Health implications of proposed Economic Partnership Agreement (EPA) between east and southern African countries and the European Union

Aulline H Mabika, Percy F Makombe, Ludwig Chizarura and Rene Loewenson

Southern and Eastern African Trade and Information Negotiations Initiative (SEATINI)
Training and Research Support Centre (TARSC)
in the
Regional Network for Equity in Health in east and Southern Africa (EQUINET)

Discussion paper 41

February 2007

Produced with support from SIDA Sweden

Table of contents

Executive summary

A proposed Economic Partnership Agreement (EPA) between the eastern and southern African countries (ESA) and the European Union (EU) is currently under negotiation. The final agreement to be signed in December 2007 could have a profound impact on areas of health and health services. Recognising this, in this report we examine the health implications of this proposed EPA between the ESA and the EU.

The report aims to inform government, civil society, parliaments and professionals working in health and in trade. It examines:

- the key areas of the EPA;
- the health implications of the EPA, specifically in terms of health inputs (examining food security) and health services (examining organisation of health services, health workers, and access to medicines);
- the options that countries have to protect health in the current EPA; and
- general issues and principles for protecting health in negotiating the EPA.

The sixteen ESA countries negotiating with the EU do not have legal status as a bloc. Unlike the EU, they do not have a formal structure of decision-making, nor an operational bureaucracy. They do not match country membership of existing regional trade areas, like Southern African Development Community (SADC) or Common Market for Eastern and Southern Africa (COMESA), even though COMESA is supporting the negotiations. This configuration can only be for negotiating purposes as at the end of the negotiations the EU will have to sign an EPA with a customs union, even as it is unclear which this will be. At present, this lack of clear correspondence with current regional arrangements weakens the integration of regional protocols, programmes and capacities in the negotiations and in the protection of health within the EPA. Nevertheless the ESA-EU EPA must also comply with prevailing regional health protocols and standards, such as the SADC Health protocol and various SADC Charters.

EPA negotiations are conducted in six clusters:

i. development issues
ii. market access
iii. agriculture
iv. fisheries
v. trade in services
vi. trade-related issues.

The negotiations will be concluded by December 2007. The EPA covers:

- trade cooperation and trade related issues, including trade in services and fisheries
- economic, development and development finance cooperation
- institutional framework and final provisions
- dispute settlement.

So far positions have been developed in the clusters of agriculture, market access, development, trade-related issues and fisheries, but not much has been done on the service cluster.

The analysis of the health implications of the EPA between EU and ESA has examined four areas:

- The **provisions for intellectual property rights**, in which the Cotonou Partnership Agreement (CPA) intention and ESA commitment to protect trade related intellectual property rights (TRIPS) flexibilities to ensure access to medicines and medical technologies is evident, but not yet articulated in the draft EPA. The experience of

other EU free trade agreements (FTAs) suggest that ESA countries and their parliaments and civil societies need to vigilantly ensure that the draft text put forward by ESA in this area is effected in the EPA, viz to **provide for full TRIPS flexibilities and for capacity support for their implementation.**

- The provisions for **trade in health and health related services** are not yet specified. In the context of EU's own protection of its public health services but pressure for wider service liberalisation under the EPA, ESA countries may be under pressure to make commitments to service liberalisation in areas that affect health. The analysis suggests that ESA countries **make no commitments in any health or health-related services beyond what is already committed at WTO**, retain government authorities to regulate health service provisioning and provide in the EPA for health impact assessment to be implemented prior to commitments being made in any areas of service liberalisation that may have an impact on health. **The EPA should also include specific commitments in health workers**, including to ethical recruitment and to EU investment in public budget support for production and financial and non financial retention measures in ESA countries;

- The **loss of revenue** through removal of tariffs is discussed. While the scale and effect is not yet clear, existing data suggests that it may be significant, unmatched by improved returns to public revenue from trade and with potential costs to low income households in reduced public expenditure and more inequitable forms of health financing. This means that the negotiations will need to **include discussion of how these adjustment costs are borne, while protecting spending in key areas such as public financing for health.**

- The **agriculture** section of the EPA promotes market access and reduced tariffs and subsidies. However in the context of the extreme and longstanding inequalities between EU and ESA agricultural production systems, the analysis suggests there will be limited or absent returns to local and smallholder producers from the EPA unless they are deliberately protected and invested in under the EPA. In contrast, a poorly sequenced liberalisation may further intensify subsidised food imports or large scale food producers, and further undermine local and small scale food production. This trend has already been associated with declining household food security. It is thus suggested that ESA countries put real pressure on the **EU to eliminate all forms of trade distorting subsidies** and provide for subsidies on African agricultural production be maintained until the complete removal of all subsidies on agriculture in the EU. Article 93 of the draft EPA text would need to specify the time-bound elimination of all direct and indirect export subsidies by a credible date.

Across these areas there is a common concern that:

- **The health implications of the EPAs be explicitly recognised,** that health officials be included in negotiations, that health impact assessments be carried out where relevant, such as in any areas where service liberalisation may impact on health, and that EU and ESA countries ensure that the EPA is fully compliant with all regional and international health protocols and conventions prior to December 2007

- **The EPA recognise and provide specific measures to remedy trade distortions that undermine household small holder production and employment in ESA**, given their relationship to health.

- **The EPA not make trade commitments in areas that affect health beyond those already made at WTO and further invest in capacities in ESA to make maximum use of the flexibilities provided for in WTO agreements**

- **The EPA make specific and explicit provision for information and capacity support** to governments and social partners to manage, regulate and implement full flexibilities in relation to the health aspects of trade.

- **ESA countries maintain their policy space to exercise the authorities and flexibilities needed at regional and national level to meet their commitments to universal access to health care** and to applying specific policy tools, such as cross subsidies, to address inequities in health.

While the EU negotiates as a bloc, with a powerful functioning bureaucracy and a team of skilled negotiators, most ESA member states, have limited experience in multilateral trade negotiations. Resources are demanded across numerous bilateral or regional levels of free trade agreements or customs unions in addition to the EPA. The EPA processes place significant demands on the limited personnel and resources for the negotiations.

Matters for concern include:
- the uneven bargaining power between EU and ESA;
- the resource limitations in ESA;
- the weak coordination between key actors;
- the lack of a clear role for governments as the main driving force in the process and thus for health ministry contributions;
- the weak consultation and involvement of non-state actors; and
- the absence of evidence or full impact assessments in key areas such as health.

This situation, and the fundamental obligations that states have to protect public health, mean that **ESA states need to apply the precautionary principle in all areas of the EPA negotiations where potential health impacts exist**, ensuring that the measure negotiated provide greatest possibility, authority and policy flexibility for protecting health or providing for health services.

Implementation of the EPA has financial implications for the ESA countries, stemming from the direct economic measures, the institutional demands on implementation and the spillover impacts of trade measures, including in areas such as health. It is likely that EU will be expected to cover EPA adjustment costs from its existing aid budget without significant additional resources, placing unfair strain on ESA countries.

The cost of implementation for ESA countries needs to be estimated, and the sources of funds to meet this agreed. Negotiations on aid need to be linked to a costing of measures and to the costs of compensating people for the losses encountered as a result of implementing the provisions of the EPA. **It is important that the EPA includes predictable funding of an EPA adjustment facility, as proposed by the AU trade Ministers.**

EPAs should be first and foremost an instrument to foster the development of African, Carribean and Pacific (ACP) countries. Their scope and content should be determined by this objective.

This paper has flagged a number of issues to draw attention to the potential health implications of the EPA. This is not sufficient. We argue that a thorough health impact assessment of the EPA on a country-by-country basis be implemented along an agreed framework, supported with EU financing and involving ESA expertise. Governments have an obligation to protect public health, at national and international level. It would provide a string signal of the genuine development intentions of the partnership if these obligations were given greater recognition, assessed and acted on in the EPA negotiations.

1. Introduction

To improve health, countries in east and southern Africa need to develop economic and trade systems which promote health and which help to organise and sustain equitable health systems. At minimum, trade and economic policies should do no harm to health. While negotiating trade agreements, states must therefore pay attention to their potential impact on health, particularly on population health, on the risks to health, on the resources available for health and on universal access to health services. Where trade agreements and trends have negative impacts on these dimensions of health, they pose increased social and economic burdens for countries and populations, and often for vulnerable groups. The Regional Network for Equity in Health in east and southern Africa (EQUINET) has thus examined trade agreements at World Trade Organisation (WTO), regional and national level for their impact on health, and argues that all trade agreements must be subject to an assessment of health impacts, publicly debated, before signing.

The EPA being negotiated between the EU and the ACP countries are economic and trade agreements that have potential impacts on health. A proposed EPA between the eastern and southern African countries (ESA) and the EU is currently under negotiation, and the final agreement signed in December 2007 could have a profound impact on areas of health and health services. Recognising this, in this report EQUINET / SEATINI have examined the health implications of this proposed EPA between the ESA and the EU.

The report aims to inform government, civil society, parliaments and professionals working in health and in trade. It examines:

- the key areas of the EPA;
- the health implications of the EPA, specifically in terms of health inputs (examining food security) and health services (examining organisation of health services, health workers, and access to medicines);
- the options that countries have to protect health in the current EPA; and
- general issues and principles for protecting health in negotiating the EPA.

1.2. Methods

The study is a result of desk research which involved the use of published reports and data that inform the EPA negotiations. The Cotonou Partnership Agreement is one of the major documents reviewed during this study. The document referred to as the ESA-EPA draft is a draft prepared by the ESA region which is being used as a negotiating document by the region. The study draws from articles and reports by other authors on EPAs and trade in general. An analysis of the EU FTAs with other regions and countries also informed this study. The draft reports were peer reviewed by people with health systems and trade expertise. We acknowledge the limitations in the use of secondary evidence in an area where there are rapid changes taking place and recognise that developments in negotiations may have taken place that affect issues raised in the report that have not been made available through accessible documentation.

