

**Addressing health implications of the African
Continental Free Trade Agreement in east and
southern Africa**

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Executive summary

The implementation of the agreement establishing the African Continental Free Trade Area (AfCFTA) in Africa broadly, and in the East and southern Africa (ESA) region in particular, signals a new chapter in the narrative of regional integration on the continent and a milestone towards achieving the long-standing aspirations enshrined in the Abuja Treaty of 1991. The agreement, which was adopted and signed on 21 March 2018, and entered into force on 30 May 2019, establishes a free trade area among African countries, where 90% of trade in goods between them will move across borders on preferential terms.

As one of the key areas for health diplomacy within the African continent, the AfCFTA poses opportunities and challenges for both health and the health sector. The effects may be positive stimulating new production and intra-regional trade, but they may also be negative as in liberalising trade in harmful or substandard products and loss of public revenue. It may also impact equity in the distribution of benefits, capacities and personnel as well as in the health sector.

This desk review on the health implications of the implementation of the AfCFTA within the ESA region was commissioned by EQUINET through TARSC, and implemented by the Southern and Eastern African Trade Information and Negotiations Institute (SEATINI) to support improved legal and policy frameworks for health in the negotiations on the AfCFTA in the East and southern Africa (ESA) region. Based on a desk review of public domain documents complemented by seven key informant interviews carried out in 2023, the paper outlines the health sector and health-related areas directly or indirectly covered by the AfCFTA and the relevant subsidiary instruments. It presents information on these and the AfCFTA provisions and their implications for trade liberalisation, which are largely consistent with those under World Trade Organization (WTO) agreements.

The paper identifies the AfCFTA's positive and negative actual and potential health sector and health-related impacts, including for health equity. It does this in terms of the products that will be subject to liberalisation, including those with potential benefit for health such as local production of health technologies and pharmaceuticals, as well as those that may be harmful to health such as tobacco and genetically modified and ultra-processed foods. It also explores the health implications of the AfCFTA on financial flows and public revenue and on the movement of people, including health personnel.

Given this analysis of impacts, measures are proposed that individual countries and the ESA region as a whole may take to protect health equity goals, including monitoring mechanisms to track and report on those impacts as listed here.

ESA countries can:

- a. Implement community and stakeholder outreach on AfCFTA and the rules, instruments and structures for regional and continental integration.
- b. Develop, with the involvement of both state and non-state stakeholders, a national implementation plan including a monitoring framework for the AfCFTA.
- c. Expedite the harmonisation of legal and regulatory frameworks that enable implementation of the AfCFTA and protect public health at national level.
- d. Establish sector-wide approaches to planning and budgeting to integrate AfCFTA and regional priorities to foster success in line with key national development priorities from the AfCFTA's implementation.
- e. Establish the necessary institutional and regulatory mechanisms and capacities for safety nets, and protection and services for disadvantaged producers and populations, including the protection of public sector services in health and education, and support for agriculture.

- f. Establish special economic zones to promote and incentivise the manufacture of health-related products for trade within the AfCFTA (health technologies and pharmaceuticals and fortified foods) along with measures that promote regional integration and sustainable development, and the establishment of agro-industrial parks across countries for products that develop value-chains and promote health and nutrition.
- g. Ensure the control of products that are harmful to health, including: establishing which products are subject to liberalisation; developing adequate port health capacities to check the quality and safety of goods particularly food products with public health impact; introducing taxes on products harmful to health to discourage their consumption and promote their substitution with local health-promoting products; fund health interventions; and improve capacities for One Health approaches for implementing measures on the sanitary and phytosanitary annex and those listed in the International Health Regulations (IHR) 2005.
- h. Prevent the movement of unregulated and substandard medicines and promote harmonised medicine standards and regulatory capacities on medicines and health technologies, including by capacitating standards authorities/ bureaus of standards to monitor compliance with agreed standards, rules and regulations.
- i. Ensure inter-ministerial collaboration among the relevant policy and enforcement authorities for regular monitoring of the AfCFTA's implementation and reporting on the outcomes, including to parliament.
- j. Assess and report publicly on the impact of the AfCFTA and other investment and trade agreements and their measures, including on their health impact.

Regional organisations, civil society and non-state technical institutions can play a role in:

- a. Advocating for a fully participatory and inclusive consultative process in the development of AfCFTA national implementation plans, and involving and informing key stakeholders in health and health-related sectors to ensure they contribute fully to identifying the key priorities for implementation aligned to existing regional policies, programmes, protocols and plans.
- b. Establishing an AfCFTA co-ordination structure or mechanism made up of an inter-ministerial committee, civil society and regional public health institutions to co-ordinate regional level processes for the implementation, including reporting of the implementation of regional programmes at national level, and for oversight and exchange of evidence and learning between national programmes, including those related to health.
- c. Supporting the development of enabling and harmonised legislation to align laws and facilitate the implementation of the AfCFTA where health promoting benefits are evident (such as in local production of pharmaceuticals and developing professional capacities) and to regulate areas where liberalised trade may be harmful to health (such as on harmful foods and other products).
- d. Developing equitable revenue sharing mechanisms for value-added products and trade stimulated by the AfCFTA.
- e. Developing an AfCFTA protocol on the movement of health personnel in line with the International Code on the Recruitment of Health Personnel and existing regional agreements, to ensure equitable distribution of health personnel and promote harmonised standards, conditions and capacities.
- f. Contributing to and implementing a regional monitoring and evaluation framework, including a peer review mechanism in which government, civil society and technical institutions in ESA countries will participate, to assess the alignment of the AfCFTA with national laws, regulations, plans and programmes. Health impact assessment and control measures to monitor and report on health equity outcomes including impacts on health personnel, health services access, universal health care (UHC) and health security, the distribution of health burdens and for the exchange of peer-to-peer learning within and across ESA countries will also fall under this framework.

1. Introduction

The agreement establishing the African Continental Free Trade Area (AfCFTA) signals a new chapter in regional integration on the continent and within East and southern Africa (ESA), and is a milestone towards achieving the long-standing aspirations enshrined in the Abuja Treaty of 1991. The agreement, which was adopted and signed on 21 March 2018, and entered into force on 30 May 2019, establishes a free trade area among African countries, where 90% of trade in goods between them will move across borders on preferential terms.

This entails the lowering and eventual elimination of import duties on goods originating from African countries to enhance intra-African trade. It is hoped it will drive the economic transformation needed to foster the sustained and inclusive growth needed to support African countries in implementing Agenda 2030 for Sustainable Development in Africa, and to achieve the global Sustainable Development Goals (SDGs) (UNCTAD, 2019). The successful implementation of the AfCFTA is intended to create more decent jobs, improve welfare and quality of life for all and promote sustainable development. Alongside the AfCFTA are protocols on investment, intellectual property rights (IPR), competition policy on digital trade (adopted in February 2023), and women and youth in trade and on services, currently under negotiation and to be concluded in 2028.

Some sources have anticipated that trading under the AfCFTA will also bring public health benefits. The United Nations Economic Commission for Africa (UNECA) notes that, despite Africa having 11% of the world's population, it carries 25% of the global disease burden (UNECA, 2022). It further notes that 50% of children dying below the age of five and 75% of people living with HIV are Africans, as are 73% of those dying annually from AIDS, and the 92% dying annually from malaria. Levels of non-communicable disease (NCD) are increasing. Most of these health burdens are preventable and treatable with access to decent food, jobs and living conditions, and access to appropriate, affordable, quality medicines. Yet 61% of the \$18 billion annually needed for medicine in Africa is imported, with just 36% produced locally but not traded. Only 3% of demand is met by intra-African trade, with high dependency on imports, even though local production is possible (World Economic Forum, 2023)

These issues make it important to assess the AfCFTA's health-related impacts, in order to prevent or mitigate harms and maximise benefits. Against this background, The Regional Network for Equity in Health in East and Southern Africa (EQUINET) through the Training and Research Support Centre (TARSC), commissioned the Southern and Eastern African Trade Information and Negotiations Institute (SEATINI), to produce a desk review on the health implications of the implementation of the AfCFTA within the ESA region. The review aimed to:

1. Outline the health sector, health-related (and commercial determinants of health) directly/indirectly covered by the ACTFA and its subsidiary instruments, and whether their status is enacted or under negotiation.
2. Within these areas, to identify and quantify potential (and projected or actual) health sector and health-related impacts, both positive and negative, for key health goals and health equity.
3. Given the analysis of impacts to: identify the legal provisions, policy and other measures to be advanced in the ESA region (law, policy, trade, services and financing, among others) to protect national health equity goals, rights and duties, and the lead sectors for negotiating/applying these measures at national and regional level.
4. Outline the proposed monitoring mechanisms to track the identified impacts and the effect of policy measures applied, diplomacy options and forums for negotiating content and the governance mechanisms for applying the recommended approaches, including intersectoral approaches.

The review aims to support improved legal and policy frameworks for health viz a vis the AfCFTA in the seventeen ESA countries (Angola, Botswana, the DRC, Eswatini, Kenya, Lesotho, Madagascar, Malawi, Mozambique, Mauritius, Namibia, South Africa, Seychelles, Tanzania, Uganda, Zambia and Zimbabwe).

As one of the key areas for health diplomacy within the African continent, the AfCFTA poses both opportunities and challenges for health and the health sector. Health and health services are affected by trade and the movement of goods across borders. The AfCFTA's implementation has the potential to impact positively on health through investments, people, health innovations and partnerships and trade in products that affect health, health security and health products that contribute to universal health coverage (UHC), among other areas.

The AfCFTA is an important issue for health in the ESA region. The Protocol on Trade in Goods was concluded In Phase1 of the AfCFTA negotiations with nine annexes, including tariff concessions on health products and health-related goods such as agricultural goods, machinery and equipment, including rules of origin, sanitary and phytosanitary measures, trade facilitation, non-tariff barriers, and technical barriers to trade, among others. This phase concluded the Protocol on Trade in Services that identified five priority sectors, namely services in: business; communication; finance; transport; and those in tourism and travel. Some health services are also covered under business and financial services. Phase two of the negotiations resulted in the conclusion of the Protocols on investment, intellectual property rights and competition policy, with negotiations underway for the conclusion of the Protocols on Digital Trade, and on Women and Youth in Trade. All these areas will also influence the health of the people and of the environment.

2. Methods

The desk review used the framework set in the objectives above to structure the data capture and content analysis, noting distributional/ equity issues within and between countries, where relevant. Online information, laws and reports were captured from: international agencies and African and ESA regional organisations; online legal databases for 1990–2023 covering the seventeen ESA countries; websites of the Africa Union (AU), United Nations Economic Commission for Africa (UNECA), the United Nations Development Programme (UNDP), African Union Centres for Disease Control (AU CDC), United Nations Conference on Trade and Development (UNCTAD), The World Health Organization Africa Region (WHO Afro); ESA government websites, and NGO websites e.g. Third World Network, South Centre and others.

Online-published literature on the AfCFTA in ESA countries was obtained using a key word search on Google, Scielo, PubMed and Medline for 2012–2023 using as search terms: AfCFTA OR African Continental Free Trade Area AND Health OR services OR health equity AND Africa. The search also included trade liberalisation AND health AND Africa OR specific ESA country names, OR SADC, EAC, or COMESA. The documents sourced included journal articles, policy documents, book chapters, media articles, academic reports, briefing papers and parliamentary reports. Documents sourced were checked for relevance to the AfCFTA and the ESA region and the key areas of the framework, with further documents obtained by snowballing from publications cited in reference lists. A thematic content analysis was then implemented to extract data using the framework outlined above.

Key informant interviews were carried out in July 2023, with eight stakeholders identified for their knowledge on the issues and their occupations related to health, trade and industry. These included: country government officials at ministries of health, industry and trade; parliamentarians from the relevant portfolio committees; officials from the regional economic communities; and respondents

from the civil society sector. The key informants gave permission for the interviews and the list of stakeholders interviewed can be found in the references section.

