What difference would a binding international legal instrument on alcohol control make? Lessons from the WHO FCTC's impact on domestic litigation

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Abstract: Since the adoption of the WHO Framework Convention on Tobacco Control in 2003, public health professionals have debated similar conventions covering other health risks, including potentially a Framework Convention on Alcohol Control. Much of this debate has focused on the merits of binding versus non-binding instruments in terms of commitments at the international level. In this paper, I draw on lessons from the WHO FCTC to discuss instead what the difference between binding and non-binding international legal instruments might mean for domestic legal frameworks for implementing regulatory measures for alcohol control. The paper looks at possible impacts on the authority of various national authorities to implement new measures, the ability of civil society to bring cases compelling more comprehensive regulatory measures, and the defence of litigation brought by commercial sector actors to prevent, delay or weaken the implementation of laws and regulations. It reflects on what lessons these might have for alcohol control governance.

Keywords: Framework Convention on Tobacco Control, Framework Convention on Alcohol Control, noncommunicable diseases, World Health Organization, international law in domestic courts

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I. Introduction

Since the adoption of the World Health Organization (WHO) Framework Convention on Tobacco Control (WHO FCTC) in 2003, public health professionals have proposed similar WHO conventions covering other health risks.[2] One of the more common proposals for such instruments is the proposal for a WHO Framework Convention on Alcohol Control (FCAC),[3] which would aim to address the 3 million deaths per year caused by alcohol worldwide and the role of the alcohol industry in causing them, in much the same way that the WHO FCTC has done so for the global tobacco epidemic and the tobacco industry.

These proposals for a WHO FCAC received renewed attention in February 2020, when the WHO Executive Board debated proposed decisions on alcohol control on the occasion of the 10th anniversary of its *Global Strategy to Reduce the Harmful Use of Alcohol* ('Global Alcohol Strategy'),[4] including, initially, the development of a binding international legal instrument for alcohol control.[5] The reference to such an instrument was not included in the final decision, which instead commits to adopting an action plan over 2022-2030 to implement the Global Alcohol Strategy, to a technical report on cross-border alcohol marketing, to additional resources and prioritisation for alcohol control within WHO's work programme, and to a review in 2030.[6] However, the Executive Board discussions have renewed interest in the role that treaties can play in the global governance of alcohol.

This paper aims to provide conceptual clarity to such discussions, by mapping the options under the WHO Constitution and what the practical differences between them may be in light of the experience of the WHO FCTC. I argue that, given the softness of enforcement in most health treaties and likely any potential alcohol treaty, and the role that soft law has played in driving action on other global health issues, the practical distinction between binding and non-binding instruments is not as bright a line as is often assumed by public health scholars. A non-binding international instrument that includes clear and specific political commitments, effective monitoring and accountability mechanisms, and generous resourcing for implementation could potentially achieve many of the goals public health advocates aim for with a treaty, especially combined with existing binding instruments on the right to health in international human rights law. However, the WHO FCTC has also had some impacts – in particular, on the powers of government to adopt regulatory measures and the ability of civil society to hold government accountable through domestic courts – that are specific to its nature as a binding treaty. Understanding which public health goals can be achieved through soft law at the international level, and what might strictly require a hard law instrument can help inform civil society strategy for both the 2022-2030 action plan and any future international legal instruments.

This paper begins by outlining different kinds of normative instruments that currently exist under the legal framework and in the practice of the WHO. It then discusses the experience of the WHO FCTC, and reflects on what the experience shows about the role of legally binding instruments in driving public health action. Finally, it argues that a key impact of the WHO FCTC has been its impact on domestic regulatory powers, and on litigation both to push for higher standards of implementation and to defend existing measures from challenge. The paper focuses on what can be achieved via each type of instrument – although one of the key challenges in alcohol governance across all instruments is getting to an agreement on the content of these commitments, for reasons of length the paper limits itself to the question of what bindingness adds.

II. A taxonomy of WHO legal instruments relevant to global alcohol control

The WHO Constitution[7] gives the World Health Assembly (WHA) the power to adopt three kinds of normative instruments – conventions (under article 19), regulations (under article 21), and recommendations (under article 23). Within this framework, conventions and regulations are binding upon member states, while recommendations are non-binding. The practice of WHO is heavily weighted towards recommendations, with only one convention

(the WHO FCTC[8]) and two regulations (the International Health Regulations[9] and the Nomenclature Regulations[10]) adopted under articles 19 and 21 so far.

Conventions may be adopted, with a two-thirds vote by the WHA, on any topic within WHO's mandate. They bind the states that sign and ratify or accede to them, as with any other treaty.

Regulations, on the other hand, may only be made on the five subjects enumerated under article 21, which are:

(a) sanitary and quarantine requirements and other procedures designed to prevent the international spread of disease;
(b) nomenclatures with respect to diseases, causes of death and public health practices;
(c) standards with respect to diagnostic procedures for international use;
(d) standards with respect to the safety, purity and potency of biological, pharmaceutical and similar products moving in international commerce;
(e) advertising and labelling of biological, pharmaceutical and similar products moving in international commerce.

