

## **A Chilling Example? Uruguay, Philip Morris International, and the WHO's Framework Convention on Tobacco Control**

### **Abstract**

The World Health Organization's Framework Convention on Tobacco Control (FCTC) is the first international public health treaty to address the global spread of tobacco products.

Ethnographic research at the 4<sup>th</sup> meeting of the FCTC's Conference of the Parties in Uruguay highlights the role of the FCTC in recalibrating the relationship between international trade and investment agreements and those of global public health. Specifically, we chart the origins and development of the Punta del Este Declaration, tabled by Uruguay at the conference, to counter a legal request by Philip Morris International, the world's largest tobacco transnational, for arbitration by the International Centre for the Settlement of Investment Disputes over Uruguay's alleged violations of several international trade and investment treaties. We argue that medical anthropologists should give greater consideration to global health governance and diplomacy as a potential counterweight to the 'politics of resignation' associated with corporate capitalism.

### **Key words**

Tobacco control, Uruguay, public health, international law, global health governance, global health diplomacy, politics of resignation

## **A Chilling Example? Uruguay, Philip Morris International, and the WHO's Framework Convention on Tobacco Control**

### **Introduction**

In this article, we present an ethnographic study of the WHO's Framework Convention on Tobacco Control (FCTC), the first international public health treaty ever negotiated by the WHO (Nikogosian 2010), and one of the most quickly and widely embraced treaties in the history of the United Nations (UN). We urge medical anthropologists to pay greater attention to these new and emergent forms of global public health governance. The assembly that governs the FCTC is the Conference of the Parties, a body made up of representatives from all countries that have ratified the treaty. This article is based on research conducted during the 4<sup>th</sup> meeting of the FCTC Conference of the Parties (COP4) held in Punta del Este, Uruguay, in November 2010. We focus particularly on a Declaration, the Punta del Este Declaration, tabled by Uruguay on Day 1 of the conference. We contextualise the Declaration with reference to an ongoing legal dispute between the tobacco transnational Philip Morris International (PMI) and the government of Uruguay, and follow the negotiations about it through to its publication as a 'Decision' by the COP on the final day of the conference.

We argue that PMI was seeking to make Uruguay a 'chilling example', a legal term for how the threat of sanction can discourage the legitimate exercise of legal rights. We see this as contributing to what Benson and Kirsch (2010) call "the politics of resignation", the "structure of feeling prevalent in late modernity that is characterized by a tendency toward cynicism in political life" (ibid:461). Resignation, they argue, is a powerful enabler of contemporary capitalism because it legitimizes corporate power as either inevitable or largely immovable. PMI's efforts appear to have backfired, however, insofar as they generated an international

Declaration that clarifies the rights of nation states to prioritize public health measures such as tobacco control over a number of international agreements that have in the past given precedence to trade. In this we argue that medical anthropologists need to “reclaim the category of hope” (Miyazaki 2004:1) by applying ethnography to better document and communicate the role that global health governance and diplomacy can play in countering the potential of neoliberal corporations such as tobacco to cause harm.

There has been a lot of anthropological interest in international laws such as the UN Charter on Human Rights and their grassroots impact, as part of more general concerns with processes of globalization and localization. War crimes tribunals (Anders 2007), refugee resettlement (Sandvik 2011), female genital mutilation (Boyle and Preves 2000) and intellectual property (Strathern 1999), provide just some examples. Merry points out that “intriguing parallels can be found between the way international law works and the law of villages without centralized rulemaking bodies and formal courts, the classic domain of legal anthropology” (2006b:101). Both, she argues, rely on custom, social pressure, collaboration and negotiation to develop rules and settle conflicts. In addition, international treaties such as the FCTC have to rub along, in a pluralist way, with state laws and other international jurisdictions. Studies of dispute resolution were very much the ‘bread and butter’ of legal anthropology for many years, and the study of international ‘law in action’ (Nelken 2007), can be seen as a continuation of this tradition. Anthropologists make invaluable contributions through their studies in this field, in tobacco control as elsewhere (Nichter 2007). However, interest in the workings of international law at grassroots level has not been matched, at least not in medical anthropology, by research and analysis into how these laws are produced in the first place (Irwin 2012) or the knowledge processes by which global governance is exercised (Hodžić 2013). We shall first examine possible reasons for this lacuna, before introducing the FCTC and our research at COP4.

Riles (who participated as a member of the Fijian delegation to the 4<sup>th</sup> UN World Conference on Women in Beijing in 1995) comments that “anthropological writings on international institutions...have tended to take the ‘expert’ knowledge practices of institutional actors as familiar and to concentrate attention on the encounter between such practices and non-Western cultures”. This, she suggests, “belies more than a simple matter of interest” (2000:187 fn9). There is certainly a pervasive *ennui* in Merry’s description of this aspect of her study of the UN Convention on the Elimination of All Forms of Discrimination Against Women. For her the meetings she attended were part of a “deterritorialized world...whose locations are diverse but whose words and practices sound and look the same...inhabited by the same mobile actors” (Merry 2006a:981).