Limitations relate to the reliability or consistency of evidence across countries, access to more recent data; data gaps in some countries and the ad hoc nature of some reporting. To address these limitations, several sources of information were triangulated and the evidence crosschecked against official sources. The AfCFTA is the first free trade agreement of such huge magnitude, and most countries are still in the initial stages of implementation meaning there are few publications on its impact or implications for health. Other information may still exist in unpublished materials, leaving gaps in the information required for the study. The key informant interviews assisted in addressing this.

3. The AfCFTA and health-related determinants

3.1 ACTFA clauses and subsidiary instruments

The Abuja Treaty of 1991 provided for the creation of the African Economic Community in several stages over a period of 34 years, as shown in *Box 1*. The AfCFTA, as stage 3 of this process, was conceived in 2012 during the 18th Ordinary Session of the meeting of African Union (AU) heads of state and government (AU, 2018a). Establishing the AfCFTA promoted integration in Africa by encouraging co-operation among African states, the idea that had led to the formation of the Organization of African Unity (OAU) in 1963 (AU, 1991). In 1980, the OAU adopted the Lagos Plan of Action, which emphasised the need for Africa's economic liberation through the promotion of intra-African trade. Several regional co-operation organisations such as the Southern African Development Co-ordination Conference (SADCC), which later became the Southern Africa Development Community (SADC), were established (AU, 1991). The Abuja Treaty of 1991 founded the African Economic Community and in 2002, the OAU was succeeded by the African Union (AU), accelerating aspirations for the economic integration of the continent and of working towards harmonising policies between existing and future Regional Economic Communities (RECs).

Box 1: Stages towards the creation of the African economic community

- Stage 1: Strengthening and creating RECs, i.e., SADC, the Common Market for Eastern and Southern Africa (COMESA) and the East African Community (EAC) among others, within the first five years;
- Stage 2: Stabilisation of tariff and other barriers to regional trade, and the strengthening of industry and energy (over the next eight years) sectorial integration, particularly in the fields of trade, agriculture, finance transport and communication;
- Stage 3: Establishment of a free trade area, now the AfCFTA, in a further ten years);
- Stage 4: Harmonisation of tariff and non-tariff systems – over two years);
- Stage 5: Establishment of a common market and the adoption of common policies (over four years);
- Stage 6: Integration of all sectors, establishment of a central bank and a single African currency, setting up of an African monetary union and creating and electing the first Pan-African Parliament

Source: AU, 1991:3

The AfCFTA is a flagship project of AU Agenda 2063 that seeks to bring together 55 countries to operate a single market for goods and services and has the potential to become the largest regional economic bloc in the world, based on the number of countries involved (Haruna and Adetoye, 2019). The AfCFTA will be implemented alongside other AU programmes and initiatives to accelerate Africa's economic growth and development and promote the continent's common identity (AU, n.d). Other Agenda 2063 flagship projects include the Integrated High Speed Train Network, the Formulation of an African Commodities Strategy, Silencing the Guns by 2020, Implementation of the

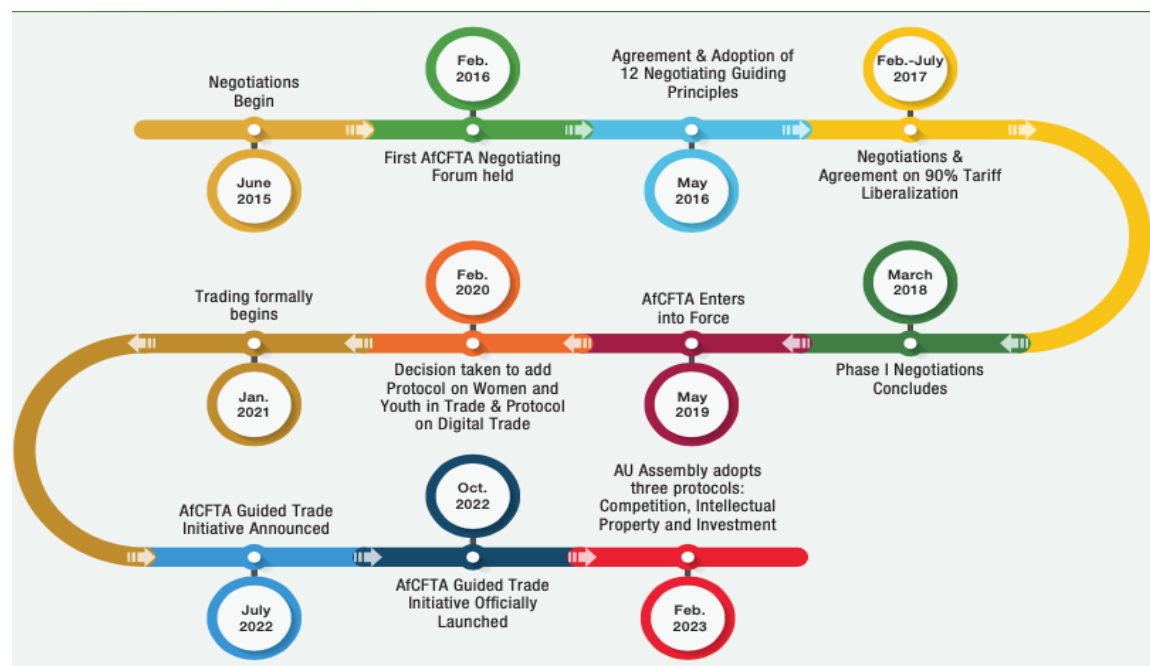
Grand Inga Dam Project, Establishment of a Single African Air-Transport Market, Establishment of an Annual African Economic Forum, Establishment of the African Financial Institutions, the Pan-African E-Network, African Outer-Space Strategy, an African Virtual and E-University, a Cyber Strategy and the Great African Museum. As a landmark continental trade agreement, if driven by women and youth – among the most valuable assets of the continent – the AfCFTA can unlock Africa's immense potential and lift millions of people out of poverty.

In theory, the AfCFTA seeks to create a market of 1.4 billion people with a gross domestic product (GDP) of \$2.5 trillion. It is expected to boost intra-Africa trade, which currently accounts for only 12% of African trade, significantly lower than that of other regions: trade within the United States is 50%, in countries in Asia 60% and 70% in Europe (Obe, 2021). The promotion of intra-African trade aims to boost Africa's trading position within the global economy.

As its overarching objective, the AfCFTA seeks to eliminate tariff and non-tariff barriers among African countries, creating a single market for goods and services. The agreement also seeks to facilitate the movement of business persons, thus deepening the continent's economic integration in pursuit of Agenda 2063 (AU, 2018b).

The agreement for a single liberalised market was achieved through successive rounds of negotiations as a foundation for the future formation of a continental customs union. Negotiations on the AfCFTA were launched on 15 June 2015, at the AU summit in Johannesburg, South Africa and were concluded in March 2018, with the adoption of the AfCFTA and its three protocols on goods, services and dispute settlement, as shown in *Figure 1*. By February 2023, 54 of the 55 African countries (with the exception of Eritrea) had signed the agreement, and 46 countries had ratified it. This laid the foundation for the necessary legal processes at national level for its domestication and implementation (Economic Commission for Africa, 2023).

Figure 1: Timeline and milestones of the AfCFTA



Source: UNECA, 2023:6

Table 1: AfCFTA subsidiary instruments and their status

Subsidiary instruments	Status (Concluded/ in force/ under negotiation)
<p>The AfCFTA is governed by five operational instruments:</p> <ul style="list-style-type: none"> • The Rules of Origin; • The online negotiating forum; • The monitoring and elimination of non-tariff barriers; • A digital payments system; and • The African Trade Observatory. 	<p>These have all been launched and are in force</p>
<p>The AfCFTA Guided Trade Initiative</p>	<p>Launched October 2022</p> <p>The Initiative supports traders in nine countries – Cameroon, Egypt, Ghana, Kenya, Mauritius, Rwanda, Tanzania, Tunisia and Zimbabwe – dealing with certain goods – such as batteries, rubber, sugar, processed meats, dried fruits, pasta, and ceramic tiles. Initially, 96 products will be traded duty-free and quote-free under the Guided Trade Initiative.</p>
<p>The Pan-African Payment and Settlement System (PAPSS)</p>	<p>As of October 2022, the PAPSS network consisted of seven central banks, twenty-eight commercial banks and five switches. It is anticipated to expand into all five regions of Africa before the end of 2023. All central banks are to sign up by the end of 2024 and all commercial banks by the end of 2025.</p>
<p>The AfCFTA Adjustment Facility Fund</p>	<p>Launched</p>
<p>The AfCFTA Private-Sector Engagement Strategy</p>	<p>Launched</p>
<p>The Rules of Origin Manual and E-Tariff Book</p>	<p>Launched</p>
<p>The United Nations Economic Commission for Africa (UNECA) and the African Business Coalition for Health (ABCHealth) have signed a partnership to develop two key initiatives namely:</p> <ul style="list-style-type: none"> • The Healthcare and Economic Growth in Africa (HEGA) II report. • The West Africa AfCFTA-anchored Pharma Initiative. 	<p>Launched and in force</p>

Source: Author's compilation from the AfCFTA website, AU,2023

Trading under the AfCFTA formally started on 1 January 2021, but with little activity among countries until the launch of the 'AfCFTA-guided trade initiative' in October 2022. Trade under the AfCFTA officially began with a pilot of eight participating countries namely Cameroon, Egypt, Ghana, Kenya, Mauritius, Rwanda, Tanzania and Tunisia, with Zimbabwe, the ninth country, joining in April 2023 (Economic Commission for Africa, 2023). By August 2023 the list of participating countries had grown to about 30.

The AfCFTA-guided initiative aimed to facilitate “commercially meaningful trading, among interested AfCFTA state parties that have met the minimum requirements for trade under the Agreement” (AU, 2023); and to encourage countries to issue AfCFTA trading documents such as certificates of origin, importer and exporter declaration forms, and to ensure that their customs laws and systems align with AfCFTA requirements. It thus aimed to encourage commercially meaningful trading under the AfCFTA to test its operational, institutional, legal and trade policy environment, and to send an important positive message to African economic operators to engage on the AfCFTA.

As *Figure 1* shows, the first phase of AfCFTA negotiations focused on the protocol on liberalising trade in goods, trade in services and dispute settlement (February–July 2017). The second phase focused on the other trade-related areas with three draft protocols on competition policy, investment, and intellectual property rights adopted at the February 2023 AU summit in Addis Ababa.

Although the protocols on goods, services and dispute settlement have been adopted, negotiations are still to be completed on certain technical areas, especially on the annexes to the protocols that enable their implementation. These areas include the contentious rules of origin, national schedules of tariff concessions (offers) on goods and national schedules of specific commitments (offers) on services.

The AfCFTA intends for countries to increase the market for their goods and services with minimum restrictions. To achieve this, countries should: eliminate tariff and non-tariff barriers to trade; liberalise trade in services; co-operate in all trade and related matters of intellectual property rights, investment and competition, among others; have a mechanism for settlement of disputes; and an institutional framework for the implementation and administration of the AfCFTA.

It is anticipated that offering larger markets will generate the investments needed to grow economies and foster development. In line with the Sustainable Development Goals (SDGs), the AfCFTA seeks to promote green jobs, fight climate change through the implementation of agreed technical standards across different sectors, and transform African economies to be competitive regionally, continentally and globally.

