Abstract While COVID-19 is fundamentally a public health crisis, it has also brought with it a global socio-economic emergency unprecedented in the history of the world. This article examines an unlikely victim of the COVID-19 pandemic, the global regime for the governance of international trade, and does so from an African perspective. Following the proliferation of national measures restricting the export of COVID-19-essential personal protective equipment and other medical products at a time when trade literally can mean saving lives, this article asks whether import-dependent countries such as most states in Africa can rely on the multilateral trading system to secure access to these life-saving equipment and supplies. Answering this question in the negative, the article argues that those African countries that lack domestic manufacturing capacity—which make up the majority on the Continent—need to rethink their commodity-export-dependent development strategy and refocus on industrialisation backed up with adequate research and development capacity. Finally, the article also suggests that States Parties to the AfCFTA Agreement should use this period as a window of opportunity to revisit the text of the Agreement so a revised AfCFTA has a better chance of coping with the next pandemic or emergency.

1 Introduction

When the COVID-19 crisis was first reported in Wuhan, China, on 31 December 2019, it was rightly perceived as an immediate threat to global health. It took only a month for the coronavirus to spread to a sufficiently large number of countries.
outside China—18 of them at the time—for the World Health Organization (WHO) to declare a Public Health Emergency of International Concern on 30 January 2020.\(^1\)

The WHO increased the alarm level and characterised COVID-19 as a pandemic on 11 March 2020, the first ever pandemic caused by a coronavirus.\(^2\)

According to the World Health Organization (WHO), the disease “can spread from person to person through small droplets from the nose or mouth which are spread when a person with COVID-19 coughs or exhales. These droplets land on objects and surfaces around the person. Other people then catch COVID-19 by touching these objects or surfaces, then touching their eyes, nose or mouth. People can also catch COVID-19 if they breathe in droplets from a person with COVID-19 who coughs out or exhales droplets.”\(^3\) Because the disease can be transmitted through contact with mouth and nose droplets from a person with COVID-19, the demand for a number of so-called personal protective equipment (PPEs) and other medical supplies, which the WTO Secretariat has termed “COVID-19 medical products”, such as surgical and medical masks, gloves, respirators, and face shields, has risen dramatically in most parts of the world.

As the virus spread and the scientific community and the world learnt more about the disease, the recommended preventive measures also evolved. What has been clear from the outset is that COVID-19 is as much a health pandemic as a global socio-economic and political emergency. With the virus spreading further and deeper, and countries entering periods of various degrees of lockdown, economic activity plummeted, schools and businesses closed, millions of workers lost their jobs; the world entered the most abrupt and unanticipated economic contraction in its history.

An equally significant, if less anticipated, casualty is the reputation of the global system of regulation to guarantee access to medical products essential in the fight against COVID-19. Despite repeated calls for global solidarity and against disruption of the movement of essential products across borders,\(^4\) almost the instinctive reaction of most countries in the world has been to impose restrictions on the export of COVID-19-essential PPEs and related medical products. As a result, already on 30 March 2020, the WHO DG had to address G20 Trade Ministers about ways of resolving what he called “the chronic shortage of personal protective equipment and other essential medical supplies”, stressing that free movement of such products is “vital for saving lives and curbing the social and economic impacts of the pandemic.”\(^5\) The challenge posed by COVID-19 is thus not limited to national health

\(^1\)See WHO (2020a).
\(^2\)See WHO (2020b).
\(^3\)See WHO (2020c).
\(^4\)For example, the Director-General of the WHO, when he declared COVID-19 as a global health emergency on 30 January 2020, he specifically noted: “there is no reason for measures that unnecessarily interfere with international travel and trade.” See WHO (2020d).
\(^5\)See WHO (2020e).
and socio-economic systems; it has also exposed the deep and systemic deficiencies of the global economic regulatory system at a time of great distress.

Until this crisis struck, who could have thought it possible that Germany would ban the exportation, to France or Italy, of such potentially life-saving medical supplies as face masks and respirators? Who could have thought that the most successful European single market, the envy of much of the rest of the world, would fail to guarantee intra-EU trade in essential medical equipment and supplies at a time when trade literally meant saving lives? These are extraordinary times where European contracts for the purchase of COVID-19 medical supplies have been rendered “not worth the paper they were written on” because of export bans.

If the European single market cannot guarantee access to supplies from within the EU, it is hardly plausible to expect better outcomes from the much looser and less effective global trading regime.

According to the International Trade Centre (ITC), as of mid-May 2020, just over 90 countries have introduced export prohibitions or restrictions as a result of the COVID-19 pandemic. CNN and other media sources also reported that the spread of the pandemic across Europe and the United States has unleashed “a global scramble for medical equipment such as respirator masks and gloves.” For countries without domestic technological and manufacturing base, the effect is likely to be devastating.

In this short article, I have the modest objective to carry out a brief legal analysis to demonstrate, from an African perspective, the inadequacy of the global trading system to guarantee access to vital medical supplies during the global emergency to save lives and the absence of a legal or policy fix for it at that level. To that end, the rest of this article describes the trade-related aspects of the COVID-19 crisis in general and its implications for access to essential medical supplies in particular, outlines the policy options available to poor African countries in the fight against COVID-19 and its associated socio-economic consequences, interrogates the extent

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6 As Chad Bown reported, following France’s decision of 3 March 2020 to “requisition all domestic production of respirators for French health care workers” and Germany’s decision to introduce export restrictions on masks, face shields, and other PPE on 4 March, “Italy and other areas of the continent faced shortages, Europeans lost access to life-saving equipment made in other EU Member States.” See Bown (2020), p. 33.

