INTERNATIONAL CONTROL OF ALCOHOL: ALTERNATIVE PATHS FORWARD

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Abstract

Alcohol was the first psychoactive substance to be subject to international control, but these agreements between colonial powers have long since fallen away. In the wake of the entry into force of the Framework Convention on Tobacco Control (FCTC), paths forward for international control of alcohol are considered. The choices embedded in the FCTC are discussed, and the justifications for a parallel convention for alcohol considered. An alternative would be scheduling alcohol under one or more of the international drug conventions, most likely the 1971 convention, though the convention would have to be amended to allow use outside “medical and scientific purposes” and without a prescription regime. In considering potential contents of an alcohol convention, it is noted that both the FCTC and the drug conventions are at least as much concerned with domestic markets as with international trade.

ALCOHOL AND INTERNATIONAL CONTROL

Alcohol was the first psychoactive substance to be subject to international control. By a century ago, an international convention among the European colonial powers was in effect concerning banning or restricting the availability of some forms of alcohol – distilled spirits, in fact – in a wide swathe of Africa (Pan, 1975; see Figure 1).

Alcohol was also the first psychoactive substance to be removed from international control. The convention provisions on alcohol fell into disuse by the 1940s, although there is evidence that British colonial authorities were still paying attention to the provisions as late as the early 1950s (Willis, 2002:223). Otherwise, international treaties concerning alcohol are limited to bilateral treaties in the 1920s in the era of national prohibitions (Tyrrell, 1997), and a provision in the Convention Concerning the Protection of Wages of the International Labor Organization, which forbids "the payment of wages in the form of liquor of high alcoholic content" (Article 4, Section 1) and the "payment of wages in taverns", except for a tavern's employees (Art. 13, Sec. 2) (ILO, 1949).

In the modern era, countries (and the subnational units which often have primary responsibility for alcohol control) have been left essentially on their own, in terms of any specific treaty provisions governing international trade in alcohol. In fact, in a world which is increasingly integrated in terms of flows of goods and travelers across borders,
this means that alcohol controls at the national level have been considerably weakened. International agreements, particularly on trade and common markets, have actively contributed to the weakening of alcohol controls (Babor et al., 2003:231-244; Grieshaber-Otto et al., 2000), with countries sometimes reciprocally seeking to tear down each other’s control systems (Room and West, 1998; Room et al., in press).

The contrast is stark between the hostility of the international trade law environment to alcohol controls and the evidence on the scope and seriousness of alcohol problems. The Comparative Risk Analysis undertaken as part of the World Health Organization (WHO) Global Burden of Disease 2000 estimates (Ezzati et al., 2002) has underlined how important alcohol is as a factor contributing to the total burden of disease. On a global basis, it is almost on a par with tobacco, accounting for 4.0% of the total burden.

Meanwhile, after a substantial effort led by WHO, a Framework Convention on Tobacco Control (FCTC) came into force on 27 February, 2005, and by mid-June, 2005 had been ratified or approved by 70 parties. In this context, the question arises, what about a new international treaty for alcohol? This paper considers precedents and options for such a treaty or agreement, and what its content might be, beginning with a consideration of the contents and implications of the newly-signed tobacco Convention.

THE FRAMEWORK CONVENTION ON TOBACCO CONTROL: THE EMBEDDED CHOICES

The Framework Convention on Tobacco Control (WHA, 2003) was adopted at the 56th World Health Assembly in May, 2003, as the culmination of a long process initiated by a World Health Assembly resolution in 1995 (Resolution 48.11). (http://www.who.int/gb/fctc/) The FCTC represents the first use by WHO of its powers, under Article 19 of its Constitution, to develop a legally binding international convention.

The instrument of a Framework Convention, as well as the content of the convention, reflected a series of choices among alternatives, most of which were already anticipated (Taylor and Roemer, 1996) at the time when the decision to press for a Framework Convention was being taken.

The decision to seek an international instrument. The first choice, of course, was to seek an international instrument for tobacco control. The justification for this decision is commonly stated in terms of four factors:

(i) the scope of the damage makes tobacco a public health tragedy of the first order; (ii) the problem exists in every country; (iii) key elements – smuggling, for instance – transcend national boundaries; and (iv) the tobacco problem has proved incapable of being fully tamed by countries acting in isolation. (Joossens, 1999).

A taken-for-granted fifth element in the decision is that there was no suitable preexisting convention or other framework within which tobacco control could be fitted. It is interesting that there is no reference in the discussion by Taylor and Roemer (1996) to the possibility of including tobacco in the international narcotics control conventions, although at the time there were at least passing thoughts in the narcotics control system about bringing tobacco within its ambit. For instance, the Director-General of the United Nations Drug Control Programme noted in 1994 that it was
increasingly difficult to justify the continued distinction among substances solely according to their legal status and social acceptability. Insofar as nicotine-addiction, alcoholism, and the abuse of solvents and inhalants may represent greater threats to health than the abuse of some substance presently under international control, pragmatism would lead to the conclusion that pursuing disparate strategies to minimize their impact is ultimately artificial, irrational and uneconomical. (Giacomelli, 1994)

Another possible framework, one which was explored by WHO in conjunction with the push for a FCTC, was the structure of collaboration between national regulators of pharmaceutical products. Under WHO auspices, there is a periodic International Conference of Drug Regulatory Authorities. At its ninth meeting in 1999, the WHO Director-General’s address included substantial attention to tobacco regulation (Brundtland, 1999), and a session was devoted to this topic at the conference. However, the Proceedings record that questions were raised as to whether tobacco would fit the legal definition of a ‘drug’ or ‘medicine’ under the existing medicines control legislation in different countries. One regulator suggested that, if tobacco could be considered as a ‘drug’, alcohol in alcoholic drinks could also become a ‘drug’ for the same reason.

The moderator’s summary accordingly retreated: the panel “did not mean to suggest that drug regulators should solve the entire problem in each country. Rather, it intended to encourage them to be part of the solution in each country…. ” (WHO, 1999)

At the end of the session, it was recommended that tobacco should be included as an agenda item at the next ICDRA conference, but it did not in fact appear on that agenda (WHO, 2002).

Clearly, a sixth element in the decision was the conviction that there was a good chance that a push for an international convention would succeed. The analysis by Taylor and Roemer (1996) was clearly attuned to the issue of the political possibilities, concluding that “the time is ripe” for “the employment of international instruments”, and calling for WHO to “develop political support for the promulgation of an international framework convention for tobacco control”.