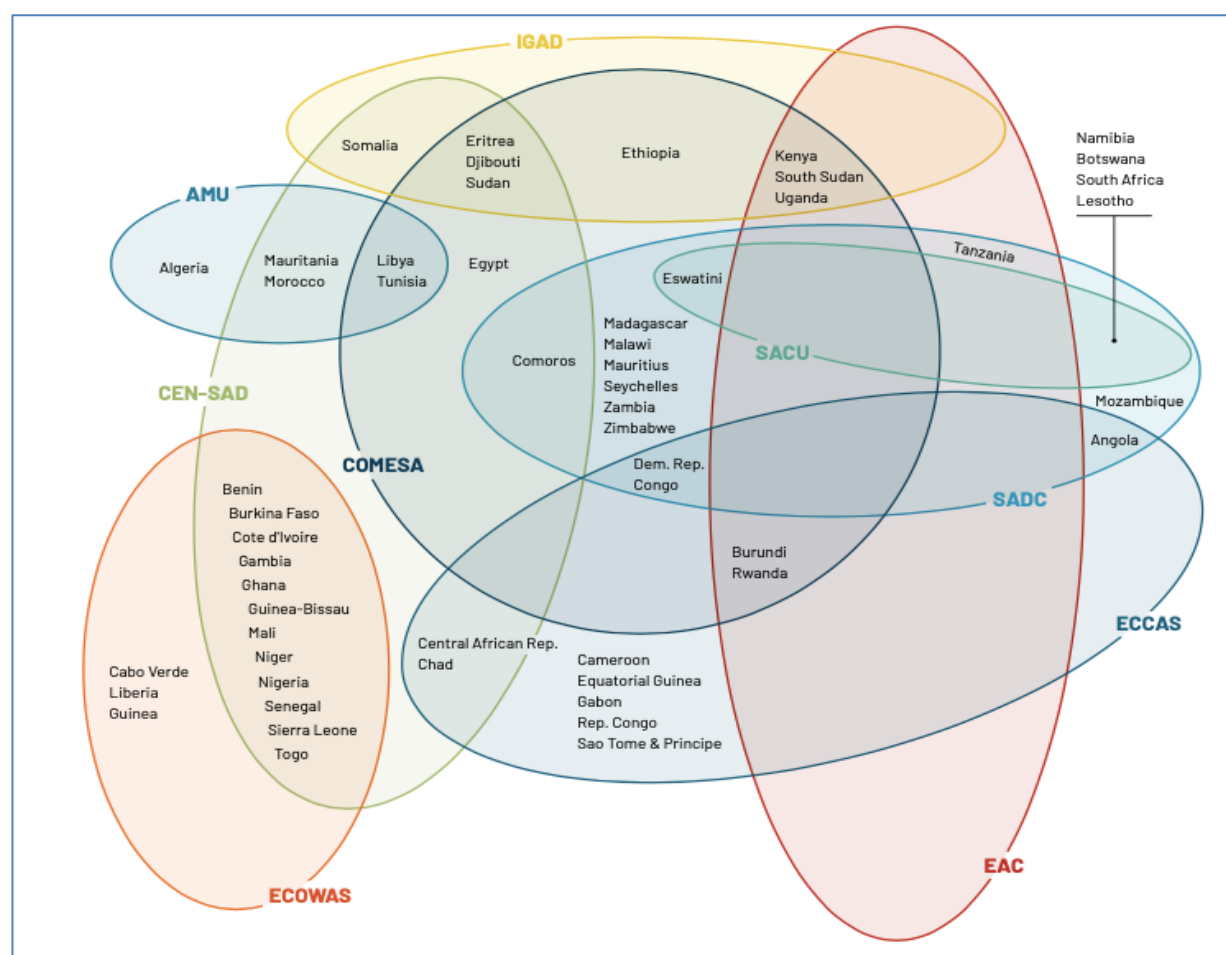
These noble objectives face challenges, however, in inherent systemic and structural issues, including non-tariff barriers that have impacted trade among African countries, like licensing requirements, red tape, governance issues and time consuming and inefficient border procedures (Hartzenberg, 2011). The agreement aims to promote gender equality and structural transformation of AU member states by including women and youth in trade, and to foster the competitiveness of African economies both within the continent and globally through industrial diversification, regional value-chain development, agricultural development and food security (AU, 2018).

The AfCFTA also intends to address the multiple and overlapping memberships of various regional blocs, as shown in *Figure 2* overleaf.

If fully implemented, the AfCFTA should play a central role in establishing an appropriate institutional mechanism to manage regional integration given the multiple REC memberships indicated in *Figure 2*. For example, individual SADC countries are implementing various protocols under various REC groupings that include SADC, COMESA, the Southern African Customs Union (SACU), the East African Community (EAC), East and Central Community of African States (ECCAS) and the Community of Sahel-Saharan States (CEN-SAD).

Multiple REC membership has been found to lead to duplication of effort, poor co-ordination and alignment of policy and to countries prioritising one REC over another, depending on where the member state has more influence or benefit (Hartzenberg, 2011). AfCFTA implementation mechanisms may thus operate as a central authority at sub-regional and national levels, to manage the various protocols, including as they relate to those at REC levels.

Figure 2: Overlapping membership in regional trading blocs in Africa



Source: Gobena, 2019

3.2 Trade liberalisation under the AfCFTA

In liberalising trade among African countries, the AfCFTA provisions cover the same issues as those covered in World Trade Organization (WTO) agreements and must comply with the international trade rules set by the WTO. The principle of special and differential treatment is at the heart of the liberalisation schedule. This principle recognises that countries are at different levels of development meaning reduction and eventual elimination of tariffs should be implemented over different time frames with shorter times for more advanced African economies, and longer implementation periods for less developed countries (LDCs). State parties to the AfCFTA have agreed to eliminate tariffs on 97% of products over an agreed period as explained below, excluding only 3% of total products from liberalisation.

Products whose tariffs will be reduced and eventually eliminated make up 97% of all products. They are divided into two categories.

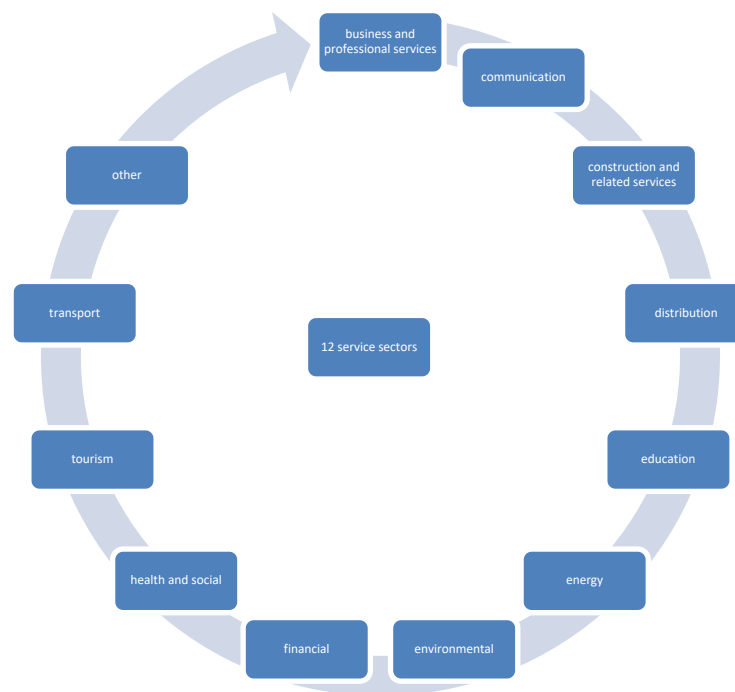
- For the first 90% of products, tariffs will be eliminated over five years in the more advanced African countries: Botswana, the DRC, Eswatini, Kenya, Mozambique, Mauritius, Namibia, South Africa, Seychelles and Zimbabwe, and over ten years for the LDCs such as Angola, Lesotho, Madagascar, Malawi, Tanzania, Uganda and Zambia.

- The remaining 7% of tariff lines designated as sensitive, will still be reduced and eliminated, but over a longer timeframe: in middle-income countries, over 10 years, and in LDCs over 13 years. In all cases, the reductions take place in equal annual instalments (UNECA, 2023:17). For example, using the baseline of 2020 to start reducing tariffs, a middle-income country will reduce its tariffs by 5% each over five years, until zero tariffs are reached in 2025.

As of January 2023, 46 member states had submitted their tariff schedules for reductions and eventual elimination. In the services sector, twelve services are classified for trade purposes as shown in *Figure 3*.

State parties to the AfCFTA have agreed to prioritise transport, communication, finance, tourism and business services for immediate liberalisation. These are predominantly the same sectors that have been liberalised by most ESA member states under other trade regimes such as in WTO and other economic partnership agreements (Lejarraga, 2023). During earlier WTO negotiations on liberalisation of services, African countries identified communication, transport, finance and tourism services for liberalisation, as it was regarded that these sectors facilitated infrastructure expansion (communication, transport) or were ones where they had a comparative advantage (tourism), thus enabling economic growth in the region (Keck and Djiofack-Zebaze, 2006).

Figure 3: Services sectors in the AfCFTA



Source: Author's illustration

3.3 Implementing the AfCFTA

To a large extent, the AfCFTA mirrors the WTO at continental level thus, once AU member states have ratified the agreement, they must work to ensure that its provisions are domesticated, i.e., translated into domestic laws, regulations, institutions and relevant practices to ensure implementation. The AfCFTA is a legally binding instrument and countries are required to adhere to its provisions. In the case of failure to do so, a dispute settlement mechanism is used to ensure member compliance with the obligations. As the United Nations Economic Commission for Africa noted, domestication of the AfCFTA “is a complex undertaking...in many cases, new institutions may have to be established (for example competition authorities, regulatory institutions, standards associations where they have not been in existence, etc.) new practices introduced, capacities created, [and] approaches adopted” (UNECA, 2023:9).

The Dispute Settlement Mechanism forms part of the AfCFTA’s governance structure under the Protocol on Rules and Procedures of the Agreement. It is structured to ensure the settlement of disputes between state parties to the agreement and has key institutions, namely the Dispute Settlement Body, the Adjudicating Panels, and the Appellate Body, which is an appeals body.

The Dispute Settlement Body comprises all state parties to the agreement and adopts the reports of the Panels and the Appellate Body, and ensures that their rulings and recommendations are upheld. The Adjudicating Panel comprises qualified individuals with the necessary expertise and experience in law, international trade, and related matters covered by the Agreement. Each state party nominates two individuals to the pool of experts in an indicative list maintained by the AfCFTA Secretariat. Individuals are then selected from this list as needed, to address relevant issues. The Appellate Body is the tribunal, which upholds, modifies or reverses the legal findings and conclusions of the Adjudicating Panel. As the AfCFTA appeals body, once its decisions have been adopted, they are legally binding on the disputing parties. It comprises seven persons with recognised authority and expertise in law, international trade and the AfCFTA subject matter (AU, 2023).

3.4 Health sector and health related areas

The WHO notes in its report on the social determinants of health, the many social, environmental and economic determinants of health with significant influence health equity outcomes including: income and social protection education; employment and job security; working life conditions; food security; housing; basic amenities; environments; early childhood development; social inclusion and non-discrimination; conflict; and access to affordable decent quality health. The same report notes that the contribution to population health outcomes of sectors outside the health service sector exceeds those of the health sector.

There is growing recognition of these ‘upstream’ causes of avoidable and unfair differentials in opportunities to be healthy, and in health outcomes between groups of people or communities. Similarly, health inequities arising from these socio-economic determinants are noted to undermine the development of communities and countries, further exacerbating inequalities and preventing people and future generations from fulfilling their potential. These inequalities are further entrenched by the differing impacts of advances in technology and urbanisation on various communities and countries, leaving some behind and widening the gaps in health outcomes (WHO, various, 2021a).

WTO trade rules encroach into many of these areas, with determinants of health affected by trade-related issues like competition policy, investment policy and intellectual property rights among others. Trade liberalisation under WTO rules has covered almost all known sectors, including agriculture, services and market access in other areas, and with the AfCFTA adopting the same liberalisation agenda it has the same potential to impact on the various determinants of health. This is discussed in the next section.