7 These are words used by Mr Mark Roscrow, an official in the British health care sector, in a testimony he gave to the International Trade Committee of the British Parliament on 23 April 2020. As an example, Mr Roscrow used the ban on the export of a shipment of face masks from France in January 2020. See Hodgson (2020).

8 See ITC (2020) and WTO Secretariat (2020a).

9 The COVID-19 crisis has tested not just the fitness of the global regulatory system for trade for emergency times, it has severely strained the close ties of friendship between the leading Western Powers that has been forged over decades of strategic partnership in times of peace and war. In what the French have labelled the guerre des masques—the war of the masks—German government officials have gone as far as accusing the US Government of committing “an act of ‘modern piracy,’ alleging that a consignment of 200,000 respirator masks destined for the Berlin police had been diverted to the US while in transit in Bangkok.” See Lister et al. (2020).
to which the multilateral trading system can be relied upon for access to such supplies, subjects the AfCFTA Agreement to the same test to determine whether or to what extent it improves upon the rules of the multilateral trading system when it comes to access to essential supplies from within the Continent, and concludes by identifying a list of legal and policy takeaways. What readily emerges from the analysis is the realisation that, in times of real emergency like this, law is never a substitute for humanity and solidarity; self-reliance and self-sufficiency—every country for itself—are reclaiming their traditional places. Two important lessons follow from this for Africa: (i) the need to revisit the provisions of the AfCFTA Agreement to better anticipate global and continental emergencies such as this and provide for appropriate remedies; and (ii) the imperative to build its scientific and industrial base, something that has been known for a long time but whose significance has been elevated to a different level because of the pandemic.

### 1.1 The COVID-19 Crisis and Its Trade-Related Implications

The outbreak of the coronavirus and the disease associated with it, known as COVID-19, has engulfed the entire world within a short period since it was first reported in Wuhan, China, on 31 December 2019. Because the disease can be transmitted through contact with mouth and nose droplets, the demand for “COVID-19 medical products”, such as surgical and medical masks, gloves, respirators, and face shields, has risen dramatically in most parts of the world. In response, countries have taken several quintessentially trade-related measures that have domestic as well as international implications.

Domestically, many governments have directed industry to repurpose their activities and manufacture COVID-19 medical products to the extent possible, including with the help of incentives and subsidies; at the same time, however, a lot of businesses in far too many countries have resorted to hoarding these items with profiteering motives in the full knowledge that supply is naturally slow to respond (the domestic dimension). Furthermore, almost the instinctive first step for many countries—from Australia to South Africa, the EU and the USA—has been to impose restrictions on the export of PPEs (the international dimension). Also, at a time when over 90% of global merchandise trade is seaborne, virtually all coastal

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10 As Joseph Stiglitz observed recently: “Economists used to scoff at calls for countries to pursue food or energy security policies. In a globalized world where borders don’t matter, they argued, we could always turn to other countries if something happened in our own. Now, borders suddenly do matter, as countries hold on tightly to face masks and medical equipment, and struggle to source supplies. The coronavirus crisis has been a powerful reminder that the basic political and economic unit is still the nation-state.” Stiglitz (2020).

11 For the chronology of how COVID-19 started in one place and spread to the entire world, see WHO (2020b).

12 For details, see World Customs Organization (2020).
states in the world have introduced some degree of restriction on port access to cargo ships. According to recent reports, nearly all coastal states, with the notable exception of Canada, have adopted “variously restrictive measures which range from indiscriminate prohibitions on access to ports to measures discriminating between ships on account of their nationality or based on objective considerations, like previous calls in infected areas.”

Considering that over three billion people around the world are dependent on international trade for their food security, this has raised significant concerns that the global health crisis caused by the coronavirus outbreak can easily become an equally global food crisis, thereby necessitating a G20-level effort to nip this challenge in the bud. Indeed, according to a recent report, “more than 20 governments had imposed some form of restrictions on food exports” by end of April 2020 as part of their responses to the COVID-19 crisis. The report found that “Covid-19 is estimated to lower the world’s export supply of food by 12.7 percent, on average in the quarter following the outbreak of the pandemic. Many important staple foods, including rice, wheat and potatoes have drops in export supplies of over 15 percent.”

