIONS LAW § 207 (1988). Commentators have considered how to develop international regulatory models for the conduct of transnational corporations. *See, e.g.*, Gunther Handl, *Environmental Security and Global Change: The Challenge to International Law*, *in* ENVIRONMENTAL PROTECTION AND INTERNATIONAL LAW 59, 66-68 (Winfried Lang et al. eds., 1991). International law offers only a few examples of such a regulatory approach. For example, strict liability has been established through treaty for ship operators and nuclear plant owners for marine pollution and nuclear hazard. *See, e.g.*, Toru Iwama, *Emerging Principles and Rules for the Prevention and Mitigation of Environmental Harm*, *in* ENVIRONMENTAL CHANGE, *supra* note 178, at 107, 109. Thus, as Gunther Handl has suggested, "it is unlikely that, at anytime soon [transnational corporations'] legal status would be upgraded to the point where they could be both a direct claimant and respondent under international law without any mediation by states." Handl, *supra*, at 67. At times, of course, transnational enterprises are treated as "partial or functional subjects of international law." *Id.*; *see also infra* note 209 (describing international codes of conduct for transnational corporations).

182. Widely known examples of this process are U.N. General Assembly human rights resolutions in areas including torture, racial discrimination, and the rights of children, later followed by detailed conventions. The International Covenant on Economic, Social and Cultural Rights and the International Covenant on Civil and Political Rights "legislate essentially what the Universal Declaration [of Human Rights] had declared." LOUIS HENKIN, THE AGE OF RIGHTS 20 (1990) (citing *International Bill of Human Rights*, U.N. GAOR, 3d Sess., Supp. No. 1, at 71, U.N. Doc. A/565 (1948)).

celebrated examples of the development of international standards through this dynamic process have been in the area of environmental protection by such organizations as UNEP and the IMO.[184] Other multilateral organizations are now applying the model to emerging areas of international concern. For instance, the United Nations Education, Scientific and Cultural Organisation (UNESCO) is at work on the development of a nonbinding intergovernmental declaration on the human genome, to be followed by the codification of a binding treaty.[185] The modest level of global commitment to tobacco control also suggests that an incremental and dynamic approach to international standard setting will be the most effective way to achieve international action to reduce the prevalence of tobacco. By providing an ongoing diplomatic forum, over time WHO may heighten governmental concern about tobacco control and perhaps transform that concern into widespread support for the adoption and implementation of an international convention mandating national tobacco regulation.

Of course, the effective lawmaking experiences of UNEP, the IMO, and other international organizations may not accurately indicate WHO's potential to garner broad support for international tobacco control legislation. On the one hand, tobacco control shares the characteristic of "scientific certainty" that has galvanized international action in some realms of environmental law, including acid rain and the ozone layer.[186] The latter was addressed through the Vienna Convention for the Protection of the Ozone Layer, the Montreal Protocol, and the London Amendments to the Montreal Protocol, in which UNEP fostered broad political consensus among states for measures to reduce depletion of the ozone layer.[187] Like the ozone hole above Antarctica which led to the conclusion of the Montreal Protocol,[188] the health consequences of tobacco consumption are scientifically firmly established.[189]

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183. *See, e.g.*, PATRICIA W. BIRNIE & ALAN E. BOYLE, INTERNATIONAL LAW AND THE ENVIRONMENT 16-17 (1992); Alexandre Kiss, *The Implications of Global Change for the International Legal System*, *in* ENVIRONMENTAL CHANGE, *supra* note 178, at 315, 320.

184. *See, e.g.*, Kiss, *supra* note 183, at 320. An example is the partial hardening of UNEP's Cairo Guidelines and Principles for the Environmentally Sound Management of Hazardous Wastes, which served as a forerunner to the 1989 Basel Convention on the Control of Transboundary Movement of Hazardous Wastes. *Environmentally Sound Management of Hazardous Wastes*, UNEP Governing Council Decision 14/30, at 83, U.N. Doc. A/42/25 (1987); Basel Convention on the Control of Transboundary Movements of Hazardous Wastes and Their Disposal, Mar. 22, 1989, 28 I.L.M. 657 [hereinafter Basel Convention]; *see also* Peter H. Sand, *Lessons Learned in Global Environmental Governance*, 18 B.C. ENVTL. AFF. L. REV. 213, 240 (1991) (discussing hardening of UNEP soft law by international practice).

185. Declan Butler, *Ethics Treaty to Target Genome Implications*, 371 NATURE 369, 369 (1994).

186. *See generally* LAWRENCE E. SUSSKIND, ENVIRONMENTAL DIPLOMACY: NEGOTIATING MORE EFFECTIVE GLOBAL AGREEMENTS 63 (1994) (discussing impact of scientific evidence on international action).

187. Vienna Convention for the Protection of the Ozone Layer, Mar. 22, 1985, 26 I.L.M. 1516; Montreal Protocol on Substances that Deplete the Ozone Layer, Sept. 16, 1987, 26 I.L.M. 1550 (entered into force Jan. 1, 1989) [hereinafter Montreal Protocol]; Amendment to the Montreal Protocol on Substances that Deplete the Ozone Layer, June 29, 1990, 30 I.L.M. 537, 541 [hereinafter London Amendments to the Montreal Protocol].

188. SUSSKIND, *supra* note 186, at 66; Edward A. Parson, *Protecting the Ozone Layer*, *in* INSTITUTIONS FOR THE EARTH: SOURCES OF EFFECTIVE ENVIRONMENTAL PROTECTION 27, 30-34 (Peter M. Haas et al. eds., 1993) [hereinafter INSTITUTIONS FOR THE EARTH]. *But see, e.g.*, *Holed Up: Chemical Production*, ECONOMIST, Dec. 9, 1995, at 63 (describing how Montreal Protocol is being undermined by chlorofluorocarbon (CFC) smuggling in rich states and heightened production in developing states).

189. *See supra* Part II.A.

On the other hand, the tobacco pandemic lacks some of the features that have led to the more successful environmental agreements, including the Montreal Protocol. For example, the proposed restrictions of the Montreal Protocol were actually supported by one of the industry leaders, Dupont.[190] In addition, in a number of the successful environmental treaties, international organizations were able to forge political consensus with regard to issues that would appear, at least at first glance, to be of more universal concern than domestic tobacco regulation. Perhaps most importantly, many successful international agreements, including the Montreal Protocol, have sought to protect the environment by regulating the market behavior of producers. While a global tobacco control convention shares this characteristic in part, it would also ultimately seek to change deeply ingrained human behavior. International efforts can have only a limited effect on the social, cultural, and physiological forces that drive individuals to consume tobacco.

Although WHO may not be able to mirror the standard setting success achieved in a number of environmental agreements, the organization can still play an important, albeit limited, role in containing the tobacco pandemic by educating and motivating national leaders to rethink priorities and to redirect attention to controlling the tobacco pandemic using a continuous and dynamic international strategy. WHO's efforts to achieve global public support for an international regulatory framework may stimulate national policy change and thus make a dramatic contribution to curtailing the spiraling pandemic even if WHO is ultimately unable to secure global consensus on far-reaching international norms.

The process of seeking international agreement can encourage nations to adopt and implement effective national measures to contain the tobacco epidemic by expanding global concern and by increasing the political, financial, and technical capacity of states to make adjustments in their domestic policy. Although this legislative prescription may not lead to the attainment of a smoke-free world, the development of an international legislative strategy for tobacco control may be a reasonable and politically achievable approach to progressive implementation of national standards to prevent the further spread of the tobacco pandemic. This would be vastly preferable to the existing rule vacuum.