4. Impacts of the AfCFTA

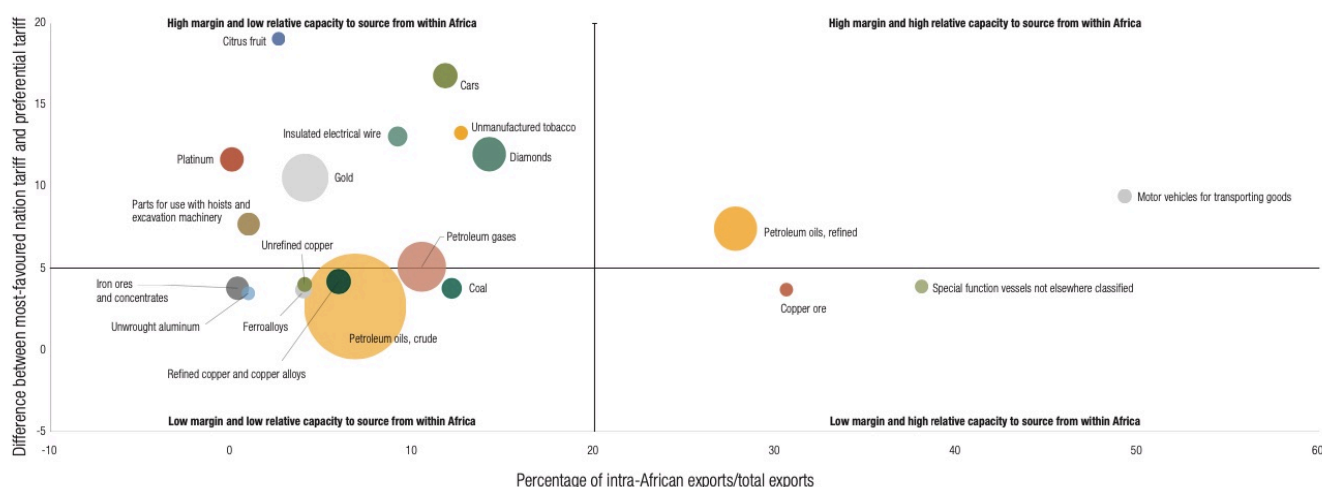
This section outlines the health-related areas that are likely to be influenced by the implementation of the AfCFTA, informed by literature and evidence including from the implementation of past liberalisation agreements.

4.1 Products subject to liberalisation and associated health impacts

With the earlier noted aim of eliminating tariffs on 97% of traded goods between African countries, and with the remaining sensitive products determined by individual countries, countries were tasked to submit their schedules of products and time frames to achieve this, and to indicate those products that will not be subject to tariff reduction, and the criteria applied, such as protection of infant industries. As at the time of writing, 46 out of 54 African countries have submitted these schedules. However, government officials have done so with little or no consultation with key stakeholders from the private sector, civil society or directly affected communities (Africa Trade Network, 2023). This lack of adequate consultation implies that some products whose economic and social importance calls for the retention of tariffs may in fact have been listed for tariff elimination and may include products where the removal of tariffs may affect survival incomes for households or access to food, health, shelter and education.

An [AfCFTA e-tariff book portal is in place](#), with information to guide importers and exporters of various products. With 97% of products to be liberalised, the portal includes goods produced by African countries. *Figure 4* shows the top 20 products from Africa with the highest export values for the period 2014–2016. These products are mostly concentrated in the extractive industry, which has been described as causing environmental damage and contributing to climate-related challenges (Jegede, 2016), with their attendant impacts on health. These products are primarily exported to China, Europe, the USA and other industrialised countries (Economist Intelligence Unit, 2023). It is highly unlikely that these will be traded under the AfCFTA since few African countries have a developed manufacturing sector for mineral commodities, despite some initiatives on this. However, with or without the AfCFTA, the continued extraction of these resources will exacerbate environmental damage and climate-related impacts, increasing the health burdens associated with the sector, including respiratory and cardio-vascular disease and cancers, as well as the displacement of people from farmland.

Figure 4: Top 20 products with highest export values, 2014–2016



Source: UNCTAD, 2019:81

Other products primarily produced and traded within ESA countries have low export values. These include foods such as meat, fruit and vegetables and some processed foods such as crisps, biscuits and confectionaries. Evidence shows that sub-Saharan Africa's top agriculture-related exports are cocoa, coffee, tea and cotton, while its main food imports are wheat, rice, soybeans, other oilseeds and frozen meat products. Tobacco is dealt with separately in *Section 4.2*. The proportion of food imports originating from other African countries is currently very low, consistently averaging about 20% over the past few decades, with one country – South Africa – accounting for over a third of intra-African food trade (Fox and Jayne, 2020).

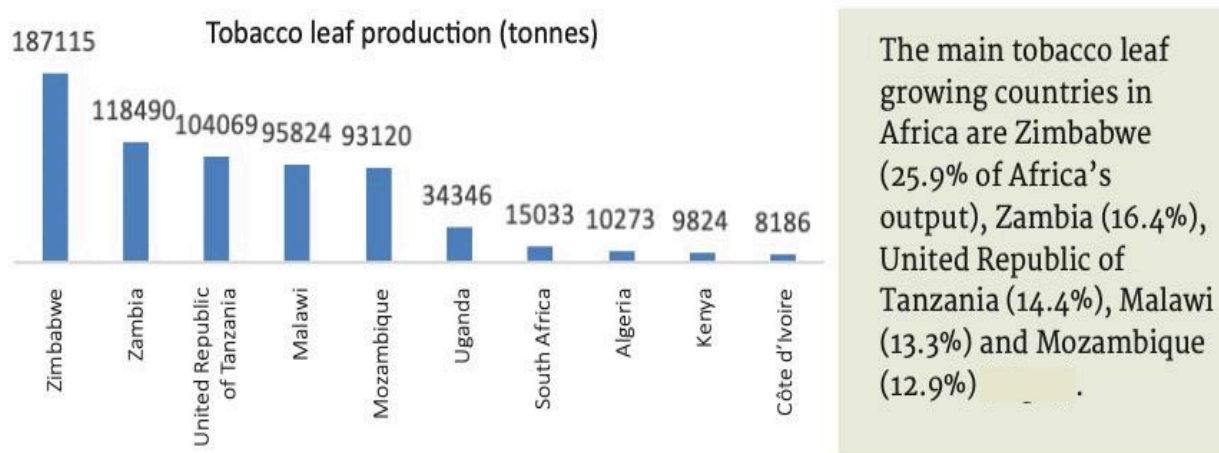
The AfCFTA may therefore see an increase in food products, especially of manufactured foods, crossing the borders of African countries (Fox, and Jayne, 2020). Should liberalisation increase inflows of processed foods, and particularly sugar-sweetened products and ultra-processed foods, this may intensify the 'nutrition transition' towards processed foods, leading to an increased incidence in NCDs, including nutrition-related cancers, hypertension, cardio-vascular disease and diabetes mellitus. The ESA countries are already experiencing an increase in NCDs, with over 40% of deaths in East Africa attributable to them (Kraef et al., 2020). WHO AFRO estimates that by 2030, NCDs will be the leading cause of death in sub-Saharan Africa (WHO Afro, 2022).

Studies on the impact of implementing trade agreements have revealed an increase in imported unhealthy food products and processed foods after import tariffs were reduced (Thow and Hawkes, 2009; Lin, et al., 2018; Kruger and Karim, 2022). In addition, a study of the relationship between increased foreign direct investment (FDI), trade openness and dietary habits in Cameroon, Kenya, Nigeria and South Africa, found a disproportionate increase in the import of sugar and sugar products, with a growing rate of daily caloric intake in the population, with the exception of Kenya (Kruger and Karim, 2022).

4.2 Tobacco trade

As shown in *Figure 4*, unmanufactured tobacco is a highly traded high-value product in Africa. The WHO reports that ESA countries account for 92.5% of tobacco leaf production in Africa, with Zimbabwe, Zambia, Tanzania, Malawi, Mozambique, Uganda, South Africa and Kenya occupying the first eight of the ten slots of top producers in Africa, alongside Algeria and Cote d'Ivoire, as shown in *Figure 5* (WHO, 2021b).

Figure 5: Top 10 tobacco leaf growers in Africa (quantity in tonnes), 2012



Source WHO, 2021b:3

The AfCFTA may further increase the already high level of trade in tobacco leaf in Africa. Just five countries, two of which are in the ESA region – South Africa (US\$134 million), Kenya (US\$87 million), Nigeria (US\$55 million), Senegal (US\$49 million), and Tunisia (US\$39 million) – accounted for 81.8% of African cigarette exports in 2018. The value addition of the product on the continent suggests that countries are likely to use the AfCFTA to increase trade of tobacco, and tobacco products.

Whilst countries will gain economically from this, increased trade in tobacco products? from the AfCFTA presents a major public health challenge. Eight million people are estimated to die annually from tobacco use globally. The WHO Framework Convention on Tobacco Control aimed to limit tobacco use, but progress in meeting the global target set to reduce the prevalence of tobacco use by 30% by 2025 was reported in 2021 to be off-track, with inadequate monitoring capacity in Africa, while several African countries are increasing “localised cultivation”, which translates into increased prevalence of tobacco use (WHO, 2021b).

4.3 Trade in genetically modified foods

The cultivation and consumption of genetically modified (GM) foods has been a matter of some debate, with supporters arguing that it is the answer to Africa’s food challenges, and critics asserting that as newly developed technologies, GM products present untested and potential health and environmental risks (Tsatsakis et al., 2017). Foods with altered genetic material may be resistant to insects, herbicides or drought, but may potentially also pose health problems, including cancers and other NCDs (Tsatsakis et al., 2017).

Some ESA countries have integrated the production and consumption of GM products in their economies while others have not. For example, South Africa has been growing GM crops since 1998 and was the first African country to commercialise GM crops that include *Bacillus thuringiensis* (Bt) cotton, Bt maize, herbicide tolerant maize, herbicide tolerant cotton and herbicide tolerant soybean (AU-NEPAD, 2020). Maize is a key staple food in the ESA region, grown largely by small holder farmers and important in sustaining food security. Some ESA countries such as Zambia and Zimbabwe have not allowed GM maize production in their territories but have accepted its consumption where the maize arrives pre-milled from other countries. A key informant in Zimbabwe’s Ministry of Industry confirmed the caution over growing GM foods in the country.

GMO commercialisation is not yet embraced for the agriculture sector, especially on unmanufactured commodities like grains (maize, wheat, soya beans etc). Goods are only allowed under exceptional circumstances, for example manufactured products like mealie meal. Maize grain comes into the country straight for milling or for stock feed manufacturing under supervised importation (Zimbabwe KI 4).

The AfCFTA’s trade liberalisation measures may aid the expansion of GM technologies with implications for local food production, food standards and seed stocks and may facilitate trade in GM technologies for both production (GM seed) and consumption (GM foods). It also raises concern whether countries will continue to have the latitude to put in place rules governing GM food production in response to climate challenges.

4.4 Food safety and standards

The globalisation of trade in food has seen increased instances of contaminated food moving across borders (Kruse, 1999), making port health a key issue for the AfCFTA. Previous EQUINET research on food safety law in the ESA region indicates that while ESA countries have developed regulatory frameworks for food safety as a public health issue, including measures for foodborne disease outbreak investigation and response, many of these need to be updated to comply with current regional and international standards (LUANR et al., 2023; Machemedze, 2018). While various aspects of biosafety, food standards, and ‘farm-to-fork’ regulation are in progress in ESA, gaps in

legal provisions required to protect the health of people in the entire food chain remain, “and in how far they explicitly include measures for risk assessment and analysis, and for management and communication in the control of health-related food risks” (LUANR et al., 2023:2).

AfCFTA instruments may help to partially address this challenge in the annex on sanitary and phytosanitary (SPS) measures. These facilitate trade while: safeguarding human, animal or plant life, or health in the territories of state parties; enhance co-operation and transparency in the development and implementation of SPS measures to ensure that they do not become unjustifiable barriers to trade; and enhance technical capacity of state parties for the implementation and monitoring of SPS measures while encouraging the use of international standards in the elimination of barriers to trade. (AU, 2019:1)

The annex is comprehensive, drawing on WTO SPS measures, as shown in *Box 2*. Countries are implementing measures to enforce standards. For example, In Uganda, a Ministry of Health official key informant noted that:

All imported and exported goods, including foods, are routinely inspected and tested for safety. The tests include aflatoxin levels for grains and relevant foods, micro-organisms and other contaminants. The National Bureau of Standards is mandated to perform that task.
(Uganda KI 6)

However, enforcement depends on institutional and laboratory capacities and on national laws and regulations. Capacity deficits in ESA countries may be more apparent as demand grows due to increased trade (LUANR et al., 2023). The AfCFTA annex may incentivise investment to improve capacities, as it obliges member states to assess risks in order to determine the appropriate levels of SPS protection, as well as other state duties, as shown in *Box 2*.