In what venue? Two main choices were discussed for a venue in which to pursue an international treaty on tobacco control: the World Health Organization and the United Nations (Taylor & Roemer, 1996).

WHO clearly has the competence, as the “directing and coordinating authority on international health work”, to undertake the creation of international instruments relevant to health.

The UN has overlapping jurisdiction in the area of health, under Article 55 of its Charter, which includes the promotion of “solutions of international economic, social, health and related problems”. The UN has an active history of adoption of both non-binding recommendations and binding conventions with application in the health field. An example of a nonbinding statement of principles is the “principles for the protection of persons with mental illness and the improvement of mental health care”, adopted by the General Assembly in 1991 (UNGA, 1991). The International Covenants on Human Rights and the Single Convention on Narcotic
Drugs are examples of binding conventions which have application in the health field. An example currently in the process of negotiation is a proposed Comprehensive and Integral Convention on Protection and Promotion of the Rights and Dignity of Persons with Disabilities (UNGA, 2003; UN Global Programme on Disability, 2005).

In the case of a tobacco convention, Taylor and Roemer (1996:17) presented the argument for taking the route of the WHO rather than the UN in these terms: the General Assembly has neither the necessary expertise nor, perhaps, the time to engage in standard-setting in relation to tobacco control…. Most importantly, WHO has the legal capacity and the public health expertise to encourage nations to promptly adopt a framework convention and implementing protocols on tobacco control as global political consensus for these instruments develops. As the premier authority on world health matters, WHO has a unique capacity and the extraordinary opportunity to serve as a key catalyst, sponsor and negotiator for a framework convention on tobacco control.

The argument about the UN General Assembly seems somewhat beside the point. The relevant UN body to oversee negotiation of a treaty would be the Economic and Social Council (ECOSOC) rather than the General Assembly, and in any case normally a special body would be named for the actual treaty negotiation, as indeed WHO did for the negotiation of the FCTC. On the other hand, there is more strength in the argument about WHO’s special expertise in the health field, and the implicit judgement that a public health-focused body would be more likely to stay the course through a recurrent process is credible.

It should be noted, however, that for other issues which have a large health component WHO has not been the choice as the negotiating venue. The international narcotic control conventions operate under the oversight of ECOSOC, despite the fact that much of their justification is in terms of public health. The Comprehensive and Integral Convention on Protection and Promotion of the Rights and Dignity of Persons with Disabilities is being negotiated under UN rather than WHO auspices, although WHO, for instance, has the responsibility for the international classification of disabilities (WHO, 2001). In this case, it seems likely that the choice of the UN as the venue was in part a reflection of an ideological preference for framing the topic other than in medical terms:

Traditional approaches to disability have depicted it as a health and welfare issue, to be addressed through care provided to persons with disabilities in the form of charitable handouts…. This approach has also been accompanied by a way of thinking about disability (known as the ‘medical model’ of disability, among other names)…. In recent years, however, this approach has been superseded by a broader understanding of disability, sometimes referred to as the ‘social model’. This analysis recognizes that the circumstances of people with disabilities and the discrimination they face are socially created phenomena and have little to do with the impairments of people with disabilities. (United Nations Consultative Expert Group ..., 1998)

Some segments of the disability field, indeed, have been actively hostile to WHO’s actions in the field. Commenting on a Draft WHO Manual on Mental Health Legislation, a board member of the World Network of Users and Survivors of
Psychiatry offered the view that “WHO is a health agency, not a human rights agency. The public policy approach adopted by WHO in its draft legislative manual subordinates human rights to the dictates of public health as WHO defines it” (Jensen, 2001).

**What kind of instrument?** WHO’s Constitution provides for three kinds of international instruments: binding conventions under Article 19, non-binding recommendations or codes under Article 23, and binding regulations under Article 21. Under Article 21, the World Health Assembly can adopt regulations on standards for the safety, purity and potency, and for advertising and labeling, of “biological, pharmaceutical and similar products”. Despite some advantages for such an approach, Taylor and Roemer concluded that it “can never serve as a comprehensive international framework to address many of the critical issues of global tobacco control”.

Most of WHO’s actions have taken the form of recommendations to governments under Article 23. This route has been used by WHO on numerous occasions and in various forms, notably in the form of resolutions of the World Health Assembly. As noted, the effort to negotiate the FCTC is the first time WHO has sponsored a binding treaty or convention.

The basic choice between a legally binding convention or treaty, on the one hand, and a nonbinding intergovernmental resolution, code, or set of principles, on the other, also applies if the UN is the venue for action.

**Nonbinding instruments.** Taylor and Roemer (1996) subdivide the nonbinding instruments into two types. An “intergovernmental resolution” usually expresses “the common interests of many states in specific areas of international cooperation”, typically in the form of recommendations to governments. Taylor and Roemer (1996) comment that, although resolutions are much easier and quicker to adopt than treaties, they may not be effective; for example, the many WHA resolutions on tobacco “have proved insufficient as an isolated strategy to slow the growth of tobacco consumption”. Resolutions usually also do not address the issue of resources for implementation and lack effective “international machinery … for monitoring state compliance”, while this is “typically incorporated in an international convention”.

The second subtype of nonbinding instrument, an “intergovernmental code of conduct”, as Taylor and Roemer (1996) explain it, “may call upon governments to implement the terms of the code through national legislation and entreat industry to voluntarily adhere to the provisions of the code”. According to Taylor and Roemer, such codes of conduct emerged in the mid-1970s “as a new mechanism of international relations to manage the increasingly troublesome issues related to the rapid expansion of multinational business activities”. An example of such a code is the International Code of Marketing of Breast-Milk Substitutes adopted by the WHA in 1981 to set standards for advertising, labelling and marketing of infant formula (see Table 1). Taylor and Roemer point out that the process of negotiating an intergovernmental code of conduct is often quite a slow process.

