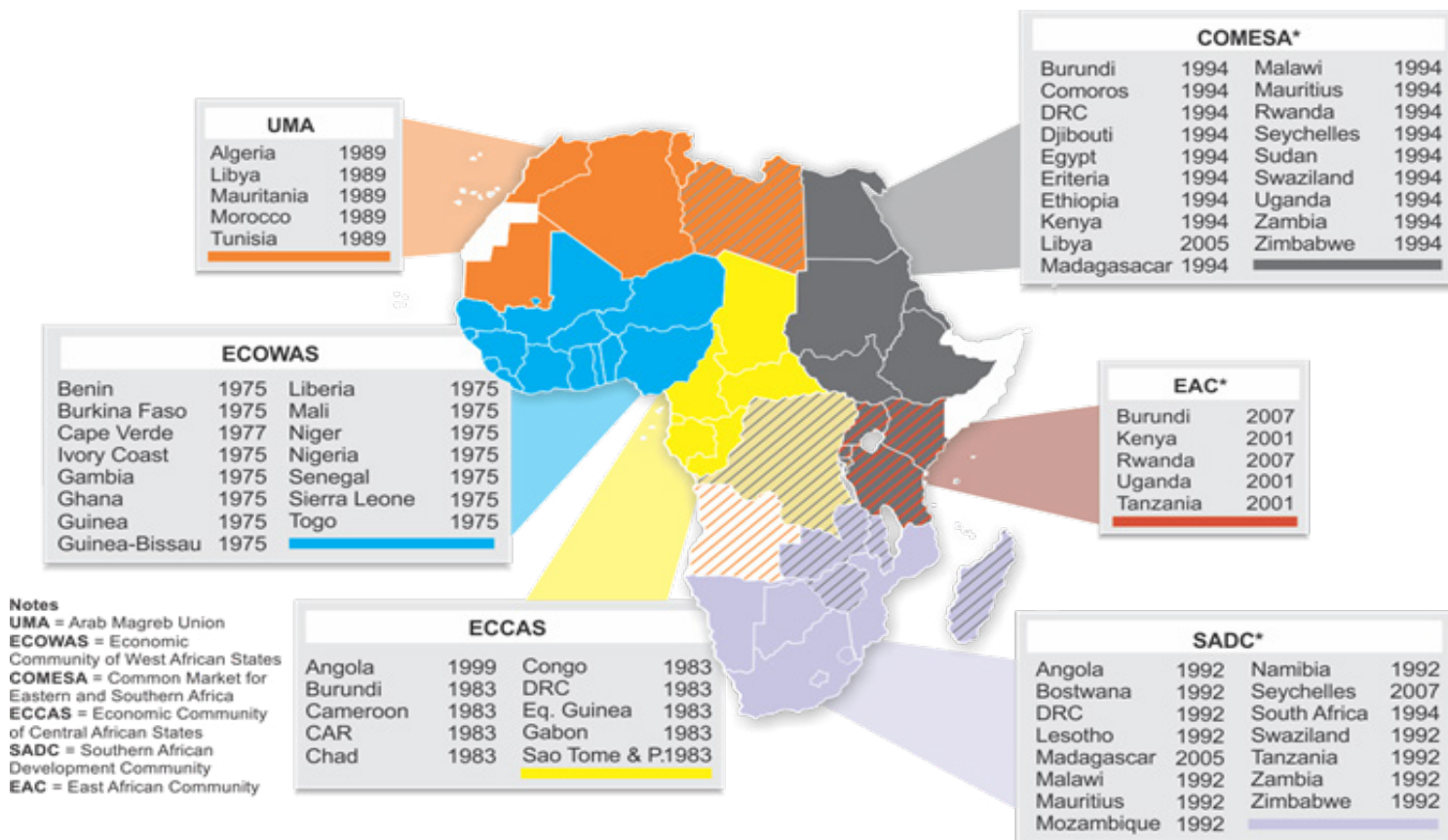




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## AFRICAN STRATEGIES FOR HEALTH



# REGIONAL ECONOMIC COMMUNITIES

Results from a Landscape Analysis of Regional Health Sector Actors in Africa: Comparative Advantages, Challenges, and Opportunities

November 2014

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**African Strategies for Health (ASH)** is a five-year project funded by the United States Agency for International Development (USAID) and implemented by Management Sciences for Health (MSH). ASH improves the health status of populations across Africa through identifying and advocating for best practices, enhancing technical capacity, and engaging African regional institutions to address health issues in a sustainable manner. ASH provides information on trends and developments on the continent to USAID and other development partners to enhance decision-making regarding investments in health.