2. The EPA and its key areas

2.1. From Lome to Cotonou Partnership Agreement to EPA

The relationship between the EU and African countries dates back to the signing of the successive Lome Conventions in 1973.The Lome conventions were set up to govern the trade relationship between ACP countries and European Economic Commission (EEC), taking into account their different levels of development. While the gains from Lome are debated, the expiration of the Lome convention led to the negotiation and subsequent signing of the Cotonou Partnership Agreement (CPA) on 23 June 2000 between the EU and 77 countries in the ACP. The CPA is a 20-year cooperation agreement that entered into force in April 2003. It builds on a long relationship between the EU and the ACP countries. The ACP countries were split into six groups for the CPA negotiations – Caribbean, Central Africa, ESA, Pacific, West Africa and SADC. We discuss in a later section the difficulties for ESA countries with the geographical split of countries in the current EPA.

The stated intention of the CPA is to bring sustainable development and help with poverty reduction. Article 34.1, of the Agreement states, for example:

> *Economic and trade cooperation shall aim at fostering the smooth and gradual integration of the ACP States into the world economy, with due regard for their political choices and development priorities, thereby promoting their sustainable development and contributing to poverty eradication in the ACP countries.*

The CPA provided, for example, certain trade, tariff and market access preferences to ACP countries in trade with the EU. Under the Cotonou preferences, all imports of manufactured goods from the ACP countries enter the EU duty-free. Also many ACP agricultural products also enter the EU duty-free except for 990 tariff lines covering agricultural and processed agricultural products produced in the EU, which are granted only small tariff preferences. The most valuable preferences for ACP countries have been those extended to a few traditional primary exports such as sugar, meat and fish.

These preferences, not given to other countries, were carried over from Lome. The preferences were for the ACP group only and not to be enjoyed by other developing countries. As a result, the EU's trade regime with ACP countries was deemed by the WTO to be contrary to the WTO rules of non-discrimination. By discriminating between developing countries they were seen to violate the principle (Article 1) of the General Agreement on Tariffs and Trade (GATT), where preferences can only be given on development grounds, and not on grounds of geographical location or political affiliation. Partners to the CPA sought and were granted a waiver (Article IX (3) of the WTO) in 2001 that lasts until 31 December 2007. Even with the waiver, some aspects of the Cotonou regime are vulnerable to disputes in the WTO. For instance the EU's commodity protocol governing preferential trade in bananas with the ACP countries has already been successfully challenged under the WTO dispute settlement regime (Wallach and Sforza, 1999).

Under the CPA, the current tariffs applying to trade between EU and ACP countries will be maintained until 31 December 2007 after which they will be replaced by reciprocal Economic Partnership Agreements (EPAs) from 1 January 2008. Key steps in this process are summarised in *Table 1* overleaf.

Table 1: Major steps in negotiating the Economic Partnership Agreements (EPAs) between EU and ACP

Timing	Steps in the EPA negotiations	Relevant trade events
June 2000	Cotonou Agreement signed, which included an understanding to agree, by 2008 at the latest, on new development-oriented and WTO-compatible trading arrangements.	
March 2001		The EU launches the 'Everything-but-Arms' (EBA) initiative for least developed countries (LDCs), which provides for full duty-free access to EU markets for almost all products from LDCs.
November 2001	WTO waiver granted to the EU to continue its existing Lome preferences for ACP countries until 2008.	4th Ministerial WTO meeting in Doha referred to as the 'Doha Development Round'.
September 2003	Start of phase 11 negotiations with those ACP regions that consider themselves ready to enter into Economic Partnership Agreements (EPAs).	5th Ministerial WTO meeting in Cancun, without results for the form and content of the new ACP-EC trade relations.
2004	EU and ACP countries study alternatives for non-LDC countries that decide that they are unable to enter into EPAs. ESA countries launch their negotiations.	EU revises its Generalised System of Preferences (GSP) and reforms its Common Agricultural Policy (CAP).
2006	EU and ACP ensure that the negotiations calendar permits adequate preparation.	
January 2008	Application of a new ACP-EC trade regime; end of the ACP Lome preferential regime.	
2008 -2020	Implementation of the EPAs.	

Source: ECDPM, 2003.

2.2. The geographical configuration for the EPA

The 8th COMESA Summit decided in March 2003 that ESA countries should negotiate the EPA as a group. COMESA is now the principal agency for facilitating the negotiations for an EPA between the EU and sixteen countries in ESA, covering *Burundi, Comoros, Democratic Republic of the Congo (DRC), Djibouti, Eritrea, Ethiopia, Kenya, Madagascar, Malawi*, Mauritius, *Rwanda*, Seychelles, *Sudan, Uganda, Zambia* and Zimbabwe (LDCs are shown in italics).

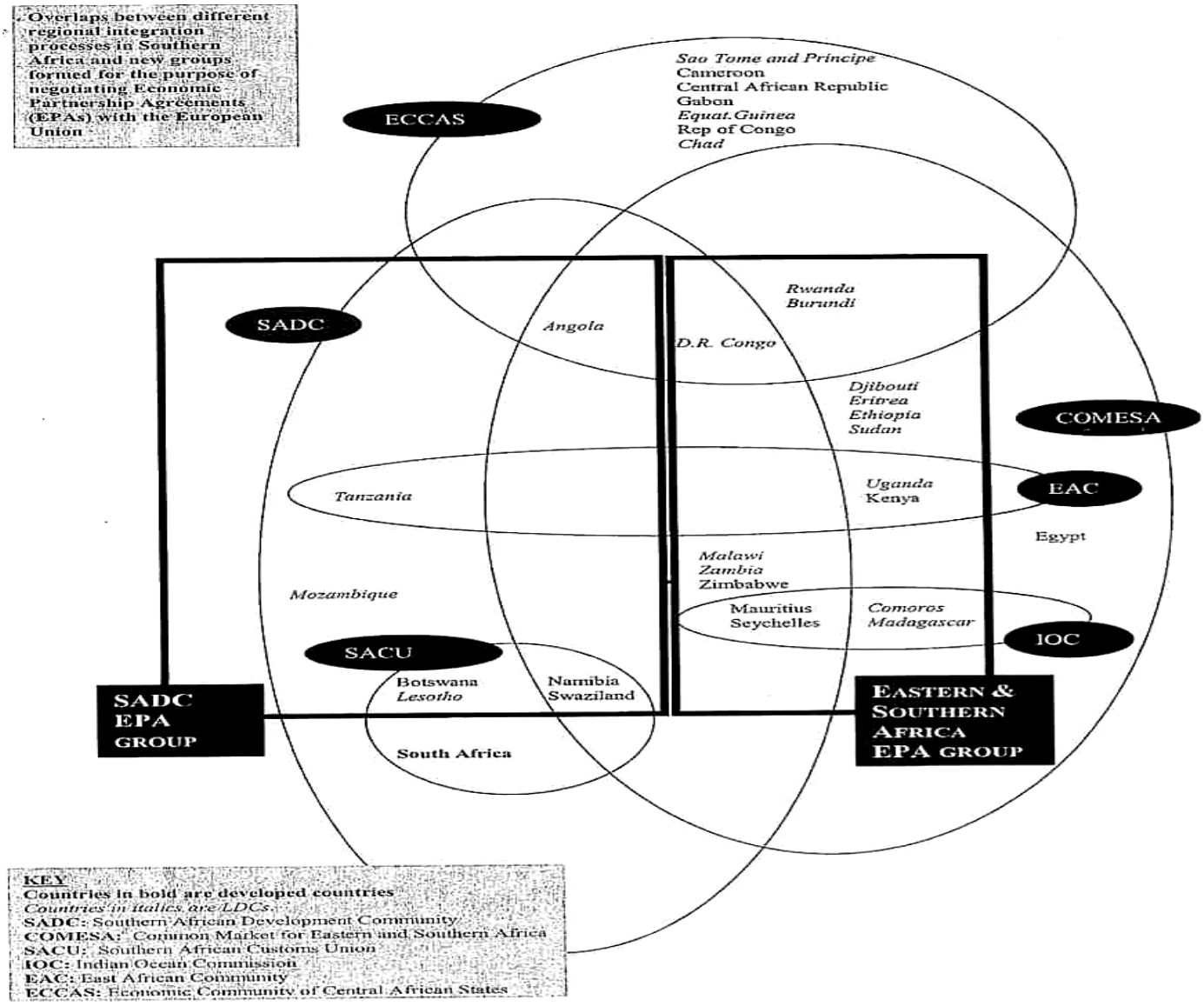
The EU negotiates as a bloc. It has legal status, institutional structure (including the Council of Ministers and the European Parliament), a powerful functioning bureaucracy that sits in Brussels, and a team of skilled negotiators under the authority of a single EU negotiator.

The European Commission recognises that 'the EU itself has built its strength on regional integration' (European Commission, 2003:5); 'the EU has thus pledged that the EPA will be built on existing initiatives for regional integration in the ACP' (European Commission, 2003). Article 35(2) of the CPA articulates that EPAs should strengthen regional integration.

The benefits of regional integration for ESA countries are detailed in other EQUINET and Southern African Development Community (SADC) publications (e.g. Muroyi, 2003; SADC 2006). The selection of the countries for the ESA-EU EPA can however be argued to fragment existing regional initiatives.

The sixteen ESA countries negotiating with the EU do not have legal status as a bloc. They do not have a formal structure of decision-making, nor an operational bureaucracy. The ESA configuration strides over five overlapping economic groups that is SADC, COMESA, East African Community (EAC), Southern African Customs Union (SACU) and Indian Ocean Community (IOC). (See Figure 2)

Figure 2: Impact of EPA negotiations on Regional Integration Efforts



Source: ECDPM 2001 in Kamizda 2004 www.seatini.org/publications/articles/2004/epas.htm

The countries included in these in the EPAs are

- SADC EPA group - Angola, Tanzania, Mozambique, Botswana, Lesotho, Namibia, Swaziland
- ESA EPA Group – DR Congo, Rwanda, Burundi, Djibouti, Eritrea, Ethiopia, Sudan, Uganda, Kenya, Malawi, Zambia, Zimbabwe, Muaritius, Sychelles, Comoros, Madagascar

The countries included in the regional trade arrangements are in contrast

- SADC- Angola, Tanzania, Mozambique, Botswana, Lesotho, Namibia, Swaziland, DR Congo, Malawi, Zambia, Zimbabwe, Mauritius, Madagascar, South Africa
- SACU – Botswana, Namibia, south Africa, Lesotho, Swaziland
- IOC – Mauritius, Saychelles, Madagascar, Comoros
- EAC- Kenya, Tanzania, Uganda
- COMESA- Angola, Namibia, Swaziland, DR Congo, Malawi, Zambia, Zimbabwe, Mauritius, Madagascar, Seychelles, Comoros, Rwanda, Burundi, Djibouti, Eritrea, Ethiopia, Sudan, Kenya, Uganda

While COMESA is supporting the negotiations, three of its members - Angola, Egypt and Swaziland - are excluded from the EU-ESA EPA. Tanzania has withdrawn from the ESA group in the EU-ESA EPA. Tanzania and Namibia are part of the 'SADC' group that also seeks to negotiate an EPA with the EU. This 'SADC' group does not, however contain four members of SADC, namely Zimbabwe, Zambia, Mauritius and Malawi. South Africa sits in the 'SADC' negotiations with the EU only as an observer.