We would caution against permitting the ethnographic palate to succumb to boredom just at the time when, in global health for example, the need for analysis of international law in production and its potential to influence change in the global neoliberal economy has never been greater. Riles suggests there may be a problem engaging with such institutions in anthropological terms since their familiarity and shared aesthetic with the knowledge practices of academia means there can be “no ‘outside’ to our analyses, no position beyond our own knowledge from which we can reflect critically on them” (ibid:26). While accepting that contextualisation is inherently problematic (ibid: 186 fn5; cf. Huen 2009), our ethnography demonstrates the importance of situating COP4 and its mobile actors within the meeting’s specific geographical and political contexts, since these played a fundamental role in shaping its course and particular outcomes. Nor has a ‘shared aesthetic’ prevented more recent ethnographies, at least in fields other than medical anthropology, from taking international laws, actors and institutions as research subjects in their own right rather than as objects for advocacy work (Goodale 2006). Particularly in

environmental anthropology (e.g. Little 1995; Brosius and Campbell 2010; MacDonald 2010; Maclin 2010), but also the aforementioned vanguard studies of UN initiatives concerning women (Riles 2000; Merry 2006a&b), an emergent field can be discerned. This article applies some of the ideas and approaches from this work to the domain of medical anthropology. We hope it inspires greater engagement with the issues surrounding global health governance amongst medical anthropologists, as well as greater involvement in global health diplomacy as a field that, based on first-hand experience, offers “new and necessary perspectives in global health” (Adams et al. 2008:322), as well as opportunities for both advocacy and critique.

## **Methods**

We attended COP4 by becoming affiliates of organizations accredited by the Framework Convention Alliance (FCA), a global tobacco control organization created in the year 2000 to work for the development, ratification and implementation of the FCTC (Mamudu and Glantz 2009). Being ‘embedded’ (Lewis and Russell 2011) as part of the FCA gave us observer status in both plenaries and committee meetings as well access to the FCA’s ‘closed’ morning and evening briefing sessions. AR and MW are medical anthropologists. Firstly, their process of affiliation was facilitated by AR having met members of the accredited organization a year earlier at the 14<sup>th</sup> World Conference on Tobacco or Health in Mumbai, India. Secondly, MW had been in Uruguay since September 2010 undertaking a 12 month period of ethnographic fieldwork. This had involved participating in and observing the work of the FCA-accredited organization’s members as well as documenting the political tobacco control context before and after COP4 (Wainwright, 2013). HM is a political scientist who has researched and published extensively in the field of global health governance and tobacco control, including the FCTC. To the best of our knowledge, this is the first example of collaborative research between anthropologists and a political scientist, which lends interdisciplinary strength to this article. It is

also the first study of an FCTC Conference of the Parties to involve ‘real time’ description of its deliberations.

To the extent permitted by circumstances and resources, we followed the ‘collaborative event ethnography’ approach of Brosius and Campbell (2010), an anthropological methodology with much promise for researching UN ‘mega-events’ (Little 1995) such as this. During the six days of the conference (15-20<sup>th</sup> November 2010) we divided up in order to cover all public events except occasional business sessions that were ‘closed’ to FCA representatives. We took notes by hand or on laptops which could subsequently be compared with verbatim recordings of the debates and the summary records of each country’s position which were transcribed and made available online by the FCTC Convention Secretariat, the administrative organ of the FCTC (FCTC 2011). Further important sources of information included documents produced ahead of and during the conference by the Convention Secretariat, Uruguayan newspapers, publications by NGOs at and around the conference venue, and informal interviews with participants and observers. Between us, we spoke three of the six official UN languages (English, French, and Spanish). Public statements were more rarely made in the other three UN languages - Arabic, Chinese and Russian – but where they were we could follow them thanks to devices provided which offered simultaneous translations into all six of the official languages by interpreters working in real time. Study protocols were approved by the relevant Ethics and Institutional Review Boards of the authors’ respective home institutions.

### **Background – The History of the FCTC**

‘Tobacco smoke is the single greatest cause of preventable death worldwide’ (Kohrman and Benson 2011:330; cf. US Department of Health and Social Services 2010). The FCTC was established as a response to the need for collective, global action to the global health threat

represented by tobacco (Yach 2014). According to Brandt “by the early 1990s, it had become apparent that the considerable progress international health efforts had made in improving life expectancy through disease prevention and better nutrition might be completely undone by cigarettes” (2007:470). The 100 million estimated deaths from tobacco-related illnesses in the 20<sup>th</sup> century (Mackay et al. 2006) are set to increase tenfold in the 21<sup>st</sup> century, with 70% of them likely to be in low- and middle-income countries (LMICs) (Soon-Young Yoon 2003; Jha 2009; WHO 2008). Early proposals that the WHO should exercise its right (enshrined in its 1948 constitution) to negotiate a global health treaty on tobacco met with considerable resistance from officials within the WHO’s headquarters. One senior official is reported to have written that the WHO was being over-ambitious and that it was “important to be realistic” (Roemer et al 2005:937). Others strongly recommended developing the initiative as a nonbinding code of conduct instead of a treaty (similar to the WHO’s International Code of Marketing Breast-Milk Substitutes) or making it a treaty under the auspices of the UN in general rather than the WHO. It was Gro Harlem Brundtland (former prime minister of Norway), elected Director-General of the WHO in 1998, who gave added impetus to the tobacco control agenda (Roemer et al. 2005; Mamudu and Glantz 2009; Reynolds and Tansey 2012). Her leadership led to the unanimous adoption of the FCTC by the World Health Assembly on 21<sup>st</sup> May 2003 (Roemer et al.2005; Yach 2014).