Box 2: Assessment of risk to determine appropriate level of sanitary or phytosanitary protection

1. State Parties shall, in responding to market access requests, ensure that their sanitary or phytosanitary measures are based on an assessment, as appropriate, of the circumstances of the risks to human, animal or plant life or health taking into account risk assessment techniques developed by the relevant international organisations.
2. State Parties shall, in assessing risk and determining the sanitary or phytosanitary measures to be applied to achieve the appropriate level of protection, take into account available scientific evidence, relevant processes and production methods, relevant inspection, sampling and testing methods, prevalence of specific diseases or pests, existence of disease or pest free areas, relevant ecological and environmental conditions and quarantine, or other treatments.
3. In assessing the risk to animal or plant life or health and determining the measure to be applied for achieving the appropriate level of sanitary or phytosanitary protection from such risks, the State Parties shall take into account as relevant economic factors; the potential damage in terms of loss of production or sales in the event of entry, establishment or spread of a pest or disease; the costs of control or eradication in the territory of the importing State Party; and the relative cost effectiveness of alternative approaches to limiting risks.
4. In cases where relevant scientific evidence is insufficient, a State Party may provisionally adopt sanitary or phytosanitary measures on the basis of available pertinent information including that from relevant international organisations as well as from sanitary or phytosanitary measures applied by other State Parties. In such circumstances, the State Parties shall seek to obtain the additional information necessary for a more objective assessment of risk and review the sanitary or phytosanitary measure accordingly, within reasonable time frames agreed by the concerned State Parties.

5. When a State Party has reason to believe that a specific sanitary or phytosanitary measure introduced or maintained by other State Parties is constraining, or has the potential to constrain its exports, and the measure is not based on the relevant international standards, guidelines or recommendations, or such standards, guidelines or recommendations do not exist, an explanation of the reasons for such sanitary or phytosanitary measure may be requested and shall be provided by the State Party maintaining the measure and if the aggrieved State Party is not satisfied, request for the review of the measure in accordance with the provisions of this Annex.

Source: AU, 2019:2

4.5 Illicit financial flows

One of the major legacies of colonialism in Africa is the foothold of transnational corporations (TNCs) and monopolies that operate in almost all economic sectors, mostly extracting raw materials for manufacturing plants in high-income countries. Monopolies are not only created by TNCs, but also by some local entities, including state-owned companies and parastatals, some occupying huge market shares in key economic sectors (World Bank, 2023). An AU and UNECA high-level panel on illicit financial flows (IFFs) from Africa emphasised the need for the G20 to improve transparency and exercise tighter oversight of international banks and offshore financial centres that absorb these flows (AU and UNECA, 2015). In 2014, the G20 adopted a new automatic exchange of information that was intended to further bridge the information asymmetry between taxpayers and tax authorities and to increase transparency and deter tax evasion.

While these systems have addressed the supply side of information exchange, the demand side in Africa remains weak, because the standards and processes required are onerous to implement (South Africa KI 8). The health sector has not been spared the lost revenue from IFFs, with Africa estimated to lose more than US\$50 billion annually, a figure that exceeds the gap in health financing for UHC (Loewenson and Mukumba, 2022).

There are various ways in which IFFs take place. “Commercial IFFs stem from business-related activities such as transfer pricing, trade mispricing, mis-invoicing of services and intangibles and use of unequal contracts. This is reported to enable tax evasion (illegal), aggressive tax avoidance (legal), and illegal export of foreign exchange” (Loewenson and Mukumba C, 2022:20). These practices have enabled corporations to minimise their tax liabilities in ESA countries. In addition, ESA countries, like many low- and middle-income countries in other regions, are vulnerable to anti-competitive practices, particularly:

- high entry barriers due to poor business infrastructure, including distribution channels;
- regulatory and licensing regimes that impede the entry and success of new entrepreneurs;
- inadequate investment in the institutions of competition law and policy,
- Weak capacities, inadequate consultations with citizens on competition law and policy
- Asymmetries of information in both product and credit markets.

These challenges are increased in the presence of a large informal economy.

The AfCFTA might provide an avenue for further IFFs unless relevant regulatory and legislative frameworks and institutional capacities are put in place. As one measure to address such challenges, the AfCFTA has a protocol on competition policy adopted by the heads of state in February 2023. This protocol includes in its scope:

- Abuse of a dominant position in the market by some corporations including joint ventures;
- Mergers and acquisitions with continental dimensions in markets;
- Certain vertical business practices;
- Certain horizontal business practices, and
- Anticompetitive practices (AU, 2023a).

The protocol aims to manage the interrelationship between competition regimes and sectoral regulation at national, regional and continental levels. To implement it, African countries need to establish institutional mechanisms to set and apply competition law.

The Competition Protocol advances competition policy as both a productive and distributive legal instrument. Many ESA countries lack updated competition laws or policies or face challenges in enforcing them. Competition policies are also based on neoliberal paradigms that do not cater for the need to protect the growth of relatively small African companies in a global context, which in the past was dealt with by national preference through laws and their enforcement (South Africa KI1). This raises the question of how far the AfCFTA will protect domestic industry in key sectors such as in food processing, or indeed state-owned parastatals, in areas of essential services for health such as water and energy.

The Competition Protocol in the AfCFTA does recognise the power imbalances in these economic interactions, noting the ‘abuse of economic dependence’ in African economies. Economic dependence is deemed to exist where undertakings as suppliers or purchasers of certain goods or services are dependent on another undertaking or group of undertakings in a way that denies sufficient and reasonable possibilities for switching to third parties, and where there is a significant imbalance between the power of such undertakings or group of undertakings, and the countervailing power of the other undertakings (AU, 2023a:13). This recognition is a positive development that will require ESA countries to develop/or update their competition laws and establish competition authorities able to monitor and provide adequate regulatory oversight of these provisions.

4.6 Investment in local production of health technologies

AfCFTA liberalisation of trade in goods and services promises to fast-track industrialisation and improve value addition on the continent provided certain prerequisites are put in place. The African Union Action Plan for Boosting Intra-Africa Trade (BIAT) aims to deepen African market integration and increase the volume of trade between African countries (AU, 2012). The plan covers seven clusters namely trade facilitation, trade policy, productive capacities, trade-related infrastructure, trade finance, trade information and factor market integration with programmes in each cluster, although with variable levels of implementation, particularly in the productive capacity cluster. Most ESA countries are heavily dependent on the export of primary commodities and Africa remains the least-developed manufacturing region globally, accounting for less than 1% of the value-added in global manufacturing (Bachin et al., 2016). The AfCFTA aims to address these challenges, particularly in sectors that have the potential to contribute to global trade, including in the health sector,

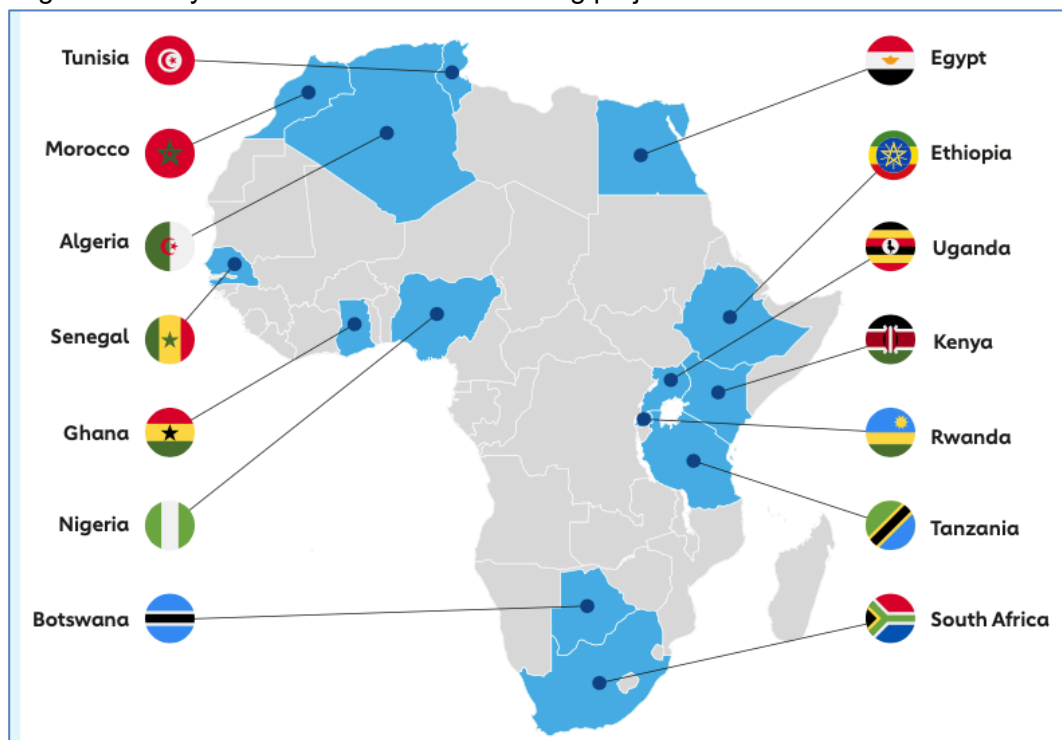
Cross-border movement of health services may be possible in the AfCFTA if included in the services protocol, while trade in health-related products may expand if included in the protocols on trade and on intellectual property rights. Assessment of potential health sector investment areas needs to be implemented to assess the potential risks, benefits and equity impacts of the inclusion of health services. This section focuses on the AfCFTA impact on production of health-related products.

A private sector development expert with COMESA observed that investment in local production of health technologies and related products will be enhanced by the implementation of the AfCFTA.

The AfCFTA emphasises the concept of local content value addition where the-use of raw materials from within the continent, especially in pharmaceuticals, is encouraged. Such a concept will create jobs and save foreign currency as we source raw material from within. Coupled with the standardisation processes, manufacturing will be improved, thereby promoting intra-Africa trade (Zambia KI 7).

The recently concluded AfCFTA investment protocol also has the potential, if implemented strategically with other instruments, to attract public investments in productive sectors for intra-African trade, including transport infrastructure and logistics, as well as in health infrastructure. The latter includes investment in health-related equipment, technology and medicines with potential impact on lowering the cost of and access to essential medicines including to low-cost generic medicine from efficient producers within the continent, provided adequate quality control mechanisms are established. The COVID-19 pandemic has spurred some ESA countries to initiate processes for local vaccine production, as shown in *Figure 6* on new vaccine manufacturing projects announced on the continent. Provided other prerequisites are put in place, the AfCFTA raises opportunities for vaccine manufacture.

Figure 6: Thirty African vaccine manufacturing projects announced across 14 countries



Source: GAVI Alliance, 2022:6

The AfCFTA draft protocol on intellectual property facilitates innovation, while technology transfer is a further critical enabler of local production of health-related products. Some SADC countries and others beyond the region have intensified global demand to address such constraints in access to and production of key health technologies. In October 2020, India and South Africa, with Eswatini, Kenya, Mozambique and Zimbabwe as co-proposers, along with countries from other regions, requested that the General Council of the WTO waive the implementation, application and enforcement of four forms of intellectual property rights (IPRs) covered by the Trade Related Aspects of Intellectual Property Rights (TRIPS) Agreement for a specified period, to enable the prevention, containment and treatment of COVID-19 (Machemedze et al., 2022). The proposed waiver covered copyright and related rights, industrial designs, patents and trade secrets.