These are peculiar geographic reconfigurations of eastern and southern Africa. They also reflect national decisions by various countries, such as Tanzania and Namibia's withdrawal from COMESA. This raises a number of questions in relation to existing mechanisms for regional integration.

This configuration can only be for negotiating purposes as at the end of the negotiations the EU will have to sign an EPA with a customs union. Through what regional configuration therefore will ESA countries eventually sign the EPA? How will the agreements reached on the EPA relate to the common external tariffs agreed in a regional trade agreement, such as in SADC (Nalunga and Kivumbi, 2004)?

While this appears to be more an issue for economic and trade policy than for health, the current peculiar configurations are also not compatible with the manner in which the SADC social and human development directorate, the Regional Health Secretariat for East Central and Southern Africa (ECSA) or the East African Community health desk are organised, weakening the integration of regional protocols, programmes, and capacities in the negotiations and in the protection of health within the EPA.

While the health implications of the EPA will be discussed later, the precautionary principle must apply in the negotiations process in relation to health, and all existing regional health protocols should have force in the EPA. Hence, in addition to complying with International conventions affecting health, i.e. the ESA-EU EPA must also comply with prevailing regional health protocols and standards of SADC, the EAC and ECSA. Such protocols include, for example, the SADC Health Protocol (2004), the SADC Charter of Fundamental Social rights (2003), the SADC code on AIDS and Employment and the SADC declaration and business plan for HIV and AIDS (2003)

2.3. The EPA agenda for negotiation

The CPA (Chapter 5, Articles 45-51) currently provides for competition policy, Intellectual Property Rights, standardisation and certification, sanitary and phytosanitary measures, as well as trade and environment issues, trade and labour standards and consumer policy.

EPA negotiations are conducted in six clusters: development issues, market access, agriculture, fisheries, trade in services and trade-related issues. The EPA covers trade cooperation, trade related issues, trade in services, fisheries, economic and development cooperation, development finance cooperation, institutional framework and final provisions, dispute settlement. (Article 4.1)

Negotiations to set priorities were done in March-August 2004; substantive negotiations were implemented in September 2004-December 2004 and are being continued and finalised between January 2006-December 2007. Trade experts from ESA countries have been discussing among themselves in a bid to formulate a regional position that will be discussed with the EU. National consultations have taken place within the umbrella of the National Development and Trade Policy Forums (NDTPF), while the regional position is being formulated within the context of a Regional Negotiating Forum (RNF). So far positions have been developed in the clusters of agriculture, market access, development, trade-related issues and fisheries. ESA has produced a draft text covering these five clusters.

Not much has been done on the services cluster. A session on Services was held in Madagascar in August 2006, but a study by the COMESA secretariat on the impact of existing liberalisation commitments in the area of services in the sixteen ESA countries was not yet complete. According to Mpande-Chulu (2006), programme manager for the trade in services project (COMESA) this assessment will investigate the:

- extent of service liberalisation, how open sectors are, where restrictions exist and why;
- policy environment: competition and entry requirements;
- regulatory environment: regulator, access to sector;
- market structure: number of firms; market share, ownership pattern;
- performance indicators: price and quality measures, employment and investment data;

The assessment will focus on policies affecting regional and international trade and investment in services.

Notably the impact of services liberalisation on social outcomes, such as access to health services, equity in service provisioning, or other national policy goals is not covered in this assessment. However for health-related essential services such outcomes are more critical to policy decision making on services given their role in protecting public health and their nature as public goods. Until such health audit is included in assessments on health-related services, the information to support national and regional decision making on services is too incomplete to facilitate such decisions.

This EQUINET assessment of health implications will examine three of the six broad areas – agriculture, services and trade related issues – but we suggest that such assessment should be done across all areas of the negotiations.

3. The health implications of the EU-ESA EPA

3.1. Access to medicines and intellectual property rights

Intellectual Property Rights (IPR), very broadly, are rights granted to creators and owners of works that are results of human intellectual creativity. These works can be in the industrial, scientific, literary and artistic domain. Examples of IPRs are copyrights, trademarks, patents and others. The WTO TRIPS Agreement (1995) requires member countries to provide for patent protection in their national legislation for a minimum of 20 years. TRIPS sets out the

minimum patent protection requirements for WTO members to enforce through their national laws. Developed and developing countries should by now have made their laws TRIPS compliant. The Least Developed Countries (LDCs) have until 2016. Many of countries in east and Southern Africa (ESA) are LDCs.

The Doha declaration allows WTO members to interpret TRIPS in a manner supportive of their efforts to protect public health and promote access to medicines. The Doha declaration gave countries the authority to use the flexibilities provided in the TRIPS Agreement in the interest of public health, including:

- giving transition periods for laws to be TRIPS-compliant;
- providing for compulsory licensing or the right to grant a license, without permission from the license holder, on various grounds including public health;
- providing for parallel importation or the right to import products patended in one country from another country where the price is less;
- exceptions from patentability and limits on data protection; and
- providing for early working (known as the *Bolar Provision*) allowing generic producers to conduct tests and obtain health authority approvals before a patent expires, making cheaper generic drugs available more quickly at that time.

Member states have the authority to use these flexibilities when this is necessary to protect public health and to promote access to medicines. TRIPS is more fully discussed in other publications. The Cotonou Agreement (Article 46), recognised the need to ensure an adequate and effective level of protection of intellectual property rights (IPRs) and other rights covered by the TRIPS, although with some limitations (see *Table 2*).

Table 2: Intellectual property rights and access to essential medicines: Comparing EPAs and TRIPS

IPR/ Access to medicines	What is found in TRIPS?	What is found in the Cotonou Agreement?
Ensuring an adequate, fair and effective level of IPR protection considering countries' levels of development and social welfare needs.	TRIPS Article 7 states that the protection and enforcement of IPRs should contribute to the promotion of technological innovation and to the transfer and dissemination of technology. This should be to the mutual advantage of producers and users of technological knowledge and in a manner conducive to social and economic welfare, and to a balance of rights and obligations.	Article 46 (1) of Cotonou does not give room to ACP countries to negotiate an "adequate and effective" level of IPRs protection according to their levels of development as provided for by TRIPS which differentiates between Least Developing Countries, Developing countries and Developed countries.
Definition of and exclusion from, patentability.	TRIPS Article 27 (3) allows WTO member countries the option to exclude diagnostic kits and therapeutic methods from patentability.	Cotonou Article 46 (5) doesn't allow patentability exclusions to the same level as TRIPS and includes patents on life forms such as plants and animals.
Consideration for other ongoing and active multilateral negotiations	TRIPS is a multilateral agreement and the Doha Declaration on TRIPS and Public Health has given developing countries a clear direction when negotiating all WTO trade issues which have a bearing on public health	Article 46 imports IPR negotiations into bilateral EPAs negotiations, over-burdening the ACP multilateral negotiating process. ACP countries may lose focus on Doha.

The process of negotiating IPR Issues	Under TRIPS, the mandate to negotiate, amend, review and monitor compliance to IPR issues falls to the TRIPS Council (Articles 68 and 71).	IPR issues in the EPAs negotiation are clustered with "development issues", a cluster already over-crowded with other issues. The negotiating structure for IPR issues in the EPAs is, therefore, less clear than it is in the TRIPS Agreement

Adapted from HAI, 2006.

Test data protection or data exclusivity refers to a type of 'intellectual property protection' by which a country grants exclusive marketing rights to pharmaceutical companies even in relation to medicines that are not under patent protection, and sometimes even when there has been no new invention. Where data protection is only exercised for protection against unfair competition, authorities can rely on the data to give marketing approval to a similar drug by a company other than the originator of the test data, for example a generic manufacturer, provided that the later drug is proven to be similar in clinical function to the one already on the market. 'Data exclusivity' prevents this.

The TRIPS Agreement in its Article 39.3 requires only ‘to protect … test data against unfair commercial use … [and] disclosure” – there is no mention of exclusivity and no specified period of protection as is required under EU laws.

Article 46 of the Cotonou Agreement defines intellectual property rights to include, among others, the "legal protection of data bases and the protection against unfair competition as referred to in Article 10a of the Paris Convention … and protection of undisclosed confidential information on know how". Article 10a of the Paris Convention however contains no reference to unfair competition. While this could be a mere oversight, some commentators argue that this is not accidental and is a clever strategy by the EC to introduce demands on data exclusivity in the EPA (HAI, 2006).

The negative impact of including ‘data exclusivity' provisions in the EPAs is that generic manufacturers would not be able to place versions of known drugs on an African market unless they compile their own test data. Such a process could take several years and may be prohibitively expensive. Thus, an ESA country which exercises its rights under the Doha declaration to issue a compulsory licence for the supply of cheaper drugs may find that there is nobody to supply the drugs. This in turn affects the availability and affordability of essential medicines for ESA people.

The current EPA process recognises the importance of IPRs and the ESA draft EPA has provisions on Intellectual Property rights. The draft prepared by ESA countries contains provisions (Title VI Articles 64 to 68) on IPRs. The ESA draft provides important safeguards for essential medicines, including:

- Ensuring availability of legal, institutional and human resources capacities and policy frameworks for the protection of intellectual property rights whilst respecting and safeguarding public policies of ESA countries.
- Ensuring the implementation of the flexibilities as is provided under the TRIPS Agreement.
- Providing for enhanced incentives for the development and research into new technologies especially in pharmaceutical products, including the production of generic medicine.