Regulations automatically bind WHO member states unless a member specifically rejects or makes reservations to them. Regulations are generally also considered to be treaties, although they can also be thought of as sui generis international legislative acts.[11] Consent to be bound to a regulation derives from the WHO Constitution (itself a treaty) rather than from the regulation itself – accession to or ratification of the WHO Constitution establishes 'standing' consent for adopted article 21 regulations unless a state indicates otherwise.[12]

Finally, the WHA may also make non-binding recommendations on any topic within WHO's mandate, under article 23 of the WHO Constitution. Given that alcohol control is not one of the five topics that the WHA may make regulations on, the choice of instrument within WHO is therefore essentially a choice between conventions and recommendations.

WHO's previous practice has often subdivided both treaties and recommendations into further subcategories. For example, the Director-General's feasibility study for the WHO FCTC, which was presented to the WHA prior to the WHO FCTC negotiations, divided the article 19 treaty category into 'conventions' and 'the framework convention/protocol approach'.[13] Similarly, the article 23 'recommendations' category is in practice a catch-all term for a wide variety of other kinds of documents, including resolutions and decisions, strategies, codes, declarations, and so forth. These subcategories, discussed below, are largely practical and descriptive labels, rather than legal distinctions.

1. Conventions, including 'framework conventions'

There is no formal legal distinction between a 'framework convention' and a 'convention'. Neither the Vienna Convention on the Law of Treaties,[14] nor article 19 of the WHO Constitution distinguishes between framework conventions and other kinds of conventions, and a study group of the International Law Commission in 2006 also considered that the law of treaties did not recognise separate rules for framework-protocol versus other conventions.[15]

However, as a descriptive term, the term 'framework convention' or 'framework-protocol convention' sometimes describes an approach common in international environmental law where an initial 'framework convention', such as the Ozone Convention[16] or the UN Framework Convention on Climate Change,[17] establishes institutions such as a Conference

of Parties (COP), a treaty secretariat, and a system of procedures and general principles for further negotiations, while substantive obligations are left to a series of later, related treaties, known as protocols (the UNFCCC, for example, has the Kyoto Protocol[18] and the Paris Agreement,[19] and the Ozone Convention protocols include the Montreal Protocol on Substances that Deplete the Ozone Layer[20]). The framework convention format, as understood in international environmental law, is intended to allow states to progressively develop the legal framework as the evidence evolves.

In the context of the WHO FCTC, the name 'framework convention' is largely historical. It reflects the initial proposal to model a treaty for tobacco control on such conventions in international environmental law in the work of legal academics Allyn Taylor and Ruth Roemer,[21] later reflected in the WHO feasibility study and decisions initiating the WHO FCTC negotiations.[22]

It was originally envisaged that the WHO FCTC would be a framework convention as understood in the UNFCCC sense.[23] However, the treaty as concluded is now arguably what Taylor in her original article called a 'comprehensive convention', in that it mandates extensive regulatory measures to be implemented by states, rather than a UNFCCC-style framework-protocol convention where such matters are left to protocols.[24] The model is now more similar to that of the Basel Convention on the Transboundary Movement of Hazardous Wastes, where the main treaty has substantial obligations forming a comprehensive regulatory regime, but details of implementation are elaborated upon in technical guidelines adopted by the COP.[25] Although the concluded WHO FCTC does still adopt a convention-plus-protocols structure, with one protocol on illicit trade and broad powers to adopt more, the WHO FCTC protocols now deal with specialised issues under the treaty rather than its main substance.[26]

The term 'framework' in the title of the WHO FCTC means its legal nature is often not well understood,[27] and has sometimes been misrepresented by the tobacco industry in legal challenges against measures to implement the WHO FCTC. In British American Tobacco v. Kenya, for example, BAT argued that Kenya could not invoke the WHO FCTC in defending its Tobacco Control Regulations because it was only a framework convention and did not impose substantive obligations.[28] The argument was unsuccessful – it is clear from the content of the treaty that it does impose substantive obligations.[29]

The proposals for new 'framework conventions' in public health, including the proposals for a WHO FCAC, generally use the term in the WHO FCTC sense, rather than the UNFCCC sense – they propose one detailed convention for a particular issue, not the progressive negotiation of a series of protocols under a common institutional framework. The terms 'framework convention' or simply 'convention' would be largely interchangeable and for descriptive purposes in this context.

2. Recommendations under WHO Constitution article 23

A more straightforward set of subcategories concerns the different kinds of names that are given to recommendations under article 23 of the WHO Constitution. These can take the form of WHA resolutions, or they can take the form of codes of conduct/practice (such as the WHO International Code of Conduct on the Marketing of Breast Milk Substitutes[30] or the WHO Global Code of Practice on the International Recruitment of Health Personnel[31]), sets of recommendations (such as the Set of Recommendations on the Marketing of Foods and Non-Alcoholic Beverages to Children[32]), 'technical packages' (such as WHO's SAFER for

alcohol control [33] or SHAKE for salt reduction[34]), and various kinds of plans, strategies, or other documents which may have recommendations attached to them (such as the Global Alcohol Strategy[35] and the WHO Global Action Plan on Noncommunicable Diseases 2013-2020[36] and its appendix III: Best Buys and Other Recommended Interventions for the Prevention and Control of Noncommunicable Diseases (known as the 'Best Buys' for NCDs[37]).

These names also mostly reflect practical considerations about how the instruments should be used, and there is no general legal distinction between them in terms of how member states should relate to them, although some may define institutional mandates in WHO's internal law. None of them directly create legal obligations on members, although they typically reflect political commitments by member states of WHO.