It was initially met with resistance during TRIPS council discussions at the WTO, but the WTO Ministerial Conference adopted a decision to grant the waiver, giving eligible members the legal rights “by authorizing the use of the subject matter of a patent required for the production and supply

of COVID-19 vaccines without the consent of the right holder to the extent necessary to address the COVID-19 pandemic” (WTO 2022:1). This included the ingredients and processes necessary to manufacture COVID-19 vaccines.

The AfCFTA thus provides measures that could strengthen the pharmaceutical sector in the region, including to address the technology needs of pandemics/ epidemics improving access and local expertise, providing economic benefits and expanding ESA capacities to manufacture vaccines and medicines. To this end, in April 2021, the AU through the African Centre for Disease Control and Prevention (Africa CDC) developed the Partnerships for African Vaccine Manufacturing (PAVM) Framework for Action (AU, Africa CDC, 2021). The framework provides for measures to improve environments and implement programmes to scale up the development and manufacture of vaccines over the next two decades.

As noted by a South African civil society lawyer key informant, the AfCFTA position on IPR essentially codifies existing multilateral treaties, particularly the parts of the World Intellectual Property Organization (WIPO) incorporated into the WTO agreement. It emphasises development aspects such as technical assistance, multi-layered co-operation and capacity building in the administration and enforcement of IPR, with deference to, but ineffective measures to address the interests of women and small, micro and medium enterprises, noting but not adequately setting measures to protect their rights:

It focuses on protecting innovation but fails to recognise that many countries have an IPR deficit on their accounts – meaning that [the] benefits of protection of rights is for others not the nations signing up, in real terms. After the preventable tragedies of HIV and COVID on the continent, it would have behoved the African Union to assert collectively other rights under WIPO and WTO treaties, such as compulsory licenses for patented medicines (South Africa KI 1).

This key informant noted that adopting the WTO’s IPR protocol more or less as is, means that African countries will be putting on a straitjacket, rather than deploying African unity to advance the health interests of its people.

In 2007, the AU adopted the Pharmaceutical Manufacturing Plan for Africa (PMPA) to hasten and expand local pharmaceutical production. As a result, Ethiopia, South Africa, Senegal, Nigeria, Morocco, Tunisia, and Algeria have since started vaccine production and manufacturing. However, because of the continent’s unpredictable supply chains and limited local scientific skills capacity, production of vaccines and medicines remain low (AU Development Agency, 2023). Locally produced vaccines and medicines are thus largely augmented by imports, with inadequate investments by African governments in vaccine manufacturing, ineffective regulatory capacity for vaccine research and development and limited support for production, resulting in uncertainties in meeting demands for Africa-made vaccines (AU Development Agency, 2023).

The AU High-Level Panel on Emerging Technologies (APET) recommends that African countries enhance capabilities to manufacture both vaccines and medicines (AU Development Agency, 2023). Co-ordinating national and regional policies and initiatives to promote local production could assist in creating synergies across countries at different economic levels, sharing the workload and avoiding wasteful duplication. The APET notes that African countries can draw lessons and replicate past successes, such as in the 2010 African efforts to eradicate the Group A Meningitis epidemic through the meningitis vaccine project. This global collaboration involved public health experts, the WHO, non-governmental organisations and commercial firms to produce the ‘MenAfriVac’. The MenAfriVac was a cost-effective vaccination utilised to conduct large immunisation campaigns that significantly reduced the incidence of meningitis. The initiative facilitated technology transfer, regulatory approval and testing to enhance the local production of vaccines and medicines (South Africa KI 8).

Strengthening local production of pharmaceuticals needs to be accompanied by the strengthening of quality and medicines standards, especially through the ratification of the African Medicines Agency.

Learning from COVID-19, ESA countries will need to diversify the supply chains of strategic industries and focus on the development of regional value-chains. Rather than being a competitive process, this calls for reimagined and transformative African economies built on the principles of fairness and inclusivity, benefitting the many, allocating resources to those with the greatest health needs and using inclusive green and digital policy directives (South Africa KI 8). For example, a UNECA-led AfCFTA- anchored pharma initiative provides a validated and continentally anchored blueprint for scaling up sexual, reproductive, maternal, new born and child health (SRMNCH) commodities, as demonstrated by the various offshoot initiatives such as WA-Pharma Initiative, Africa Medical Suppliers Platform and African Vaccine Acquisition Trust, with the latter two put in place as measures to mitigate the COVID-19 pandemic as part of the Pooled Procurement Pillar (South Africa KI 8).

UNECA and partners are also developing an instrument, the Common African System for Pooled Procurement covering health, agriculture and energy, to ensure health, food, nutrition and energy security for Africa. Under the local production pillar, after the launch of an expression of interest (EOI) for select SRMNCH medicines, two manufacturing entities from Kenya and Senegal were selected to receive technical and investment support from UNECA and partners. A second EOI has been published with the expectation of onboarding more manufacturers to produce SRMNCH products. A third pillar on harmonised regulatory standards and a quality framework contributed towards the ratification of the African Medicines Agency (South Africa KI 8).

A health equity test for the AfCFTA will thus be how far ESA countries can diversify production, make trade more inclusive and do so in a manner that fairly and inclusively benefits, boosts productive capacities in and allocates resources to, those countries and communities with the greatest health needs.

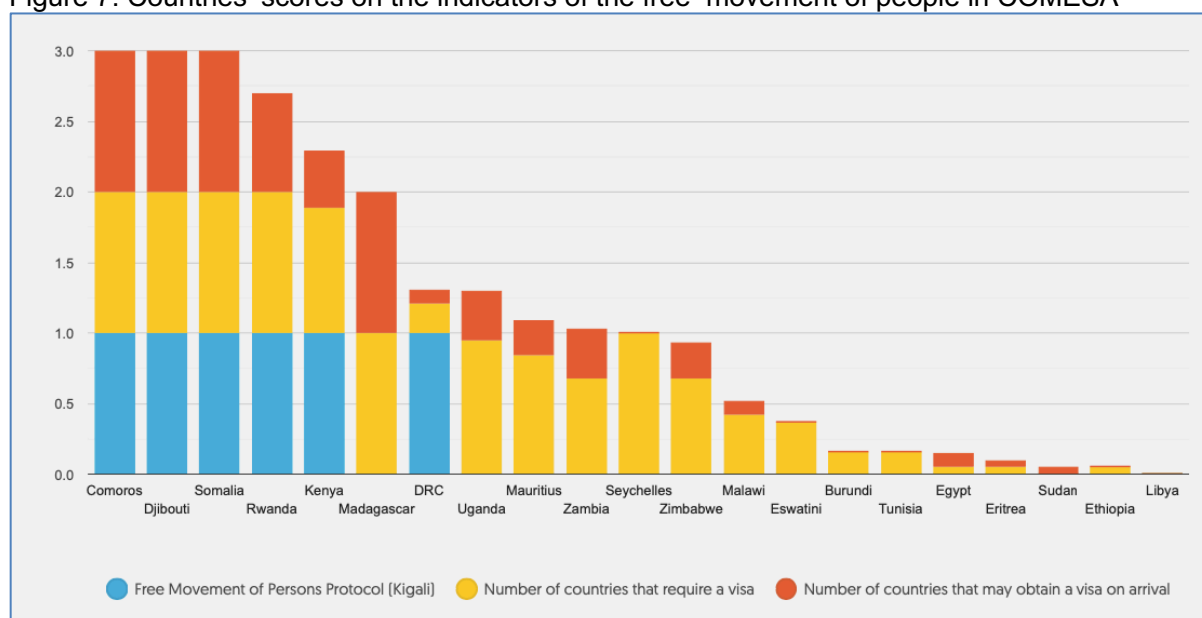
4.7 Cross-border movement of people

There are further impediments to local production of and infra-African trade in health technologies and indeed in provision of health services, including in the necessary professional capacities. Non-tariff measures (NTMs) and non-tariff barriers (NTBs) exist in many of ESA countries, including various other barriers such as licensing requirements, red tape, governance issues, sanitary and phytosanitary measures, and technical standards that raise the cost of doing business by an estimated 14.3% (UNECA, 2023). A further issue is the cross-border movement of people to facilitate the movement of professionals to improve production and services. Removing visa requirements in ESA countries, enhances the movement of people (Zambia KI 7). A continental protocol on the free movement of people and right of residence – the African Union Protocol on Free Movement of Persons, Right of Residence and Right of Establishment – to promote integration and facilitate improvements in science, technology, innovation, education, research and tourism was passed in 2018, but has only been ratified by four African countries (AU, 2018b).

The Africa Regional Integration Index notes that there is great disparity in countries' scores on the Free Movement of People. As shown in *Figure 7*, many ESA countries score below African averages. "This finding reflects the roadblocks that African citizens encounter when they travel, making it harder for them to conduct business, act as tourists, and help integrate the continent in general." (Africa Regional Integration Index, 2023;1). The index report concludes that greater visa openness would lower transaction costs, increasing trade and the efficiency of production. At the same time, while it may be facilitated by the AfCFTA for economic benefit, free movement of people does have costs, including in its health and health sector impacts. Easy cross-border movement of people and commodities can lead to the spread of communicable diseases across ESA countries unless effectively controlled and regulated, particularly at border points and through harmonised

surveillance systems. This will require that African countries make greater investments in health-related surveillance systems, as provided for in International Health Regulations (WHO, 2008)

Figure 7: Countries' scores on the indicators of the free movement of people in COMESA



Source: Africa Regional Integration Index, 2023:1

During cross-border pandemics and other cross-border health challenges, countries need to ensure port health checks to protect public health, but to do so in a manner that supports trade in essential health products and other key areas such as food. Digital platforms and apps can help minimise physical contact and enable advance procedures at borders, as well as monitoring and information exchange and need to be widely embraced.

As in other trade pacts, the AfCFTA free-movement rules will allow people to access government-funded health services in any member country. This will increase the number of foreign patients seeking treatment in countries in the ESA region with relatively strong health care systems, such as South Africa, Namibia, Kenya and Uganda. The new free-trade area is also expected to drive growth in private health care, including medical tourism. For example, as demand for cancer treatment soars, visa-free travel could enable people in the fifteen African countries without radiotherapy services to seek care elsewhere (Ochieng, 2019).

However, unless adequate mechanisms are in place to equitably manage the movement of health workers, the AfCFTA may result in a skewed distribution of health workers, leaving huge deficits in lower income countries in the region, particularly given the push and pull factors inherent in differentials in working conditions, salaries, services and career prospects. (SEATINI, ACHEST, TARSC, 2011). The WHO Global Code of practice on the International Recruitment of Health Personnel provides guidance on the management of such flows through designated national authorities (WHO, 2010), as do other bilateral and regional agreements; it important to ensure that the implementation of the AfCFTA does not disrupt these measures.

4.8 Foreign direct investment and tariff revenue impacts

Increased foreign direct investment (FDI) is one goal of trade liberalisation and, at global level, allows TNCs such as transnational food corporations to extend their production, distribution and marketing channels.

That this has negatively impacted on food systems in African states is already evident in the growing dominance of South African supermarket chains selling South African products in most ESA countries, crowding out local retailers and potentially, also local food producers (South Africa KI 8). Another example of the possible skewing of increased FDI in the food sector is investment under the New Alliance for Food Security and Nutrition in Africa, launched under the auspices of the G8 and aimed at investing in the agri-food sector in several countries including Malawi, Mozambique, and Tanzania in the ESA region (South Africa KI 8).

These potential impacts point to how far the AfCFTA Protocol on Competition Policy and the Protocol on Investment will ensure that weaker countries are cushioned and enabled to produce goods and services that are tradable in fair competition with economically stronger African countries and indeed, with international TNCs. This implies the need for affirmative action such as by ensuring appropriate FDI in lower income countries, such as in special economic zones in RECs in ESA countries. Tariffs have traditionally provided revenue for ESA countries, and reduced tariffs as a result of liberalised trade could disrupt public sector revenues. While different regimens in the WTO, Economic Partnership Agreements, the SADC Trade protocol, the COMESA Free Trade agreement and the East African Community (EAC) among others, have already liberalised trade, African countries are more reliant on trade taxes than other regions (Okunogbe and Santoro, 2023).