It is important for access to medicines that these are negotiated and present in the final EPA. The ESA draft goes further to provide for support for the implementation of these flexibilities, i.e.:

- EU shall support ESA countries to enable them benefit from the relevant provisions of the TRIPS Agreement and the in-built flexibilities especially with regard to public health, including access to pharmaceutical products at a reasonable price.
- EU shall support ESA countries to enact appropriate laws, formulate policies and develop infrastructure for local production of pharmaceutical products, transfer of technology and the attraction of investment in their pharmaceutical sectors (Section 66).

These clauses would support implementation of TRIPS flexibilities, which is currently not uniform across the region, despite WTO and most legal frameworks enabling them.

This ESA draft is still subject to negotiation with the EU. The position taken by the EU in other FTAs is to push for standards that go beyond those outlined by the WTO TRIPS Agreement. Numerous EU bilateral treaties (e.g. *The EU-South Africa FTA of 1999*; *The EU-Syria FTA 2004*) bind developing countries to enforce the "highest international standards" of IPR protection. It is unclear which standards these are. For example, it could refer to European standards, WIPO standards or new de facto standards emerging from the increasing number of bilateral treaties on trade and investment. Another example of an EU FTA which provides for TRIPS plus provisions is the South African FTA which state: 'South Africa shall ensure adequate and effective protection for patents on biotechnological inventions. South African must also implement "highest international standards" of IPR protection and undertake to go beyond TRIPS standards of IPR protection' (EC, 1999).

The draft EPA text between the EU and 15 Caribbean countries suggests that while some commitment has been expressed towards respecting TRIPS flexibility, the EU inclusion into that EPA of overly restrictive intellectual property protection through TRIPS plus provisions based on the EU enforcement directive suggests that ESA negotiators need to be vigilant against TRIPS plus provisions in the EPAs and build a string lobby, with parliamentary and civil society support for the clauses provided in the draft ESA text (Intellectual Property Watch, 2006).

It is further suggested that ESA countries ask the EU to make clear that it will not push for TRIPS-plus measures within European Partnership Agreements, and that it will give developing countries the policy space to freely use TRIPS flexibilities. The EPA should clearly provide that the EU should give ESA countries political and technical support to use the safeguards under TRIPS to ensure access to affordable medicines and to encourage development of ESA countries' pharmaceutical industries.

3.2. Trade in health and health related services

Services generally refer to products of human activity aimed at satisfying a human need and does not constitute a tangible commodity. Examples of services include but are not limited to electricity transmission, education, heath delivery and water purification (Muroyi, 2001). Under the WTO General Agreement on Trade and Services (GATS) (1995) trade in services is regulated within the WTO multilateral trading system. Information on the GATS is provided in other references (see for instance the WTO website)

Of twelve service sectors included in GATS, at least five are directly related to health care systems, i.e. the business, distribution, education, finance, and health and social services sectors. The professional services under the business service sector deal with services of health professionals. The distribution service sector relates to services in pharmaceutical retailing. The education service sector involves the training and education of health professionals. The financial sector deals with health insurance and flows of foreign capital for investment in private hospitals. The health and social services sector includes hospital services, medical and dental services, diagnostic services and management of health service facilities.

The CPA expects countries to comply with their GATS obligations. Countries make obligations under GATS by formally committing sectors. For those countries who have liberalised their health services by making commitments under GATS, the EPA will reinforce these commitments. Those who haven't made such commitments face no additional legal pressure from the CPA to service liberalisation.

They may however face political pressure. The EU has promoted extensive liberalisation of the services sector of ESA countries under the GATS by requesting opening up of ESA countries' service sectors. The CPA (Article 41.4) states: "The Parties further agree on the objective of extending under the economic partnership … the liberalisation of services in accordance with the provisions of GATS and particularly those relating to the participation of developing countries in liberalisation agreements." In 2004, the EU had proposed that LDCs and other unspecified vulnerable states should not be required to further open their markets. Instead they would "benefit from improved access to developed and rich developing markets…" (European Commission, 2004). In contrast the liberalisation of services and the opening of markets to foreign investors is part of the EPA negotiations and EPAs are expected to 'substantially all trade'.

EQUINET proposes great caution over making any commitments in the health sector. Broad opportunities and risks in trade in health services are summarised in *Table 3*, however specific country assessments indicate that for ESA, the risks can have a severe impact on already fragile health systems (Nalunga and Kivumbi, 2004).

Table 3: Opportunities and risks of trade in health services

	Opportunity	Risk
Mode 1 Cross-border supply	Increased care to remote and under-served areas.	Diversion of resources from other health services.
Mode 2 Consumption abroad	Much-needed foreign exchange earnings for health services.	Crowding out of population and diversion of resources to service foreign nationals.
Mode 3 Commercial presence	Opportunities for new employment and access to new technologies.	Development of a two-tiered health system with an internal brain-drain.
Mode 4 Presence of natural persons	Economic gains from remittances of health-care personnel working abroad.	Permanent outflows of health personnel, with loss of investment in educating and training such personnel.

Adapted from World Health Organization, 2006.

Given the potential for GATS to intrude on state authorities essential for public health and health equity sovereignty, EQUINET and other public health networks recommend that ESA countries:

- make no GATS commitments in the health sector or other health-related sectors;
- conduct a comprehensive 'health check' on any other GATS commitments proposed by WTO trade negotiators, with the active involvement of health ministries and civil society;
- call a halt to the current WTO negotiations on rules governing domestic regulation; and
- call for a change to GATS rules which restrict countries from retracting commitments already made under GATS.

EQUINET and WHO suggest that states should subject all requests for, and offers of, trade liberalisation in health-related services, to a thorough assessment of their health policy implications (EQUINET et al, 2005).

Hence while the specific effects of service liberalisation will vary by country, the overall understanding is for ESA countries to exercise caution in making any commitments of health services under GATS, as these will make liberalisation irreversible. This caution was expressed at the 4th Ordinary Session of the AU Conference of Ministers of Trade in April 2006, where the ministers:

> *"noted the intention of the European Community to seek extensive opening of African service sectors. We re-commit ourselves to pursuing the architecture under the WTO General Agreement on Trade in Services, of a positive list approach, and underscore the absolute need for a carefully managed sequencing of services liberalisation in line with the establishment of strong regulatory frameworks. We therefore shall not make services commitments in the EPAs that go beyond our WTO commitments and we urge our EU partners not to push our countries to do so."*

It is thus expected that ESA negotiators not make any services commitments in the EPAs that go beyond their WTO commitments and that EU partners not push for extensive liberalisation that does not recognise the absolute need for a carefully managed sequencing of services liberalisation, where necessary, preceded by the establishment of strong regulatory frameworks.

In other platforms, the EU has committed to discuss with the Regional Economic Communities how to address the human resource crisis through measures linked to the process of regional integration and the Economic Partnership Agreements. Related issues of economic migration and South-South migration should also be discussed. The aim will be to strengthen and manage the regional market in HR to mitigate the adverse impact of brain drain, and turn brain drain into 'brain gain' through regional agreements on skill sharing and development, recognizing the need for policy coherence for development (Commission of the EC, 2005). Given the extent of losses to public sector health systems through health worker migration to Europe, it would thus be expected that the EPA include specific commitments to ethical recruitment and to EU investment in public budget support for production and financial and non financial retention measures.

In the ESA-EPA draft text, the services section is blank. In an area as important as services, ESA did not have a position thirteen months to the scheduled finalisation of the negotiations. By end of November 2006 only one Dedicated Session on Trade in Services had been held. The meeting that had been scheduled for October 2006 was postponed to 2007. By end 2006 the ESA region had not yet developed its draft text in this area.

This would be a priority area for a clear position from ESA countries to:

- ensure government authority in health services;
- exclude any pressure for formal commitments of health services under GATS and recognise the need for caution in making commitments on health and health related services;
- avoid links between commitments in health and health related services with negotiations on other areas of service liberalisation;
- ensure the EPA includes specific commitments in health workers, including to ethical recruitment and to EU investment in public budget support for production and financial and non financial retention measures in ESA countries; and
- call for support for formal health impact assessments in any health-related sector where liberalisation is being proposed, whether under GATS or under the EPA.

3.3. Revenue for public services

ESA countries face a potential loss of government revenue due to tariff removals required by the EPA (see *Table 4*).

Table 4: Revenue implications of a EU-ESA EPA

Country	Revenue shortfall (US$)
Burundi	-7,664,911
DRC	-24,691,828
Ethiopia	-55,126,359
Eritrea	-7,385,208
Djibouti	-37,523,124
Kenya	-107,281,328
Madagascar	-7,711,790
Malawi	-7,090,310
Mauritius	-71,117,968
Rwanda	-5,622,946
Seychelles	-24,897,374
Zimbabwe	-18,430,590
Sudan	-73,197,468
Uganda	-9,458,170
Zambia	-15,844,184

Source: WITS/SMART Simulations cited in Oxfam, 2006.

With limited sources of domestic revenue and limited tax bases, tariffs are one key source of revenue. The IMF estimated that for 1999-2001 import duties contributed 15% to government revenue in developing countries and 34% for Africa's least-developed countries (Friends of the Earth, 2006). According to the World Bank, tariff revenues in sub-Saharan Africa average 7-10% of government revenue (Hinkle and Newfarmer, 2005). ESA countries thus rely on import taxes to contribute to government revenue to finance public services.

If tariffs are eliminated on EU imports this would seriously lower tariff revenues for ACP.Most ESA countries rely on import duties to raise government revenue, and as acknowledged by then UN Secretary-General Kofi Annan (2004 quoted in Oxfam 2006:5) the loss to public revenue can be significant, with potential consequences for spending on essential services such health and education:

> *"A Major concern, for example, is the impact that the trade liberalisation to be wrought by EPAs would have on fiscal revenue. Many of your countries are heavily dependent on income from tariffs for government revenue".*

The ripple effects of such losses are not clear. In a bid to offset revenue losses from tariff cuts, some countries may cut public spending, or resort to other forms of taxation, including less equitable taxes such as value-added tax on consumers, that impact more heavily on poor households. Revenue loss acts as a further pressure on governments to transfer the ownership and running of state utilities to both the national and international private sector. This too has negative consequences for access to health in poor households when it is associated with increased user charges, absence of free access to basic services for low income households and a reorientation in the nature and coverage of services provided.