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# **REGIONAL ECONOMIC COMMUNITIES**

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## ACRONYMS

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AEC	African Economic Community
AFD	French Development Agency
AfDB	African Development Bank
AMRH	African Medicines Regulatory Harmonization
ALMA	African Leaders Malaria Alliance
AMA	Africa Medical Association
AMRH	African Medicines Regulatory Harmonization
APRM	African Peer Review Mechanism (APRM)
ARC	African Health Profession Regulatory Collaborative for Nurses and Midwives
ASH	African Strategies for Health
ASHGOVNET	African Health Systems Governance Network
AU	African Union
BRICS	Brazil, Russia, India, China, and South Africa
CANTAM	Central African Network on Tuberculosis, HIV/AIDS, and Malaria
CARICOM	Caribbean Community and Common Market
CEMAC	Economic and Monetary Community of Central Africa
CEN-SAD	Community of Sahel-Saharan States
CEPGL	Economic Community of the Great Lakes Countries
CIDA	Canadian International Development Agency
COMESA	Common Market for Eastern and Southern Africa
CHAI	Clinton Health Access Initiative
CSO	civil society organization
DFID	Department for International Development
EAC	East African Community
ECCAS	Economic Community of Central African States
ECOWAS	Economic Community of West African States
ECSACON	East, Central, and Southern African College of Nursing
ECSA-HC	East, Central, and Southern African Health Community
GAFTA	Greater Arab Free Trade Area
GHD	global health diplomacy
GIZ	German Agency for International Cooperation (in German)
HHA	Harmonizing for Health in Africa
IDRC	International Development Research Centre

IGAD	Intergovernmental Authority on Development
IOC	Indian Ocean Commission
MCC	Millennium Challenge Corporation
MOH	Ministry of Health
MRU	Mano River Union
NGO	nongovernmental organization
NAFTA	North American Free Trade Agreement
NEPAD	New Partnership for Africa's Development
NORAD	Norwegian Agency for Development Cooperation
OAU	Organization of African Unity
PMPA	African Union's Pharmaceutical Manufacturing Plan for Africa
REC	regional economic community
SACU	Southern African Customs Union
SADC	Southern Africa Development Community
SADCC	Southern African Development Coordinating Conference
SCOT	strengths, challenges, opportunities, threats
TIDCA	Trade, Investment, and Development Cooperative Agreement
TIFA	Trade and Investment Framework Agreement
UEMOA	West African Economic and Monetary Union (in French)
UMA	Arab Maghreb Union
UNDP	United Nations Development Program
UNECA	UN Economic Commission for Africa
UNICEF	UN Children's Agency
USG	US Government
WAEMU	West African Economic and Monetary Union
WAHO	West African Health Organization
WHO	World Health Organisation
YPIP	Young Professional Internship Program

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## INTRODUCTION

Globally, there has been a growing trend towards increased regional multilateralism, integration, and cooperation in most sectors, including trade, transportation, infrastructure, tourism, water, agriculture, and peacekeeping. Some international affairs researchers have argued that the politics of austerity at home and pressing realities abroad necessitate a new form of foreign policy—one in which countries do not tackle issues alone, but in strategic alliances with other like-minded countries. The African continent has perhaps seen the most pronounced movement towards regionalism.

In Africa's health sector, regional bodies—such as regional economic communities and inter-governmental institutions, as well as regional professional associations and regional networks—have become active contributors to the development and health agendas during the last 10-15 years. Regional economic communities with health programs include the African Union (AU), the East African Community (EAC), the Southern African Development Community (SADC) and the West African Health Organization (WAHO) of the Economic Community of West African States (ECOWAS). Additionally, regional intergovernmental bodies such as the East, Central, and Southern African Health Community (ECSA-HC) and the African Development Bank play critical roles in the African health sector.

Regional bodies have established a range of relationships with governments and donor agencies and with each other, and have received assistance for the implementation of

specific health programs as well as for institutional capacity building. Most of the key African regional actors have well-defined political mandates, administrative structures, and technical capabilities; however, they also face complex challenges related to their mandates, organizational structure, coordination, and financial and human resources.