Different studies of the impact of trade liberalisation on these revenues present inconsistent narratives depending on the product focus, either leading to reduced revenue or to improved revenue due to growth in total trade (South Africa KI 8). The United Nations Conference on Trade and Development estimated that short-term loss of government revenue due to the implementation of the AfCFTA could cause a revenue shock of up to US\$4,1 billion, but that longer-term economic growth could counteract this effect (Kruger and Karim 2022). From the modelling, estimated revenue losses in ESA include: in Kenya (US\$14,2 million), in Uganda (US\$13,5 million) and in Tanzania (US\$5,3 million), noting that “while Kenya, Uganda and Burundi will experience a longer-term positive trade effect, Rwanda and Tanzania are likely to not see the revenue loss offset” (Kruger and Karim 2022:42).

As further discussed in the next section, an AfCFTA Adjustment Fund and various other initiatives have been established to cater for such concerns in a liberalised trade environment, as outlined in Box 3.

Box 3: Financing initiatives under the AfCFTA

The AfCFTA-anchored Pharmaceutical Initiative was established as part of the AU's mandate to deliver on Agenda 2063 and the SDGs and to operationalise the AfCFTA. It aims to translate private and public sector dialogue into tangible outcomes. Nevertheless, it has been commissioned in only 10 selected pilot African countries including Madagascar, Mauritius, Kenya, Seychelles in ESA. The initiative's objective is to address the socio-economic challenges facing African countries in improving access to maternal, neonatal and child health (MNCH) essential medicines and commodities and to create fiscal space for this, given rising government debt (UNECA n.d).

The Health Financing Initiative was launched in February 2019 but has been adopted under the AfCFTA. The initiative aims to narrow the health funding gap, increase commitments to and improve health spending to achieve universal health coverage across African countries. It seeks to reorient country and partner health spending and health systems to target the diseases across the life cycle with the greatest measurable impact on mortality and human capital development. The initiative brings together governments, business leaders and the global development community to co-ordinate efforts and resources for health and to ensure that African governments dedicate 5% of GDP to health (AU, 2019).

An AfCFTA **Roundtable on levelling the playing field for intra-Africa investment** was spearheaded by UNECA and held virtually on June 30, 2021. It brought together representatives of government policymakers, private sector investors, AUC, AUDA-NEPAD, RECs, state and non-state actors, and international NGOs to share technical experiences and solutions in furthering knowledge to improve access to pharmaceuticals and COVID-19 pandemic-related commodities. The roundtable focused on:

- Market obstacles hindering growth in healthcare and pharmaceuticals that includes harmonisation of quality institutions and frameworks to stimulate local production and facilitate co-ordinated national and regional regulatory schemes to achieve the 2030 SDG goals and Agenda 2063 aspirations.
- Ways of stimulating private sector investment in manufacturing in local production of medicines and products across the continent, to improve health outcomes in Africa.
- Measures needed to address health and economic emergencies and socio-economic challenges facing African countries in relation to high medicine costs and creation of fiscal space in the COVID-19 era.
- Showcase the contribution of the AfCFTA-anchored Pharma Initiative in the establishment of the African Medical Supply Platform, a consolidated online marketplace that facilitates the provision of COVID-19 related medical products by addressing supply chain issues such as shortages, delays in distributing supplies, accessibility and affordability created by the challenges and opportunities of COVID-19. (UNECA, 2021)

5. Responding to health impacts and protecting health equity

While the AU views the AfCFTA as an important step towards integrating the continent and promoting regional trade, the findings and experience of other free-trade blocs raise concerns about pressures on government-funded public health systems, potentially unequal impacts on access to health services, medical brain drain, increased consumption of unhealthy products and disease spread across borders, unless these risks are effectively addressed within the AfCFTA.

Table 2 points to areas of health sector-related law and policy that are important to avoid the risks of increased inequity in health arising from the AfCFTA.

Table 2: Legal and policy areas relevant to protecting national health equity goals

Issue	Areas of law and policy
Incorporation of the right to health in national constitutions.	Within the ESA region, while some constitutions expressly provide for the right to health many do not, and this right is either inferred from other rights, or is restricted to principles of state policy and objectives and thus not enforceable in the courts, as is the case with Lesotho. Some countries provide for the right to medical services and health care, rather than the right to health, as in the constitution of Mozambique. South Africa is a unique case within the region, as its constitution combines the right to health with other rights critical for its realisation such as the right to food, to water and to social security. All countries ought to have such provisions within their constitutions to ensure national health equity.
Development of national public health strategies addressing population health concerns	Most ESA countries have public health laws; having an explicit public health strategy within the national health strategy as a central goal of government policy. is suggested to be key to addressing health equity including in relation to trade issues. This could involve cabinet-level ownership and co-ordination of action on health equity with binding targets for other ministries, or requirements to conduct a health impact assessment (including potential effects on equity) on new policies.
Expand/ improve health infrastructure	Public investment in development of new health infrastructure and improvement of existing systems is essential for health security and UHC.
Increased budgets and dedicated public health care funding	Public health and health care services should receive increased and dedicated domestic public funding, at least in line with the provisions of the Abuja Treaty (15% of the budget to the health sector) and 5% of GDP.

Issue	Areas of law and policy
Strengthening health personnel	Health personnel require continuous capacity building through on-going training programmes, including on skills in emerging public health risks.
Enabling leadership and collective organisation	Involving leaders, members and community-based organisations from affected communities in processes that listen to community priorities from the onset, and that strengthen collective organisation, capacities and dialogue during implementation to enable equity. Leadership support from within communities, local authorities and political and institutional actors helps to champion, catalyse, scale-up and sustain innovations and services to promote health equity.
Improve accountability	Involving disadvantaged and marginalised groups in priority setting, planning and resource allocation processes.
Other measures	Investing in primary and secondary services in currently underserved areas and co-ordination between levels of care, calls for equity to be integrated in government resource allocation, taking into account health needs, poverty, capacity gaps and funding sources. Technical efficiency in relation to pharmaceuticals also needs to be addressed.
Recognise human rights and equity in international trade and economic co-operation.	AfCFTA Article 3 includes an objective to promote sustainable and inclusive socio-economic development, reflecting the RECs' recognition of human rights and equity. The AfCFTA Protocol on Rules and Procedures on the Settlement of Disputes requires the Dispute Settlement Panel and the Appellate Body to interpret provisions of the Agreement in accordance with rules of interpretation of public international law, including the 1969 Vienna Convention on the Law of Treaties

Source: Author compilation

The potential for the AfCFTA to have significant impacts on health and health equity is further suggested by previous trade liberalisation experiences and specifically in the ESA region, the International Monetary Fund and World Bank-led Structural Adjustment Programmes. These trade liberalisation policies were implemented across Africa in a context of weak safety nets and protections of public sector services including in health, education and agriculture. The decline of these services and the social, health and economic inequalities that arose after those experiences (Loewenson, 1993) make it important to assess, project and respond to the AfCFTA's impacts, including on how will be implemented. ESA countries should thus assess and counter these risks along with their potential negative health implications. The findings of this study point to some specific areas that need to be addressed.

AfCFTA promotion of the free movement of personnel could enhance availability and possibly accessibility of skilled personnel including health workers, especially for countries experiencing acute shortages. But, as noted in the findings, it could also do the opposite, as already experienced in ESA countries where skilled health professionals are pushed or pulled to higher income areas and services, further deepening existing distribution inequalities. The AfCFTA will need to be introduced together with measures for training, resourcing and incentivising retention of personnel to enhance equitable access to skilled health workers within and across ESA countries, or with transitional arrangements to manage migration of skilled health workers through agreements between ESA countries. The free movement of people may also increase the risk of cross-border disease spread, without improved investment in disease surveillance systems, port health and primary care health services.

The findings suggest that free movement provisions may lead to an increased number of foreign patients seeking treatment in countries with relatively strong health care systems that may stretch these systems and generate political tensions between countries around subsidies. Private health services and medical tourism incentivised by trade liberalisation in the tourism and services sector may induce clinicians to migrate from poorer to richer countries and from public to private health

care. This outmigration may further weaken understaffed public health systems, especially in poorer countries and communities, and create competition for jobs with local medical professionals.

While a free trade area liberalises and enhances trade between ESA countries, for gains in incomes and other health determinants to be equitably achieved amongst those with greatest health need, the benefits need to be felt by all local producers, including small scale producers, and to be equitably distributed with measures to promote investment in health-related inputs for safe, social, working and living conditions.

Wider access to new goods and services and to the spread of innovation across the region can be positive for health, but can also bring harmful changes in dietary patterns, employment conditions, physical environments and lifestyles. More open borders to trade may also make it difficult to control the expansion of harmful products including ultra-processed foods and GM products, exacerbating the rise in NCDs in ESA countries. In several Pacific Island countries, for example, consumption of processed foods and sugar-sweetened beverages rose after import taxes on those products were removed (Hughes and Lawrence, 2009). Similarly, tobacco and alcohol consumption could increase if large multinational companies use existing rules to compel countries to lift advertising restrictions on these goods. ESA countries need strong public health laws, and strong personnel, implementation and communication capacities to enforce them to avoid significant rise in NCDs and other health burdens.

With porous borders and weak institutional capacities for port health in some ESA countries, liberalised trade may further weaken checks on unsafe food products, chemicals, alcohol, sub-standard medicines and other products harmful to health, without significant investment in port health. There are already WHO reports of sub-standard and unregistered medicines appearing in markets in some of our countries (WHO, 2018). Thus, benefit and the control of public health risk from harmful products and unsafe foods calls for improved port health capacities, in line with international health regulations and with harmonised standards across countries in all ESA countries to accompany the improved flow of goods.

An ESA country ministry of health key informant noted that his country has established a national AfCFTA Implementation Committee headed by the Ministry of Trade, with one of the key issues under consideration being to ensure that the national bureau of standards is well capacitated at all ports of entry and exit to ensure effective monitoring of goods coming into the country (Uganda KI 6). A parliamentarian with the Zimbabwe Parliament Portfolio Committee on Health and Child Care called further for common, harmonised standards to be adopted by African countries through the different RECs:

We have seen the development of model laws in different areas at the REC or continental level. Such laws are a vehicle for developing common standards in different areas across the continent. If we are to curb the proliferation of substandard products including food, beverages and medicines, etc. from crossing our borders, we need to develop laws that would ensure standardisation and prevent the race to the bottom and in that way, the AfCFTA will be successful in transforming the African economic architecture (Zimbabwe KI3).

In contrast to this proposal, countries are participating in the AfCFTA processes in their individual capacities rather than within RECs. When the negotiations to establish the tripartite free trade area among COMESA, EAC and SADC gathered pace in the past ten years, hopes were high that this would be operationalised and provide the template for the AfCFTA standards (Zambia KI 7). A key informant official in SADC observed that countries in the SADC region are not engaging in AfCFTA negotiations as a block (Botswana KI 2), although COMESA, as one of the eight recognised AU RECs has been participating in the negotiations with the Secretariat and providing support to COMESA and member states (Zambia KI 7).

The findings suggest that the health benefit may be strongest in AfCFTA-anchored support of pharmaceuticals, contributing to improved access to safe medicines and the realisation of the Pharmaceuticals Manufacturing Plan for Africa through localised manufacturing and pooled procurement. It is forecast that the AfCFTA-anchored pharmaceutical project would correlate with a 30% reduction in Kenya's pharmaceutical product prices and an increase in local pharmaceutical production leading to less reliance on imports (ABC Health, 2021).

Competition and wider markets provide a possible incentive for reducing the prices of goods; the AfCFTA could enhance access to low-cost generic drugs from efficient producers within the continent. While the findings thus point to clear potential benefits for local production of medicines and other health technologies, they also raise the need for specific measures to protect health equity through more regionally inclusive strategies, with effective regulation of medicine quality and prices, a harmonised regulatory and quality framework and investment in localised production and pooled procurement.