A report by the United Nations High Commission (2001) on liberalisation of trade in services and human rights clearly states that if trade law or liberalisation ends up preventing cross-subsidisation or other policies seeking to ensure universal access for the poor and results in a reduction in the quality and quantity of services to the poor and vulnerable, it may become 'defacto discrimination'. It is thus important that governments in the ESA region maintain their policy space to interpret the EPA in a manner that gives them flexibility in using development tools such as cross-subsidies in health financing or regulation of service provisioning, where this is necessary to protect goals universal access to services.

This is particularly important given that it is not clear that the foregone revenue from tariffs will be compensated for by real growth in increased market access for ESA countries under

EPAs, given "the major supply-side constraints that impede competitive production" in ESA countries and the possibility that gains will accrue mainly to large, often foreign-owned corporates, rather than small scale local producers (Oxfam, 2006 p 9). Research reveals that a conservative estimate of the total 'adjustment costs' such as compensation for loss of tariff revenue, employment, production, and support for export development for ACP countries could be about €9.2bn. (Milner, 2006). This means that the negotiations will need to include discussion of how these adjustment costs are borne, while protecting spending in key areas such as public financing for health.

3.4. Agriculture and food security

It is not only through its effects on the resources for and organisation of the health system that EPAs may affect health. In its potential effects on agriculture and food security at the individual, household, national, regional levels the EPA can affect household access to food, dietary patterns and nutrition. While other economic sectors impact on health, this section focuses on agriculture for its close link to nutrition and its economic and social importance. The ESA region is predominantly dependent on agriculture, and agriculture is a significant source of employment (see *Table 5*).

Table 5: Agriculture in SADC Countries (1995-2000)

Country	Contribution to GDP (%)	Agricultural workers as % of total labour force
Angola	9.6	74.5
Botswana	2.4	46.4
Namibia	9.3	49.1
Zimbabwe	17.9	68.2
Malawi	35.9	86.6
Zambia	21.7	74.6
Tanzania	43.2	84.4
Mozambique	24.2	82.7
South Africa	3.4	13.5
Swaziland	15.1	39.5
Lesotho	15.4	40.1
Mauritius	6.1	16.7

Source: FAO, 2005.

With the exclusion of a few countries relying on mineral exports, the export structure of most SADC countries is largely agricultural, particularly for Zimbabwe, Tanzania, Malawi, Mozambique, Lesotho and Swaziland. The bulk of these products are sold in raw or semi-processed form for declining prices on the international markets. Per capita output has declined over the last 30 years. The agricultural production system is dominated by peasant production, largely dependent on natural rainfall patterns therefore vulnerable to natural disasters, with poor or non-existent infrastructure, poor access to modern energy and inadequate credit lines. Extension services are poor and input costs high.

EU economic activities in contrast are based on the goods and services sectors and only 5% of EU citizens work in agriculture. Agriculture generates only 1.6% of the EU's GDP, and is highly protected. The EU Common Agricultural Policy (CAP) (2005) has provided agricultural subsidies since 1962, with 49 billion euros spent on:

- price support to guarantee a minimum price for crop;
- export subsidies;
- rural development aid to diversify the rural economy; and

- set aside programme funding to leave land uncultivated and subsidies to support animal welfare and environmental protection.

EU on- and off-farm support makes it very difficult for unsubsidised farmers from poor countries to compete. Excess EU production dumped on developing country markets at low prices further erodes local production. For example:

- EU farmers are guaranteed a sugar price that is three times higher than the world average and protected by tariffs of above 300%. Mozambique loses more than £70m a year - equivalent to its entire national budget for agriculture and rural development – as a result of subsidised competition (Oxfam, 2004).
- EU CAP subsidies in Spain and Greece mean that cotton prices are reduced below those of ESA exporting countries, namely are Zimbabwe, Zambia and Malawi.
- Subsidies on EU dairy exports (especially cheese) has depressed local milk production and sales in Southern and east Africa.
- EU and USA chicken and chicken product exports in Ghana and Senegal are 50% cheaper than the local product; with the result that local producers are being pushed out of production.

Clearly the two regions are extremely unequal, in the socio-economic importance of agriculture, and the levels of public and private investment and subsidy in agriculture and in market access. Under four successive Lome conventions (1975-2000), the EU granted a preferential trade regime to ACP countries through trade preferences, commodity protocols and other instruments of trade cooperation such as financial aid and technical aid. The EU permitted certain ACP imports into the EU market through a quota system on preferential terms. The ACP countries were not obliged to reciprocate the same treatment on EU exports. These trade preferences, intended to benefit the largely agricultural economies of the ACP states, led to a variety of protocols covering trade in beef, veal, bananas and sugar. These EU-ACP preferences came under sustained attack from the US in 1995. The US took the fight supposedly on behalf of Guatemala, Honduras, Ecuador and Mexico, but in reality the fight was Chiquita Brands International Inc., a multinational corporation which had major banana interests in Central and South America. According to Article I of Protocol 5 to the Fourth Lomé Convention:

> *In respect of its banana exports to the Community markets, no ACP State shall be placed, as regards access to its traditional markets and its advantages on those markets, in a less favourable situation than in the past or at present.*

This protocol makes it the duty of the EU to maintain access to EU markets for bananas from traditional ACP exporters. The US and its allies won two rulings. The first decision in 1995 ruled that the cross subsidy that the ACP states were being granted by the EU had to be stopped. The US and Ecuador believed the ruling did not go far enough as it dealt only with bananas, they wanted all preferential trade agreements between the EU and ACP to cease on grounds that they were incompatible with WTO rules. Another panel was established by the WTO Dispute Settlement Body in January 1999 and ruled the EU-ACP banana regime was not fully compatible with WTO regulations. The WTO ruled that the EU-ACP preferences were inconsistent with the WTO requirements (Wallach and Sforza, 1999).

This development provided an impetus for the CPA and the EPAs. The CPA recognises a commodity price crisis in Africa with declining international prices for African producers. The CPA articulates the need for fairer and more transparent operation of international commodity markets.

The EPA however does not address this by reforming the EU's agro-production system. Rather, it aims to expand market opportunities for EU agribusiness by liberalising ACP economies. In the EPA, ESA countries are expected to make drastic reductions in their tariffs and other import duties to allow EU imports on zero duty. Given the inequality described above, and the collapse of a lot of local food production in Africa, this further tariff

reduction will further exacerbate the cycle of increasing agricultural imports and falling local production.

ESA countries are dependant on agriculture. Their agriculture will not survive competition with the EU producers in a free trade area arrangement. The WTO process had set 2013 as an end date for the elimination of all forms of agricultural export subsidies. Tentative indications had also been produced with respect to trade distorting domestic support measures. No real agreement was eventually produced on both forms of support measures. Presumably happy with the WTO indicators, ESA countries have put no real pressure on the EU to eliminate all forms of trade distorting subsidies. In particular, Article 93 of the draft EPA text makes no mention of time-bound elimination of export and domestic subsidies. Relying on the WTO process for an automatic feed-in on the subsidies issue can be seen as a strategic blunder. It provides no effective obligation for the EU to eliminate trade-distorting subsidies and leaves ESA producers exposed.

There is significant evidence of the link between food security policies and local production, especially small scale, female-controlled production (Chopra, 2004). Yet this is the precise area of production that will be eroded as small scale farmers abandon agriculture due to their inability to compete. Any apparent gains in reduced prices from cheap subsidised imports (Zachary, 2004) are lost through costs of unemployment and declining local agricultural production base and demands on scarce foreign exchange to purchase food.

The main objective of the old Common Agricultural Policy (CAP) was to ensure food security for EU countries in the context of the cold war. Within Europe itself the policy was to sustain high-cost and market-inefficient (market-distorting) producers through minimum grower prices guaranteed by subsidies, and dumping incidental surpluses in the world market with export rebates. Outside Europe, it was through giving preferences to producers in the colonies (later independent countries but still tied to Europe), so that they produced essential foodstuffs for Europe at guaranteed prices that were higher than artificially sustained low world market prices. Sugar is a classic case, where world prices were artificially kept low, and yet a country like Mauritius, for example, could export 100% of its sugar to Europe at higher than world prices. How can Mauritius adjust to a new regime so quickly when its sugar export dependence is still high?

Food security for Europe in the dangerous times of the cold war was a strategic objective. The cost in financial terms was heavy, but it was considered justified under circumstances then prevailing. The cost in terms of creating dependence in ACP countries was also high, but at the time it looked like a welcome "concession" to the commodity producers of those countries. With the cold war over by 1991, the high cost of storage and export refund payments were no longer justified at the domestic (that is, EU) level. Nor were the "concessions" to the ACP countries defensible. These considerations, and the impending conclusion of the Uruguay Round Agreements (URAs), motivated the CAP reform.

In 1992, a fundamental shift was made in CAP from the system of price support to one of direct aid to farmers. The aim was to reduce domestic price of agricultural products, without eroding farm incomes and in a manner that could be seen as WTO compatible. Price reduction and closing the gap between EU and world market prices provided an incentive to EU processors of agricultural products to produce for export, a major objective of the new CAP, enabling EU producers to capture a share of the world market in processed foods.

However, the EU had to overcome two hurdles. One was the liberalisation of agriculture under the WTO. Agriculture for the first time became a subject for an institutional trade regime, not having been a subject under the previous GATT. Under the WTO, the CAP was widely viewed as market distorting. The EU had to delay trade liberalisation in agriculture until the European food industry had reorganised itself under CAP reform and captured a significant share of the world market in processed foods. The EU Trade Division adroitly managed to delay negotiations in the WTO to facilitate this.

Secondly the agreement with the former colonies (first under Yaounde and then Lome) that secured high prices for several agricultural products and a guaranteed market in Europe for them had to end. With the strategic need for food from these countries now irrelevant and high prices a disincentive to industrial food processors in Europe, there was pressure to reduce the tariff walls of the ACP countries to open markets in these countries to European industrial food products. The proposed shift from non-reciprocal to reciprocal relations, with Europe and its former colonies dealing 'on equal terms', provided the policy basis for this change.