The FCTC is a document comprising a Preamble setting out core principles and 38 Articles made up of policy directives addressing many aspects of tobacco production, supply and demand (WHO 2003). Countries who ratify the framework and become ‘Parties’ to the convention undertake to implement its provisions using national policy-making and legislative frameworks. Brandt (2007:479) describes the provisions of the FCTC as “both general and modest”; Kapp (2003:315) quotes representatives of activist organizations who pilloried the final version as

“feeble” and “meaningless”, and there have been considerable efforts by the tobacco industry to infiltrate and weaken it, as well as to discourage its implementation (Mamudu et al. 2008a&b; 2009; Weishaar et al. 2012). Yet since coming into force on 27<sup>th</sup> February 2005, it has been one of the fastest growing and most widely adopted Conventions in the history of the UN (WHO 2009). There were 172 ratifying parties when COP4 commenced on November 15<sup>th</sup> 2010, a reflection of the increased political will that exists around the world for action, or at least the appearance of action, on this topic at the global level. However eight signatory countries, including the United States, have so far declined to ratify the Convention (Nichter 2007).

In the rest of this article we consider some of the ethnographic specificities of COP4, in particular the Punta del Este Declaration and the relationship between global public health and corporate trade and investment interests that it addresses. The next section sets the scene by describing the spatial arrangement of people at the conference. We then go on to consider the action launched by the world’s largest non-state tobacco corporation, Philip Morris International (PMI) against Uruguay, and the reaction to this that the Declaration represents. Following a discussion of the importance of treaties such as the FCTC to medical anthropology, and of the value of ethnography in studying global health diplomacy, we conclude with a summary of what we have learnt in this case, and what others may wish to take forward.

### **Peopling the Conference**

The conference began with a short ceremony organized by the FCA at which the ‘Death Clock’ was switched on (Figure 1). This was an electronic display mounted in the conference hotel lobby, intended as a constant reminder to all who passed it of why they were there, as the large and relentlessly increasing numbers (one person every eight seconds) tallied up both those who had died of tobacco-related diseases since the FCTC was initiated in 1999, and the 73,973 who

died during the five days of the conference. Following the Death Clock ceremony, delegates were ushered into the hotel ballroom which constituted the main hall where the opening session of COP4 took place.

Some distinctions between conference attendees became apparent in the main hall. One was the separation of 'Participants' from 'Non-Participants', marked by a blue velvet rope at the back of the hall behind which 36 chairs were placed. This was the area where those attending the conference as 'members of the public', as Non-Participants were known, were permitted to sit, across from the translators' booths (Figure 2). Members of the public were mainly representatives of the tobacco corporations and associated industries and groups. The rest of the main hall was given over to the 752 official Participants (FCTC 2010b). The divisions between them were reflected in the layout of the 'floor'. Moving back from the podium there were firstly the 'Representatives of Parties', official delegates from countries that were parties to the FCTC. Depending on country demographics, financial capacity and accessibility to Uruguay, these delegations varied in size from one person (in the case of 56 countries) to 29 in the case of Brazil (Plotnikova, Hill and Collin 2012). Protocol dictated that there should be no precedence given to one 'Party' over another, and hence the seating plan facing the podium from the front of the ballroom was based on country initials starting with a randomly chosen letter of the alphabet, in this case the letter 'R'. The countries attending were divided up into the six WHO 'regions', however, and on the second day, the hall was rearranged so that countries could sit together on a regional basis to make it easier for delegates to consult with and speak on behalf of their region. Seven of the eight countries which had signed but not ratified the FCTC were permitted to send representatives to the COP, and these 'Non-Parties' sat immediately behind the 'Parties'. Behind them came the 'Representatives of International Intergovernmental organizations' (IGOs) followed by 'Representatives of Non-Governmental Organizations' (NGOs).

The seating order for these four categories of Participant mirrored the order in which participants were given a voice in the plenaries by being invited by the President of the Conference to ‘have the floor’. People representing their region were permitted to speak before individual country delegates. Then came ‘Non-Party’ representatives, ahead of the IGOs and NGOs (WHO 2003). Such was the volume of business (and the number of Parties in attendance) that the NGOs only had the opportunity to ‘have the floor’ once during the plenary sessions at COP4. Members of the public had the right only to listen at plenary sessions, not to have the floor.

The President of COP4 had the central seat on the podium and was the person in charge of maintaining order including the order of speakers. He was flanked on his right by the Secretariat Chair, while on his left sat ‘Legal Counsel’ and a number of other committee members. Women with binoculars sat behind the President and his committee, scanning the plenary sessions assiduously so that those Parties who indicated they wanted to speak could be added to the President’s ‘list’ (Figure 3). The President adopted a further form of precedence over who could have the floor on the first day by stating he was going to honour Ministers of State who had come to the COP by giving them priority over other delegates.