3. Subsidiary instruments to conventions

Finally, although debates about normative instruments in health often assume a dichotomy of binding treaties and non-binding other instruments, there is often overlap and interaction between those two categories of instruments.

Modern treaties often set up various kinds of subsidiary instruments. For example, many treaties (including the WHO FCTC) set up a COP with the power to take decisions regarding the implementation of the treaty. Those decisions might sometimes specifically adopt guidelines for treaty implementation, such as the WHO FCTC or the Basel Convention's guidelines. Other treaties have expert bodies which are intended to monitor implementation of the treaty and provide guidance on implementation. Examples of normative instruments adopted by such bodies include the general comments drafted by human rights treaty bodies. These instruments may not in themselves create legal obligations, but they are part of the legal framework of the treaty itself and often have legal effects flowing from their parent treaty.

In particular, decisions of Conferences of the Parties can be authoritative interpretations of binding legal obligations and have significant legal weight as a result, even if they are not themselves sources of obligations. For example, in a case brought by Dutch civil society against exemptions in the Netherlands' smoke free laws, the Hague Court of Appeal found that the implementation guidelines to article 8 were a subsequent agreement to the WHO FCTC under article 31 of the Vienna Convention on the Law of Treaties, and therefore had to be taken into account in its interpretation. As such, the court considered that the obligation to provide effective protection from exposure to tobacco smoke in article 8 had to be informed by the guidelines' statement that only 100% smoke-free indoor public places provided effective protection. It struck down the exemptions in the smoke-free law and required that all indoor public places be made smoke-free in order to comply with the WHO FCTC.[38]

III. Binding and non-binding instruments and action on alcohol control

Given this taxonomy, what might be the significance of these differences? To what extent might the goals cited by public health scholars require a treaty, and to what extent might they be able to be advanced by revising and better resourcing non-binding frameworks?

Calls for an FCAC have often argued for a legally binding instrument in general terms. However, some common reasons given for a treaty in the more specific proposals include a greater recognition of the urgency of alcohol as a problem,[39] accelerating the implementation of recommended measures,[40] accountability for doing so,[41] stronger norms on the role of industry interference,[42] counterbalancing the effect of trade agreements,[43] and regulation of cross-border issues such as digital marketing.[44] Others more generally note the aim of replicating the successes of the WHO FCTC for alcohol control.[45] As is noted in the impact assessment to the WHO FCTC, these impacts have included accelerating action to implement measures at the domestic level, supporting integration of tobacco control into broader global governance and financing agendas such as sustainable development and human rights, supporting multisectoral coordination and outreach to non-health agencies, mobilising and providing framing for civil society advocacy, supporting cooperation and information exchange, raising the profile of an issue, and supporting the defence of legal challenges.[46]

Some of these aims and potential impacts relate primarily to gaps in the content of existing alcohol governance frameworks rather than in the legal status of those frameworks. These include building links with other issue areas such as human rights or sustainable development, increasing international cooperation and multisectoral coordination, and more strongly recognising the alcohol industry's role in causing health harms and ensuring protection against industry interference. For these aims, the priority for advancing these aims should be ensuring that they are included in the content of instruments, whatever the form or status of those instruments – it is not necessarily a given that a binding instrument would include them, and potentially, a binding instrument that fails to include them may freeze these gaps into the governance frameworks over the long term.

Other aims, such as better recognising the urgency of the health harms of alcohol or mobilising civil society, relate to raising the profile of alcohol control as an issue. These are also aims that can be advanced through a number of instruments, including but not limited to treaties. For example, the WHO FCTC has had a major impact in mobilising action on tobacco control, but the experience of non-binding frameworks such as the UN General Assembly's Political Declarations[47] or the Sustainable Development Agenda[48] shows that sufficiently high-profile non-binding declarations can also achieve this effect. What matters with this group of impacts is engagement with political processes, and while treaties such as the WHO FCTC have provided a forum for building the networks to do so, it is also relatively common to do so independently of treaties.

Finally, there is the aim of ensuring greater implementation of regulatory measures. A treaty advances this goal by committing states to a package of measures, creating a range of ways to hold states accountable to their commitments, by ensuring a relatively common and harmonized approach to regulation on cross-border issues, and by creating a channel for cooperation on these issues. Can non-binding instruments such as codes and strategies achieve the same ends? In terms of coordinating, cooperating, and reaching consensus on measures, yes. It is important not to discount the role of evidence, normative frameworks, advocacy, civil society networks, and networks for technical information exchange in achieving these aims. A treaty can help strengthen these assets but is not a prerequisite to creating and making use of them. The key difference between the two is generally accountability, as legally binding instruments are typically required for some of the harder enforcement mechanisms, such as dispute settlement.