This history demonstrates the purpose and interests with which regions enter the EPA negotiations, and the manner in which regions act to secure their interests. In the same way that Europe managed the WTO process to prolong the subsidies regime needed to reorganise its food industry and has managed the EPA negotiations to open market access to that industry, so too do ESA countries need to manage the Doha waiver allowing for non-reciprocity ending on 31 December 2007, and the consequences for African food producers.

Hence while ESA countries negotiate the EPA it is recommended that:

- the EPA specifically promote policies and investments to support and promote local food production, especially by smallholders;
- ESA countries continue to argue for a fair subsidy regime, i.e. the maintenance of subsidies on African agricultural production or the complete removal of all subsidies on agriculture in the EU. Any unbalanced arrangement, such as that currently prevailing, undermines food security both in the immediate and in the long term;
- ESA countries put real pressure on the EU to eliminate all forms of trade distorting subsidies; and
- Article 93 of the draft EPA text specify the time-bound elimination of all direct and indirect export subsidies have to be eliminated by a credible date, and that subsidies on African agricultural production be maintained until the complete removal of all subsidies on agriculture in the EU.

3.5. Summary of health implications

This analysis of the health implications of the EU-ESA EPA has examined four areas:

- The provisions for IPRs, in which the CPA intention and ESA commitment to protect TRIPS flexibilities to ensure access to medicines and medical technologies is evident, but not yet articulated in the draft EPA. The experience of other EU FTAs suggest that ESA countries and their parliaments and civil societies need to vigilantly ensure that the draft text put forward by ESA in this area is effected in the EPA, to provide for full TRIPS flexibilities and for capacity support for their implementation.
- The provisions for trade in health and health related services are not yet specified. In the context of the EU's own protection of its public health services but pressure for wider service liberalisation under the EPA, ESA countries may be under pressure to make commitments to service liberalisation in areas that affect health. The analysis suggests that ESA countries make no commitments in any health or health-related services beyond what is already committed at WTO, retain government authorities to regulate health service provisioning and provide in the EPA for health impact assessment to be implemented prior to commitments being made in any areas of service liberalisation that may have an impact on health.
- The loss of revenue through removal of tariffs is discussed. While the scale and effect is not yet clear, existing data suggests that it may be significant, unmatched by improved returns to public revenue from trade and with potential costs to low income households in reduced public expenditure and more inequitable forms of health financing.
- The agriculture section of the EPA promotes market access and reduced tariffs and subsidies. However in the context of the extreme and longstanding inequalities between EU and ESA agricultural production systems, the analysis suggests that there will be

limited or absent returns to local and smallholder producers from the EPA unless they are deliberately protected and invested in under the EPA. In contrast a poorly sequenced liberalisation may further intensify subsidised food imports or large scale food producers, and further undermine local and small scale food production. This trend has already been associated with declining household food security.

Across these areas there is a common concern that:

- The health implications of the EPAs be explicitly recognised, that health officials be included in negotiations, that health impact assessments be carried out where relevant, such as in any areas where service liberalisation may impact on health, and that EU and ESA countries ensure that the EPA is fully compliant with all regional and international health protocols and conventions prior to December 2007.
- The EPA recognise and provide specific measures to remedy trade distortions that undermine household small holder production and employment in ESA, given their relationship to health.
- The EPA not make trade commitments in areas that affect health beyond those already made at WTO and further invest in capacities in ESA to make maximum use of the flexibilities provided for in WTO agreements.
- The EPA make specific and explicit provision for information and capacity support to governments and social partners to manage, regulate and implement full flexibilities in relation to the health aspects of trade.
- ESA countries maintain their policy space to exercise the authorities and flexibilities needed at regional and national level to meet their commitments to universal access to health care and to applying specific policy tools, such as cross subsidies, to address inequities in health.

4. Challenges to promoting health in the negotiations and implementation

Beyond the text of the EPA, the negotiation process, capacities and funds for implementation also pose challenges that can influence health outcomes. These are briefly discussed below.

4.1. The negotiation of the EPA

The first meeting of Non-state Actors held in Addis Ababa in 2006 criticised the negotiating process for its lack of transparency, and for its limited political and public participation and debate. In the ESA region, negotiations are largely the preserve of the technical team based in COMESA, which is largely EU funded. The COMESA secretariat and Ambassadors in Brussels now largely drive the negotiations, and governments and private sector are less directly involved. Other non-state actors – civil society, media and MPs are still restricted to the periphery of engagement (Kamidza, 2004).

The negotiations are being carried out at two levels - the ministerial and the ambassadorial/ senior official level in six clusters. The ESA group has selected six ambassadors based in Brussels and six ministers to lead the negotiators. At an EU-ACP ministerial meeting held at Port Moresby in May 2006, ACP ministers called for the EC ‘to respect the negotiation process and to desist from exerting pressure at the highest political level by taking advantage of the information gap that may exist between the negotiators and the political leadership’ (ACPSEC, 2006). The ESA-EPA negotiators are based in Brussels whereas all African WTO negotiators are based in Geneva. As a result the positions of ESA in the WTO and EPA negotiations are not harmonised. As this may result in prejudice for ESA countries in the EPAs, there is a need to bring Geneva and Brussels Ambassadors together.

The EU in contrast negotiates as a bloc. It has legal status, institutional structure (including the Council of Ministers and the European Parliament), a powerful functioning bureaucracy

that sits in Brussels, and a team of skilled negotiators under the authority of a single negotiator, the EC trade commissioner.

Most ESA member states have limited experience in multilateral trade negotiations. Some ESA members are in the process of negotiations at the bilateral or regional level of free trade agreements or a customs union. Many of these regional trade arrangements have not yet been fully established and have a strong call on the analytical and negotiating capacities available in ESA countries. State and non-state delegates from each country are also expected to participate in negotiations at various levels and in preparatory trainings. These various processes place significant demands on personnel and resources for the negotiations. The institutional and financial resources for this are limited and often overstretched. Within this there is often an absence of core expertise on public health or international health law within the negotiating teams.

Matters of concern include:

- the resource limitations in ESA;
- the weak coordination between key actors;
- the lack of a clear role for governments as the main driving force in the process and thus for health ministry contributions;
- the weak consultation and involvement of non-state actors; and
- the absence of evidence or full impact assessments in key areas such as health.

There is an evident disparity in bargaining power between the EC and the ESA countries. There is no obligation to sign an EPA with the EU. Least developed countries are eligible for the Everything But Arms (EBA) initiative (2001) and developing countries may retain the EU's revised General System of Preferences under which the EU offers trade preferences to certain countries. Under the EBA arrangement, LDCs have duty-free access to the European market for 'everything but arms'. Yet the EU has the option to change preferences at any time under GSP giving ACP developing countries the same preferences as all developing countries. There is thus little security and predictability in the current option.

The uneven bargaining power has already emerged. The EC has secured numerous concessions in the negotiations to date. It was able to structure the agreement on a regional level, which ACP countries originally fought against, and convinced the ACP to agree to discuss all issues in a single setting rather than using an issue-specific approach. These two major concessions were won despite their apparent conflict with Chapter 2 of the CPA, which states that ACP countries will determine the "development principles, strategies and models of their economies and society in all sovereignty" (South Centre, 2006).

This situation, and the fundamental obligations that states have to protect public health, mean that ESA states need to apply the precautionary principle in all areas of the EPA negotiations where potential health impacts exist. This means that unless there is clear evidence, from ESA country contexts, of proven health gains, the position taken must be one that infers potential risk, and the measure negotiated should provide greatest possibility, authority and policy flexibility for protecting health or providing for health services.

4.2. Issues in the implementation

Implementation of the EPA will have financial implications for the ESA countries, such as the losses in tariff revenue discussed earlier. Adjustment costs will arise from the direct economic measures, from the institutional demands on implementation and from the spillover impacts of trade measures, including in areas such as health. Experiences of the Structural Adjustment Programmes in Africa indicate that such costs are often not recognised, planned for or funded.

EU development aid to ESA countries is provided through the Economic Development Fund (EDF) and covers areas relevant to health such as education, water, sanitation and health

itself. These funds are released in five-year cycles. The European Commission in response to the concerns of ACP countries in relation to the costs of implementing the EPAs has pledged to increase the amount pledged under the next EDF funding cycle (2008-13, the 10th EDF) to €22.7bn (Milner cited in Oxfam, 2006). While this figure seems high, it is in fact a very small increase on the €21.3bn estimated to be needed for the 10th EDF funding cycle to cover the existing aid portfolio, even without the EPA (Oxfam, 2006). Hence the 10th EDF will provide little additional funding. It is likely that EU will be expected to cover EPA adjustment costs from its existing aid budget.

Where this leaves ESA countries with unmet adjustment costs to finance from own revenue, there is a potential for revenue to be diverted from other areas, including from health. At a time when the WHO Commission on Macroeconomics and Health has pointed to the chronic under-funding of health systems in ESA, calling for a doubling of development aid to fund an essential package of services, inadequate funding support to ESA countries to meet additional resource cost of implementing the EPA is essential (Commission on Macroeconomics and Health, 2001).

Although there are indications that the EC wishes to take compensatory measures to cover the costs of implementing an EPA through the European Development Fund (EDF), the lack of significant additional resources implies that this will come from diversion of existing funds, including those allocated to essential services. It would appear that this uncertainty needs to be cleared before the EPA is concluded. The cost of implementation for ESA countries needs to be estimated, and the sources of funds to meet this agreed. Negotiations on issues of aid need further to be linked to a costing of measures and to the costs of compensating people for the losses encountered as a result of implementing the provisions of the EPA.

The African Union Conference of Ministers of Trade in January 2007 called for the urgent establishment of an additional EPA Financing Facility at national and regional levels as provided for in Declaration XIV of the revised CPA, to address these adjustment costs and support the EPA process and implementation over time. The ministers also sought a binding commitment from the EU for additional resources beyond the 10th EDF to cover EPA related costs which has to be factored into the legal text of each EPA. If the EPAs are to be meaningful to the socio-economic development of ESA countries it is important that they come with predictable funding including such an EPA adjustment facility (Addis Ababa Ministerial Declaration on Economic Partnership Agreements Negotiations, 2007).