While the domestic dimension of the problem—including the practices of hoarding and price gouging—may be blamed on human greed, the tendency to look for personal advantages regardless of the welfare of others even in the worst of circumstances, a widespread practice of it might also be a sign of failure of the underlying national legal system. The international aspect of the reaction, on the other hand, while easier to understand as it is often couched in terms of national security and national self-preservation, at the human level it is hardly any more innocent than the hoarding of supplies with profiteering motives. In legal terms, however, there is a significant distinction between these two dimensions of the problem. National legal systems are often well-equipped with the necessary powers, tools and effective enforcement mechanisms to ensure compliance by punishing the offenders to make sure supplies are made available to the consumer on reasonable terms. When it comes to international law, on the other hand, not only is it deficient in terms of enforcement capacity, there is little hard law against what is effectively

\[13\text{See Miron (2020).}\]
\[14\text{See WTO Secretariat (2020b).}\]
\[15\text{See G20 Extraordinary Agriculture Ministers Meeting: Ministerial Statement on COVID-19 (virtual meeting held on 21 April 2020 (hereafter G20 (2020))). The ministers resolved, inter alia, to cooperate and take “concrete actions to safeguard global food security and nutrition”, to “ensure the continued flow of food, products, and inputs essential for agricultural and food production across borders”, and to “guard against any unjustified restrictive measures that could lead to excessive food price volatility in international markets and threaten the food security and nutrition of large proportions of the world population, especially the most vulnerable living in environments of low food security”. G20 (2020). Available at https://g20.org/en/media/Documents/G20_Agriculture%20Ministers%20Meeting_Statement_EN.pdf (accessed 02 June 2020).}\]
\[16\text{See Espitia et al. (2020).}\]
\[17\text{Id.}\]
“national-level hoarding” that compels countries to share such vital supplies with their neighbours.18

2 International Law: A Helpless Bystander?

When local businesses in a particular country engage in hoarding or price-gouging practices in the domestic market, we typically turn to domestic law to discipline them. When nations impose export restrictions on COVID-19 medical products and engage in national-level hoarding, and to the extent this is harmful to other countries, one would hope that international law would provide the tools with which to deal with such “national malpractice”. We shall see, however, that international law has yet to provide such tools and ensure access to supplies even in times like this.

EU Law as an Example: As an instrument to blunt the sharp edges of national sovereignty and establish a system of cooperation in the common interest, complete with an enforcement mechanism approximating that of national law, nothing in international law comes anywhere close to what the EU has achieved over the past nearly seven decades. The success of this experiment is such that the standard and binary classification of law into national or municipal, on the one hand, and international, on the other, had to be supplemented with a third category, called supra-national law to describe particularly the law of the European Union that has attributes of both. Like all international law, at its foundation, EU law is the product of inter-governmental bargaining in pursuit of the common interest of its members. Unlike typical international law, however, and more like national law, the inter-governmental agreements that established EU law have been supplemented with processes and institutions through which to create new law without necessarily waiting for each member of the Union to agree. Likewise, EU law has established a judicial system that has the power to impose sanctions, including in the form of fines as well as orders to change national laws, policies and practices of the Member States.

It is this highly advanced system of integration that partly buckled under the weight of COVID-19. When the crisis struck, the free movement of goods and services that Europe rightly took for granted for a long time was the first to suffer as countries unilaterally blocked exports of protective equipment to Italy and other countries affected by the pandemic. Although trade is the exclusive competence of the European Commission under EU law, the export bans imposed by several EU Member States implied “a re-nationalisation of trade policy, not just vis-à-vis non-EU countries . . . but also vis-à-vis other EU Member States”.19 Ursula von

18For an exploration of the state of general international law during times of emergency, see “Rana Moustafa Fouad, The Legal Duty to Cooperate amid COVID-19: A Missed Opportunity?”, *EJIL: Talk*.

19See Hoekman et al. (2020a), p. 81.
der Leyen, President of the EU Commission, expressed her dismay at this practice as follows:

A crisis without borders cannot be resolved by putting barriers between us. And yet, this is exactly the first reflex that many European countries had. This simply makes no sense. Because there is not one single Member State that can meet its own needs when it comes to vital medical supplies and equipment. Not one.20

President von der Leyen made this statement in a speech she delivered at the European Parliament on 26 March 2020. Yet, less than two weeks before that, the EU Commission that von der Leyen leads had imposed restrictions on the export of those same medical supplies from the EU to third countries. In its Implementing Regulation (EU) 2020/402 of 14 March 2020, the EU Commission introduced an “export authorisation” requirement “for the export outside the Union of personal protective equipment listed in Annex I, whether or not originating in the Union.” The Commission added: “Without the production of such export authorisation, the exportation is prohibited.” Interestingly, this restriction applies not just to PPEs made in the EU; it applies to all PPEs wherever they might have been made as long as they happen to be within or transiting through the territorial jurisdiction of the EU.21 Also, while this Regulation initially applied to all third states, Commission Implementing Regulation (EU) 2020/426 was introduced five days later, on 19 March 2020, to exempt from the export restrictions the member states of the European Free Trade Association (EFTA, i.e. Norway, Iceland, Liechtenstein, and Switzerland), the overseas countries and territories of some EU Member States, and a few principalities associated with the EU, i.e. the Faeroe Islands, Andorra, San Marino and the Vatican City. A second revision came four days later, on 23 March 2020, in the form of Commission Implementing Regulation (EU) 2020/568, which reduced the list of products that require export authorisation to masks, spectacles and protective garments, and extended the geographical exception to include the Western Balkans.22

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20See speech by President von der Leyen at the European Parliament Plenary on the European coordinated response to the COVID-19 outbreak (26 March 2020). Von der Leyen (2020).