The rest of this part describes how WHO can apply this model of incremental international standard setting to secure global consensus and action on tobacco through a two stage strategy. The part first discusses the role of nonbinding intergovernmental resolutions in an incremental standard setting strategy and then analyzes the critical role that the eventual development of binding international norms can have in promoting national and international action on tobacco.

A. *Nonbinding Instrument: A U.N. Resolution*

As a first step leading to codification of an international convention on tobacco control, WHO should encourage member states of the United Nations

190. Parson, *supra* note 188, at 46.

to recommend, by joint declaration, common rules of national conduct on tobacco regulation. Other international organizations' experience of lawmaking demonstrates that declaratory resolutions, although not technically binding, can sometimes establish normative standards that influence states' behavior and can serve as forerunners to the formalization of international obligations in binding treaty law. The effectiveness of intergovernmental resolutions,[191] particularly resolutions of the United Nations General Assembly,[192] in affecting the behavior of states in other realms of international law indicates that WHO should adopt this strategy to heighten global concern about tobacco control in member states and to promote support for the development of a binding international convention on tobacco containment.

The advantage of a nonbinding intergovernmental resolution as a first step is that seeking international consensus on such an instrument will probably not engender strong political opposition. In contrast to treaty law, a nonbinding resolution does not establish legal commitments. Hence, it allows states to confront the global problems of tobacco collectively without restricting their freedom of action.[193] In addition, the simplified procedures and diminished voting requirements for adopting resolutions will enable international tobacco control to receive the attention of the international community more quickly than it would through multilateral treatymaking approaches, which generally take more time to negotiate, conclude, and bring into force.[194] In sum, consensus on a nonbinding U.N. resolution on tobacco control may be a relatively quick and politically achievable first step in a dynamic and continuous process of international standard setting.

Although nonbinding resolutions of intergovernmental organizations are often mere rhetorical and political gambits, experience in the United Nations demonstrates that such instruments can significantly affect state practice. For

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191. The United Nations and its specialized agencies produce a wide variety of nonbinding instruments, including Recommendations, Guidelines, Codes Of Practice, Standards, and Declarations of Principles, which are generally adopted in the form of intergovernmental resolutions. BIRNIE & BOYLE, *supra* note 183, at 16. Resolutions are usually intended to be nonbinding instruments expressing the common interests of many states in specific areas of international cooperation. *See id.* at 19.

192. Controversy surrounds the legal significance of General Assembly resolutions. As one authority has suggested: "While there are writers who openly claim that United Nations General Assembly resolutions constitute a new source of law, the majority of commentators prefer to base their arguments upon the effectiveness of the rules proclaimed by the General Assembly." DANILENKO, *supra* note 173, at 203. The principal argument against the view that U.N. resolutions constitute a new source of law is that the U.N. Charter accords the General Assembly no authority to enact rules of international law. *Id.* at 205; *see* discussion *supra* note 151; *see also* ROSALYN HIGGINS, PROBLEMS AND PROCESS: INTERNATIONAL LAW AND HOW WE USE IT 24 (1994). This argument is bolstered by the fact that states generally do not accept General Assembly resolutions as law. DANILENKO, *supra* note 173, at 205. As one authority has suggested: "States often don't meaningfully support what a resolution says and they almost always do not mean that the resolution is law." G. Arangio-Ruiz, *The Normative Role of the General Assembly of the United Nations and the Development of Principles of Friendly Relations*, [1972] 3 RECUEIL DES COURS 431, *quoted in* HIGGINS, *supra*, at 26.

193. A nonbinding written format can "either enable states to take on obligations that otherwise they would not, because these are expressed in vaguer terms, or conversely, [this] form may enable them to formulate the obligations in a precise and restrictive form that would not be acceptable in a binding treaty." BIRNIE & BOYLE, *supra* note 183, at 27.

194. At the World Health Organization, for example, the adoption of conventions requires a two-thirds vote of the World Health Assembly. WHO CONST., *supra* note 4, art. 198; *see also infra* notes 226-27 and accompanying text (describing slowness of treatymaking process).

example, international environmental lawmaking has included a large number of U.N. resolutions and declarations. At times, such intergovernmental resolutions have been highly persuasive, and the conduct of states has tended to follow the principles embodied in these nonbinding pronouncements. Nonlegal texts, such as the World Charter for Nature[195] and the Stockholm Declaration of 1972,[196] have had a catalytic impact on state practice.[197] The effectiveness of some nonbinding international proscriptions in changing the environmental practices of states has led some commentators to refer to them as "soft law."[198]

The basis for the effectiveness of some nonbinding instruments in modifying national conduct has been much speculated upon. Although technically nonbinding, intergovernmental resolutions may point to emerging social values of international public order[199] and "thus help extend the realm of legitimate international concern to matters of previously exclusive national jurisdiction."[200] Intergovernmental resolutions may also encourage national action by setting standards and providing direction.[201] Furthermore, diplomatic and moral pressure can be employed to encourage state parties to comply with an intergovernmental resolution.

In a number of realms, including the international protection of human rights, the status of outer space, and international environmental law, national observance of nonbinding instruments has paved the way for binding treaty law by generating an ongoing diplomatic forum. Nonbinding resolutions of international organizations may promote the development and implementation of international law by magnifying public attention, stimulating a reassessment of national interests, and generating new information that can educate states about the consequences of their actions. Hence, "[d]espite the fact that states retain control over the degree of commitment, the very existence of such an

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195. *The World Charter for Nature*, G.A. Res. 37/7, U.N. GAOR, 30th Sess., Supp. No. 51, at 17, U.N. Doc. A/37/51 (1982).

196. Stockholm Declaration of the United Nations Conference on the Human Environment, June 16, 1972, 11 I.L.M. 1416.

197. *E.g.*, Kiss, *supra* note 183, at 320. The International Maritime Organization (IMO) has also influenced national behavior through nonbinding instruments. For example, the IMO's International Maritime Dangerous Goods Code has been enacted by over 45 states, including all major ship-owning states. BIRNIE & BOYLE, *supra* note 183, at 29-30.

198. *See, e.g.*, Handl, *supra* note 181, at 63; Kiss, *supra* note 183, at 319-20. *See generally* Tadeusz Gruchalla-Wesierski, *A Framework for Understanding "Soft-Law"*, 30 MCGILL L.J. 38 (1984) (discussing enforceability of soft law). One authority defines soft law as follows: "Generally a norm may be "soft" when it either does not constitute part of a binding regime, whether of conventional or customary law, or because, even though it is contained in a binding instrument, it is not expressed in obligatory language." Paul C. Szasz, *International Norm-making*, *in* ENVIRONMENTAL CHANGE, *supra* note 178, at 41, 70. International environmental law provides numerous examples of the soft law approach to international standard setting. *See* BIRNIE & BOYLE, *supra* note 183, at 16. *See generally* Pierre-Marie Dupuy, *Soft Law and the International Law of the Environment*, 12 MICH. J. INT'L L. 420 (1991) (describing effectiveness of soft law instruments in influencing national behavior).