The spatial, temporal and communication hierarchies to be seen at COP4 somewhat belied the rhetoric of a united front (‘us’) fighting an immoral enemy (‘them’), although as we shall see later the rhetoric was part of a wider set of values linked to the production of consensus. This rhetorical tone was set by the Director-General of the WHO, Dr. Margaret Chan, in a video-recorded speech which was part of the opening ceremony of COP4:

This is an epic battle between the protection of public health and the pursuit of corporate wealth. This is a ruthless pursuit of wealth, with no regard for the damage tobacco products cause to health. Protecting public health policy from interference by the tobacco industry is a cornerstone of the Framework Convention and vital to its implementation. Public health has the evidence and the right values on its side. The tobacco industry has vast financial resources, lawyers, lobbyists, and no values whatsoever beyond the profit motive.

An FCA participant who had attended all the COPs said afterwards that it was the strongest language she had ever heard Dr. Chan use. The conflict between ‘health’ and ‘wealth’ was going to become crystallised in the next few days with the tabling of the Punta del Este Declaration and the subsequent negotiations it generated. However, in order to understand the full significance of this Declaration it is necessary to know more about the dispute which precipitated its production. This is the local political context which stimulated the Declaration and from which derived the particular tenor of many of the debates at COP4.

### **Uruguay vs. PMI: the chilling example?**

In February 2010, nine months before COP4, PMI requested arbitration at the World Bank Group’s International Centre for the Settlement of Investment Disputes (ICSID) under Article 36 of the ICSID Convention and Article 10 of the Switzerland-Uruguay Bilateral Investment Treaty (BIT). BITs are “agreements between two countries for the reciprocal encouragement, promotion and protection of investments in each other’s territories by companies based in either country” (UNCTAD 2004). In protecting a company’s ‘foreign direct investment’, BITs potentially serve an important role in the generation of investment and hence economic development. However, unique amongst international treaties, most BITs allow private investors to bring a claim directly against governments to challenge government actions (Franck 2009;

Mamudu 2014). Doing so could be characterized as PMI's attempt to make Uruguay a 'chilling example' to the rest of the world. Most disputes are settled by international arbitration tribunals such as the ICSID that are independent of both the judicial system of the country in question and the company; their rulings are not subject to appeal (Correa et al. 2012). Switzerland is second only to Germany in the number of BITs it has signed with other countries (Mamudu 2014). In invoking the Switzerland-Uruguay BIT, PMI was perhaps taking advantage of the fact that Switzerland is a non-party to the FCTC and hence is not subject to its obligations; it is significant that many tobacco companies have been setting up headquarters in the country, which offers a useful staging point for litigation against nations such as Uruguay. However, although the ICSID was created in 1965 and has settled many disputes that have health implications, until PMI-Uruguay its tribunal process had not been used by tobacco companies to challenge a state's right to implement tobacco control policies.

PMI argued that Uruguay had introduced three tobacco control measures that contravened the 1991 Switzerland-Uruguay BIT. One was the prohibition on marketing more than one version of any cigarette brand ('brand stretching' - for example having light, slim, low tar varieties of the same named brand), the second was Uruguay's requirement for tobacco packages to include pictograms with rotating graphic images of the health consequences of smoking (such as cancerous lungs), and the third was a mandate that health warnings should cover 80% of the front and back of cigarette packets. The request for arbitration invoked two multilateral treaties, the World Trade Organization (WTO)'s Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS) and the Paris Convention for the Protection of Industrial Property. The original TRIPS agreement, which came into force in January 1995, established legal standards for the protection of intellectual property rights (including trademarks) worldwide. PMI argued that Uruguay's actions threatened the integrity of its trademarks, and hence its intellectual

property. Yet these issues alone do not explain why Uruguay in particular became the focus of PMI's legal ire at this time. To understand the dispute, we need to consider the wider ramifications of Uruguay's *luchador* ('fighter') status in tobacco control (Wainwright 2013: 107).

Uruguay is a country with a long history of regulation in the interest of public health. For example, in 1911 it became the first Latin American country to introduce an obligatory smallpox vaccination programme. Its mixed private and public healthcare system dates back to social legislation enacted in 1912 and 1929. With free education at the Universidad de la Republica open to all, Uruguay has 38.7 doctors per 100,000 people, the highest rate in Latin America after Cuba (PAHO 2011). Although its demographic profile is that of an ageing population with a low birth rate, for Uruguayans older than 65 years the principle causes of death are cardiovascular diseases, tumours, chronic respiratory diseases, acute respiratory infections and pneumonia (ibid.). These are all diseases that are frequently related to smoking (Sandoya 2009), and their incidence reflects high rates of smoking prevalence in the past. Half of all men and a third of all women in Uruguay have smoked in their lifetimes and more than 60% of men over the age of 55 smoke or have been regular smokers (Sindicato Medico del Uruguay 2010). Uruguay became the first Latin American country to ratify the FCTC in September 2004.