Taylor and Roemer’s discussion of the advantages and disadvantages of the nonbinding measures is ambiguous and sometimes apparently contradictory.
one hand, they argue that nonbinding resolutions “may actually inhibit progress towards global control of tobacco, since their voluntary format enables nations to relieve some public pressure without resolving or committing to real action”. A code of conduct on tobacco, they conclude, “is unlikely to be effective, at least as an isolated strategy, in reducing worldwide prevalence of tobacco use”. On the other hand, they also argue that “the potential effectiveness of General Assembly resolutions in modifying state behaviour” means that it “may be an appropriate and effective approach” as a first step towards global tobacco control. With respect to codes of conduct, Taylor and Roemer give examples of some that they consider to be widely observed, noting, for instance, that “122 developing nations have sought to implement all or part of the aims of the International Code of Marketing of Breast-Milk Substitutes”. However, empirical studies of compliance with the Code published since Taylor and Roemer’s monograph are much less positive about its effectiveness (Taylor, 1998; Aguayo et al., 2003; Kean & Allain, 2004).

In the end, Taylor and Roemer’s leaning against nonbinding measures, except as possible first steps, rests on their assessment of the “extraordinary intransigence” of the tobacco industry. “The entrenched interests of global tobacco conglomerates and the adverse experiences of numerous nations with voluntary agreements with the tobacco industry” suggest to them that a code of conduct approach “may considerably delay and, perhaps, obstruct effective international legal action”.

On its face, this argument does not seem compelling. Examples given by Taylor and Roemer along the way suggest that the tobacco industry is hardly alone among international industries in pursuing its interests with as little constraint as it can manage. Thus they remark that “few countries have implemented the FAO Code of Conduct [on pesticides] into national law, and it has been widely abused by multinational enterprises in developing states”. On the other hand, there are examples, as Taylor and Roemer cite, where the moral pressure and shaming which can be brought to bear around breaches of a code or set of principles have been highly effective. Particularly in environmental matters, “at times, such intergovernmental resolutions have been highly persuasive, and the conduct of states has tended to follow the principles embodied in these non-binding pronouncements. The effectiveness of some non-binding international proscriptions in changing the environmental practices of states has led some commentators to refer to them as ‘soft law’.” The key to this effectiveness, presumably, is the presence of an engaged and activist community of non-governmental organizations, backed up by public opinion in powerful countries, keeping watch and ward.

The strongest argument against choosing the option of a nonbinding instrument may be the competitive force of binding conventions or treaties which intersect with the subject-matter under consideration. With respect to psychoactive substances which are also trade commodities, such as tobacco, alcohol or medications, a major consideration is the existence and development of trade and free market agreements globally (under the World Trade Organization), regionally and bilaterally. Public health interests are not routinely represented at the table in trade treaty negotiations, or in the resolution of disputes under such a treaty, and resolutions of codes of conduct will carry little weight as a counterbalance in such situations.
Legally binding instruments. Apart from the approach through regulations under WHO’s Article 21, which (as noted) they dismiss as unsuitable for a comprehensive approach, Taylor and Roemer (1996) divide legally-binding treaties or conventions also into two subtypes. One is the conventional comprehensive treaty. Taylor and Roemer cite an authority on international law, Oscar Schachter, to the effect that “nations tend to comply with international conventions even when it does not appear in their immediate interests to do so because, in many countries, officials are sensitive to the anticipated criticism in international circles or the expected disapproval by influential domestic leaders or groups…. International organizations, nongovernmental organization and other groups have also become highly effective in mobilizing the ‘politics of shame’ to ensure member state compliance with international law.” On the other hand, Taylor and Roemer note, treaty-making is a slow process; the average multilateral treaty does not become effective until five years after formal agreement has been reached. The process for an ambitious, comprehensive treaty may take much longer. Thus it was 25 years after the initiation of negotiations on the Law of the Sea Convention that it entered into force.

The other subtype is the “convention-protocol approach”, the approach of the FCTC. Taylor and Roemer note that this approach has been used successfully in the environmental field, with the 1979 Convention on the Conservation of Migratory Species of Wild Animals as an early example. “The convention-protocol approach does not try to resolve all substantive issues in a single document: rather it divides the negotiation of separate issues into separate agreements. States first adopt a framework convention that calls for cooperation in achieving broadly stated goals”, with “separate protocols containing specific measures designed to implement these goals”. Taylor and Roemer note that that such an approach “may actually inhibit progress towards global control of tobacco: the broad format of the framework convention enables nations to relieve some public pressure for action without resolving or committing to taking concrete steps to control tobacco production and consumption”. But by the same token, “it is likely to be more politically acceptable than any other binding approach to global tobacco control”. And, they note, “the framework convention creates an institutionalized forum for cooperation and negotiation for implementing protocols containing detailed obligations”.

Viewed from the perspective of 2005, the distinction between a framework convention or convention-protocol approach and a regular treaty or convention approach seems rather blurred. If we take the international narcotic control conventions as examples of regular treaties, they include many examples of the features claimed as advantages for the framework convention approach:

- an example of a protocol added to a convention -- the 1972 Protocol to the 1971 Single Convention;
- relatively simple provisions for modification in some respects as conditions change – provisions in all three conventions for adopting and changing schedules and classifications of particular substances, in line with technical advice; and
- ongoing institutionalized fora for cooperation and negotiation: the annual sessions of the Commission on Narcotic Drugs and the International Narcotics Control Board.
On the other hand, in its final form the FCTC includes many specific provisions which go well beyond broad statements of goals (see Tables 1 and 2). For instance, the FCTC includes requirements that countries adopt:

- within three years of joining the Convention, specified rules on product packaging and labeling, including health warnings, spelled out in considerable detail (Article 11);
- within five years, restrictions or a comprehensive ban on tobacco advertising, promotion and sponsorship (Article 13); and
- measures prohibiting tobacco sales to and by minors, along with a number of specified measures to increase the effectiveness of the prohibition (Article 16).

The point of billing the treaty as a Framework Convention may have been more political than substantive. To call the goal a Framework Convention signalled from the start that the enterprise was viewed as an ongoing process, rather than one which reached a goal and ended; and that the aim was to proceed in pragmatic steps within the limits of the politically possible, rather than to hold out for measures reflecting the full aims of public health activists.

WHAT KIND OF INTERNATIONAL INSTRUMENT FOR ALCOHOL?

*The justification for seeking an international instrument.* The first five of the six justifications discussed for seeking an international convention on tobacco apply at least as much to alcohol. As we shall discuss, the sixth is somewhat more problematic.