199. Kiss, *supra* note 183, at 319-20.

200. Handl, *supra* note 181, at 63-64.

201. *See, e.g.*, R.S. Pathak, *The Humans Rights System as a Conceptual Framework for Environmental Law*, *in* ENVIRONMENTAL CHANGE, *supra* note 178, at 205, 238-39. Intergovernmental resolutions create the expectation that they will be respected. Myres S. McDougal, *Contemporary Views on the Sources of International Law: The Effect of U.N. Resolutions on Emerging Legal Norms*, 73 PROC. AM. SOC'Y INT'L L. 300, 328 (1979).

instrument encourages the trend towards hardening the international legal order."[202]

Not all resolutions of intergovernmental organizations lead to the development of formalized obligations or even become a significant factor in state practice. Resolutions of the United Nations General Assembly that are supported by influential states[203] are among those intergovernmental resolutions that are most likely to influence state behavior and lead to the codification of international law. As Ian Brownlie has observed, the "acceptance [of General Assembly resolutions] by a majority vote constitutes *evidence* of the opinions of governments in the widest forum for the expression of such opinions."[204]

General Assembly resolutions often have a political significance that can stimulate the lawmaking process in other international organizations.[205] For example, UNEP, one of the most prolific lawmakers in the United Nations system, has sought to harness the potential political significance of General Assembly resolutions in the law creation process. UNEP's Governing Council has, on occasion, drafted environmental law guidelines and principles and submitted them to the General Assembly, which has either incorporated them in a resolution or recommended them to states for use in the formulation of national legislation or international conventions.[206]

Recognizing UNEP's favorable experience with General Assembly resolutions, WHO should encourage member states of the United Nations to recommend, by joint declaration, that states adopt joint rules of national conduct and formulate, adopt, and implement an international convention on tobacco control under WHO's auspices.[207]

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202. BIRNIE & BOYLE, *supra* note 183, at 27.

203. "[U]nless the more powerful and influential governments are prepared to carry out the resolutions of the General Assembly, the verbiage of the resolutions may have no more effect than harmless blowing off steam." PETER BAEHR & LEON GORDENKER, THE UNITED NATIONS IN THE 1990S 58 (1994).

204. IAN BROWNLIE, PRINCIPLES OF PUBLIC INTERNATIONAL LAW 14 (3d ed. 1979). General Assembly resolutions "may be said to be generally representative of world opinion." BIRNIE & BOYLE, *supra* note 183, at 19.

205. MERON, *supra* note 151, at 265-66.

206. *See, e.g.*, Pathak, *supra* note 201, at 238; Sand, *supra* note 184, at 239-40.

207. Although WHO is the primary authority on world health matters, the United Nations General Assembly has overlapping jurisdiction within the field of international health and the legal authority to adopt nonbinding recommendations on tobacco control. *See supra* note 151. The General Assembly also has the authority to make formal recommendations to the specialized agencies, including WHO, that the agencies are required to take into account. *See* MERON, *supra* note 151, at 259. The General Assembly has addressed global health issues in a number of nonbinding recommendations, primarily the health concerns or right to health of particularly vulnerable populations, including persons with physical or mental disabilities. *See, e.g., Prevention and Control of Acquired Immunodeficiency Syndrome (AIDS)*, art. 5(a), G.A. Res. 187, U.N. GAOR, 45th Sess., Supp. No. 49, at 114, U.N. Doc. A/45/49 (1990); *Declaration on the Rights of Disabled Persons*, art. 6, G.A. Res. 3447, U.N. GAOR, 30th Sess., Supp. No. 34, at 88, U.N. Doc. A/10034 (1975); *Declaration on the Rights of Mentally Retarded Persons*, art. 2., G.A. Res. 2856, U.N. GAOR, 26th Sess., Supp. No. 29, at 93, U.N. Doc. A/8429 (1971). There is precedent for interorganizational cooperation between the General Assembly and WHO. For example, in 1981 the General Assembly adopted a resolution endorsing the Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care, which were drafted in cooperation with WHO. *The Protection of Persons with Mental Illness and the Improvement of Mental Health Care*, G.A. Res. 119, U.N. GAOR, 46th Sess., Supp. No 49, Annex, at 188-192, U.N. Doc. A/46/49 (1991); *see, e.g.*, Eric Rosenthal & Leonard Rubenstein, *International Human Rights Advocacy Under the "Principles for the*

In the context of tobacco control, the potential effect on national behavior of a nonbinding resolution alone, even a U.N. declaration, should not, however, be overstated. Given the modest level of current global commitment to tobacco control and the powerful interests of the tobacco industry, it is doubtful that mere nonbinding proscriptions by member states of international organizations can significantly influence many national tobacco control policies. At worst, isolated nonbinding resolutions may actually inhibit progress towards global action on tobacco control, since their voluntary format enables states to relieve some public pressure without committing to real action. Notably, WHO's numerous recommendations on tobacco control strategies in the last twenty-five years have proven insufficient to slow the growth of tobacco consumption or production.[208]

Although a U.N. declaration alone will not profoundly affect member states' policies of tobacco control, the experience of other international organizations suggests that, with active organizational promotion, it can constitute a feasible and critical first step toward the formalization of obligations in a binding treaty or convention.[209] In addition, the process of states proposing and deciding on a resolution in the General Assembly will further tobacco control efforts in ways that developing a declaration in the World Health Assembly cannot. While the primary participants in WHA's policy debates and strategy development are state ministers of health, technocrats who generally lack significant domestic power, there is widespread participation of political leaders in the General Assembly. Discussion and debate on tobacco control strategies in the General Assembly can thus raise the political profile of tobacco control issues, encouraging national political leaders adequately to consider this daunting health issue. It can also create an opportunity for WHO to inform and educate the international community about the true costs of tobacco consumption and production.

Protection of Persons with Mental Illness", 16 INT'L J.L. & PSYCHOL. 257 (1993).

208. *See* discussion *supra* text accompanying note 161.

209. An alternative first step is the development of an intergovernmental code of conduct. Intergovernmental codes of conduct adopted by member states of international organizations have generally established voluntary, nonbinding, often vague standards or principles for guiding the behavior of governments and private entities, typically transnational corporations. *See generally* JOHN M. KLINE, INTERNATIONAL CODES AND MULTINATIONAL BUSINESS (1985); Robert E. Lutz & George D. Aron, *Codes of Conduct and Other International Instruments*, *in* TRANSFERRING HAZARDOUS TECHNOLOGIES AND SUBSTANCES: THE INTERNATIONAL LEGAL CHALLENGE 131 (Gunther Handl & Robert E. Lutz eds., 1989). Discussion here is limited to codes of conduct that are enacted as recommendations. *See, e.g.*, *International Code of Conduct on the Distribution and the Use of Pesticides*, U.N. Food and Agricultural Organization, U.N. Doc. M/R8130, E/8.86/1/5000 (1986). There are few examples of codes of conduct adopted as treaties. *See, e.g.*, United Nations Final Act of Conferences of Plenipotentiaries on a Code of Conduct for Liner Conferences, Apr. 6, 1974, 13 I.L.M. 910; Andean Commission: Andean Standard Code on Multinational Enterprises and the Regulations with regard to Subregional Capital, 11 I.L.M. 357 (1972). The code of conduct approach has some significant disadvantages. In particular, negotiating and implementing an intergovernmental code of conduct on politically charged issues may be a particularly slow process that may delay and perhaps obstruct effective national and international action. An extreme example is the draft United Nations Code of Conduct for Transnational Corporations, which was negotiated from 1976 until the project was suspended by the General Assembly in *Integration of the Commission on Transnational Corporations into the Institutional Machinery of the United Nations Conference on Trade and Development*, G.A. Res. 49/130 (1994).