However, at the international level, this is often not as bright a line in practical terms as assumed in public health literature.[49] For example, formal state-state dispute settlement systems are often perceived by states as adversarial and resource-intensive, and are therefore seldom the main ways of ensuring implementation of those agreements,[50] and it seems unlikely that the ability for individual claims will be a feature of any treaty on alcohol control. Many treaties that advance collective goals therefore do so through reporting and implementation review processes that review the progress of all states and report on gaps and needs in implementation. These can also be relatively extensive under non-binding frameworks. For example, both the reporting process for WHO's report on the Global Tobacco Epidemic (which is based on the non-binding MPOWER framework) and the obligatory reporting under the WHO FCTC provide detailed information on the implementation of domestic tobacco control measures.[51]

It is also important to remember that issue-specific legal instruments are not the only binding legal framework capable of accelerating action and ensuring accountability. For example, the HIV/AIDS response, another area of public health without its own treaty, has had significant successes through the use of human rights law, advocacy, and litigation.[52] Recently, a group of experts called on WHO and the UN High Commissioner for Human Rights to develop international guidelines on human rights, healthy diets, and sustainable food systems similar to those developed for HIV/AIDS in the 1990s.[53] Alcohol control could likewise also benefit from greater use of human rights law, which already binds states to take measures to ensure that individuals can enjoy the right to health and to prevent violations of that right by commercial entities, and already has a range of accountability mechanisms at both the international and domestic levels.[54] Similarly, although a comprehensive discussion of trade and investment law and alcohol control is out of scope of this paper, trade and investment law issues are difficult to address from solely within a health treaty, and policy coherence between trade and investment and health necessarily requires some direct engagement with trade and investment law.[55]

Thus, although it is undeniable that the WHO FCTC serves as an important model for other global health treaties, for many of the aims of alcohol control, there may be multiple routes to advancing action. This is not to suggest that a specific alcohol treaty would not be useful on these questions. It is quite probable that the lengthy, high-profile negotiations and ratification procedures of treaties do result in stronger political commitment and broader mobilisation toward a goal, for example. But in a context where it might be difficult to achieve consensus on a legally binding instrument until at least 2030, it is important to remember that this is not an all or nothing proposition. Many of the successful elements of the WHO FCTC, such as regular reporting and progress monitoring; technical assistance; resource mobilisation; and normative guidance on conflict of interest, links to human rights and sustainable development, and the design and implementation of regulatory measures could be meaningfully spun off into non-binding governance frameworks if disagreements over bindingness are the sticking point in negotiations. The inability to reach agreement on a treaty should not prevent these aims from being advanced elsewhere.

IV. The impact of binding instruments: the WHO FCTC in domestic legal orders

Rather, if we look closely at the FCTC experience, we find that those impacts which specifically turn on the WHO FCTC's status as a legally binding instrument are often those

which concern the legal framework for action within the domestic legal order. How a treaty will affect a given country's domestic legal order will vary by the country. But often, legal systems at a domestic level distinguish between binding and non-binding instruments in ways that the relevant actors at the international level do not.

1. Powers to implement treaties

For example, in many countries, particular parts of government are given the power to implement treaties, or powers under existing legislation might be interpreted by reference to international law. This can make it easier to pass relevant measures, or it can support the defence of legal challenges. Many of these powers are specific to the status of the WHO FCTC as international law.

In Costa Rica, for example, the Constitutional Division of the Supreme Court considered a legislative consultation brought by ten lawmakers questioning whether or not there was an adequate legal basis for certain provisions of the tobacco control law. It upheld the law, and found in particular that articles 6, 8, 13, and 16 of the WHO FCTC provided an adequate legal basis for excise tax, smoke-free laws, a comprehensive ban on tobacco advertising, promotion and sponsorship, and a minimum pack size law, given the legislature's powers to implement laws to give effect to international law.[56]

In Sri Lanka, the Court of Appeal of Sri Lanka heard a challenge arguing that the National Authority on Tobacco and Alcohol (NATA) Act, which grants NATA the ability to adopt regulations on 'health warnings', did not give NATA authority specifically for graphic health warnings. The Court of Appeal found that the NATA Act did include the power to adopt graphic as well as text health warnings, finding that the NATA act needed to be interpreted in harmony with international law, including the FCTC. The Court stated that:

> *Our Supreme Court in decided cases emphasized the need to interpret domestic law in harmony with Sri Lanka's commitments even in cases where no specific domestic law had been enacted… Having read FCTC and the guidelines for implementing of Article 11 of the FCTC there cannot be any prohibition to convey the message by pictorial health warnings … Our courts recognize international commitments and [relevant articles] of the Constitution endeavor to foster respect for international law and treaty obligation.*[57]

In Kenya, a requirement to contribute to a compensation fund under the Kenyan Tobacco Control Regulations was challenged as being an 'attempt to irregularly apply the FCTC'. The Court of Appeal of Kenya rejected this challenge, finding that 'the enactment of the Tobacco Act… can only be viewed as an attempt to fulfil [the] obligation' in article 3 of the WHO FCTC, 'to implement measures to protect its present and future generations from the devastating social and environmental consequences of tobacco consumption and exposure to tobacco smoke'. It also found that the WHO FCTC fell within article 2(6) of Kenya's Constitution, which states that 'any treaty or convention ratified by Kenya shall form part of the law of Kenya under this Constitution'. It therefore rejected the challenge to the compensation fund contribution requirement on the grounds that 'the enactment of the Tobacco Act and Tobacco Regulations are anchored on the Constitution of Kenya and no inconsistency arises.'[58]

In Australia, ratification of the WHO FCTC likely gives the federal government the power to implement tobacco control measures nationwide in areas that previously were left to states

and territories, as a result of the external affairs power under the Australian Constitution. Although states and territories already have legislation implementing the WHO FCTC as a result of a strong commitment to tobacco control at all levels of government in Australia, the WHO FCTC would make it possible for the federal government to adopt a single comprehensive and uniform act on tobacco control should the need to harmonise Australian tobacco control laws arise.[59]

These examples show that the existence of a treaty can change the domestic legal framework for action, either by empowering certain actors, or strengthening potential defences against legal challenges. Because these are typically based on how international law is recognised within a country's constitutional framework, only binding legal obligations will have such effects.