In a historic election victory in the month following ratification, a centre-left coalition party was elected to power on a pro-welfare, anti-privatisation mandate. The Frente Amplio wrenched the presidency from a 174 year history involving two rival parties – the Colorados and the Blancos – which between them had maintained power since the country's independence (Moreira 2010). The new president (Dr Tabaré Vasquez) was an oncologist and his term of office (2005-2010) was marked by further exceptional measures in tobacco control. For example, he initiated

legislation prohibiting smoking in enclosed public spaces in 2006, making Uruguay the first country in the Americas to enact such a law nationwide. The effectiveness of the country's smoke-free legislation, amongst other things, is reflected in a decline in Uruguay's smoking rates from 31.8% in 2006 to 24.8% in 2009 (29.4% for men and 20.9% for women) (CIET 2010). For his leadership and public health policy achievements in tobacco-control, President Vasquez received the WHO's 'World No Tobacco Day' award in 2006. Uruguay's status both as an early implementer of the FCTC's Articles, and as a small, middle-income country in the Americas with a president at the forefront of a global campaign, gave it symbolic and political capital. This was further enhanced when the country offered to host COP4, an arrangement agreed at COP3 in Durban, South Africa, two years before. Such commitments are a significant cost to a small country, but in this case helped enhance Uruguay's position as a *luchador* for tobacco control, both in Latin America and worldwide (Bloomberg Philanthropies 2010).

It is also significant that PMI's request for arbitration was filed just days before the firebrand President Vasquez left office. PMI's 'investment' in Uruguay began in 1979 with its acquisition of Abal Hermanos, a local company which had been manufacturing and marketing tobacco products since 1877. By introducing new brands and new versions of existing brands, PMI increased Abal Hermanos' share of the domestic market from 8% in 1979 to 31% in 1996. When PMI filed its ICSID claim against Uruguay, it was marketing no less than twelve different varieties of five main brands in the country ('Marlboro' 'Fiesta' 'L&M', 'Philip Morris' and 'Casino') and thus was particularly affected by Uruguay's ruling on 'brand stretching'.

Another legal case at national level was going on in parallel with the PMI vs. Uruguay international counterpart. On 10 November 2010, just before the start of COP4, Abal Hermanos went to the Supreme Court of Uruguay to file a case for the unconstitutional nature of the

country's tobacco control policies, specifically Articles 9 and 24 of Law 18.256 ('Control de Tabaquismo'). This law gave the state executive powers to force tobacco companies to cover at least 50% of the cigarette pack with public health warnings. Abal Hermanos' lawyers claimed that the powers contained in these Articles implied regulations that could be executed without limits, something which they argued went against individual rights as protected by the constitution. Their claim was unanimously rejected by the Supreme Court. Ostensibly as a result of this decision, in October the following year PMI closed its production plant in Montevideo, the state capital, and moved its cigarette manufacturing operations to neighbouring Argentina, laying off 62 staff while retaining approximately 28 to work in sales and distribution (Reuters 2011). In an online statement released on November 26<sup>th</sup> 2011 the office of the Uruguayan President advised that, despite its concern for the welfare of the jobless workers, the closure of the plant would not change the country's anti-tobacco policies (Presidencia de la Republica 2011). This was tough-talking rhetoric but, while holding fast to its principles at the national level, the potential remains for Uruguay's resolve to falter, making it a 'chilling example' internationally. In this context, the Declaration tabled by Uruguay at COP4 became even more salient, a rallying point for the diverse interests represented both within the delegations at COP4 as well as those outside it.

### **The Punta del Este Declaration**

At the first plenary of COP4, the Director of Uruguay's tobacco control programme proposed an addition to the agenda - adding a draft 'Declaration on Commercial Interests related to the Implementation of the WHO Framework Convention on Tobacco Control'. Brazil, followed by Peru, took to the floor in support of Uruguay. There being no objections the President declared "the matter that has been raised by Uruguay is included on the agenda". While the trigger for the Declaration was the PMI vs. Uruguay case, it encompassed more general issues concerning the

relationship between commercial agreements and health (FCTC 2010a). The Declaration builds on the opening perambular paragraph of the FCTC which states that Parties to the Convention are “*Determined* to give priority to their right to protect public health” (WHO 2003:1). The Declaration then records the FCTC Parties’ “firm commitment to prioritize the implementation of health measures designed to control tobacco consumption in their respective jurisdictions”, “their concern regarding actions taken by the tobacco industry that seek to subvert and undermine government politics on tobacco control” and their “right to define and implement national public health policies pursuant to compliance with conventions and commitments under WHO, particularly with the WHO FCTC” (FCTC 2010a:2). Uruguay’s presentation prompted the head of the Norwegian delegation to remind delegates of Norway’s own legal battle with PMI, aimed at its new point-of-sale tobacco display ban, and the need for joint action to counteract “powerful multinationals” taking “well-coordinated untimely action against single Parties”.

The discussion of the ICSID arbitration elicited particularly heated responses from LMIC delegations, especially those from Latin America and the Caribbean where there is a long history of exploitation by multinational corporations such as the tobacco industry (Stebbins 2008). LMIC delegates clearly recognised PMI’s bullying of Uruguay, and understood its intention to discourage other countries from enacting their own tobacco legislation for fear of becoming similarly embroiled in costly litigation. The Jamaican delegate recited the lines of a poem: “I watched my neighbour being beaten in the morning and I took no action, and in the evening they came for me”, which expressed the need for concerted action in support of Uruguay in a particularly eloquent way. The Declaration was supported by fourteen of the seventeen delegations that took the floor to debate it. Three - China, the European Union (EU) and Japan - expressed general support, but wanted to deliberate further on the draft rather than permit its

immediate approval. The EU invoked a 24-hour rule, providing delegates with the opportunity to read the Declaration more carefully, consult with their governments, and propose amendments. Thus a small Working Group led by Uruguay was formed to redraft and renegotiate components of the Declaration.