B. *Legally Binding Instruments: Framework Convention-Protocol Approach*

Through a measured, dynamic, and continuous approach to international standard setting, using U.N. resolutions as a first step, WHO may gradually develop global political consensus for the adoption and implementation of binding international norms on tobacco control. This section details the function of multilateral lawmaking in an international strategy for tobacco control and considers alternative international regulatory strategies that WHO can use to promote global agreement and action.

The experience of multilateral environmental organizations that have achieved some success in serving as platforms for international treatymaking may serve as a precedent and model for global efforts to control the tobacco epidemic.[210] The United Nations and its agencies have become key catalysts, sponsors, and coordinators for multilateral environmental negotiations, stimulating international consensus and action on a wide range of global environmental concerns through the development and implementation of international law. Indeed, most environmental treaty negotiations are now initiated by international organizations, particularly by UNEP, which has become the primary catalyst for international environmental agreements in recent years.[211]

The ability of multilateral environmental institutions to encourage and assist states in overcoming powerful and organized industry resistance to regulation through the traditional treatymaking process is further evidence of the important role that active organizational support for international lawmaking could play in efforts to regulate the activities of the transnational tobacco conglomerates. For example, the International Maritime Organization, through the formation of a powerful coalition of states, has helped states to overcome the resistance of influential oil and shipping interests and to foster international agreement and action on measures to control marine pollution through a number of international conventions.[212] As a further example,

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210. Specific areas of international legislative activity, closely related to the issues in global tobacco control, set critical precedents for global tobacco control efforts. For example, the international regulation of ozone depleting substances in the Vienna Convention and Montreal Protocol marks the first time the international community has sought to limit the production and use of a particular man made product. *See, e.g.*, Department of Econ. & Social Dev. Transn'l Corps., *International Environmental Law: Emerging Trends and Implications for Transnational Corporations*, Environment Series No. 3, at 19, U.N. Doc. ST/CTC/137 (1993). An emerging area of international legal activity that may be particularly relevant to global tobacco control efforts is international norms related to corporate advertising. Particularly noteworthy is the 1989 European Economic Community Directive on the pursuit of television broadcasting activities. "The Broadcasting Directive establishes minimum standards for, inter alia, television programme and television advertising content, and provides that 'television advertising shall not . . . encourage behaviour prejudicial to the protection of the environment.'" *Id.* at 21 (quoting 1989 O.J. (L 298) 23). This legislation is powerful evidence of the extent to which states may be willing to place limits on corporate marketing techniques in order to protect the environment and public health.

211. SUSSKIND, *supra* note 186, at 24; *see also* Gonzalo Biggs, *The Montevideo Environmental Law Programme*, 87 AM. J. INT'L L. 328, 329-30 (1993) (describing accomplishments of UNEP's legal division between 1981 and 1991 as "formidable"); Mark A. Gray, *The United Nations Environmental Programme: An Assessment*, 20 ENVTL. L. 291, 297-306 (1990); Parson, *supra* note 188, at 35; Sand, *supra* note 184, at 239-40.

212. BIRNIE & BOYLE, *supra* note 183, at 53-56; *see also*, International Convention on Oil Pollution Preparedness, Response and Cooperation, Nov. 30, 1990, 30 I.L.M. 735; International Convention for the Prevention of Pollution from Ships, Nov. 2, 1973, 12 I.L.M. 1319. As a further example, authorities

authorities credit regional organizations for enabling states on the North and Baltic Seas to override industry objections and adopt and implement conventions to control marine pollution in these seas.[213] Indeed, "every international environmental agreement has some substantive implications for industry"[214] and has the potential for generating substantial costs for business concerns if implemented as national law.[215] Overall experience in international standard setting in the U.N. system suggests, however, that "the dynamics of international negotiations . . . and sometimes coalition pressures, can force nations to take positions they might not have taken on their own."[216] Thus, the process of international standard setting can assist nations in overriding powerful industry resistance to costly and restrictive regulation.

In responding to the international community's demand for rapid and effective lawmaking, treaties have become a flexible concept encompassing extremely diverse manifestations of state consent to be bound.[217] A primary criterion in the selection of any treaty instrument to forge international consensus and action on tobacco control, however, must be the political acceptability of such a mechanism. Although treaties are a useful medium for creating international norms, many either do not enter into force or do so for only a limited number of states.[218] Given the politics of global tobacco control, there may be difficulty in forging sufficient political consensus for binding rules.

Perhaps the least effective treaty that can be used to promote global

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credit the IMO for increasing global concern over oil pollution and thus helping states overcome industry resistance to international regulations imposing substantial equipment costs on the industry. *See, e.g.*, Ronald Mitchell, *Intentional Oil Pollution of the Oceans*, *in* INSTITUTIONS FOR THE EARTH, *supra* note 188, at 183, 186. Commentators also have noted that, through its lawmaking efforts, UNEP encouraged states to bring a multibillion dollar industry to a halt to protect the ozone layer, despite the objections of some of the industry leaders. *See, e.g.*, William R. Moomaw, *Protecting the Ozone Layer: A Revolutionary Approach to Evolutionary Treaties*, *in* TRANSNATIONAL ENVIRONMENTAL LAW AND ITS IMPACT ON CORPORATE BEHAVIOR 329, 335 (Eric Urbani et al. eds., 1994).

213. *See, e.g.*, Peter M. Haas, *Protecting the Baltic and North Seas*, *in* INSTITUTIONS FOR THE EARTH, *supra* note 188, at 133, 134.

214. Judith T. Kildow, *The Impact of International Environmental Treaties and Agreements on Corporate Strategy*, *in* TRANSNATIONAL ENVIRONMENTAL LAW AND ITS IMPACT ON CORPORATE BEHAVIOR, *supra* note 212, at 281, 295.

215. The importance of international organizations in environmental policy standard setting is reflected in the fact that industries have formed multinational and nationwide associations to negotiate with international organizations. *See id.* at 294.

216. *Id.* at 284.

217. Treaties are a traditional and frequent method of creating binding international legal standards. *See* STATUTE OF THE ICJ art. 38(1)(a). Pursuant to the Vienna Conventions on the Law of Treaties, a treaty is defined as "an international agreement concluded between States in written form and governed by international law, whether embodied in a single instrument or in two or more related instruments and whatever its particular designation." Vienna Convention on the Law of Treaties, May 23, 1969, art. 2, 1155 U.N.T.S. 331, 333. The 1986 Vienna Convention on the Law of Treaties extends this basic definition of a treaty to international agreements concluded between states and international organizations and to agreements concluded among international organizations. Vienna Convention on the Law of Treaties between States and International Organizations or between International Organizations, Feb. 18–Mar. 21, 1986, art. 2, at 4, U.N. Doc. A/Conf.129/15.

218. In the absence of a supranational authority, both the codification and implementation of international law depend upon the will of states. *See, e.g.*, Oscar Schachter, *International Law in Theory and Practice: General Course in Public International Law*, 178 ACAD. OF INT'L L. OFFPRINT FROM THE COLLECTED COURSES 32-39 (1982-V) (on file with author).

tobacco control action is one that aims to be comprehensive, in that it lays down clear, detailed, and specific rules. The United Nations Convention on the Law of the Sea,[219] originally intended to govern all uses of the ocean, exemplifies the comprehensive convention. To use this model for global tobacco regulation, WHO could encourage states to adopt a comprehensive convention, mandating that states enact extensive tobacco control regulations that encompass all of WHO's recommendations for the last twenty-five years, including the critical regulatory strategies outlined in Part III above.