1. The scope of the damage from alcohol is arguably larger than for tobacco. In the Comparative Risk Analysis conducted as part of the Global Burden of Disease, alcohol accounted for almost as many disability/adjusted life-years (DALYs) lost as tobacco – 4.0% vs. 4.1%. The figure for alcohol is a net figure, after subtracting any health-protective effects of alcohol, primarily for heart disease. However, unlike tobacco, alcohol is also responsible for a substantial burden of work, family and other social problems not included in the Global Burden of Disease estimates. While estimation of the social problems from drinking is not nearly as well developed as for the health problems, estimates in some societies suggest that the burden of social harm from drinking is roughly equal to the burden of health harm (Babor et al., 2003).

2. The damage from alcohol is substantial in most regions of the world. Exceptions to this are some Moslem countries where use of alcohol at all is relatively uncommon. While the highest levels of alcohol consumption are found in European countries, alcohol’s contribution to lost DALYs seems to be highest in the developing countries with the lowest mortality and the best record of economic growth (Ezzati et al., 2002).

3. Key elements of alcohol problems transcend national borders. Although most alcohol is consumed in the country in which it is produced, alcohol is an increasingly important commodity in international trade, and smuggling and informal cross-border trade is an increasing problem both in developing and developed parts of the world.

4. Although alcohol policies have typically been a national or a subnational matter, there is ample experience in the present-day world that the problem of alcohol...
cannot be dealt with by countries in isolation. This is not only a matter of illicit trade across borders. In an increasingly integrated world, there is also a substantial need for comity – for nations to honour and support the alcohol control policies of other countries.

5. As noted earlier, alcohol is in much the same situation as tobacco in terms of the lack of any suitable pre-existing convention or other international agreement.

6. Alcohol and tobacco are in different political situations. For a number of reasons, there is likely to be more difficulty in gaining international agreement on a convention for alcohol than there was for tobacco.

- In north America and many European countries, anti-tobacco campaigns and programs have been well-established as part of public health and in the public arena for a number of years. The counter-campaign by the heavily-concentrated multinational tobacco industry, while successful in the short run, laid up a record of power politics and bad-faith dealing which has now come back to haunt it. The alcohol industry, on the contrary, has had a much better press and has been treated by public health agencies much more gently (Jones, 2003).

- For tobacco, the public health message is clear and unambiguous: smoking at all is a threat to health, both for the individual and in terms of the society. The alcohol message, in contrast, tends to be complicated: don’t drink too much, though “moderate drinking” may be good for your health; and don’t drink too much if you might end up driving at the end of the evening.

- In most countries, politicians, and middle- and upper-class people generally, are more likely to drink, and more likely to drink regularly, than the population at large. On the contrary, in many countries tobacco smoking is becoming associated with lower- rather than middle- or upper-class lifestyles. For politicians and journalists, alcohol tends to be “our drug”, while tobacco is increasingly “theirs”.

- In many developing countries – particularly former British colonies – drinking some forms of alcohol was a prerogative of the colonialists (Room et al., 2002), and the colonial drinking-style tended to be taken up by elements of the new national elite. In some countries, alcohol has still not lost its association with freedom and self-determination. On the other hand, alcohol is forbidden to any faithful follower of Islam, and abstention is also recommended or honoured in many other religious traditions.

In terms of the first four factors, those put forward by Joossens (1999) as justifications for seeking a tobacco convention, it is clear that alcohol qualifies at least as strongly as tobacco. The problem for alcohol will be determining when the sixth criterion is met – that the time is ripe.

Binding or nonbinding? As noted, the foremost example of a nonbinding instrument under WHO auspices is the International Code of Marketing of Breast-Milk Substitutes (http://www.who.int/nut/documents/code_english.PDF), adopted in 1981 and reaffirmed in 1996. At the time of its adoption, it was extremely controversial, and was a main cause of the U.S. Reagan Administration’s suspicions that WHO’s programs were not “in accord with the principles of private enterprise” (Starrels, 1985; Jernigan & Mosher, 1988). Table 1 summarizes provisions of the Code which concern market controls inside countries; the code contains no provisions for international controls, other
than a requirement for annual national reports to WHO, and a biennial status report by the WHO (§§11.6, 11.7).

In the wake of the Code’s passage, the participants in the Technical Discussions on alcohol at the World Health Assembly in 1982 called for negotiation of an International Code of Practice on trade in alcohol (Jernigan & Mosher, 1988). However, with the subsequent downgrading of the WHO alcohol programme (Room, in press-a), this idea was not picked up.

Intergovernmental resolutions on alcohol already exist -- in the form, for instance, of WHA resolutions in 1979, 1983 and 2005. In the WHO European Region, specific nonbinding instruments have been adopted: the 1995 European Charter on Alcohol (http://www.euro.who.int/AboutWHO/Policy/20010927_7), the 2001 Declaration on Young People and Alcohol (http://www.euro.who.int/AboutWHO/Policy/20030204_1) and the 2000-2005 European Alcohol Action Plan (EAAP; http://www.eurocare.org/pdf/who/2000-05eaap.pdf). The last-named of these includes a number of specific actions which are recommended to countries in the region in pursuit of ten sets of outcomes. However, the Plan’s legal force does not go beyond recommendations, and there is no formal mechanism for measuring compliance with the recommendations beyond the general commitment that the WHO Regional Office will “identify and draw attention to persistent or emerging health concerns”. The fact that actions by governments and European Union organs contravene the recommendations of the EAAP draws little or no attention – for instance, when the British government’s new alcohol Licensing Act, allowing round-the-clock opening of taverns, contravenes the EAAP recommendation that governments “control the availability of alcohol by … restricting hours or days of sale”; or when the Danish and Finnish governments, in reducing spirits taxes, move in the opposite direction from the recommendation that governments “develop a taxation policy that ensures a high real price of alcohol”.

On the other hand, actions taken under treaties and other binding international instruments have become major threats to the ability of national states to control and reduce alcohol-related problems. Trade dispute adjudications and negotiations have constrained the abilities of national and subnational governments to restrict the alcohol market (Babor et al., 2003:230-244; Room et al., in press), and further such restrictions are under consideration (Grieshaber-Otto & Schacter, 2002). A binding public health-oriented agreement on alcohol control is needed as a means of countering these developments.

In what venue? The basic choices laid out by Taylor and Roemer (1996) apply to alcohol as well as tobacco: the WHO has special jurisdiction over health issues, while the UN has concurrent jurisdiction over health as well as other topics.