21For an example of how this works in practice, see Hoekman et al. (2020b). The authors’ account of an incident involving Mölnlycke and the Government of France is insightful. Mölnlycke, a Swedish company that supplies medical products, has a warehouse and logistics centre in Lyon, France, but it does not have any production facilities in France. Following President Macron’s decree of 3 March 2020 to requisition all stocks of medical supplies in France and distribute them to French health workers, “French authorities, in full compliance with the decree, requisitioned the entire stock of surgical masks that Mölnlycke had in Lyon that had been produced by plants in Asia and that were in transit to clients in other European countries. This included 1 million masks purchased by Italian customers and 1 million bought by clients in Spain. . . . The requisition led to a diplomatic dispute at the highest political (Prime Minister) level between France and Sweden. The resulting political pressure and media attention resulted in an eventual decision by the French government to allow all Mölnlycke’s consignments of masks to be released to their intended final destinations with a 1 month delay.”

22For further information, see https://trade.ec.europa.eu/doclib/press/index.cfm?id=2139 (accessed 02 June 2020).
The rest of the world—Africa included—would not have access to these essential, life-saving, medical equipment in this time of emergency unless and until the competent authority in an EU Member State decides that the export of a particular product would not affect the Union’s ability to meet internal demand. The application of these EU decisions is not affected by any of the unilateral or reciprocal preferential trade arrangements to which the EU is a party. As such, those African countries that have concluded Economic Partnership Agreements (EPAs) with the EU are subject to the EU export restriction as much as any other country outside the small list of exempted countries in Europe. To use the example of the 2016 EPA concluded between the EU and the six members of the Southern African Development Community (SADC), i.e. Botswana, Lesotho, Mozambique, Namibia, South Africa and Swaziland, which entered into force in February 2018, Article 39 thereof simply refers the issue of export restrictions to the GATT/WTO system, as follows: “The Parties may apply quantitative restrictions provided such restrictions are applied in conformity with the WTO Agreement.” Likewise, although Article 17 (3) of the 2004 Association Agreement between the EU and Egypt, which aimed to progressively establish a free trade area between the two parties, prohibits the use of “quantitative restrictions or measures having equivalent effect” in their trade, Article 26 of the same brings back GATT Article XX-type exceptions that would justify export restrictions on grounds, inter alia, of “the protection of health and life”. Finally, nor are those African countries that are subject to the EU’s Generalised System of Preferences (GSP), including the “Everything but Arms” law of the EU, exempt from the EU restrictions on the export of COVID-19 medical supplies.

The conclusion from this brief examination of EU law governing trade relations with different categories of African countries is that the whole of Africa, regardless of whether their trade relations with the EU are governed by an EPA, an Association Agreement or indeed through the EU’s regime for generalised tariff preferences, including Everything but Arms, is completely shut off from the EU market for COVID-19 medical supplies during this emergency. Moreover, both the restrictions imposed by EU Member States against the exportation of COVID-19 medical supplies to other EU Member States, as well as the Commission’s restriction of such exports from the EU to third countries are justified under provisions of the Treaty on the Functioning of the European Union (TFEU) that provide for exceptions to the free movement rules on grounds of public health. As Hoekman et al.

23See Euro-Mediterranean Agreement Establishing an Association between the European Communities and their Member States, of the one Part, and the Arab Republic of Egypt, of the Other Part, signed in June 2001 and entered into force in June 2004, available at Official Journal of the European Union L 304/43 (30.9.2004), https://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2004:304:0039:0208:EN:PDF (accessed 02 June 2020).
24Note that the EU GSP scheme as applied through Regulation (EU) No 978/2012 is limited to tariff preferences. As such, countries eligible under this Regulation do not benefit from any preferences when it comes to non-tariff measures, such as the export restrictions applying to COVID-19 medical supplies.
25See, e.g. Glöckle (2020).
underline, such measures are “not prohibited by the EU treaty. Export bans are permitted when necessary to address emergencies and safeguard national health and safety.”  

26 But, of course, legality is one thing; morality or economic rationality quite another. As Glöckle rightly observes, “unilateral export restrictions vis-à-vis other EU Member States are legal under EU law, but their moral and political justification as well as their economic rationality may be highly disputed.” 

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3 The GATT/WTO System

As indicated above, just as EU Member State measures to restrict exports of supplies to fellow EU Member States can be justified under EU law, so also are EU Commission measures to restrict exports of supplies to third countries justifiable under WTO law, the only multilateral regime that governs such conduct at a global level.  

28 As under EU law, there is an old and established principle under world trade law against the use of quantitative restrictions on exports. Article XI (1) of the General Agreement on Tariffs and Trade (GATT) is sweeping and unequivocal in its prohibition of quantitative restrictions:

No prohibitions or restrictions other than duties, taxes or other charges, whether made effective through quotas, import or export licences or other measures, shall be instituted or maintained by any contracting party on the importation of any product of the territory of any other contracting party or on the exportation or sale for export of any product destined for the territory of any other contracting party.

This provision contains an important articulation of the fundamental bargain struck at the very start of the multilateral trading system in 1947—that to the extent complete free trade was unattainable in the short term, tariffs would be the preferred and therefore accepted method of protection while all non-tariff barriers would, in principle, be prohibited.  