There are, however, decisive barriers to using the comprehensive convention approach for global tobacco control. There may be particular difficulties in gathering global support for a comprehensive tobacco control convention that requires states to enact extensive regulation. There are further difficulties in obtaining widespread ratification of such an instrument without significant reservations.[220]

The most politically feasible strategy for securing global support for tobacco control is the framework convention-protocol approach. Unlike a comprehensive treaty, the convention-protocol approach does not attempt to resolve all significant issues in a single instrument. Rather, states first adopt a framework convention that calls for international cooperation in realizing broadly stated goals. Ideally, the parties to the convention will then conclude separate protocols containing specific measures designed to implement these goals.[221]

The convention-protocol approach to the creation of international law is likely to be more politically acceptable than any other binding approach to global tobacco control. Although technically binding, framework conventions actually fall somewhere between nonbinding resolutions and treaty law since they contain no explicit obligations. Nevertheless, the framework convention creates an institutional forum in which states can cooperate and negotiate for the conclusion of implementing protocols containing detailed obligations.

The convention-protocol approach may be particularly well suited to efforts to secure global agreement and action on the tobacco epidemic because it is a continuous and dynamic process of lawmaking that can gradually and incrementally build support to reduce tobacco use. As a categorical model for standard setting, the convention-protocol approach is also consistent with the approach to tobacco control taken by most states. Thus, the development of a framework convention may be more likely to secure political consensus and significant action on tobacco control than any other form of binding instrument.

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219. United Nations Convention on the Law of the Sea, Dec. 20, 1982, 21 I.L.M. 1261 [hereinafter Law of the Sea Convention].

220. The experience of the Law of the Sea Convention shows that an ambitious, comprehensive format that seeks to resolve all substantive issues in a single instrument may paralyze negotiations. On November 16, 1994, more than 25 years after negotiations of the Convention began, the Law of the Sea Convention entered into force. For an appraisal of the Law of the Sea Convention, see generally John R. Stevenson & Bernard H. Oxman, *The Future of the United Nations Convention on the Law of the Sea*, 88 AM. J. INT'L L. 488 (1994) and Philip Allott, *Mare Nostrum: A New International Law of the Sea*, 86 AM. J. INT'L L. 764 (1992).

221. *See, e.g.*, BIRNIE & BOYLE, supra note 183, at 13; Handl, *supra* note 181, at 61-63; Iwama, *supra* note 181, at 112-13 (discussing "double-track" approach).

The convention-protocol approach has been used frequently and sometimes successfully to secure international agreement and action on environmental matters.[222] An early instance in this field was the 1979 Convention on the Conservation of Migratory Species of Wild Animals.[223] In the most celebrated use of this method, UNEP fostered broad political consensus among states for measures to reduce depletion of the ozone layer, resulting in the Vienna Convention for the Protection of the Ozone Layer, the Montreal Protocol, and the London Amendments to the Montreal Protocol.[224] The Framework Convention on Climate Change is also patterned on this convention-protocol format.[225]

The convention-protocol approach does have particular drawbacks as an international lawmaking strategy. For example, although the treatymaking process is generally slow,[226] the convention-protocol approach may be particularly sluggish since it requires at least two rounds of international negotiation and national ratification.[227] Another potentially critical limitation of the convention-protocol approach is that, like nonbinding instruments, it may actually inhibit progress toward the codification of concrete international norms for the global control of tobacco. The broad format of the framework convention enables states to relieve public pressure for action without resolving to take concrete steps to control tobacco production and consumption.[228]

International environmental organizations have developed various techniques to deal with these shortcomings.[229] WHO can use many of these strategies to prompt timely consensus and action on cogent implementing protocols to an international tobacco control convention. For example, environmental framework conventions and protocols are often designed to encourage state parties to adopt implementing protocols by mandating regular

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222. *See, e.g.*, Handl, *supra* note 181, at 61-63; Kiss, *supra* note 183, at 321-22.

223. Convention on the Conservation of Migratory Species of Wild Animals, June 23, 1979, 19 I.L.M. 11 [hereinafter Bonn Convention]; *see* Kiss, *supra* note 183, at 322.

224. Vienna Convention for the Protection of the Ozone Layer, *supra* note 187; Montreal Protocol, *supra* note 187; London Amendments to the Montreal Protocol, *supra* note 187.

225. Intergovernmental Negotiating Committee for a Framework Convention on Climate Change, U.N. Doc. A/AC.237/18 (Part II)/Add.1 (1992).

226. According to a 1971 United Nations Institute for Training and Research (UNITAR) study, multilateral treaties do not generally become effective until two to twelve years after the formal agreement has been reached, with the average being about five years. *See* U.N. INST. FOR TRAINING & RESEARCH, TOWARD WIDER ACCCEPTANCE OF U.N. TREATIES 34-40 (1971).

227. For example, the first protocol to the 1979 Economic Commission for Europe (ECE) Convention on Long-range Transboundary Air Pollution, 18 I.L.M. 1446, was signed five years after the convention was adopted. Protocol to the 1970 Convention on Long-range Transboundary Air Pollution on Long-term Financing of the Cooperative Programme for Monitoring and Evaluation of the Long-range Transmission of Air Pollutants in Europe (EMEP), Sept. 28, 1984, 27 I.L.M. 701. The fourth protocol to the Convention was adopted 12 years after the Convention was signed. Protocol to the 1979 Convention on Long-range Transboundary Air Pollution, Concerning the Control of Emission of Volatile Organic Compounds or their Transboundary Fluxes, Nov. 18, 1991, 31 I.L.M. 573.

228. The experience of international law making also indicates that when states with strongly held and widely divergent interests try to reach an agreement on implementing protocols, they often settle on international standards reflecting the lowest common denominator. Sand, *supra* note 184, at 219.

229. *See generally id.* at 248-75 (discussing import/export controls, licensing requirements, notification schemes, and environmental audits).

and institutionalized meetings of the participating parties.[230] The Convention on the Conservation of Migratory Species of Wild Animals expressly requires periodic review of the progress made and evaluation of the need to take additional measures.[231] Periodic review and assessment are also a basic feature of the Vienna Convention for the Protection of the Ozone Layer and the Montreal Protocol thereto.[232] Periodic meetings of the contracting parties encourage states rapidly to adopt protocols containing cogent obligations by drawing public attention to the issues and debates. This, in turn, may generate public pressure for national accountability.[233] In the case of some framework conventions, the mandatory provisions for consultation "offer the prospect of a virtually continuous legislative enterprise."[234] The success of other international organizations in using periodic meetings of contracting parties to forge international consensus indicates that this process should be included as a basic provision of an international convention on tobacco control.

Another legislative technique commonly used to secure agreement and action on environmental framework conventions and implementing protocols is to structure the agreements to generate the widest possible consensus by using broadly framed international obligations coupled with requirements for implementation through domestically crafted legislation. For example, the International Maritime Organization has employed the technique of *nationally* designed implementation measures to secure *international* agreement on environmental matters. In the Convention on Oil Pollution Preparedness, Response and Cooperation, each nation is required to set up its own national system for preparedness and response, including a national contingency plan.[235] Through this model of lawmaking, the international legislation developed by the IMO and other international organizations has been both detailed enough to confer specific obligations upon member states and broad enough to cultivate political consensus and accommodate the divergent circumstances of individual nations.