2. Civil society litigation

In some countries, membership of a treaty also gives civil society organisations and others the power to hold government directly accountable for its implementation. For example, in the Netherlands, tobacco control NGOs were able to launch a legal challenge against a smoke-free law that allowed certain establishments to retain indoor smoking areas on their premises. The court ordered that the exceptions for smoking areas be removed to ensure consistency with article 8, finding that the article 8 obligation to implement effective measures to protect people from exposure to tobacco smoke should be read in light of technical guidance in the article 8 guidelines that only 100% smoke free laws were truly effective.[60] A similar case was launched by Dutch civil society organisations arguing that the code of conduct for civil servants was insufficient for implementing article 5.3 of the WHO FCTC (which requires parties to protect public health policies from the commercial and other vested interests of the tobacco industry). The case was not successful, but it did result in a review and revision of the guidelines to ensure better implementation of article 5.3 of the WHO FCTC.[61]

Whether a treaty will provide such opportunities depends largely on the extent to which international law is directly enforceable within the courts of that country. In many, it may not be, and there may also be rules about standing and admissibility that limit the ability to bring such cases in practice. But it is safe to say that in countries where such litigation is a possibility, it is likely to depend on the existence of international obligations.

3. Giving content to constitutional health-related rights

In other countries, a treaty may be indirectly enforceable, through its impact on the interpretation of constitutional rights. The WHO FCTC has often given content to constitutional rights to health or life, both in civil society litigation and in defences to legal challenges brought by the tobacco industry.[62] In India, for example, public interest litigation based on the right to health (as a component of the constitutional right to life) has led to courts ordering feasibility studies into the adoption of plain packaging, as a result of reading constitutional rights in light of international obligations under the WHO FCTC.[63]

In hearing a legal challenge against a ban on smoking in indoor public places, and outdoor areas of health and education institutions, the Constitutional Court of Peru also found that the WHO FCTC informed the scope of constitutional rights under the constitution. After finding that the WHO FCTC was a human rights treaty and therefore part of the constitutional order of Peru, it found that the constitutionally obligatory aim of ensuring the right to health by implementing the WHO FCTC could serve as a limitation on the freedom

to smoke in public places and on commercial rights of venues.[64] The WHO FCTC has also been recognised as informing constitutional rights to health or life in South Africa,[65] Belgium,[66] Uganda,[67] Colombia,[68] Panama,[69] and Guatemala,[70] among other countries.[71]

To a certain extent, human rights arguments can also be assisted by non-binding instruments, since a finding that a right has been violated will also often involve evidentiary or factual questions, or more general discussions of international practice or recommendations, that are not dependent on the legal status of cited documents. But many constitutions will explicitly recognise or require a role for international obligations in the interpretation of human rights obligations (as was the case in Peru), so a treaty can be helpful in such cases.

4. Defending measures from legal challenges brought by industry

Finally, a key impact of the WHO FCTC has been its role in defending legal challenges.[72] This role overlaps with its effect on powers to legislate and human rights, which are often at issue in legal challenges. For example, the Costa Rica, Sri Lanka, and Kenya legal challenges discussed above concerned a legal challenge on the basis of powers to regulate, while in the legal challenges in Uganda, Peru, and South Africa, concerned legal challenges on the basis of commercial rights, which courts rejected partly on the basis of competing rights to life, health, and a healthy environment.

In other legal challenges, the WHO FCTC has been important for translating evidence, or sometimes in order to establish the purpose of a measure or assess its nature. For example, in a range of cases dealing with legal challenges to retail display bans, courts have cited WHO FCTC article 13 and its guidelines in support of factual findings that advertising, promotion and sponsorship drive tobacco consumption and that retail display is a form of advertising, promotion and sponsorship.[73] In the WTO plain packaging cases and the investment dispute against Uruguay's tobacco packaging laws, the WHO FCTC guidelines were cited in support of the efficacy and reasonableness/justifiability of the measures. These kinds of citations are not specific to legal instruments, although an agreed treaty may be a more succinct and familiar shorthand for a court or tribunal than a large amount of scientific evidence.

Both the scientific and the legal nature of the WHO FCTC have been important in legal challenges to tobacco control measures. As a broad generalization, in trade and investment law cases, the WHO FCTC has mostly been cited for its evidentiary value (due to complainants or home states of complainants being non-parties to WHO FCTC), whereas constitutional cases have relied more heavily on the WHO FCTC imposing binding obligations on its member states. Depending on the nature of the argument, both binding and non-binding instruments can play a role in such defences – Uruguay, for example, has defended its tobacco control laws by reference to the WHO FCTC, but also responded to Specific Trade Concerns about its food labelling laws in the WTO's Technical Barriers to Trade Committee by citing the Sustainable Development Goals and WHO recommendations on preventing childhood obesity.[74] But at least some of these arguments will depend on the legal status of an instrument.

V. Conclusion and lessons for new instruments

From the above, we can see that for some countries, the binding nature of the WHO FCTC has been highly significant to some aspects of its impact, such as its integration into legal

frameworks at the domestic level, and its use by civil society to bring public interest litigation for higher standards of implementation.