29 That is why Article XI(1) was written in such sweeping terms: that any trade-related measure that takes a form “other than duties, taxes or other charges” is prohibited regardless of how it is framed or implemented—i.e. “whether made effective through quotas, import or export licences or other measures”. The prohibition does not distinguish between imports and exports; it applies to both. In other words, just as it is unlawful in principle to ban the importation of a product for purposes, say, of protecting the domestic industry or rationalising the use of foreign exchange, so is it unlawful in principle to ban the exportation of a particular product to ensure availability of adequate supplies domestically or to keep supplies away from an unfriendly foreign state.

26 See Hoekman et al. (2020a), p. 81.
27 Id.
28 For a brief but authoritative and up-to-date analysis of the legal issues, see WTO (2020).
29 It is notable that this prohibition has a long pedigree, being one of the GATT provisions that was “taken from the reciprocal trade agreements of the 1930s” in the USA. See Irwin (2017), p. 479.
It is notable at this point that most trading partners, including the EU Commission itself as described above, that introduced restrictions on COVID-19 medical supplies did not impose outright bans on exports; instead, they often made exportation subject to production of a license or authorisation to that effect. To use the EU example once again, Article 1 of Implementing Regulation (EU) 2020/402 of 14 March 2020 provides:

1. An export authorisation established in accordance with the form set out in Annex II shall be required for the export outside the Union of personal protective equipment listed in Annex I, whether or not originating in the Union. . . . 2. Without the production of such export authorisation, the exportation is prohibited.

Article 2 of this Regulation then provides for an open-ended list of factors that may be considered by the competent national authorities in deciding whether or not to grant an export authorisation, making this a typical example of a discretionary export licensing regime. More importantly, as paragraph 7 of the recitals to this Regulation makes clear, the purpose of the export licensing regime is openly restrictive in that it is intended “to ensure adequacy of supply [of covered PPEs] in the Union in order to meet the vital demand”. It is thus clear that Implementing Regulation (EU) 2020/402 establishes a system of quantitative export restrictions effected through a discretionary export licensing regime. Stated in the language of GATT Article XI(1), this is a typical example of an export restriction “made effective through . . . export licences”, and therefore prohibited on the same level as outright export bans. This also fits into an old and established distinction under GATT/WTO law between discretionary or non-automatic import or export licensing regimes on the one hand and automatic licensing procedures on the other, prohibiting the former while tolerating the latter. As the WTO Panel in China—Raw Materials observed specifically on the question of whether export licences amount to prohibited quantitative export restrictions:

China’s export licensing regime is not per se inconsistent with Article XI:1 on the basis that it permits export licensing agencies to require a licence for ‘goods subject to . . . export restrictions’. . . . The Panel finds, however, that the discretion that arises from the undefined and generalized requirement to submit an unqualified number of ‘other’ documents of approval . . . as applicable to goods subject to export licensing only, or the ‘other materials’ . . . amounts to an additional restriction inconsistent with Article XI:1. 30

We can thus conclude that measures to restrict the export of COVID-19 medical supplies, such as those contained in EU Commission Implementing Regulation (EU) 2020/402, establish quantitative export restrictions of the type that falls squarely within the language of GATT Article XI, having “a limiting effect on the quantity or amount of a product being . . . exported.”31 As such, these measures are in principle incompatible with a fundamental principle of WTO law as articulated in GATT Article XI(1).

30See WTO (2011).
31See WTO (2011) para. 319.
However, the rule under GATT Article XI(1) is subject to so many exceptions and “carve-outs”\textsuperscript{32} that, in some senses, the rule itself might appear to be the exception rather than the other way round. To mention just a few examples, paragraph 2(a) of GATT Article XI already provides that the principle enunciated in paragraph 1 “shall not extend to . . . Export prohibitions or restrictions \textit{temporarily applied to prevent or relieve critical shortages of foodstuffs or other products essential to the exporting contracting party}.” While one may ask detailed and technically sophisticated questions relating to how long is “temporary” or what products are “essential” in a particular case, it is plausible to suggest that national measures restricting the export of potentially life-saving COVID-19-related medical products during a global medical emergency that has been declared a global pandemic by the world’s preeminent scientific institution—the World Health Organization (WHO)—should easily meet the requirements set out in paragraph 2(a) of GATT Article XI. Whenever a country decides to restrict exports under this provision, the only other condition it has to meet is that of non-discrimination in the sense of most-favoured nation treatment—i.e. under GATT Article XIII, the prohibition or restriction of exports must apply in a similar fashion to all third countries without distinction. Likewise, these measures are also likely to find justification under the General Exceptions provision of GATT Article XX(b) and (j) as being “necessary to protect human . . . life or health” or “essential to the acquisition or distribution of products in general or local short supply” provided they meet the additional requirement that they are “not applied in a manner which would constitute a means of arbitrary or unjustifiable discrimination between countries where the same conditions prevail, or a disguised restriction on international trade”. Indeed, one could go further and argue that these measures might even fall under the national security exceptions of Article XXI(b)(iii) as measures taken under conditions of “emergency in international relations”.\textsuperscript{33}

International health law also follows the same approach and defers to the WTO system regarding restrictions on the movement of goods necessitated by the pandemic. The \textit{International Health Regulations (2005)} administered by the World Health Organization (WHO) allow countries to take all necessary health measures “in response to specific public health risks or public health emergencies of international concern”, including measures of the type indicated above. In doing this,

\textsuperscript{32}WTO law distinguishes between exceptions, on the one hand, and carve-outs, on the other. The WTO Secretariat describes the difference thus: “A carve-out is different from an exception. Members can resort to exceptions, such as those under Article XX of the GATT 1994, to justify a measure that would otherwise be inconsistent with their GATT obligations. By contrast, an exemption or a carve-out, such as Article XI:2, excludes certain measures from the scope of a GATT obligation, thereby removing certain measures from its coverage. Accordingly, where the requirements of Article XI:2(a) are met, there would be no scope for the application of Article XX, because no obligation exists. This distinction has implications for the burden of proof in the context of WTO disputes.” See WTO (2020).