A Kenyan key informant noted that while the AfCFTA provides opportunities to consolidate markets and incentivise local production, particularly for medicines, this was not guaranteed and further legal reforms were needed to ensure this outcome.

The AfCFTA is one of the potential vehicles to enable the ecosystem to produce and respond to pandemics and other health emergencies. In the context of our own development, the consolidation of the market through the AfCFTA is guaranteed. However, what is not guaranteed is the actual production of medicines, vaccines and other health products to be traded. African countries need a deliberate transformative action that is based on reforming our legal framework to ensure that production is incentivised" (Kenya KI 5).

ESA countries still have weak medicine and health technology production capacities and rely on imports, so the AfCFTA needs to be accompanied by measures to promote investment in value-added production in an organised collaborative manner, and for supporting infrastructures and personnel capacities. Prior liberalisation policies have been accompanied by escalation in the cost of these health products (Loewenson, 1993) and large pharmaceutical companies may also lobby for restrictions on imported generic medicines into ESA under the AfCFTA, as happened in Guatemala after the Central America Free Trade Agreement entered into force (Shaffer and Brenner, 2009).

Such restrictions would raise the cost of medicines, with greatest impact on poorer countries and people. The AfCFTA must thus monitor and show evidence of a fall in the price of essential medicines, commodities and health services for the population, as a measure of its success. Health equity gains in the AfCFTA thus depend on both the implementation of the agreement and the protective measures and capacity investments embedded within it.

There are certainly efficiencies that can be gleaned from integration, but it is essentially a free trade agreement building on a history of mixed results for countries at different levels of development and reinforcing stronger nations' producers at the expense of weaker ones (South Africa KI 1). As noted by one key informant:

The most damaging aspect of this kind of maldevelopment is that it tends to wipe out the most advanced sector in the weaker nation, primitivizing the economy. If the past is any guide, the AfCFTA will likely impact revenues from customs duties, enhance commodity dependence and lead to more immiserating growth. As such, the majority of people will not see rises in income, and gains from liberalisation will be largely monopolised by the already well to do. The implication is more poverty for the bottom and more wealth for the top. This is a tendency noticed even in the developed world, and can be expected to be more pronounced in our continent. With declining incomes, the AfCFTA invites us to more

morbidity and mortality, as budgets for health are slashed – as customs and other revenues fall, and self-care capabilities reduced. The good thing about this is that it will make us more credible recipients for aid, but even that has not helped us: aid tends to alleviate suffering, but is not about poverty eradication... as our history shows (South Africa KI 1).

Thus, the findings indicate that the AfCFTA will have negative implications for production and public revenues. Removal of tariffs that protect domestic industries exposes them to competition, where success or closure will depend on their capital and capacity to manage the change. Without adequate social security, negative shifts in jobs and incomes for countries that become net importers rather than net producers could be very harmful for health, unless countries diversify their production and sources of employment.

For some ESA countries, a growth in production may generate new tax revenue, but where local production is replaced by imports, tax revenues may fall. As experienced in the structural adjustment programmes in ESA countries in the 1980s, when this happens, public health budgets are cut increasing dependency on external funders for primary health care for low-income households (Loewenson, 2022). Therefore, the commitment to mobilise and equitably allocate domestic financing for UHC should be recognised within AfCFTA public financing plans.

The findings note the existence of the AfCFTA Adjustment Fund that supports ESA countries to adjust to the new trading regime. It includes a Base Fund, funded from country contributions, grants and technical assistance funds to address tariff revenue losses as tariffs are progressively eliminated, and to support countries to implement the Agreement. A General Fund consists of concessionary funding from different funding partners, while a Credit Fund will mobilise commercial funding to support both the public and private sectors, enabling them to adjust to the new trading environment.

It is estimated that over the next 5–10 years, the Adjustment Fund requires about US\$10 billion for these purposes, with Afreximbank already having committed \$1 billion towards this. (AU, 2023). This funding need raises a caution on potential reliance on external funding and interests, and a call for institutions like the African Development Bank and Afreximbank to play a key role in mobilising resources for the AfCFTA to be truly African in executing its mandate. (Kenya KI 5).

The AfCFTA could be a tool for fostering south-south co-operation on the continent with potential benefits for health; countries could provide mutual support to strengthen capacity gaps and reduce inequalities. However, the issues raised above indicate that trade alone cannot achieve this without complementary measures to ensure wider benefit within and between countries, co-operation on production of health commodities and technologies, and strengthened capacities and measures to protect public health. As the negotiations to finalise the texts and implementation continue, it is imperative that the health sector takes an active role, not only to understand the implications of the AfCFTA, but to negotiate for measures within it that will safeguard the health of the people.

A COMESA key informant summarised the importance of this co-operation:

The issue of integrated regional manufacturing is going to be critical under the AfCFTA. Zambia produces a lot of copper, for example, and if it is promoted through regional value chains it will be mined in Zambia, processed in Egypt and then sold as an intermediate good and final processing done in Ethiopia. That integrated regional manufacturing will boost production and create opportunities for many countries. The same can happen in the health sector and that would mean employment and investment is spread throughout the region. So each member state stands to gain (Zambia KI 7).

In line with this, COMESA has established common cross-border projects, such as an African agro-industrial park between Zambia and Zimbabwe (Zambia KI 7). Under the programme, the two countries will set up joint ventures in agricultural value chains starting with maize and dairy. The joint ventures will spearhead collaboration on skills development and production of goods and services for bilateral consumption between the two countries. Other products earmarked for development under the programme include cotton, sugar beans, rice and soya beans. Such cross-country programmes could be scaled-up to ensure a spread of benefit from the AfCFTA across countries.

6. Conclusions and recommendations

The implementation of the AfCFTA demands concerted efforts from various stakeholders, including public actors and civil society, to monitor its implementation and the extent to which health equity is protected given the many determinants of health impacted by the agreement.

Harmonising a large market with heterogeneous economies of different sizes, levels of economic development, diversification, cultures and ethnic groups requires cohesion, solidarity and co-ordination to ensure broad-based and equitable gains for all member states and the communities within them.

Existing income disparities within Africa are a challenge the AfCFTA must confront, where the 32 least-developed African countries face challenges in creating jobs and expanding production capacities. Equally, disparities in access to health services, infrastructure and technologies pose risks of widening health inequities if not addressed, with potential for rising ill health and social conflict. A global health governance architecture where private actors have been incorporated into what used to be a publicly dominated health governance system intensifies the impact of TNCs on health, as noted in the findings.

For ESA countries, it is critical to expedite the engaging of officials across all sectors that impact on health, public health professionals and civil society, to raise awareness on the AfCFTA. Within an enabling environment, civil society may also raise public awareness on the AfCFTA's provisions, and its benefits, and actions to prevent its harms to health, as well as monitoring its implementation.

ESA countries can:

- a. Implement community and stakeholder outreach on AfCFTA and the rules, instruments, and structures for regional and continental integration.
- b. Develop, with the involvement of both state and non-state stakeholders, a national implementation plan including a monitoring framework for the AfCFTA.
- c. Expedite the harmonisation of legal and regulatory frameworks that enable implementation of the AfCFTA and protect public health at national level.
- d. Establish sector-wide approaches to planning and budgeting to integrate AfCFTA and regional priorities to foster successes in line with key national development priorities from the AfCFTA's implementation,
- e. Establish the necessary institutional and regulatory mechanisms and capacities for safety nets, and protection and services for disadvantaged producers and populations, including the protection of public sector services in health and education, and support for agriculture.
- f. Establish special economic zones to promote and incentivise the manufacture of health-related products for trade within the AfCFTA (health technologies and pharmaceuticals and fortified foods along with measures that promote regional integration and sustainable development, and the establishment of agro-industrial parks across countries, for products that develop value chains and promote health and nutrition.

- g. Ensure the control of products that are harmful to health, including: establishing which products are subject to liberalisation; developing adequate port health capacities to check the quality and safety of goods particularly food products with public health impact; introducing taxes on products harmful to health to discourage their consumption and promote their substitution with local health-promoting products; fund health interventions and improve capacities for One Health approaches for implementing measures on the sanitary and phytosanitary annex and those listed in the IHR 2005.
- h. Prevent the movement of unregulated and substandard medicines and promote harmonised medicine standards and regulatory capacities on medicines and health technologies, including by capacitating standards authorities/ bureaus of standards to monitor compliance with agreed standards, rules and regulations.
- i. Ensure inter-ministerial collaboration among the relevant policy and enforcement authorities for regular monitoring of the AfCFTA's implementation and reporting on the outcomes, including to parliament.
- j. Assess and report publicly on the impact of the AfCFTA and other investment and trade agreements and their measures, including on their health impact.

Regional organisations, civil society and non-state technical institutions can play a role in:

- a. Advocating for a fully participatory and inclusive consultative process in the development of AfCFTA national implementation plans, involving and informing key stakeholders in health and health-related sectors to ensure they contribute fully to identifying the key priorities for implementation aligned to existing regional policies, programmes, protocols and plans.
- b. Establishing an AfCFTA co-ordination structure or mechanism made up of an inter-ministerial committee, civil society and regional public health institutions to co-ordinate regional level processes for the implementation, including reporting of the implementation of regional programmes at national level, and for oversight and exchange of evidence and learning between national programmes, including those related to health.
- c. Supporting the development of enabling and harmonised legislation to align laws and facilitate the implementation of the AfCFTA where health promoting benefits are evident (such as in local production of pharmaceuticals and developing professional capacities) and to regulate areas where liberalized trade may be harmful to health (such as on harmful foods and other products).
- d. Developing equitable revenue sharing mechanisms for value-added products and trade stimulated by the AfCFTA.
- e. Developing an AfCFTA protocol on the movement of health personnel in line with the International Code on the Recruitment of Health Personnel and existing regional agreements, to ensure equitable distribution of health personnel and promote harmonised standards, conditions and capacities.
- f. Contributing to and implementing a regional monitoring and evaluation framework, including a peer review mechanism that government, civil society and technical institutions in ESA countries will participate in the to assess alignment of the AfCFTA with national laws, regulations, plans and programmes. Health impact assessment and control measures to monitor and report on health equity outcomes including impacts on health personnel, health service access, UHC and health security, the distribution of health burdens, and for the exchange of peer-to-peer learning, within and across ESA countries will also fall under this framework.

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Acronyms

ACFTA	African Continental Free Trade Area
AU	African Union
COMESA	Common Market for Eastern and Southern Africa
EAC	East African Community
ESA	East and Southern Africa
FDI	Foreign Direct Investment
GM	Genetically Modified
IFF	Illicit Financial Flows
IHR	International Health Regulations
IPR	Intellectual Property Rights
REC	Regional Economic Community
SADC	Southern Africa Development Community
SPS	Sanitary and Phytosanitary
TNC	Trans-National Corporation
TRIPs	Trade Related Aspects of Intellectual Property Rights
UNECA	United Nations Economic Commission for Africa
UHC	Universal Health Coverage
WHO Afro	World Health Organization Africa Region
WTO	World Trade Organization

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 east and southern Africa, including

- Protecting health in economic and trade policy, in extractives
- Local production of health technologies
- Urban health and wellbeing
- Building universal, participatory, primary health care oriented health systems
- Equitable, health systems strengthening responses to pandemics
- Fair Financing of health systems
- Promoting public health law and health rights
- Social empowerment and action for health
- Monitoring progress on equity and equity analysis

EQUINET is governed by a steering committee involving institutions and individuals co-ordinating theme, country or process work in EQUINET from the following institutions: TARSC, Zimbabwe; CWGH, Zimbabwe; CEHURD Uganda; SEATINI, Zimbabwe; REACH Trust Malawi; University of Zambia, Zambia; IWGSS Kenya and South Africa; Innovations for Development, Uganda, SATUCC Botswana and Tax Justice Network Africa, Kenya

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