But we also see that there are many aspects of the WHO FCTC, such as its role in developing evidentiary consensus; providing clear, actionable, and comprehensive recommendations on how measures should be implemented; bringing together civil society and expert networks; ensuring that an issue is kept on the agenda and receives adequate political attention and resources; making links with other areas such as sustainable development; and providing regular reporting and oversight; which are of a more technical or political nature.

A few lessons follow from this analysis. First, it matters what is in a non-binding instrument, and those who are advocating for strong international governance frameworks for alcohol control should pay attention to the content of such instruments and make use of them in their work once concluded. It may be that a legally binding instrument would be desirable in alcohol control. But that should not crowd out the need to put in better systems for implementation and in some cases update the language (such as by recognising links to broader issues such as sustainable development or the right to health, or setting norms on conflict of interest) of non-binding instruments such as the Global Strategy and its soon to be negotiated action plan for 2022-2030.

Second, legally binding treaties do open opportunities that are not available under other governance frameworks, especially in countries with a strong recognition of international law in their constitutions. This is a more specific impact than many of the more commonly cited reasons for a treaty, but in some countries it can significantly change the environment for action.

Finally, processes for implementation, including civil society and scientific networks, information sharing and assistance between governments, litigation that invokes international commitments, and regular meetings to monitor progress and update standards, are a key part of making sure commitments translate to progress at the country level. Treaties such as the WHO FCTC can establish such systems, but such systems are arguably even more important if the governance framework is non-binding. Building this kind of ecosystem is an important part of ensuring that commitments in international instruments become progress in practice.

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[20] Montreal Protocol on Substances that Deplete the Ozone Layer (opened for signature 16 September 1987, entered into force 1 January 1989)1522 UNTS 3 (Montreal Protocol).

[21] Allyn L. Taylor, 'An International Regulatory Strategy for Global Tobacco Control' (1996) 21 Yale Journal of International Law 257; Ruth Roemer, Allyn Taylor and Jean Lariviere, 'Origins of the WHO Framework Convention on Tobacco Control' (2005) 95(6) American Journal of Public Health 936-8.

[22] World Health Organization, *WHO FCTC Feasibility Study*, UN Doc EB97/INF.DOC./4 (n 13).

[23] World Health Organization, *WHO FCTC Feasibility Study*, UN Doc EB97/INF.DOC./4 (n 13).

[24] Taylor (n 21) 294. Taylor described such conventions in the tobacco control context as 'mandating that states enact extensive tobacco control regulations that encompass all of WHO's recommendations for the last twenty-five years'. Arguably, the WHO FCTC as adopted is an example of a comprehensive convention so defined, having included and in many respects gone further than WHO's recommendations in the resolutions of the 25 years before it.

[25] Basel Convention on the Control of Transboundary Movements of Hazardous Wastes and their Disposal (opened for signature 22 March 1989, entered into force 5 May 1992) 1673 UNTS 57 (Basel Convention). The Basel Convention technical guidelines differ from the FCTC guidelines in that they

are more strictly technical and cover different applications of the obligation to manage waste in an environmentally sound manner to different forms of waste: see, e.g. Conference of the Parties to the Basel Convention on the Control of Transboundary Movements of Hazardous Wastes and Their Disposal, 'Technical Guidelines for the Identification and Environmentally Sound Management of Plastic Wastes and for their Disposal' (COP Doc No UNEP/CHW.6/21, 23 August 2002). The FCTC guidelines are more normative and cover recommended ways to implement most of the demand reduction obligations under the FCTC, including clarification and guidance on the meanings of relevant terms under the Convention.

[26] Similarly, the Basel Convention has a Basel Protocol on Liability and Compensation for Damage Resulting from Transboundary Movements of Hazardous Wastes and their Disposal (opened for signature 10 December 1999, not yet into force) UNEP/CHW.1/WG/1/9/2 (Basel Protocol).

[27] See generally Jonathan Liberman, 'The Power of the WHO FCTC: Understanding its Legal Status and Weight' in Andrew D Mitchell and Tania Voon (eds), *The Global Tobacco Epidemic and the Law* (Edward Elgar Publishing 2014).

[28] *British American Tobacco Ltd v Cabinet Secretary for the Ministry of Health* (High Court (Kenya), Mumbi J, No Petition No 143 of 2015, 24 March 2016) [107].

[29] Ibid [111]. See Liberman (n 27)27; Suzanne Zhou and Jonathan Liberman, 'The Global Tobacco Epidemic and the WHO Framework Convention on Tobacco Control— The Contributions of the WHO's First Convention to Global Health Law and Governance' in Gian Luca Burci and Brigit Toebes (eds), *Research Handbook on Global Health Law* (Edward Elgar Publishing 2018) 340.

[30] World Health Organization, 'International Code of Marketing of Breast-milk Substitutes' (Code adopted in WHA Res No 34.22, 21 May 1981).

[31] World Health Organization, 'WHO Global Code of Practice on the International Recruitment of Health Personnel ' (Code adopted in WHA Resolution No 63.16, 21 May 2010).

[32] World Health Organization, 'Set of Recommendations on the Marketing of Foods and Non-Alcoholic Beverages to Children' (Recommendations adopted in WHA Res No 63.14, 21 May 2010).

[33] World Health Organization, 'SAFER: Preventing and Reducing Alcohol-Related Harms'.

[34] World Health Organization, 'SHAKE the Salt Habit: The SHAKE Technical Package for Salt Reduction'.