5. Conclusion and recommendations

This report indicates that the social development aspects of Cotonou are insufficiently integrated into the EC's negotiating mandate and as a result may not come out in the final EPA Agreement. The positive aspects of the EPA (regional development, creation of national and regional internal markets, etc.) may be offset by the considerable differences in levels of development between the EU and the ACP countries. In light of the health implications within the EPAs identified in this work the following is recommended for ESA countries stakeholders:

- EPAs should not pressure ESA countries governments into undertaking commitments that go beyond existing multilateral agreements.
- EPAs should be first and foremost an instrument to foster the development of ACP countries. Their scope and content should be determined by this objective. Should they fail to deliver on their development promises, the ACP should consider alternative options. It is however beyond the scope of this study to pursue the alternative to EPAs but a comprehensive report on the subject can be found at www.ecdpm.org.

Countries need to commit and include that the EPA needs to be audited for its public consequences and a principle of review integrated where negative consequences are identified. It is imperative for ESA to prepare adequately for EPA negotiations while at the same time ensuring good relationships between and/or among Brussels, Geneva, capitals,

COMESA and ACP Secretariat. In this way, ESA should always follow up issues as well as coordinate various efforts employed in this process. In addition, the configuration should intensify training courses for negotiators as well as blending this with experience (SEATINI, 2004). It is recommended that:

- The health implications of the EPAs be explicitly recognised, that health officials be included in negotiations, that health impact assessments be carried out where relevant, such as in any areas where service liberalisation may impact on health, and that EU and ESA countries ensure that the EPA is fully compliant with all regional and international health protocols and conventions prior to December 2007.
- The EPA recognise and provide specific measures to remedy trade distortions that undermine household small holder production and employment in ESA, given their relationship to health.
- The EPA not make trade commitments in areas that affect health beyond those already made at WTO and further invest in capacities in ESA to make maximum use of the flexibilities provided for in WTO agreements.
- The EPA includes specific commitments in health workers, including to ethical recruitment and to EU investment in public budget support for production and financial and non financial retention measures in ESA countries;
- The EPA make specific and explicit provision for information and capacity support to governments and social partners to manage, regulate and implement full flexibilities in relation to the health aspects of trade.
- ESA countries maintain their policy space to exercise the authorities and flexibilities needed at regional and national level to meet their commitments to universal access to health care and to applying specific policy tools, such as cross subsidies, to address inequities in health.
- Where the time remaining to the mandated to end of negotiations is inadequate to implement Impact assessments the precautionary principle noted above should apply. ESA countries should not be hurried to conclude the negotiations until they are ready.

Part of the 'readiness' needed is to ensure that Members of Parliaments, and non-state actors in ESA are aware of the EPA negotiations and the choices being proposed. Debates in parliament should be held and publicised to make clear what is being committed to within the EPA and its consequences. Governments have an onerous responsibility, as stated in the Consensus of UNCTAD XI (paragraph 8), June 2004 and signed by most countries in the EC and ESA governments:

> *It is for each Government to evaluate the trade-off between the benefits of accepting international rules and commitments and the constraints posed by the loss of policy space. It is particularly important for developing countries, bearing in mind development goals and objectives, that all countries take into account the need for appropriate balance between national policy space and international disciplines and commitments.*

This paper has flagged a number of issues to draw attention to the potential health implications of the EPA. This is not sufficient. We argue that a thorough health impact assessment of the EPA on a country-by-country basis be implemented along an agreed framework, supported with EU financing and involving ESA expertise. Governments have an obligation to protect public health, at national and international level. It would provide a strong signal of the genuine development intentions of the partnership if these obligations were given greater recognition, assessed and acted on in the EPA negotiations.

References

1. African, Caribbean and Pacific Group of States and European Economic Community (1975) 'ACP-ECC Convention signed at Lome on 28 February 1975,' *Official Journal of the European Union* available at http://www.acpsec.org/en/conventions/lome1.htm#CONVENTION on 7 March 2007.
2. African, Caribbean and Pacific Group of States (2006) Resolutions and decisions from the ACP council of ministers meeting in Port Moresby, 2006. ACP: Port Moresby available at http://www.acpsec.org/en/com/83/ACP2500606_decisions_e.pdf.
3. African Union (2006) *Nairobi Ministerial Declaration on Economic Partnership Agreements*. AU: Nairobi (14 April).
4. African Union (2007) 'Ministerial declaration on Economic Partnership Agreements negotiations,' *Conference of Ministers of Trade of the African Union 3rd Extraordinary Session, 15-16 January 2007, Addis Ababa, Ethiopia*. African Union: Addis Ababa.
5. Annan K (2004) 'UN Secretary-General Kofi Annan's message to the Fourth Summit of Heads of State and Government of the African, Caribbean, Pacific Group,' delivered by KY Amoako, Executive Secretary, Economic Commission for Africa in Maputo (23 June) available at http://www.un.org/News/Press/docs/2004/sgsm9386.doc.htm on 7 December 2006.
6. Baker B (2004) *Processes and issues for improving access to medicines: Willingness and ability to utilise TRIPS flexibilities in non-producing countries*. DFID Health Systems Resource Centre: London.
7. Balakrishnan R (2004) *Why MES with Human Rights? Integrating Macro Economics Strategies with Human Rights*. MaryMount Manhattan College: Manhattan
8. Brenton BP (2005) *HIV/AIDS, Food Insecurity and Genetically Modified Food Aid in Southern Africa: Seeking Common Ground Solutions through a Commitment to Peace, Justice and Sustainability* available at www.metanexus.net on 12 December 2006.
9. Chopra M (2004) 'Discussion paper 22: Food security, rural development and health equity in Southern Africa' *EQUINET Discussion Paper Series*. EQUINET:Harare.
10. Commission of the European Communities (2005). Communications from the Commission to the Council and the European Parliament: EU Strategy for Action on the Crisis in Human Resources for Health in Developing Countries, Brussels
11. Correa C (2002) *Protection and Promotion of Traditional Medicine: Implications for Public Health in Developing Countries*. South Centre: Geneva.
12. East and Southern African and European Commission (2004) *Negotiations of an Economic Partnership Agreement between Eastern and Southern Africa and the European Community – ESA-EC Joint Roadmap.*
13. Europa (2005) 'Common Agricultural Policy: Overviews of the European Union Activities – Agriculture,' *Europa*. European Community: Brussels available at http://europa.eu/pol/agr/overview_en.htm
14. European Centre for Development Policy Management (2006) 'Overview of the regional EPA negotiations: SADC-EU Economic Partnership Agreement,' *ECDPM In Brief 14B*. European Centre forDevelopment Policy Management: Maastricht available at http://www.ecdpm.org/Web_ECDPM/Web/Content/Navigation.nsf/index2?readform&http://www.ecdpm.org/Web_ECDPM/Web/Content/Content.nsf/7732def81dddfa7ac1256c240034fe65/208a260b4e2b06c1c125723d005a1c71?OpenDocument
15. European Centre for Development Policy Management (2003) *The Cotonou Agreement: A User's Guide for Non-State Actors*. ECDPM: Brussels.
16. European Commission(2003) *Economic Partnership Agreements: A New Approach in the Relations Between the European Union and the ACP Countries*. European Commission: Belgium.
17. Europa (2004) 'WTO-DDA: EU ready to go extra mile in three key areas of the talks,' *Europa* (10 May 2004). European Community: Brussels available at http;//europa-eu un.org/articles/lt/article_3490.lt.htm.

18. European Commission (2001) 'Everything but arms initiative,' *Generalised System of Preferences: Council Regulation Amending the GSP so as to Extend Duty and Quota Free Access to Least-Developed Countries (LDCs)*. EC: Brussels available at http://ec.europa.eu/trade/issues/global/gsp/eba4_sum.htm on 7 March 2007.
19. European Community and South Africa (1999) 'Agreement on Trade, Development and Cooperation between the European Community and its Member States, of the one part, and the Republic of South Africa, of the other part,' *Official Journal* L311 of 4 December 1999: 0003-0297 available at http://www.bilaterals.org/article.php3?id_article=419
20. European Union-Syria Association Agreement (2004) 'Proposal for a Council Decision on the conclusion of a Euro-Mediterranean Association Agreement between the European Community and its Member States of the one part, and the Syrian Arab Republic, of the other part,' *COM 17 December (2004) 808 final* EU: Brussels available at http://www.bilaterals.org/article.php3?id_article=2549 (accessed 28 February 2007).
21. EQUINET (2004) 'Policy paper 12: The WTO Global Agreement on Trade in Services (GATS) and Health Equity in Southern Africa,' *EQUINET Policy Series*. EQUINET: Harare.
22. EQUINET, CHP, SEATINI, TARSC (2005) *Training Manual for the Promotion of Health in Trade Agreements training, Workshop held in Harare 15-17 August 2005*. EQUINET: Harare.
23. EQUINET, Global Equity Gauge Alliance (GEGA) in co-operation with Southern African Development Community (SADC) Parliamentary Forum (2003) 'Resolutions of the meeting on Parliamentary Alliances for Equity in Health in Southern Africa, Gauteng, South Africa, 20-22 August 2003,' *EQUINET Meeting Report*. EQUINET: Harare.
24. East and Southern African and European Commission (2004) *Negotiations of an Economic Partnership Agreement between Eastern and Southern Africa and the European Community – ESA-EC Joint Roadmap.*
25. Food and Agriculture Organisation (1996) *Rome Declaration on World Food Security and World Food Summit Plan of Action. World Food Summit 13-17 November 1996*. FAO: Rome.
26. Friends of the Earth (2006) *Corporate Conquest: Why the UK and Its Partners Must Stop Forcing EPAs Upon Developing Countries.* Friends of the Earth: London available at http://www.foe.co.uk/resource/briefings/corporate_conquest.pdf (accessed 11 December 2006)
27. Friends of the Earth (2006) *ACP-EU Economic Partnership Agreements: Implications for Ghana and other ECOWAS countries*. Friends of the Earth: Ghana available at http://www.foeghana.org/trade_environment/impacts_ecowas.pdf (accessed 1 March 2007).
28. Grain (2005) *Bilateral agreements imposing TRIPS-plus intellectual property rights on biodiversity in developing countries update of August 2005*. Grain: Barcelona available at www.grain.org/go/bilats-tp (accessed 23 November 2006).
29. Health Action International (Africa) (2006) *Briefing Paper*. HAI: Nairobi available at www.haiafrica.org (accessed 14 November 2006).
30. Hinkle L and Newfarmer RS (2005) 'Beyond Cotonou: Economic Partnership Agreements in Africa,' in Newfarmer RS *Trade, Doha and Development: A Window into the Issues*. The World Bank: Washington DC.
31. Hormeku T (2005) *Data Exclusivity: How the EU could use EPAs to Undermine Access to Affordable Medicines*. Third World Network Africa: Accra, Ghana available at http://www.twnafrica.org/print.asp?twnID=788 (accessed 14 December 2006).
32. Houghton I (2006) 'The second sex,' *Pambazuka News* 179 (21 September 2006). Fahamu: Oxford available at www.pambazuka.org (accessed 14 December 2006).
33. Kamidza R (2004) *ESA-EPA Negotiations Still Lack Substance and Direction*. SEATINI: Harare available at //www.seatini.org/publications/articles/2004/esa-epa.htm. (accessed 14 December 2006).
34. Kamidza R (2004)The Economic Partnership Agreement Negotiations : Subregional Development Challenges In The EU-ESA Relations www.seatini.org/publications/articles/2004/epas.htm (accessed 14 March 2007).
35. Kagarlitsky B (2000) *The Twilight of Globalization: Property, State and Capitalism*. Pluto Press: London.
36. Koivusalo M (2003) 'Impact of WTO agreements on health and development policies,' *Policy Brief* 3. Globalisation and Social Policy Programme: Finland.