The combination of broadly framed international agreements and requirements for implementation through domestically crafted legislation is particularly appropriate for global tobacco control efforts. WHO can formulate common tobacco control principles in such a way that they can be applied

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230. Handl, *supra* note 181, at 61-62.

231. Bonn Convention, *supra* note 223, art. VII, para. 5.

232. Vienna Convention for the Protection of the Ozone Layer, *supra* note 187, art. 6.; Montreal Protocol, *supra* note 187, art. 6; *see also* Intergovernmental Negotiating Committee for a Framework Convention on Climate Change, *supra* note 225, art. 7(a) (establishing same for Framework Convention on Climate Change).

233. Amplifying public pressure by publicizing meetings and conferences of contracting parties to an international convention can help conquer low levels of government concern, overcome industrial and governmental resistance to international regulation, and provide international organizations with the opportunity to quickly advance negotiations. Marc A. Levy et al., *Improving the Effectiveness of International Environmental Institutions*, *in* INSTITUTIONS FOR THE EARTH, *supra* note 188, at 397, 399-400. For example, regional institutions helped to amplify domestic environmental concern and political pressure on the states of the North and Baltic Seas to act on marine pollution by developing Ministerial Conferences and by widely publicizing the results of such conferences. Haas, *supra* note 213, at 133-134.

234. Handl, *supra* note 181, at 62.

235. *See* International Convention on Oil Pollution Preparedness, Response and Cooperation, *supra* note 212.

effectively in each nation despite unique health circumstances and cultural conditions. Such common tobacco control principles and criteria can be developed because, as described above, tobacco control legislation reveals a variety of trends common to states despite differences among them. In practical terms, however, a standard body or model of legislation cannot be established. Implementing protocols on tobacco control must be conceived and drafted to form broad guidelines that can be harmonized with the legislation of individual nations. Through these techniques and others developed by multilateral organizations,[236] WHO can encourage speedy adoption, ratification, and implementation of international norms on tobacco control.

Although both the United Nations General Assembly and WHO have the legal capacity to sponsor the creation of a framework convention and of implementing protocols on tobacco control, such instruments should be drafted, negotiated, and implemented under WHO's auspices. As described above, the General Assembly has neither the expertise nor, perhaps, the time to engage in negotiating complex standards with regard to tobacco control, particularly if extensive negotiation of an international instrument is required.[237] Statutory provisions concerning the complex technical issues surrounding tobacco control should be established and supervised by WHO — the most qualified and experienced international organization in the fields of public health and tobacco control.

WHO's constitution confers authority upon the World Health Assembly to develop three types of instruments: (1) conventions under article 19; (2) regulations under article 21; and (3) nonbinding recommendations under article 23.[238] Although WHO's authority under article 21 is strictly limited, the organization's legal capacity to encourage member states to adopt recommendations or conventions extends to any matter within the competence of the organization. Hence, WHO has broad legal authority to facilitate an international tobacco control convention.

Although WHO must ultimately look to states to execute treaties and

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236. Rapid implementation of a tobacco control convention also can be encouraged by developing a treaty which establishes "selective incentives" for the parties. For a discussion of "selective incentives," see Sand, *supra* note 184, at 221. In environmental treaty bargaining, the selective incentives most commonly used are access to funding, resources markets, technology, and technical advice and assistance. *Id.* at 221-24; *see also infra* Part V.C.2 (describing role of technical and financial assistance in supporting global tobacco control convention). WHO can also beat the bottom line approach characteristic of many treaties by following the examples set by international environmental agreements and by promoting overachievement among state parties. *See* Sand, *supra* note 184, at 231. For example, many international environmental conventions expressly confirm the right of parties to take more rigorous measures than are required by the conventions. One example is the Convention on International Trade in Endangered Species of Wild Fauna and Flora, Mar. 3, 1973, 27 U.S.T. 1087, 993 U.N.T.S. 243 [hereinafter CITES Convention], *reprinted in* Sand, *supra* note 184, at 232. In cases where national achievements are reviewed frequently, compared internationally, and widely publicized, any over-achievement may pay political dividends to states, while underachievement can result in heightened public awareness and public pressure. Sand, *supra* note 184, at 233.

237. *See* MERON, *supra* note 151, at 278.

238. WHO CONST., *supra* note 4, arts. 19, 23, 21. For an analysis of WHO's authority to encourage states to adopt binding and nonbinding international instruments, see generally CHARLES H. ALEXANDROWICZ, THE LAW-MAKING FUNCTIONS OF THE SPECIALIZED AGENCIES OF THE UNITED NATIONS 49-56 (1973); FLUSS & GUTTERIDGE, *supra* note 164, at 9-22; Claude-Henri Vignes, *Towards the Harmonization of Health Legislation: The Role of the World Health Organization*, 46 INT'L DIG. HEALTH LEGIS. 422 (1995).

fulfill commitments, it can use its constitutional powers to mobilize support for and initiate action on an international tobacco control framework convention and the associated implementing protocols. The success of UNEP, the IMO, and other international organizations in stimulating national action on environmental and other international concerns demonstrates that international organizations can influence member state decisionmaking by providing a forum for creating legally binding international norms. Their ability to foster political consensus for binding international norms in politically charged areas in which the relevant industries strongly resist regulation suggests that WHO may have some effect on the global tobacco political process.

C. *Implementation of an International Strategy for Tobacco Control*

WHO has the legal capacity and public health expertise to serve as a catalyst, sponsor, and negotiator for multilateral tobacco control instruments detailing national obligations to counter the tobacco epidemic. To ensure that efforts to develop international instruments are not purely symbolic, WHO must establish mechanisms to overcome some governments' incapacity or apathy, as well as other nations' resistance to such regulation. Although WHO must ultimately look to nations to fulfill international commitments, it can generate incentives that change the balancing of national interests and encourage compliance with international instruments on tobacco control. This section details some of the specific strategies that WHO can employ to encourage national implementation of binding and nonbinding international tobacco control instruments.

1. *System of National Monitoring and Reporting*

Monitoring the implementation of state obligations is perhaps the most powerful mechanism available to international organizations to ensure that states give adequate attention to their international commitments. Disclosure of substandard national efforts in an international arena can create powerful pressure on governments to comply with their international obligations to implement tobacco control policies.[239]

International human rights law and international environmental law provide numerous examples of effective supervisory institutions.[240] There are different approaches to international monitoring of multilateral commitments. A common approach in encouraging compliance with international instruments is a system of periodic national reporting.[241] This

239. *See, e.g.*, Oran Young, *The Effectiveness of International Institutions: Hard Cases and Critical Variables*, *in* GOVERNANCE WITHOUT GOVERNMENTS: ORDER AND CHANGE IN WORLD POLITICS 160 (James N. Rosenay & Ernst-Otto Czempiel eds., 1992) (describing effectiveness of "politics of shame" in international system).

240. *See, e.g.*, Kiss, *supra* note 183, at 326-29 (explaining that surveillance methods were created in field of international protection of human rights and extended to international protection of environment).