### **‘An Example for the Rest of the World’**

The Declaration went through two rounds of revision involving bilateral and multilateral discussions between Uruguay and a few other delegations during the course of COP4. All delegations had the opportunity to contribute to these negotiations, but as they mostly occurred outside of formal meetings, only those states with sufficient delegate numbers were able to participate in them. Uruguayan representatives at the conference reported that their country’s main goal was to retain the Declaration’s original intention of affirming the priority of public health over trade and investment agreements. Other delegations, however, such as China and the EU, sought substantive changes. Some amendments, proposed and/or accepted, served to dilute the substance and spirit of the Declaration. China, for example, argued that the title should be changed from its specific focus on commercial interests to the *Punta del Este Declaration*, insisting that the Declaration addressed issues not only of commerce but also patent, law and some country policies. The EU insisted on adding phrases such as ‘provided that such measures are consistent with the TRIPS agreement’ (the so-called ‘TRIPS clause’) at several places in the Declaration, for reasons that raised suspicion amongst some delegates that the EU was attempting what one FCA representative called a ‘back door move’ to prioritize this aspect of international trade law – i.e. intellectual property rights – over health.

Not all such amendments were approved, however. The draft Declaration submitted to the sixth plenary session for final approval on 18<sup>th</sup> November 2010 shows that a Chinese proposal to limit

the scope of the final section (Section 8) of the Declaration to encourage countries to ‘implement the FCTC’ but not ‘its associated guidelines’ had failed. However, China did not take this rejection of its proposed amendment lightly. In the plenary debate which followed the Chinese delegation argued repeatedly that (e.g.) “We [Parties] can ask non-contracting parties to approve the treaty, but we [Parties] cannot ask them to do anything [comply with the guidelines]”. Their arguments, however, were met with vehement opposition from most other delegations including South Africa, Brazil, Guatemala, Kenya and Turkey (amongst others). The atmosphere in the ballroom became very tense and there were numerous murmurings and comments against China. The Chinese delegation only very reluctantly agreed to retaining the phrase in Section 8 when delegates from Latin America started threatening consensus by calling for a vote, which China as well as the Chair resisted. Having to call a vote would have been a mark of failure, according to one FCA representative, since it would have indicated a degree of irresolvable dissent. Such issues are important in international law where, as in village level dispute resolution traditionally studied by anthropologists, opportunities for real jurisdiction from a higher order legislature are limited (Merry 2006b).

The EU had also suggested weaker proposals in one of the sections of the Declaration, alluding to the TRIPS agreement allowing “a balance between public health and intellectual property objectives”. This was deleted, but other frequent references to the TRIPS Agreement were retained due to the EU’s strong insistence on their inclusion as a condition for its continuing support of the Declaration. A statement from Palau, supported by South Africa, expressed concern that by restating the TRIPS Agreement at several points in the document “we may allow the industry to use it to weaken our efforts to prioritize public health policies over trade and the spirit of this declaration”.

The EU responded by expressing its thanks to Uruguay “for this important initiative and also the willingness to integrate all the amendments that came during the working group...we think the draft that is presented and as it stands, is a good and balanced draft”. The EU further countered that reopening negotiations on the draft would mean going back to the Working Group again. With the threat of re-negotiation hanging over the debate, Peru urged acceptance of the revised draft as presented by Uruguay and requested “flexibility” from the other delegations. The Brazilian delegation, however, stated its support for South Africa’s request to delete one of the TRIPS clauses. The EU then reiterated its position, claiming that the sentence in question came directly from the TRIPS agreement itself.

At this point, with an impasse forming, Australia was ‘given the floor’. While expressing its solidarity for Uruguay and sympathy to both Palau and China about their concerns, it supported the EU’s contention that this was “a well-balanced declaration” and asked other Parties to support it “in solidarity with the Government of Uruguay”. Concerned with the prospect that disagreement over the TRIPS clause could derail the entire Declaration, Samoa made a statement supporting the EU and Australia. At this point, the Chairman intervened to ask whether, in light of the EU’s explanation that its amendments were simply reiterating what was already in the TRIPS agreement, delegations would consider withdrawing their objections to it. Palau and South Africa, the two major opponents of the TRIPS clauses, reluctantly agreed to support the Declaration and, with no objection from Uruguay and other delegations, the *Punta del Este Declaration on the Implementation of the WHO Framework Convention on Tobacco Control* was passed with general acclamation and was published as a ‘Decision’ the following day. In a statement to the floor afterwards, the WTO delegate recognized the need for a balance between legitimate interests such as health and the requirement that trading practices should not

discriminate between partners or set up unnecessary barriers. The WTO rules, he suggested, should be seen as a “toolbox” which Parties could and should use to support public health.