As the Comparative Risk analyses for WHO’s Global Burden of Disease 2000 estimates (Rehm et al., 2004) make clear, alcohol has a very substantial impact on public health. But while most of the problems from tobacco fall in the sphere of public health, problems from alcohol are not limited to this sphere; alcohol also makes a substantial contribution to social problems. Estimates of the burden of societal responses in several developed countries suggest that the burden of alcohol on social services and policing equals or exceeds the burden on health services
(Babor et al., 2003). This means that a good part of the harm from alcohol lies outside the core territory of WHO’s competence (though admittedly very little lies outside the broadest WHO definition of health).

It has been argued (Hauge, 2000) that the formulation of arguments concerning alcohol policy in public health terms has weakened the political power of the arguments:

The earlier main aim of alcohol policy was to prevent the occurrence of the ill effects of alcohol that generally visited third parties: the victims of the abusers’ criminal activities, relative reduced to poverty because the money to support them went to drink, or children neglected and mistreated by their drunken parents. But influenced by the public health perspective, the central objective [becomes instead] to avert health problems befalling the drinkers themselves.

Hauge points out that this is politically a much weaker argument, involving the kind of “paternalistic considerations [which] are accepted in the main only in relation to children, the mentally impaired, and others considered unable to act rationally”.

On the other hand, at the international level, WHO has a long tradition of at least some attention to alcohol (Room, in press-a), with work in the area continuing today, whereas there has been little attention to the topic by other global intergovernmental bodies. And many of WHO’s present-day programs -- for instance, on the prevention of violence (Krug, 2002), or for that matter the Code on the Marketing of Breast-Milk Substitutes (WHO, 1981) – involve issues where actions by one person or group result in harm to another. Public health approaches to alcohol are increasingly including harms to others besides the drinker in their analysis (Babor et al., 2003).

What would lie down the road if the choice were to seek action through a UN body? The responsibility would undoubtedly be assigned to the UN’s Economic and Social Council (ECOSOC). In that context, the issue of the relation of alcohol to the international narcotics control conventions and machinery would undoubtedly come up.

One option would be to add alcohol to the lists of substances covered by one or more of the three Conventions controlling drugs. For the 1961 and 1971 Conventions, this would be accomplished by a recommendation from an Expert Committee of WHO for such scheduling, including which schedule it should be added to, and approval at the annual meeting of the Commission on Narcotic Drugs. The 1961 Convention. The 1961 Convention primarily covers opiates, cocaine and cannabis. However, Article 3, Paragraph 3(iii) provides that

if the World Health Organization finds that [a substance it is considering] is liable to similar abuse and productive of similar ill effects as the drugs in Schedule I or Schedule II … it shall communicate that finding to the Commission which may, in accordance with the recommendation of the World Health Organization, decide that the substance shall be added to Schedule I or Schedule II.

The official Commentary on this section, prepared by Adolf Lande, former Secretary of the bodies which preceded the International Narcotics Control Board, notes that it is “generally left to the judgement of the World Health Organization to decide what it
considers as ‘similarity’” (UN, 1973:87). However, the Commentary notes a 1969 ruling by the Office of Legal Affairs that barbiturates, tranquillizers and amphetamines – which were to become the focus of the 1971 Convention – were “outside the scope” of the 1961 convention, since “there was an understanding” to that effect “at all stages of the drafting” of the 1961 Convention. On the other hand, the Legal Office also stated that this obstacle “could informally be removed by agreement” among the parties to the Convention.

From the point of view of the wording of the 1961 Treaty itself, there would be no bar to including alcohol, if an WHO Expert Committee decided that alcohol is liable to at least as much abuse and productive of at least a much in the way of ill effects as any substance covered by the Convention, and this decision was then approved by the Commission and ratified by the UN Economic and Social Council (see Article 3 of the Convention). A strong argument can be made that alcohol qualifies under these criteria (see Hall et al., 1999).

The 1971 Convention. A “psychotropic substance” may be scheduled under the 1971 Convention:

if the World Health Organization finds

(a) that the substance has the capacity to produce

(i) (1) a state of dependence, and

(2) central nervous system stimulation or depression, resulting in hallucinations or disturbance in motor function or thinking or behaviour or perception or mood, or

(ii) similar abuse and similar ill effects as a substance [already covered by the Convention], and

(b) that there is sufficient evidence that the substance is likely to be abused so as to constitute a public health and social problem warranting the placing of the substance under international control…. (Article 2, Paragraph 4)

If alcohol were considered by a WHO Expert Committee for scheduling, it seems certain that, by this criterion, alcohol would be recommended for scheduling under the Convention. As the official Commentary prepared by Lande notes, “alcohol appears to be covered by both” clauses (i) and (ii).

There is also ample evidence that it is being widely abused so as to constitute a very serious ‘public health and social problem’. Alcoholism is, moreover, a serious problem in many countries, and in this sense it is a very important international problem.

Nevertheless, alcohol is not fully covered by the [specified] terms … and therefore cannot be placed under the control of the … Convention. The “public health and social problem” which alcohol presents is not of such a nature as to warrant it being placed under “international control”…. Alcohol does not “warrant” that type of control because it is not “suitable” for the régime of the [1971] Convention. It appears to be obvious that the measures that the application of the administrative measures for which the treaty

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1 A footnote in the Commentary adds: “or for the régime of the [1961] Convention”.

12
provides would not solve or alleviate the alcohol problem. In fact this was also the view of the 1971 Conference, which did not intend to apply the … Convention to alcohol…. (UN, 1976:48)

The Commentary then goes on to provide similar reasoning for the why tobacco “is not covered” by the paragraph.

A quarter-century later, the reasoning offered by the Commentary seems relatively easily countered. Though those negotiating the 1971 Convention may not have intended to include alcohol (or tobacco), there is no exclusionary wording in the Convention. There is a great deal of smuggling of alcohol into a number of countries, evidence in itself that the lack of controls in one country weakens the control in other countries. There is ample evidence that controls on the alcohol market can reduce rates of problems related to drinking (Babor et al., 2003; Room et al., 2002).

The implications of coverage under the 1971 Convention. While alcohol might well also be schedulable under the 1961 Convention, it seems more likely that the 1971 Convention would be applied. We might guess that alcohol would be assigned to Schedule II: “substances whose liability to abuse constitutes a substantial risk to public health and which have little to moderate therapeutic usefulness”, or to Schedule III, which differs only by indicating “moderate to great therapeutic usefulness”.