\textsuperscript{33}For a detailed account of these and other possible justifications under WTO law, see Pauwelyn (2020).
members are required to act “in accordance with their . . . obligations under interna-
tional law” and to ensure that these measures “shall not be more restrictive of
international traffic . . . than reasonably available alternatives that would achieve
the appropriate level of health protection.” Needless to say, this language is crafted
in such a way that national obligations in respect of the movement of goods as
provided under the GATT/WTO system remain applicable even when taking mea-
urses specific to health emergencies.

The conclusion is therefore clear, that international law does not guarantee access
to such life-saving medical equipment and supplies for countries that lack the
capacity to produce them. The next question then is: for countries like many in
Africa lacking in domestic research and development capacity to develop new cures
for such diseases, or indeed the manufacturing capacity to produce the most basic
PPEs such as respirators with proven life-saving qualities, what options do they have
in the short term and beyond given that they cannot rely on the international market
to access them?

4 Preparing for the Next Pandemic: Is COVID-19 What It Takes for Africa to Take Industrialisation and R&D Seriously?

When the international market for COVID-19 products suddenly dried up, much of
the developed world as well as developing countries with relevant manufacturing
capacity adopted policies to mass-produce such products domestically at short notice
through, inter alia, ordering and/or incentivising private companies to shift their
activities, repurpose their manufacturing operations, cancel export contracts, etc. and
secure adequate domestic supplies of such products. The research and development
(R&D) institutions in these countries also redeployed themselves into the search for
vaccines, cures, and other means of fighting the pandemic, which are already
showing encouraging signs. However, much of Africa’s ability to resort to such
policies has been hampered by the poor state of its manufacturing sector and its
undeveloped R&D capacity and associated human capital. ECA estimates show that
Africa is dependent on imports for as much as 94% of its total pharmaceutical and
medical supplies. When it comes specifically to COVID-19, a recent CNN report
shows that there are fewer than 2,000 functional ventilators in 41 African countries
and less than 5,000 intensive care unit beds in 43 countries, which comes to “about
five beds per 1 million people, compared to 4,000 beds per 1 million people in
Europe”. In response to this worrisome reality, several African countries, including

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34 See WHO (2005). WHO, International Health Regulations (2005) (3rd ed. 2016), Article 43, available at https://www.who.int/ihr/publications/9789241580496/en/ (accessed 02 June 2020).
35 See ECA (2020).
36 See Woodyatt (2020).
Ethiopia, Ghana, Kenya, Nigeria, Senegal, and South Africa, are known to be taking a lead in encouraging repurposing of domestic manufacturing supply chains to address shortages in essential medical equipment.37

Furthermore, there is consensus among the global scientific and policy community that this pandemic will not be the last; sadly, it can only be the first of many to come. As such, this is time for Africa to take decisive action to ensure it will not find itself in a similar predicament next time another pandemic or other disaster strikes—to invest in industrialisation and associated research and development capacity so as to have in place the necessary infrastructure for adaptability and resilience.

This does not mean Africa should look inward, aim to be self-sufficient in all such medicines and medical products, prepare to isolate itself from the rest of the world, and live exclusively on what it can produce. Far from it. Indeed, for a region such as this, there is no substitute for a rules-based multilateral trading system that establishes a set of mutually-agreed limits on national sovereignty for the common good and enforced through an impartial adjudicatory system.38

The advice is for African policymakers to ensure they have the minimum capacity for resilience, the capacity to ramp up production of essential supplies at short notice and the human and institutional capacity to undertake research and development (R&D) to quickly understand and explain disease outbreaks or other natural disasters, identify the coping mechanisms and precautions and devise appropriate solutions.

These are not new lessons or ideas for Africa. Indeed, far too many policy papers have been written, and high-level decisions adopted, about the need to launch Africa on a path to industrialisation. Already in 1980, the Lagos Plan of Action, that landmark document in the history of Africa’s efforts towards economic integration, considered industrialisation as a critical element of the cure for all the Continent’s ills and declared that industrialisation “constitutes a fundamental option in the total range of activities aimed at freeing Africa from underdevelopment and economic dependence.”40 The adoption of the Lagos Plan of Action was immediately followed by successive declarations of the so-called Industrial Development Decades for Africa (IDDA), with the current iteration, IDDA III, lasting until 2025.41