In the FCA’s view, as well as declaring the need to continue to implement tobacco control policy and share information about tobacco industry interference, the Declaration affirmed the right of Parties to “adopt measures to protect public health, including regulating the exercise of intellectual property rights in accordance with national public health policies, provided that such measures are consistent with the TRIPS Agreement” (FCA 2010a). In an open letter to the President and the Uruguayan Government at the end of the conference the FCA wrote “The Government of Uruguay is demonstrating the priority it places on public health, and not only defending the health of its own population, but by defending its sovereign right, it is setting an example for the rest of the world” (FCA 2010b).

## **Discussion**

Benson and Kirsch identify a ‘politics of resignation’ associated with the overweening power of multinational capitalist corporations, particularly those that they term ‘harm industries’, “capitalist enterprises that are predicated on practices that are destructive or harmful to people and the environment...[for which] harm is part and parcel of their normal functioning” (2010:461). Tobacco is one of the examples they use of a harm industry, although the threat to public health may be common to all corporations. Wiist, for example, argues that “the primary purpose of the corporation is to increase shareholder value” (2010:6), while for Martin “the corporation’s only legitimate mandate is to exploit others for profit” (2006:284). When the corporation in question is global in its reach, and is engaged in marketing a ‘killer commodity’ (Singer and Baer 2009) likely to kill half its long-term users, then treaties such as the FCTC seeking global solutions to global problems are of vital importance to medical anthropology.

The FCTC can be seen as an attack on the politics of resignation. We have seen how its very adoption was a triumph of hope over adversity, persistence over resistance; COP4 and its outcomes, in their turn, become what Miyazaki (2004:128) terms “the performative inheritance of hope”.

Ethnographic research in global health diplomacy offers valuable contextual, theoretical and critical perspectives on the processes involved. The sense of the tobacco industry and its associates engaged in a battle of ‘wealth’ against ‘health’, exemplified by the request for arbitration against Uruguay filed by PMI nine months before the start of COP4, gave a particular tenor to the debates and discussions at the conference, as well as directly influencing some of its outcomes. It is quite likely, as local journalist Cabrera (2010) maintains, that in filing its request PMI was deliberately trying to undermine the global tobacco control movement ahead of COP4 and test the commitment of President Vasquez’s successor to continuing the country’s fight for tobacco control. PMI seemed to believe Uruguay would back down in a humiliating way and hence provide a chilling example to the rest of the world of what happens when a middle-income country, particularly one in the global south, attempts to take on the might of a multinational conglomerate, since PMI has an annual revenue which is twice Uruguay’s Gross Domestic Product.

However, if this was the company’s strategy, it was somewhat misguided. Rather than hindering the progress made at COP4, PMI’s action appeared to strengthen the resolve of many participants present to resist such threats to national sovereignty. The Punta del Este Declaration crystallized this resolve and engendered a spirit of hope that challenged the resigned assumption that free trade considerations will always override public health concerns. Such contexts, the basis upon which international laws are produced, often slip out of sight once conventions,

articles or treaties are ratified and taken forwards on the global stage. As Irwin puts it, in the negotiation of shared meanings that international agreements represent “certain voices, experiences and narratives are excluded or diluted in the process” (2012:13). It is here that ethnography can unpack the black box of decontextualized treaties, drawing attention to their social production and the important ways in which the local affects the global, and vice versa.

Brandt calls the conflict with the neoliberal, free trade regimes of the WTO “the ultimate test for the FCTC”, and regrets that “after considerable debate during the drafting process, the final text [of the FCTC] is silent on the inevitable conflicts between public health restrictions and trade liberalization” (2007:480; cf. Mamudu et al. 2011). In 2002 Dodgson et al. could write “the ability of WHO to influence the WTO has been hampered by the fact that states (many of which are members of both organizations) have accorded a higher priority to trade issues, rather than those relating to human health. As such, there remain considerable barriers to incorporating health as a legitimate and worthy concern on the global trade agenda” (2002:13). But as international law has developed, in recent dispute settlements “WTO panels and the Appellate Body have proven to be more deferential to non-trade goals than some commentators once feared they would be” (WHO 2012:14), and their agreements allow states some ‘flexibilities’ to protect public health (WTO/WHO 2002). Such negotiations, however, usually take place behind closed doors, by trade and investment experts who frequently have limited understanding of public health concerns. Nor do LMICs necessarily have the capacity to forge favourable BITS agreements with wealthier countries and the multinational corporations based within them, or the resources to pursue the costly litigation that a BIT claim involves. The Punta del Este Declaration, however, “shows a confidence that international trade and investment agreements leave States sufficient regulatory space to adopt and implement FCTC measures without being concerned that they will fall foul of other international obligations, and...may be expected to be

referred to by courts or tribunals in any proceedings brought against an FCTC Party under trade or investment agreements” (Lieberman 2012:217).