Tables 1 and 2 list, respectively, the requirements of intranational measures and of cooperation on international control required for substances covered by the 1971 Convention. Scheduling alcohol in Schedule II or Schedule III of the Convention would immediately raise two important problems. The sections which it would be problematic to apply to alcohol are Article 5, 2nd paragraph, and Article 9, first paragraph:

- Use and possession of the substance is to be limited “to medical and scientific purposes” (Art. 5, Para. 2)
- A country must require that the substance “be supplied or dispensed for use by individuals pursuant to medical prescriptions only, except when individuals may lawfully obtain, use, dispense or administer such substances in the duly authorized exercise of therapeutic or scientific functions”. (Article 9, Para. 1)

However, “small quantities” can be retailed without prescription “for use for medical purposes by individuals in exceptional cases”. (Para. 3)

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2 A footnote refers back to an earlier paragraph of the Commentary, from which “warrant” and “suitable” have been quoted. That paragraph reads, in part: “The ‘public health and social problem’ must be of such a kind as to warrant ‘international control’. If the substance is abused or likely to be abused in more than one country so as to constitute a public health and social problem in those countries, the problem is ‘international’; but this international character alone does not warrant ‘international control’. What is required is that the controls of the … Convention are suitable to solve or at least to alleviate the problem and that lack of those controls in one country … weakens the control in other countries which have such a problem.” (UN, 1976:47)

Conceivably, it could be argued that moderate use of alcohol serves a “medical purpose”, given the evidence of health-protective effects of small amounts of alcohol. However, there is no question that the 1971 Convention can only reasonably be applied to alcohol if a way can be found to exempt alcohol from Articles 5 and 9. In all its other main provisions, the 1971 Convention would be very suitable for application to alcohol.

The 1988 Convention. The 1988 Convention against Illicit Traffic in Narcotic Drugs and Controlled Substances includes provision for a system to monitor the international trade in “substances used in the illicit manufacture of narcotic drugs or psychotropic substances” (Article 12). Import and export documentation is required for substances on the Convention’s Tables I and II, and countries may request prior notification of shipments to the country of substances on Table I.

Substances listed in the tables of the 1988 Convention are primarily not themselves psychoactive, although the lists do include psychoactive substances (e.g. ephedrine). Technically, alcohol could clearly be included in the tables, as it has frequently been used as a solvent in medications (“tinctures”), including medications such as laudanum which contain opiates. The Convention’s requirements for import and export documentation, and for prior notification of shipments, would be extremely useful in discouraging international smuggling of alcoholic beverages.

Seeking coverage of alcohol under the 1988 rather than the 1971 Convention would have the advantage of not requiring amendment or other neutralization of Articles 5 and 9 of the 1971 Convention. However, there are many other aspects of the market in a substance consumed for its own sake on which the 1988 Convention is silent, so that coverage under the 1988 Convention would be just a first step in what would be desired from an international agreement on public health aspects of alcohol. It is also clear that the 1988 Convention’s focus is on chemicals “used in the illicit manufacture of … psychoactive substances”, and brewers and vintners, for instance, would no doubt protest vigorously and with some justification against their products being defined this way.

CONTENT OF A FRAMEWORK CONVENTION ON ALCOHOL CONTROL

Procedurally and technically, including alcohol under the 1971 Convention would be a simple path forward. But enormous resistance to this could be expected, both from the alcohol beverage industry and in terms of the cultural understanding of alcohol among elites in most countries and among ordinary people in quite a few countries. Politically, the path forward would be difficult, and made more difficult by the necessity to do something about Articles 5 and 9. There would also be a need for some reorientation of the agencies responsible for managing the drug conventions and their staff, away from an overwhelming emphasis on enforcement and crime and towards a more public health-oriented approach.

The controversy which would be generated by an effort to list alcohol under the 1971 Convention might be regarded in itself as a useful exercise in public education. It may be argued, however, that the effort to frame and to gain signers and ratification of a convention specifically on alcohol would provide a somewhat simpler focus for public education, without the complications involved in taking on the reorientation of the illicit drug control system. Something like such considerations
presumably lay behind the fact that those seeking international control on tobacco seem never to have publicly considered moves to schedule tobacco under the Conventions.

The alternative binding instrument would be something like a Framework Convention on Alcohol Control. To a considerable degree, this could be modeled on the Tobacco Convention. In terms of domestic measures, most of the provisions listed in Table 1 would apply, although alcohol controls, partly reflecting the much longer period of control measures in many countries, are often more developed and have somewhat different emphases from tobacco control.

Control of the domestic market. Licensing of production, distribution and retailing of alcohol, for instance, has a long history in many countries, and has been much more extensively used for alcohol than for tobacco. It should be required or strongly urged in the Convention. An alternative to licensing, as in the 1961 Narcotics Convention (Article 23), should be state monopoly of the production, distribution, and/or retailing. Licensing and monopolization provide effective means of state control of the industry and market; in the case of licensing, the threat of withdrawal of a license is a cost-effective spur to compliance on the part of commercial interests. As a condition of licenses, requiring record-keeping by manufacturers, distributors and retailers (a prominent feature of the drug conventions, but not mentioned in the FCTC) is an important means of ensuring taxes are paid and the product stays within legitimate channels.

Testing, measuring and regulating the contents, and requiring labels with alcohol strength and other information, including health and safety warnings, should be required for alcohol, as they are in the FCTC.

Taxation is as important a measure for minimizing rates of harm related to alcohol as it is for tobacco, and language urging its use as “effective and important” should be included as in the FCTC. Prohibition of sales to minors is also as relevant for alcohol as it is for tobacco.

The FCTC’s other provisions on controls of sales, concerning free distribution, self-service sales and sales in vending machines, to some extent reflect the particular history and circumstances of tobacco sales. For alcohol, the important point is the more general one that limiting the numbers, locations and types of on-premise and off-premise sales points, and their hours and days of opening, have been in many countries an effective way of reducing harm related to drinking, including reducing access for minors. Countries should be urged to adopt and enforce measures to limit availability by time and place which are culturally appropriate and effective.