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37 See Tony Blair Institute for Global Change (2020).
38 For an elaborate discussion on why inward-looking policies are detrimental to everyone, see Baldwin and Evenett (2020).
39 See, e.g. the African Union programme for Accelerated Industrial Development in Africa (AIDA), available at https://au.int/sites/default/files/documents/30985-doc_plan_of_action_of_aida.pdf, which describes industrialisation as “a critical engine of economic growth and development” and equates it with development itself.
40 See OAU (1980) para. 56.
41 The first IDDA was declared by the UN General Assembly on 5 December 1980; IDDA II, covering the period 1991–2000, was declared by UN General Assembly on 22 December 1989, followed by IDDA III which was declared once again by the UN General Assembly on 25 July 2016 covering the period from 2016–2025. For further information, see OAU, ECA and UNIDO (1997), para 43.
The result, while encouraging, remains far from satisfactory. The COVID-19 crisis once again demonstrates that the old model of a global division of labour in which Africa still supplies predominantly raw materials and largely imports finished products has left it unable to produce even basic PPEs essential to save lives. If Africa ever needed one more wake-up call to build its industrial and R&D capacity, COVID-19 has provided it. Until now, the driver for the industrialisation imperative in Africa has been economic; COVID-19 has now made it a matter of life and death. This needs to end, and end soon.

5 COVID-19 Lessons for the AfCFTA

At this point, we need to pause and ask one important question: imagine several countries in Africa invest, and build, sufficient manufacturing and R&D capacity that has enabled them to produce and supply PPEs and other medical products at short notice. Would those African countries that do not have manufacturing capacity be able to rely on the AfCFTA to access those supplies in the event of a medical emergency such as now? The answer to this question is in the negative.

As of today, there is no obligation that precludes a State Party to the AfCFTA Agreement, say South Africa, from imposing a ban on the exportation of PPEs to another State Party, say, Uganda, during this time of emergency. Today, some 14 African countries have imposed export restrictions on COVID-19 medical supplies unrestrained by their WTO and/or other international obligations. The AfCFTA Agreement does not make much improvement on the GATT/WTO regime for export restrictions described earlier. Indeed, the AfCFTA effectively reproduces the principle under GATT Article XI along with the exceptions and carve outs associated with it. Article 9 of the Goods Protocol to the AfCFTA Agreement provides that principle, saying:

The State Parties shall not impose quantitative restrictions on imports from or exports to other State Parties except as otherwise provided for in this Protocol, its Annexes and Article XI of GATT 1994 and other relevant WTO Agreements.

Articles 26 and 27 of the Goods Protocol then provide for a list of general and security exceptions, respectively, in language closely based on, if not reproducing verbatim, the texts of GATT Articles XX and XXI. In other words, all the inadequacies of the multilateral trading system in the regulation of export restrictions outlined above are alive and well inside the AfCFTA as well. What this means is that even if a group of African countries parties to the AfCFTA were to have the capacity to produce all COVID-19 medical equipment and supplies, to the extent those countries would not wish to allow exports of such products, even an AfCFTA in

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42 See ITC (2020).
43 See Article 9 of the Goods Protocol to the AfCFTA Agreement.
full operation would not have helped to save lives in other African countries without such production capacity.

It is thus recommended that the States Parties to the AfCFTA Agreement launch a process to review and amend the AfCFTA Agreement to ensure that, in times of emergency, AfCFTA parties would not impose restrictions on the export of life-saving medical and/or other supplies. The fact that even the EU legal system is struggling to ensure intra-Union trade in COVID-19 medical products today is indicative of the gravity of the challenge for Africa to make the AfCFTA fit for purpose in the event of such emergencies, but it is clear that the AfCFTA Agreement as it stands today is not an option.

There are views in some circles that the AfCFTA Agreement cannot be reviewed or amended before the Agreement celebrates its fifth anniversary of operation. This, it is submitted, is a misreading of the relevant provisions of the AfCFTA Agreement. Article 28 of the AfCFTA Agreement contains a mandatory built-in agenda to review the Agreement every five years after its entry into force, making 2024 the first opportunity for this review to take place. However, it is notable that Article 28 only prescribes mandatory review; it does not preclude other reviews that States Parties to the AfCFTA may deem necessary at any other time. Indeed, Article 29 on amendment establishes an autonomous process through which the AfCFTA Agreement can be amended. Under Article 29(1), the right to propose an amendment process is available to each State Party to the Agreement. If such a proposed amendment is successful, it will be adopted by the AU Assembly and enter into force under Article 23 of the same Agreement. As noted earlier, the COVID-19 pandemic has demonstrated that, even if the AfCFTA Agreement were in force, Africa would still remain vulnerable to damaging protectionist measures affecting intra-African trade that would be within the permissible limits of the Agreement. That is why the fact that COVID-19 happened just before the AfCFTA Agreement was to enter operational phase must be taken as a window of opportunity to revisit the rules of the game and craft additional provisions to cater for such contingencies.