241. *See, e.g.*, Elisabeth Kornblum, *A Comparison of Self-Evaluating State Reporting Systems*, 35 INT'L REV. RED CROSS 39 (1995).

strategy requires participating states to submit reports on measures they have adopted and progress they have made in fulfilling international commitments. Institutionalized periodic review of states' performance is a basic feature of many international environmental conventions,[242] including the Montreal Protocol.[243] A weakness of the reporting system, however, is that much of its effectiveness depends upon the accuracy with which states report on their own conduct.[244]

Recognizing the limitations of state self-reporting systems, international organizations have developed other forms of monitoring to secure national implementation of international instruments. One highly effective mechanism is regular auditing of member state compliance by an independent, technical committee. The procedure developed by the International Labour Organization (ILO), for example, combines annual or biennial reporting by governments with regular auditing by an independent committee. The ILO Conference Committee on the Application of Conventions and Recommendations then publicly debates the audited reports.[245] With the active participation of both trade unions and employers' associations, this auditing procedure has "turned into a worldwide public hearing that clearly induces more compliance by governments than the threat of any intergovernmental action would."[246]

Recognizing the United Nations' favorable experience with national reporting and auditing programs, WHO can use its own constitutional reporting procedure to promote member state compliance with an international tobacco control instrument. Pursuant to article 62 of WHO's constitution,[247] member states must report to WHO annually on measures taken to implement WHO's recommendations, regulations, or conventions. This procedure could be transformed into an effective supervisory mechanism if WHO critically and publicly reviewed state reports on national tobacco control measures. In addition, an institutionalized national reporting or auditing system could be incorporated into the structure of a binding international instrument on tobacco control.

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242. *See, e.g.*, Basel Convention, *supra* note 184, art. 13 (requiring states to submit annual report on all aspects of transboundary trade and disposal of regulated substances and on "such matters as the conference of the Parties shall deem relevant"); CITES Convention, *supra* note 236, art. III (providing that state parties must maintain records of trade in listed species and report on number and type of permits granted).

243. Montreal Protocol, *supra* note 187, art. 7. The United Nations' experience with periodic human rights reporting systems indicates that member states' reports can promote state compliance with international obligations if the reports are critically evaluated by international organizations that can also obtain information from nongovernmental sources. Philip Alston, *The United Nations' Specialized Agencies and the Implementation of the Covenant on Economic, Social, and Cultural Rights*, 18 COLUM. J. TRANSNAT'L L. 79, 96-99, 100-01 (1979); *see also* Virginia A. Leary, *Lessons for the Experience of the International Labour Organization*, *in* THE UNITED NATIONS AND HUMAN RIGHTS 580, 595-602 (Philip Alston ed., 1992).

244. *See, e.g.*, BIRNIE & BOYLE, *supra* note 183, at 167.

245. For an analysis of the ILO procedure, see generally Leary, *supra* note 243, at 595-602.

246. Sand, *supra* note 184, at 273. The U.N. Commission on Human Rights uses a comparable procedure of state reports and public hearings, in which nongovernmental organizations actively participate. *Id.*; *see also* Torkel Opsahl, *The Human Rights Committee*, *in* THE UNITED NATIONS AND HUMAN RIGHTS, *supra* note 243, at 369, 397-407 (describing process of submission of reports and examination by Human Rights Committee).

247. WHO, BASIC DOCUMENTS, *supra* note 4, at 15.

2. *Technical and Financial Assistance: An International Tobacco Control Fund*

Establishing international technical and financial assistance arrangements is an essential ingredient of successful tobacco control efforts. As noted above, many states simply lack the administrative and technical capacity to develop and implement cogent tobacco control legislation, while other states are highly dependent on tobacco tax revenue.[248] Appropriate funding is crucial to finance tobacco control measures in the least developed countries, train personnel in tobacco control strategies, support monitoring and implementation of tobacco control measures, and fund crop substitution programs. Establishing programs for technical advice and assistance has been critical to the success of a number of U.N. programs, including programs of the ILO[249] and international population institutions.[250] As authorities have aptly noted, "International [organizations], when they are effective, are not merely rulemaking bodies. They are also vehicles for transferring skills and expertise, and for empowering domestic actors who are motivated to solve domestic problems of international importance."[251]

Establishing sufficient funding for the implementation of the international tobacco control instrument is critical. Indeed, neither the World Bank nor the FAO currently funds tobacco crop substitution programs in developing states.[252] There is an immediate need for international organizations to reexamine health priorities, including the importance of tobacco control.[253] WHO can dramatically assist states by encouraging the international donor community to recognize tobacco control as a development priority and by establishing a global network for the mobilization of tobacco control financing.

Existing international financial assistance models provide a launching point for considering a new global financial program to support implementation of international instruments on tobacco control.[254] One paradigm is provided by the 1990 London Amendments to the Montreal Protocol to the Vienna Convention for the Protection of the Ozone Layer. The amendments established a $240 million multilateral trust fund to assist

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248. *See supra* note 129 and accompanying text.

249. Leary, *supra* note 243, at 589 (describing how technical assistance efforts have underscored and have been integrated with standard setting by ILO).

250. Barbara B. Crane, *International Population Institutions: Adapting to a Changing World*, *in* INSTITUTIONS FOR THE EARTH, *supra* note 188, at 351, 390-92.

251. Levy et al., *supra* note 233, at 413-14.

252. *See, e.g.*, *Multisectoral Collaboration on Tobacco*, *supra* note 155, at 6-8; Pamphil Kweyuh, *Tobacco Costs the Earth*, PANOSCOPE, Oct. 1994, at 14.

253. A cost effectiveness study carried out by the World Bank "revealed a number of neglected and emerging health problems which should be accorded far greater priority. Topping the list of emerging problems are the tobacco related diseases." Jamison & Mosley, *supra* note 67, at 18-19. Nevertheless, the low priority that the World Bank has characteristically assigned to tobacco control is reflected by the fact that the 1980 World Bank Health Sector Report did not even mention tobacco related diseases. *Id.* at 18.

254. *See* John C. Dernbach, *The Global Environment Facility: Financing the Treaty Obligations of Developing Nations*, 23 ENVTL. L. REP. 10124, 10124-32 (1993); Theron A. Mehr, Comment, *International Technology Transfer: Constructing and Financing an Environmental Program*, 15 LOY. L.A. INT'L & COMP. L.J. 731, 743-46 (1993).

developing states in meeting their obligations under the Protocol.[255] Another example is the Global Environmental Facility (GEF), established by the World Bank as a general fund to aid developing countries in correcting global environmental problems.[256] The GEF is overseen and administered by the World Bank with the assistance of UNEP and the United Nations Development Programme.[257] WHO should consider establishing an international financial support mechanism within the context of a global tobacco control convention or developing a separate facility apart from a binding convention to support tobacco control efforts. Such a fund can be managed under the authority of any number of organizations, including WHO or the World Bank.

3. *Role of Other International and Nongovernmental Organizations*

Multisectoral collaboration of a wide range of organizations will be required to implement effectively an international instrument on tobacco control. Given the lack of support for tobacco control programs by many international organizations, WHO must enlist the support of other multilateral organizations by effectively informing and educating the international community about the impact of the tobacco pandemic and about strategies to prevent its spread. In addition to financially promoting tobacco control programs, other international organizations and nongovernmental organizations[258] can assist WHO's efforts by promoting support for appropriate tobacco control policies among their constituencies.[259]

Collaboration with other international organizations in the development and implementation of an international convention also may advance WHO's efforts to curb the growth of tobacco use through a regulatory framework. Given WHO's limited experience in the politics and processes of sponsoring, drafting, negotiating, and implementing international legal instruments, collaboration with other intergovernmental organizations experienced in securing international agreement and action on instruments of high technical quality may prove critical to the success of an international strategy for

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255. London Amendments to the Montreal Protocol, *supra* note 187, part T, art. 10 (amendment to article 10 of the Montreal Protocol). *But cf. Holed Up*, *supra* note 188, at 63 (noting that industrialized states failed to pay $26 million of $149 million pledged in 1994). Similar trust funds have been established under a number of international environmental conventions, all using weighted contributions based on the global assessment scale set forth by the U.N. General Assembly. *See* Sand, *supra* note 184, at 224-26.