Sometimes ethnography can act as a corrective to propaganda and lies. For example, in an address to shareholders in 1999, the Chairman of British American Tobacco, one of the world’s ‘big four’ multinational tobacco corporations, claimed the FCTC was “a developed world obsession being foisted on to the developing world” (BAT 1999). His attempt to undermine the development of the FCTC by arguing that it represents a form of western political hegemony is belied by the evidence from our participant-observation at COP4, where real-time processes of treaty-making, Declaration-approval, and guideline-endorsement present a very different picture. For example China, with a state tobacco corporation that dwarfs even PMI, has ratified the FCTC but lived up to its reputation for bellicosity and trying to weaken FCTC agreements and Declarations. Yet it was the Latin American countries that won the day by threatening China with a vote. Similarly it was the Pacific nation of Palau that took the lead against the EU on the TRIPS clause. Contrary to the BAT Chairman’s opinion, it has been developing countries which have taken the lead in pushing for more progressive versions of the tobacco control agenda (cf. Bates 2001; Hammond and Assunta 2003; Mamudu and Glantz 2009).

At the theoretical level, Merry’s pillars of both village-level and international law - custom, social pressure, collaboration and negotiation – can be clearly seen in the LMICs’ efforts to push forward the tobacco control agenda in the face of capitalist forces of state and corporate power. The need for consensus reveals itself as a particularly powerful principle of global health diplomacy and was the element that was ultimately responsible for China having to climb down from its stance on the ‘guidelines’ issue. Again, these insights, deriving from the first-hand experience of geographical and political contexts, not to mention the affective dynamics of the

debates themselves, contribute to a better understanding of the final products of such meetings - the decontextualized Declarations, Articles and guidelines themselves. Here lies a key contribution medical anthropologists can make through adopting an ethnographic approach to global health diplomacy.

Contrary to a politics of resignation, the Punta del Este Declaration offered support to international governance efforts to recalibrate global health and trade policies away from prioritizing trade over health. The FCTC, with its legal obligations to regulate tobacco, itself acts as a fulcrum for change in this relationship. For Uruguay, hosting COP4 not only provided moral support but resulted in a Declaration which, as a consensus decision by all Parties present, is now incorporated into the documentation of the FCTC and the annals of global health diplomacy. This has undoubtedly strengthened Uruguay's position against PMI, even though the status of the Declaration as a legal document is not entirely clear (WHO 2012:80). At the same time, in standing tall against the 'enemy', Uruguay's status as tobacco control *luchador*, forged through its exemplary tobacco-control measures, was further enhanced globally and, equally importantly, locally. At the local level, civil society organizations have been able to draw on the symbolic capital provided by the continued international recognition of the country's leadership in tobacco control, in order to maintain political and public support for stringent tobacco control policies at home.

In this article we have focussed on the production of just one piece of legislation at COP4, the Punta del Este Declaration, as part of the ongoing development and refinement of the FCTC. We have pointed out the important role small nations in the global south have played in this process. The Punta del Este Declaration attempts to fill in a gap in the original treaty, concerning the relationship and relative priority accorded health compared to trade (Mamudu et al. 2011).

Despite its significance, however, the risk remains that the threat of litigation becomes a chilling effect on the political will of governments to enact national tobacco control laws, that “the arbitration involving Uruguay could be seen as a means of dissuading other countries from implementing similarly strong measures or delaying such action” (ibid:91). The WHO’s report on the issue explains, perhaps optimistically, that “it is an established principle of international law that treaties should not be interpreted in isolation from one another” (ibid:73), as well as that “customary international law gives priority to the treaty concluded later in time” (ibid:75; cf. Brandt 2007:480). The Punta del Este Declaration provides a useful additional assertion of the right of sovereign states to regulate health in the public interest. Yet the intellectual property rights issue has continued to stimulate international legal debate concerning other areas of tobacco control beyond the COP (WTO 2011), and the door remains open for other challenges to efforts to change the relationship between trade, investment and global health.

## **Conclusion**

Our ethnography has dissected international law in production at the FCTC’s governing body meeting, COP4. Research of this type can reveal much, not only about structure and organization but also the contextual and affective elements that underpin the production of international laws at UN ‘mega-events’ like this. Rather than assuming these instances of transnational modernity necessarily all sound and look the same, we have looked in detail at the specific topical, historical and contextual dynamics of the FCTC and specifically what happened at COP4. The Punta del Este Declaration represents an attempt to address the conflicts between the interests of health and those of trade and investment as these are represented in their respective international treaties. The issue behind it, namely the request for arbitration by PMI against Uruguay at the ICSID, threatened to make a chilling example of Uruguay to the rest of the world in contravention of the flexibilities permitted states to protect public health under the WTO

agreements. The Punta del Este Declaration was a foil to this initiative, and served to consolidate Uruguay's international *luchador* status in tobacco control.

Anthropological research into how international law is produced presages further discussion of what treaties such as the FCTC can and cannot do, and their potential for addressing other global health issues. We have argued for acknowledgement and support of the FCTC's ability to rekindle the category of hope against the politics of resignation that corporate capitalism in the form of tobacco and other 'harm industries' can engender. As well as the dynamics of global health governance and diplomacy itself, medical anthropologists are well equipped to explore whether and if so how a treaty such as the FCTC changes the power dynamics surrounding public health policy and planning in national jurisdictions when delegates return to their home countries. While the outcomes of these researches might refract the politics of resignation, the fact that we have an FCTC at all should be a reason for hope.

## Notes

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