6 Conclusion

In a world economic model where Africa exports predominantly raw materials and imports mainly finished products, including in this particular case much of the Covid-19 medical supplies, the crisis seems to leave Africa facing a double whammy:

(1) the economic lockdown in much of the world has sent the price of commodities of export interest to Africa, including oil and hard minerals, to record lows, thereby causing significant and dramatic declines in much-needed foreign exchange revenues for most resource-dependent African countries; and

(2) when advanced countries with production and supply capacity impose restrictions on the export of essential medical supplies, the inevitable outcome is a
sudden drop in supplies, a jump in prices, and an equally dramatic escalation in import bills for African countries at a time when their already meagre resources are overstretched.\textsuperscript{44}

Even if African countries were able to find resources from somewhere—loans, grants, local fund-raising initiatives, cancellation of other priorities, and the like—their ability to procure a sufficient supply of essential drugs and equipment to save lives is being stymied because the products are in short supply on the market in the first place. As John Nkengasong, director of the Africa Centres for Disease Control and Prevention, recently noted, “African countries have funds to pay for reagents but cannot buy them” because the market for such products has dried up; “instead of global solidarity, global protectionism has prevailed”.\textsuperscript{45} Powerful nations such as members of the European Union procure these essential medical supplies collectively, further diminishing Africa’s ability to compete and purchase these products on the open market. As a result of this combination of factors, African governments whose foreign exchange reserves are fast-depleting due to falling commodity prices have to compete globally to purchase life-saving COVID-19 essential products whose supplies are low and declining and whose prices are high and rising. As the Financial Times reported recently, “African countries have often found their orders for vital medical equipment denied because they tend to be smaller — in the hundreds of thousands of pieces versus millions from western countries. Many countries have also placed restrictions on manufacturers’ ability to export.”\textsuperscript{46} Considering the structural nature of the challenge, there is little that can be done in the short term. The current efforts to establish a system of pooled procurement in which African countries would pool their requirements together and use a centralised purchasing entity, such as Africa CDC, to place their purchase orders in bulk is the only meaningful step being attempted today. Consequently, much of Africa is once again forced to rely significantly on the charity of others. The questions African policymakers are facing include: for how long and at what cost in terms of human lives, and what is the way out?

First comes the industrialisation imperative. A cardinal lesson COVID-19 has taught the developed world is about the unreliability of the economics of offshoring and outsourcing, whose otherwise efficient production and supply chains ceased to function as soon as the pandemic struck. As a result, and despite the fact that offshoring has, under normal circumstances, enhanced global production efficiency and led to cheap products on the market without compromising on quality, a number of developed countries are seriously considering policies of reshoring manufacturing operations, thereby potentially trading a degree of economic efficiency for supply security. This marks a significant turn in policy thinking spurred by the COVID-19 crisis. If such policy prescriptions are valid for the developed world, they are even

\textsuperscript{44}For initial reflections on these issues, see ATPC (2000).
\textsuperscript{45}See Nkengasong (2020).
\textsuperscript{46}See Munshi (2020).
more so for African countries. The economic case for industrialisation in Africa has been compelling for too long; COVID-19 now makes it a matter of survival for the Continent and its citizens. The COVID-19 crisis is a wake-up call for the continent; Africa must now put industrialisation at the core of its development strategy.

Second, and related to the industrialisation imperative, is the need for an infrastructure of knowledge made up of skilled manpower to maintain a degree of research and development capacity. Africa can succeed in its industrialisation drive only if it is underpinned by robust research and development strategy and knowledge base. It is COVID-19 today; tomorrow it will be another pandemic-driven or natural disaster that makes certain products a matter of life and death. Medical supplies, PPEs and professional skills in high demand today to fight COVID-19 might not necessarily be of use tomorrow when another pandemic or other emergency strikes. In such circumstances, a society can only rely on its human and institutional infrastructure to carry out research to understand and explain new hazards, develop coping mechanisms, and design and manufacture necessary equipment and supplies. To this extent, R&D capacity, therefore, becomes an essential complement to a policy of industrialisation.

Third, not only does industrialisation take time, even an industrialised Africa cannot aim to become self-sufficient in medical supplies or indeed other essential products; trade with the rest of the world will remain a critical part of the search for supply security in all sectors and for all countries. As such, Africa needs to continue to advocate for effective multilateralism in trade that ensures the rules of the game are tightened and interpreted and applied by its members in good faith, in the collective interest, and with a sense of solidarity.

Fourth, and learning from the deficiencies of the global trading system exposed by COVID-19, Africa needs to explore legal and policy tools that would enable the AfCFTA Agreement to guarantee the freest possible flow of trade in essential products at times of difficulty such as this. From this perspective, Africa should keep the momentum triggered by COVID-19 to introduce new rules into the AfCFTA framework intended to remedy the deficiencies identified earlier.

Finally, the COVID-19 crisis has demonstrated that international law is inadequate as a basis for international cooperation in times of emergency. It is difficult to imagine a scenario where government officials would sit around a table and agree to a binding treaty obligation that limits their sovereign prerogative, and indeed obligation, to prioritise the lives of their citizens over those of others in times of emergency. To that extent, in times of emergency, the use of export restrictions may be impossible to discipline by law. The challenge for diplomats and trade negotiators is to find a point of equilibrium between the current state of international law where governments are free to impose export restrictions almost at will under certain

47 Former WTO Director-General Pascal Lamy recently argued, for example that the WTO might benefit from the export-side equivalent of the “Agreement on Safeguards”, saying “the WTO should have a similar agreement allowing countries to take emergency measures in exporting, but the key is how to define and contain these exceptions to prevent abuse.” See Tianyu (2020).
circumstances, on the one hand, and that imaginary world where states will be under a strict legal obligation to share essential supplies with their neighbours, on the other. A good place to start is to ensure that, whenever governments have to impose such restrictions, they do so in a manner that is “targeted, proportionate, transparent, and temporary” as the G20 recently observed. 48

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