Unlike for tobacco, liability of producers of legal alcohol has not been established in any legal system,4 while liability of sellers has been established in some U.S. jurisdictions, and to a limited extent in other British common-law countries (Goodliffe, 2003). The general principle that the seller has legal liability for harm resulting from sales that are defined as illegal (e.g., to an under-age person, or to someone already drunk), should be encouraged for the purposes of alcohol control. There is some evidence of its effectiveness for this purpose (Babor et al., 2003:144-145).

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4 For a case study in the failure of such an effort in the U.S., see Golden (2005).
There will probably be little resistance to including in an alcohol convention provisions against any trade which is illicit under local law, since such legislation is close to universal. The separate, important but more difficult issue of legislation controlling trade which is illicit elsewhere is discussed below.

Restriction of advertising and other promotion will be an important topic for discussion in negotiations for an alcohol convention. The FCTC’s provisions for banning it if constitutionally allowed, and otherwise restricting it, would be appropriate for alcohol (although the emphases in the restrictions would be different), but this area will be hard-fought.

Primary attention in terms of limits on times and occasions of use of alcohol should be given to drinking-driving legislation, which should include a requirement of a per-se law criminalizing driving a motor vehicle with a blood-alcohol level of .05% or above, and a recommendation for active use of deterrent enforcement such as random breath-tests. Beyond this, it might be appropriate to specify circumstances in which any significant drinking of alcoholic beverages should be discouraged, including the workplace, pregnancy, or when engaged in dangerous activities. Otherwise, the “enclaving” of alcohol in terms of particular types of occasions and times in the weekly or seasonal round is well established in most cultures, but differs considerably from culture to culture, and probably should not appear in an international convention.

It would be appropriate to include provisions for providing and promoting treatment, and for promoting awareness of alcohol problems. As a matter of course, these would be worded differently from those in the FCTC.

**International control.** The heart of the FCTC’s purpose with respect to controlling the international market is to establish comity with respect to national laws, so that nations are obliged to support another nation’s laws concerning what is legal and illegal on that nation’s territory. This is accomplished in the FCTC, as noted above, by the way that “illicit trade” is defined. The other provisions concerning international trade in the FCTC in support of this principle, including provisions on product markings, tracking and tracing regimes, and exchange of information, are also appropriate for alcoholic beverages. The wording of the FCTC for these provisions is predominately voluntary rather than in terms of requirements. It would be highly desirable, in terms of reducing international smuggling of alcohol, that the provisions be mandatory as in the 1971 Convention.

**Alternative development.** Unlike cigarettes or cocaine, alcoholic beverages are made from a variety of agricultural materials, with considerable substitution between different materials according to costs for many spirits and brewed beverages. Wine-grape growing is the crop which would be most obviously and specifically affected by a reduction in alcohol consumption. Accordingly, the European Union has spent large sums in recent decades to ease the crisis of overproduction of wine in Europe, including support for crop substitution and what might be called “alternative development”. Few low- or middle-income countries are prominent in terms of wine production (exceptions include Chile, Argentina and Moldova), but such countries might be considered for alternative development assistance if an alcohol Convention
actually reduces world alcohol consumption, rather than simply holding down the rate of increase.

The strongest argument for alternative development with respect to alcohol lies in another direction – with the home and cottage producers and sellers of indigenous brewed beverages in Africa and Latin America. Often these small producers and sellers are single women with children, where the whole family is dependent on these resources (Maula, 1997). Development and industrialization tends to mean the replacement of these small-scale producers by industrial production, whether by western-style beer or by industrial forms of indigenous beverages (Room et al., 2002). It would be useful and practical to take the precedent of the FCTC and build into an alcohol convention provision for support of alternative development in such circumstances.

Collecting and sharing information and expertise. The many provisions of the FCTC in this area should be adopted without much change in an alcohol convention.

Institutional arrangements. Again, the provisions of the FCTC could be adopted without substantial change. However, it may be possible to take advantage of the precedents established in the ongoing negotiations to implement the FCTC, and spell out these arrangements more specifically in the alcohol convention.

THE DEMONSTRATION EFFECT OF PURSUING AN ALCOHOL CONVENTION

It has been a common experience in alcohol policy, as for other policies, that the public discourse and debate about adopting a policy is as important in changing behaviour, at least initially, as the legal instruments which are the result of the debate. Thus Hingson et al. (1987) found a decrease in drink-driving casualties in Maine and Massachusetts in connection with the adoption of new laws against drink-driving – but found that the main effects occurred prior to the actual passage of the laws, during a period of societal debate about their substance. Likewise, Møller (2002) found a reduction in drinking among Danish teenagers aged 15 and above, as well as a greater reduction among younger teenagers, when a law was passed instituting a minimum legal off-sales purchasing age of 15. He interpreted this finding as reflecting that the law resulted from “a huge discussion in Denmark about teenagers’ drinking … during the whole of 1998”, which had sensitized parents to “pay attention to and be more concerned about their children’s drinking”.

Discussion in the World Health Assembly about the need for and potential provisions of an international instrument on alcohol is quite likely in itself to have some effects. Thus, for example, the principles and objectives of the WHO European Alcohol Action Plan were taken home to Italy and incorporated into the national legislation on alcohol and alcohol-related problems passed in 2001 (Patussi, 2001; Scafato, 2001). Negotiation of a convention or other intergovernmental instrument is also likely in itself to affect action at the national level, often in complex ways. Thus one motivation for the domestic anti-narcotic legislation in the U.S. in 1906 and 1909
was to strengthen the U.S.’s position in the negotiations at the inception of the international drug control system (Bewley-Taylor, 1999:21-22).

The implementation of a psychoactive substance convention can also be expected to have substantial concrete effects, particularly on the legal international trade and markets in the substance. While the international drug control conventions cannot be considered very successful in suppressing the trade in drugs defined by them as illegal, they have had substantial effects on the licit trade in pharmaceuticals, playing a part, for instance, in the near-disappearance of problems from barbiturate use from the global scene.

Though the primary justification for an international convention is the need for international action about trade and problems which cross boundaries, the strongest effects of such conventions may be at national and sub-national levels. The broad coverage in the FCTC of measures in the domestic market, stated often in terms of encouragement rather than requirement, reflects its framers’ intentions to set new norms and practices not only for international trade but also for national and subnational legislation and regulation.

REFERENCES


Jones, A. (2003) First the target was tobacco. Then burgers. So how has Big Alcohol stayed out of the lawyer’s sights? *Financial Times*, 8 July.