[35] World Health Organization, 'Global Strategy to Reduce the Harmful Use of Alcohol' (2010).

[36] World Health Organization, 'Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013-2020'.

[37] World Health Organization, 'Best Buys and Other Recommended Interventions for the Prevention and Control of Noncommunicable Diseases: Updated (2017) Appendix 3 of the Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013-2020', 31 May 2017).

[38] Ibid.

[39] See, eg, Shiu Lun Au Yeung and Tai Hing Lam, 'Unite for a Framework Convention for Alcohol Control' (2019) 393(10183) The Lancet 1778.

[40] Sally Casswell and Jürgen Rehm, 'Reduction in Global Alcohol-Attributable Harm Unlikely After Setback at WHO Executive Board' (2020) 395(10229) *Lancet* 1020; Sally Casswell and Thaksaphon Thamarangsi, 'Reducing harm from alcohol: call to action' (2009) 373(9682) The Lancet 2247-57.

[41] See, eg, Yeung and Lam (n39); Robin Room, 'Healthy is as healthy does: Where will a voluntary code get us on international alcohol control?' (2013) 108 Addiction 456.

[42] See, eg, Casswell, 'Will alcohol harm get the global response it deserves?' (n 3).

[43] See, eg, ibid; Ben Baumberg, 'World trade law and a framework convention on alcohol control' (2010) 64 Journal of Epidemiology and Community Health 473-4.

[44] See, eg, Casswell and Rehm, 'Reduction in global alcohol-attributable harm unlikely after setback at WHO Executive Board' (n 40).

[45] The Lancet, , 'A Framework Convention on Alcohol Control'(n 3).

[46] Conference of the Parties to the WHO Framework Convention on Tobacco Control, *Impact assessment of the WHO FCTC: Report of the Convention Secretariat*, 6th sess, Agenda Item 4.7, UN Doc FCTC/COP/6/15 (16 June 2014) ('*Impact assessment of the WHO FCTC: Report of the Convention Secretariat*'); Conference of the Parties to the WHO Framework Convention on Tobacco Control, *Impact assessment of the WHO FCTC: Report by the Expert Group*, 7th sess, Agenda Item 5.2, UN Doc FCTC/COP/7/6 (27 July 2016) ('*Impact assessment of the WHO FCTC: Report by the Expert Group*').

[47] See, eg, UN General Assembly, *Political Declaration of the Third High-Level Meeting of the General Assembly on the Prevention and Control of Noncommunicable Diseases*, Resolution 73/2, UN Doc A/RES/73/2 (17 October 2018, adopted 10 October 2018); UN General Assembly, *Political Declaration of the High Level Meeting on Universal Health Coverage*, GA Res 74/2, UN Doc A/RES/74/2 (18 October 2019, adopted 10 October 2019).