256. *See* Mehr, *supra* note 254, at 744.

257. *See id.*

258. Nongovernmental organizations (NGOs) can also play a significant role in efforts to adopt and implement an international tobacco control instrument. NGOs can spotlight the importance of global tobacco control measures and influence states to adopt an international instrument on tobacco control. In addition, NGO participation may be critical for effective monitoring of national compliance with an international tobacco control instrument. The history of human rights periodic national reporting and auditing systems in the United Nations is evidence of the essential role that NGOs can play in international normmonitoring. *See, e.g.*, Lawrence S. Finkelstein, *The Politics of Value Allocation in the UN System*, *in* POLITICS IN THE UNITED NATIONS SYSTEM, *supra* note 151, at 1, 28-30; Leary, *supra* note 243, at 601, 617.

259. UNCTAD, the United Nations designated focal point on tobacco, can assist WHO's efforts by ensuring that the multisectoral approach to tobacco control takes place in a timely and effective manner. *See supra* note 155 (describing role of UNCTAD in global tobacco control efforts).

tobacco control. For example, UNEP, whose mandate is closely related to the purposes and aims of global tobacco control efforts, could facilitate WHO's preparatory work with its extensive and successful experience in developing and implementing international legislation closely related to human health.[260] In addition, the ILO, the international organization with the most successful and extensive record of utilizing international supervisory institutions in the U.N. system, could assist WHO in the development of a monitoring institution to promote effective implementation of tobacco control norms.

WHO's collaboration with other international agencies experienced in the dynamics of international lawmaking on a regulatory framework for tobacco control may also contribute to WHO's evolution away from its conservative anti-law culture through a process of cross fertilization. There are numerous examples of "transfers of experiences and procedures" from one organization to another in the annals of the United Nations.[261] Collaboration with international organizations that are more skilled in international standard setting and less conservative in outlook, such as UNEP and the ILO, may stimulate WHO's dormant and, perhaps, politically suppressed ability to develop and contribute to the acutely necessary evolution of WHO's anti-law culture.

VI. CONCLUSION

This Article has shown that WHO has both the cardinal responsibility and the extraordinary opportunity to serve as a platform for international instruments, stimulating national and international action on tobacco control. Tobacco presents an extraordinary global public health hazard. The time is ripe for WHO to revise existing strategies and to encourage and assist national regulation of tobacco through the employment of international instruments. Utilizing an international regulatory strategy, WHO can expand contemporary global awareness of tobacco's health hazards and generate top level political attention, agreement, and action on tobacco control.

The experiences of other multilateral organizations that have achieved some success in serving as platforms for international standard setting and implementation may guide WHO's efforts to develop international policies on tobacco control. WHO should incrementally develop political consensus, first promoting a noncontroversial U.N. General Assembly declaration on agreed upon policies, and then progressively moving to a WHO framework convention and implementing protocols of increasing strength and scope.

WHO can facilitate the transition from a framework convention to implementing protocols by encouraging states to develop and implement multilateral agreements that are similar to the international environmental

260. There is established precedent for interorganizational cooperation between WHO and UNEP. For example, most of WHO's environmental projects are tackled in collaboration with UNEP, including the 1981 WHO/FAO/UNEP Memorandum of Understanding Governing Collaboration in the Control of Water Borne and Associated Diseases in Agricultural Water Development Activities. Paul C. Szasz, *Restructuring the International Organizational Framework, in* ENVIRONMENTAL CHANGE, *supra* note 178, at 379-83.

261. *Id.* at 379-83.

agreements described in this Article. Hence, WHO should advance a framework convention that institutionalizes ongoing meetings of the parties to the convention. As global political support for concrete measures develops, protocols focused on high priority, commonly advocated measures[262] can be incrementally adopted. WHO can promote compliance with protocols by drafting agreements containing general principles of tobacco control obligations, coupled with requirements for implementation through domestically crafted legislation.

WHO must also establish mechanisms to enlist the support of governments faced with many competing concerns and to overcome states' resistance to regulation. A system of monitoring and national reporting can exert powerful pressure on states to comply with their international obligations to protect their populations from tobacco. In addition, generating an international tobacco control trust fund from the international donor community and wealthy states is critical to the success of an international strategy for tobacco control.

Although WHA48.11 urges the development of an isolated instrument to further global tobacco control efforts, the current weak level of global commitment to tobacco control underscores the inevitable inadequacy of a single shot approach. In contrast, a dynamic and continuing long term plan that focuses on incremental and modest targets has a greater likelihood of encouraging national action to control tobacco.

Advancing an international regulatory strategy does, of course, pose some political risks for WHO. Given the politics of global tobacco control, WHO may ultimately hinder tobacco control efforts and the institution itself if it broadly interprets its mandate and aggressively confronts nations. However, this Article has outlined a strategy, modeled upon the successful experiences of other international organizations, that WHO can adopt to avoid becoming a political battleground in efforts to achieve international consensus and action on tobacco. The adoption of a measured approach to the development of international instruments can allow the global regulatory initiative to keep pace with the political feasibility of tobacco control in member states, and thus possibly ward off claims that WHO is inappropriately interfering in public health matters within the domestic jurisdiction of states.

Collaboration with other organizations in an international regulatory strategy may also serve to protect WHO from charges of politicization. This Article has recommended that efforts to achieve an international convention should be preceded by an endeavor to garner a U.N. General Assembly resolution endorsing both WHO's directives on tobacco control and the eventual codification of an international convention under WHO's auspices. In addition, the involvement of other international organizations, such as UNEP and the ILO, in the preparatory talks and drafting of an international convention and protocols on tobacco control can also fend off claims that WHO is a rogue organization by adding weight and legitimacy to the

262. WHO can assess political consensus for the adoption of key protocols, including, for example, protocols on tobacco ingredients and measures to prevent young people from smoking, by circulating questionnaires among convention participants.

international strategy. Hence, with significant collaboration from other international organizations, WHO can actively encourage international consensus and action on tobacco control while limiting political risks to the organization.

WHA48.11 creates a pivotal opportunity for WHO to stimulate national action on tobacco control by becoming an effective forum for the development and implementation of international instruments. In the present world order dominated by independent nations, WHO and other international organizations can have only a limited influence on the conditions that have driven the tobacco pandemic. Although member states will ultimately decide about their commitment to tobacco control, active promotion of tobacco control standards through an international regulatory strategy is an important step toward the protection of global public health.

On May 26, 1996, after this Article went to press, the World Health Assembly adopted a resolution calling upon the Director-General of WHO:

> *(i) to initiate the development of a framework convention in accordance with Article 19 of the WHO Constitution;*
> *(ii) to include as part of this framework convention a strategy to encourage member nations to move progressively towards the adoption of comprehensive tobacco control policies, and also to deal with aspects of tobacco control that transcend national boundaries . . . .*[263]

263. *International Framework Convention for Tobacco Control*, WHA Res. 49.17, 49th Ass., 6th Plen. mtg., WHO Doc. A49/VR/6 (1996). *See generally*, Allyn L. Taylor & Ruth Roemer, *International Strategy for Tobacco Control*, WHO Doc. WHO/PSA/96.6 (1996).