37. London L (2004) 'Policy brief 14: Human rights as a tool for Equity,' *EQUINET Policy Brief*. EQUINET: Harare.
38. Mazbender D (2003) 'EU CAP Reform and Southern Africa,' *TRALAC Brief* 8/2003. TRALAC: Stellenbosch.
39. McIntyre D, Gilson L, Mutyambizi V (2005) 'Discussion Paper 27: Promoting equitable health care financing in the African context: Current challenges and future prospects,' *EQUINET Discussion Paper Series*. EQUINET: Harare.
40. Milner C (2006) 'An assessment of the overall implementation and adjustment costs of Economic Partnership Agreements with the EU,' in Oxfam International (2006) *Unequal Partners: How EU-ACP Economic Partnership Agreements (EPAs) Could Harm the Development Prospects of Many of the World's Poorest Countries*. Oxfam: Oxford.
41. Mohammed E (2005) 'From TRIPS-minus to TRIPS-plus: Implications of IPRs for the Arab world,' Journal of World Intellectual Property 8 (1). Blackwell Publishing: Malden, USA.
42. Mpande-Chuulu C (2006) *COMESA Workshop for ESA Non State Actors on EPAs, 7 – 8 November 2006, Addis Ababa, Ethiopia*. Common Market for Eastern and Southern Africa: Lusaka.
43. Muroyi R (2001) *The General Agreement on Trade in Services (GATS): An Overview of Concerns for Southern Africa*. SEATINI: Harare.
44. Nalunga J and Kivumbi D (2004) *The Economic Partnership Agreements: Implications and Way Forward: A Case for Uganda*. SEATINI: Uganda.
45. New W (2006) 'Draft EU-Caribbean Agreement Shows Escalated IP Provisions' *Intellectual Property Watch*. Intellectual Property Watch: Berlin available at http://www.ip-watch.org/weblog/index.php?p=463&res=1024_ff&print=0 (accessed 25 November 2006).
46. Oxfam (2004) Dumping on the World. Oxfam: Oxford available at www.oxfam.org (accessed 13 November 2006).
47. Oxfam (2004) *Six Reasons to Oppose the EPAs in Their Current Form*. Oxfam: Oxford available at www.oxfam.org.uk/what_we_do/issues/trade/epas.htm (accessed on 15 November 2006).
48. Oxfam (2006) *In the Public Interest: Health, Education, and Water and Sanitation for All*. Oxfam: Oxford available at www.oxfam.org (accessed 30 November 2006).
49. Oxfam International (2006) *Unequal Partners: How EU-ACP Economic Partnership Agreements (EPAs) Could Harm the Development Prospects of Many of the World's Poorest Countries* available at www.oxfam.org (accessed13 November 2006).
50. Padarath A, Chamberlain C, McCoy D, Ntuli A, Rowson M, Loewenson R (2003) 'Discussion Paper 3: Health personnel in Southern Africa: Confronting the maldistribution and brain drain,' *EQUINET Discussion Paper Series*. EQUINET: Harare.
51. Southern African Development Community (SADC) (2003) *SADC Charter of Fundamental Social Rights*. SADC: Gabarone available at http://www.sadc.int/index.php?action=a1001&page_id=charters_social_rights.
52. SADC (2003b) *SADC Code on AIDS and Employment/ SADC Declaration and Business Plan for HIV and AIDS*. SADC: Gabarone available at http://www.sadc.int/index.php?action=a1001&page_id=declarations_hiv.
53. SADC (2004) *SADC Health Protocol*. SADC: Gabarone available at http://www.sadc.int/english/documents/legal/protocols/health.php.
54. SADC (2005) **Regional Indicative Strategic Development Plan (RISDP) SADC Gaberone at** http://www.sadc.int/english/documents/risdp/index.php
55. Bilal S and Rampa F (2006) 'Alternative (to) EPAs: Possible scenarios for the future ACP trade relations with the EU,' *Policy Management Report* 11. ECDPM: Maastricht.
56. South Centre (2006) *State of Play in the ACP-EU Economic Partnership Agreement Negotiations*. South Centre: Geneva.
57. The Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement), 1994 (Geneva: World Trade organization, 1997), WIPO Publication No 223 (E).
58. UN High Commissioner for Human Rights (2001) 'Liberalisation of Trade in Services and Human Rights,' *Sub-commission on Human Rights Resolution* 2001/4. UN: New York. Available at

http://www.unhchr.ch/huridocda/huridoca.nsf/(Symbol)/E.CN.4.Sub.2.RES.2001.4.En?Opendocument (accessed 17 January 2007).

59. UN Millennium Project (2005) 'Who's got the power? Transforming health systems for women and children,' *Summary Version of the Report of the Task Force on Child Health and Maternal Health*. United Nations: New York.
60. Van Rensburg HC, Fourie A (1994) 'Inequalities in South African health care: Setting the record straight (Part II),' South African Medical Journal 84(2): 99-103.
61. Wallach L and Sforza M 1(999) *Whose Trade Organisation? Corporate Globalisation and the Erosion of Democracy.* Public Citizen: Washington D.C.
62. Whitehead M (1990) *The Concepts and Principles of Equity and Health*. Copenhagen: World Health Organisation.
63. WHO Commission on Macroeconomics and Health (2001) *Macroeconomics and Health: Investing in Health for Economic Development*. World Health Organisation: Geneva.
64. WHO Commission on Social Determinants of Health (2005) *Action on the Social Determinants of Health: Learning from Previous Experiences*. World Health Organisation: Geneva.
65. WHO (2006) *Poverty, Trade and Health: An Emerging Health Development Issue*. African Regional Office for Africa, World Health Organisation: Geneva.
66. Wibulpolprasert S, Jindawatthana A, Hempisut P (2000) 'General Agreements on Trade in Services and its possible implications on the development of human resources for health,' Annual Meeting of the American Public Health Association (APHA). APHA: Boston.
67. World Trade Organisation (1995) 'The General Agreement on Trade in Service,' *Annex* 1B of the WTO agreements. WTO: Geneva available at www.wto.org/English/tratop_e/serv_e/serv_e.htm (accessed on 1 March 2007).
68. Zachary PG (2004) 'Cheap chickens: Feeding Africa's poor,' *World Policy Journal* XXI (2) available at www.worldpolicy.org/journal/articles/wpj04-2/Zachary.html (accessed 21 January 2007).

Other useful sources

www.oxfam.org
www.ipwatch.org
www.southcentre.org
www.haiafrica.org
www.epawatch.net
www.acp-eu-trade.org
www.ecdpm.org

Acknowledgements

The authors would like to express appreciation to reviewers Nick Drager, Riaz Tayob, Antoinette Ntuli and Mickey Chopra who gave insightful and constructive comments to the manuscript. The views and inaccuracies that may be contained in this paper remain the authors' responsibility.

List of acronyms

ACP	African Caribbean Pacific
AIDS	Acquired Immuno Deficiency Syndrome
CAP	Common Agricultural Policy
CARIFORUM	Caribbean Forum
CESCR	Committee of Economic Social and Cultural Rights
COMESA	Common Market for Eastern and Southern Africa
CPA	Cotonou Partnership Agreements
DRC	Democratic Republic of Congo
EC	European Commission
EDF	Economic Development Fund
EPAs	Economic Partnership Agreements
ESA	Eastern and Southern Africa
EU	European Union
FTA	Free Trade Agreements
GATS	General Agreement on Trade in Services
GDP	Gross Domestic Product
HIV	Human Immuno Virus
ICESCR	International Covenant on Economic Social and Cultural Rights
IMF	International Monetary Fund
IPR	Intellectual property Rights
LDCs	Least Developed Countries
MFN	Most Favoured Nation
NDTPF	National Development and Trade Policy Forum
NT	National Treatment
RNF	Regional Negotiating Forum
SADC	Southern Africa Development Community
TK	Traditional Knowledge
TRIPS	Trade Related Aspects of Intellectual Property Rights
UN	United Nations
UNECA	United Nations Economic Commission for Africa
WHO	World Health Organisation
WTO	World Trade Organisation

Equity in health *implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.*

EQUINET implements work in a number of areas identified as central to health equity in the region:

- Public health impacts of macroeconomic and trade policies
- Poverty, deprivation and health equity and household resources for health
- Health rights as a driving force for health equity
- Health financing and integration of deprivation into health resource allocation
- Public-private mix and subsidies in health systems
- Distribution and migration of health personnel
- Equity oriented health systems responses to HIV/AIDS and treatment access
- Governance and participation in health systems
- Monitoring health equity and supporting evidence led policy

For further information on EQUINET please contact the secretariat:
Training and Research Support Centre (TARSC)
Box CY2720, Causeway, Harare, Zimbabwe
Tel + 263 4 705108/708835 Fax + 737220
Email: admin@equinetafrica.org
Website: www.equinetafrica.org

Series Editor: Rene Loewenson
Issue Editor: Rebecca Pointer