Figure 1. The “African Prohibition Zone” under the Brussels General Act of 1890, effective in 1901. (Hayler, 1913:202)
Table 1. Convention and code requirements of domestic measures to control the market and use

<table>
<thead>
<tr>
<th>Measure</th>
<th>FCTC – tobacco</th>
<th>1971 Convention – e.g., amphetamine</th>
<th>Breast-milk substitutes code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Licensing of production, distribution, retailing</td>
<td>Optional (§15.7)</td>
<td>required (§8); also inspections (§15)</td>
<td>-</td>
</tr>
<tr>
<td>Record-keeping</td>
<td>-</td>
<td>required for manufacturers, distributors, retailers (§11)</td>
<td>-</td>
</tr>
<tr>
<td>Testing, measuring regulating contents</td>
<td>Required (§9)</td>
<td>-</td>
<td>required &amp; specified (§9.4)</td>
</tr>
<tr>
<td>Labeling contents</td>
<td>Required for constituents &amp; emissions (§11.2); and for where to be sold (§15.2.a)</td>
<td>(declaration of contents attached to export packages §12.2)</td>
<td>-</td>
</tr>
<tr>
<td>Warnings on or in packaging</td>
<td>Required, detailed (§11)</td>
<td>required (§10)</td>
<td>required (§9.2)</td>
</tr>
<tr>
<td>Taxation</td>
<td>urged as “effective and important” (§6)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Subsidies/bonuses to distributor, marketer</td>
<td>-</td>
<td>-</td>
<td>forbidden (§6.4, 7.3, 8.1)</td>
</tr>
<tr>
<td>Limits on numbers of outlets, opening times</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Distribution free or in small quantities</td>
<td>Prohibited (§16.2&amp;3)</td>
<td>-</td>
<td>forbidden, if to general public (§5.2)</td>
</tr>
<tr>
<td>Sales in vending machines</td>
<td>Optional commitment to prohibit (§16.5)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Self-service sales</td>
<td>Optional ban (§16.1.b)</td>
<td>(requirement for prescription §9)</td>
<td>-</td>
</tr>
<tr>
<td>Sales to minors</td>
<td>Prohibited (§16)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Liability of producers or sellers</td>
<td>Encouraged “for the purpose of tobacco control” (§19)</td>
<td>(confiscation of illicit goods §22.3)</td>
<td>-</td>
</tr>
<tr>
<td>Legislation against illicit trade</td>
<td>Required (§15.4.b)</td>
<td>required, as “punishable offence” (§22)</td>
<td>-</td>
</tr>
<tr>
<td>Advertising</td>
<td>banned if constitutionally allowed; otherwise restricted (§13)</td>
<td>banned to the general public (§10.2)</td>
<td>forbidden, if to general public (5.1)</td>
</tr>
<tr>
<td>Other promotion, sponsorship</td>
<td>banned if constitutionally allowed; otherwise restricted (§13)</td>
<td>-</td>
<td>no point-of-sale promotions, gifts of paraphernalia (§5.3&amp;4)</td>
</tr>
<tr>
<td>Limits on times, occasions of use</td>
<td>Protection required from tobacco smoke in indoor public &amp; workplaces (§8)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Providing and promoting treatment</td>
<td>Encouraged (§14.2)</td>
<td>encouraged (§20)</td>
<td>-</td>
</tr>
<tr>
<td>Promoting public awareness</td>
<td>Required (§12)</td>
<td>required “if there is a risk that abuse … will become widespread” (§20.3)</td>
<td>government responsibility for information &amp; education (§4.1)</td>
</tr>
</tbody>
</table>
Table 2. Convention requirements for cooperation on international control

<table>
<thead>
<tr>
<th>Requirement</th>
<th>FCTC – tobacco</th>
<th>1971 Convention – e.g., amphetamine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enacting and strengthening legislation against illicit trade</td>
<td>Required (§15.4.b)</td>
<td>required (§21, 22)</td>
</tr>
<tr>
<td>Cooperation with other countries and with international organizations</td>
<td>Encouraged “as appropriate” on policies (§5), and “as mutually agreed” on expertise and assistance (§22)</td>
<td>“having due regard to ... constitutional, legal and administrative systems”, required for action against illicit traffic (§21)</td>
</tr>
<tr>
<td>Requiring and exchanging import and export authorizations</td>
<td>to consider “developing a practical tracking and tracing regime” (§15.2.b)</td>
<td>required; import authorization required before issuing a matching export authorization (§12)</td>
</tr>
<tr>
<td>Support other country’s prohibition of specific substance</td>
<td>-</td>
<td>required to ensure no export to that country (§13.2)</td>
</tr>
<tr>
<td>Sales and imports of tax- and duty-free products</td>
<td>May prohibit or restrict “as appropriate” (§6.2.b)</td>
<td>-</td>
</tr>
<tr>
<td>Marking products with destination and origin</td>
<td>Required (§15.2)</td>
<td>(export declaration including contents with package §15.2.b)</td>
</tr>
<tr>
<td>Monitoring &amp; controlling of goods in transit or bonded</td>
<td>Required for products held or moving “under suspension of taxes or duties” (§15.4.d)</td>
<td>required (§12.3.c&amp;f)</td>
</tr>
<tr>
<td>Seizure and confiscation of manufacturing equipment and goods in illicit trade</td>
<td>Destruction of seized equipment and goods required (§15.4.c)</td>
<td>required (§22.3)</td>
</tr>
<tr>
<td>Confiscation of proceeds derived from illicit trade</td>
<td>to be adopted “as appropriate”</td>
<td>(covered by Article 5 of 1988 Convention)</td>
</tr>
<tr>
<td>Elimination of cross-border advertising, promotion, sponsorship</td>
<td>May ban and penalize such cross-border promotion on basis equal to penalties on domestic promotion (§13.7)</td>
<td>-</td>
</tr>
<tr>
<td>Assistance to other countries on civil or criminal liability</td>
<td>Encouraged (§19.3)</td>
<td>(§5 of 1988 Convention has detailed provisions for collaboration on confiscations)</td>
</tr>
<tr>
<td>Reporting requirements to international bodies</td>
<td>Periodic reports, on a schedule to be agreed on, on laws, surveillance, taxation, trade, etc. (§21)</td>
<td>annual statistical reports; annual report on changes and developments (§16)</td>
</tr>
</tbody>
</table>