[48] UN General Assembly, *Transforming our world: the 2030 Agenda for Sustainable Development*, Resolution 70/1, UN Doc A/RES/70/1 (21 October 2015, adopted 25 September 2015).
[4949] For a discussion on the differences between domestic and international regulation in these respects, see Allyn L Taylor and Ibadat S Dhillon, 'An international legal strategy for alcohol control: not a framework convention—at least not yet' (2013) 108 Addiction 450; Room (n 41); Allyn L. Taylor and Ibadat S. Dhillon, 'Twenty-first century international lawmaking for alcohol control' (2013) 108 Addiction 461; Jonathan Liberman, 'Alternative legal strategies for alcohol control: not a framework convention—at least not right now' (2013) 108 Addiction 459.
[50] For example, according to the WHO FCTC Secretariat in its report on dispute settlement under the treaty, no cases have been brought under the formal dispute settlement systems of multilateral environmental agreements: Conference of the Parties to the WHO Framework Convention on Tobacco Control, *Issues Related to Implementation of the WHO FCTC and Settlement of Disputes Concerning the Implementation or Application of the Convention: Report by the Convention Secretariat*, FCTC/COP/7/20 (27 July 2016).
[51] Compare World Health Organization, 'WHO Report on the Global Tobacco Epidemic 2019' (Report, 26 July 2019). and Secretariat of the WHO Framework Convention on Tobacco Control, '2018 Global Progress Report on Implementation of the WHO Framework Convention on Tobacco Control' (Report, 2018).
[52] See, eg, Jamie Enoch and Peter Piot, 'Perspective—Human Rights in the Fourth Decade of the HIV/AIDS Response: An Inspiring Legacy and Urgent Imperative' (2017) 19(2) Health and Human Rights <www.hhrjournal.org/2017/12/perspective-human-rights-in-the-fourth-decade-of-the-hiv-aids-response-an-inspiring-legacy-and-urgent-imperative/> accessed 13 August 2020; Luisa Cabal and Patrick Eba, 'Editorial—Learning from the Past: Confronting Legal, Social, and Structural Barriers to the HIV Response' (2017) 19(2) Health and Human Rights <www.hhrjournal.org/2017/12/editorial-learning-from-the-past-confronting-legal-social-and-structural-barriers-to-the-hiv-response/> accessed 13 August 2020.
[53] Kent Buse et al, 'Urgent Call for Human Rights Guidance on Diets and Food Systems' (*BMJ Opinion*, 30 October 2019) <https://blogs.bmj.com/bmj/2019/10/30/urgent-call-for-human-rights-guidance-on-diets-and-food-systems/> accessed 13 August 2020. See Office of the United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS, *International Guidelines on HIV/AIDS and Human Rights* (2006 consolidated version, UNAIDS, 2006).
[54] See Clare Slattery, 'Using Human Rights Law to Progress Alcohol Control' (2020) European Journal of Risk Regulation, available online first at <https://www.cambridge.org/core/journals/european-journal-of-risk-regulation/article/using-human-rights-law-to-progress-alcohol-control/268536F17A3EBA1C7B1A6FAB058088AD> accessed 13 August 2020; International Covenant on Economic, Social, and Cultural Rights (opened for signature 16 December 1966, entered into force 3 January 1976) 993 UNTS 3 (ICESCR); Committee on Economic, Social and Cultural Rights, General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art 12), UN Doc E/C.12/2000/4 (11 August 2000).
[55] For more on this point, see Suzanne You Zhou, 'Managing Fragmentation between International Trade and Investment Law and Global Priorities for Noncommunicable Disease Prevention in Food and Alcohol' (2018) 18(1) QUT Law Review 169-190.
[56] *Legislative Consultation with Constitutional Division of the Supreme Court* (Supreme Court (Costa Rica), No No. 2012-003918, 20 March 2012).
[57] *Ceylon Tobacco Company v Minister of Health* (Court of Appeal (Sri Lanka), No CA 336/2012 (Writ), 12 May 2014).
[58] *British American Tobacco Ltd v Cabinet Secretary for the Ministry of Health* (Court of Appeal (Kenya), No Civil Appeal No 112 of 2016, 17 February 2017).
[59] Cancer Council Victoria, 19.2 Implications of the WHO FCTC for Australia' (*Tobacco in Australia: Facts and Issues*, Septermber 2018)<www.tobaccoinaustralia.org.au/chapter-19-ftct/19-2-implications-of-the-who-fctc-for-australia> accessed 13 August 2020.
[60] *Dutch Non-Smokers Association CAN (Club of Active Non-Smokers) v The State of the Netherlands*, Case Number: 200.205.667/01, 13 February 2018 (Hague Court of Appeal).
[61] *Stichting Rookpreventie Jeugd v. de Staat der Nederlanden* (Court of First Instance of the Hague, No Case No. c/09/475711 / HA ZA 14–1193, 9 November 2015) ('*Youth Smoking Prevention Foundation v Netherlands*'). See generally Gohar Karapetian and Brigit Toebes, 'The Legal Enforceability of Articles 8.2 and 5.3 of the WHO Framework Convention on Tobacco Control: The Case of the Netherlands' (2018) 4 Brill Open Law 1-13, for discussion of these cases and overview of WHO FCTC enforcement litigation in the Netherlands.

[62] Oscar A Cabrera and Juan Carballo, 'Tobacco Control Litigation: Broader Impacts on Health Rights Adjudication' (2013) 41(1) Journal of Law, Medicine & Ethics 147-162.
[63] *Love Care Foundation v Union of India*, Writ Petition No.1078 (M/B) of 2013 (Supreme Court of India, 21 July 2014)
[64] *5000 Citizens against Article 3 of Law No. 28705*, Exp No. 00032-2010-PI/TC, 19 July 2011 (Constitutional Court of Peru).
[65] *British American Tobacco South Africa (Pty) Ltd v Minister of Health (463/2011)* [2012] ZASCA 107; [2012] 3 All SA 593 (SCA) (20 June 2012).
[66] Arrêt n° 37/2011 du 15 mars 2011, Constitutional Court of Belgium (2011)
[67] *British American Tobacco Ltd v Attorney General and Centre for Health, Human Rights and Development* (Constitutional Court of Uganda No 46 of 2016, 28 May 2019).
[68] Judgment C-830/10 (Constitutional Court of Colombia, 20 October 2010).
[69] *Action of Unconstitutionality Brought by Rodriguez Robles and Espinosa on Behalf of British American Tobacco Panama SA, against an Article in Executive Decree No. 611 of 3 June 2010 of the Ministry of Health*, Docket No. 192-11 (Supreme Court of Justice, 28 May 2014).
[70] Case No. 2158-2009 of 16 February 2010, Constitutional Court of Guatemala.
[71] See generally McCabe Centre for Law and Cancer and Campaign for Tobacco Free Kids, *Report on WHO FCTC in Legislation and Litigation* (7 August 2015); Suzanne Y Zhou, Jonathan D Liberman and Evita Ricafort, 'The Impact of the WHO Framework Convention on Tobacco Control in Defending Legal Challenges to Tobacco Control Measures' (2019) 28(Suppl 2) Tobacco Control, s113.
[72] Zhou, Liberman, and Ricafort (n 71).
[73] See eg *Philip Morris Norway AS v Ministry of Health and Care Services* (Oslo District Court (Norway), No 10-041388TVI-OTIR/02 14 September 2012) ('*Philip Morris v Norway*'); *R v Mader's Tobacco Store* [2010] NSPC (Canada) 52 ('*R v Mader's Tobacco Store*').
[74] See, eg, *Uruguay - Labelling of Packaged Foods: Statement by Uruguay to the Committee on Technical Barriers to Trade 6 and 7 March 2019*, G/TBT/W/614 (25 March 2019) ('*Uruguay - Labelling of Packaged Foods: Statement by Uruguay to the Committee on Technical Barriers to Trade 6 and 7 March 2019*'), paras 6-11.