While Africa's health sector has not been excluded from the continually evolving paradigm of regionalism, there is a very sparse and limited body of literature examining the relationships, power dynamics, limitations, and strategic advantages of regional bodies. As funding for global health efforts becomes stagnated and as international donor agencies and their implementing partners have provided financial and technical support to regional bodies, understanding the role of regional actors in African becomes all the more critical.

The following paper discusses regionalization as a critical trend in Africa and presents findings and conclusions from a landscape analysis of key regional organizations in the African health sector. It contributes to a greater understanding of the relationships, power dynamics, limitations, and strategic advantages of regional bodies in Africa. The findings and conclusions presented in this paper are not intended to be exhaustive or prescriptive.



## METHODOLOGY

With funding from the United States Agency for International Development's (USAID) Bureau for Africa, the African Strategies for Health (ASH) project examined the trend towards regionalization in Africa as well as of key regional African health sector bodies. This study contributes to the similar but larger scale landscape analysis commissioned by Harmonizing for Health in Africa (HHA) with support from the Norwegian Agency for Development Cooperation (NORAD).<sup>1</sup> For the purpose of this landscape analysis, the study team defined regional African health sector organizations according to the following criteria:

- A group of individuals or of organized entities structured around a common purpose
- Involved in health-related activities in two or more African countries
- Headquartered in sub-Saharan Africa<sup>2</sup>

Data collection methods used for this study included stakeholder mapping, a review of key documents and literature (scientific and grey literature), and key informant interviews.

Stakeholder mapping sought to identify key regional bodies to be examined as part of the study. These regional bodies were divided in three categories: 1) regional economic communities and inter-governmental institutions composed of groupings of member states; 2) regional professional associations and regional networks, and; 3) regional technical institutions.

The review of literature was performed by researching information and publications on websites of key institutions and by entering phrases such as “health [and] regional integration [and] Africa”, “health [and] regional-economic-communities [and] Africa” in search engines that indexed the full text of scholarly literature to include Google Scholar, PubMed, Medline, and EBSCO.

The study team used convenience sampling to select key informants for interviews. Key informants included senior officials from regional organizations as well as other stakeholders with experience collaborating with regional organizations such as international donor agencies and nongovernmental organizations.

The desk review and key informant interviews sought to examine the following series of variables:

- **Contextual Factors** The contextual development of regional and subregional institutions and networks in Africa, including factors related to the development and devolution of regional institutions – political economy and global trends towards regionalization, globalization, integration, and cooperation.
- **Governance and Structure** Principles by which institutions are structured, governed, and staffed, including: 1) organizational structures, staff and funding levels, and decision-making processes and how these are carried forward to member states and collaborating organizations; 2) documenting mechanisms (legal and other) by means of which decisions at the regional level are implemented by its members.
- **Financial and Technical Support** Financial and technical partners which cooperate with and influence regional institutions and networks.
- **Membership and Convergence** Actual membership, ways to become a member, reasons for countries maintaining membership of multiple regional institutions and networks, and how this is effectively managed by member states.
- **Policies and Planning** Existence and substance of overarching policy and strategic planning documents to provide direction to regional or subregional initiatives, programs, and interventions.
- **Health Programming** Rationale for incorporation of health as a sector within regional intergovernmental institutions; the principles according to which health is incorporated (e.g. disease control, harmonization of health service provision, and equality of care) and the roles of these institutions in working with member states.
- **Common Approaches and Differences** Areas of divergence and areas of commonality such as harmonization of policies and the development of bulk procurement systems for drugs.
- **Collaboration** Relationships and collaboration between intergovernmental institutions and other regional networks, associations, and institutions.

Qualitative and quantitative data collected was compiled in a database. The study team identified and categorized information from the literature review by the variables listed above. Data from key informant interviews were triangulated with information gathered through the literature review, and data analysis was performed using Strengths, Challenges, Opportunities, Threats (SCOT), social networking, and landscape analysis techniques.

<sup>1</sup> While ASH's landscape analysis focuses solely on key regional actors, the HHA exercise seeks to include key actors at the regional, national, and sub-national levels.

<sup>2</sup> For the purpose of this study, international organizations with regional offices in Africa were not considered regional African organizations



## Study Limitations

Several limitations should be acknowledged:

- Although data is cross-verified with websites and information from neutral other key stakeholders, the sensitive nature of information requested made some respondents uneasy about sharing data.
- Website data may be outdated.
- Some organizations were very responsive and willing to share information, while others were either unavailable, unresponsive, and/or had very limited information available.
- Interviewing one key informant per organization provides the perspective of only one person, which may be limited and/or biased.

**Table 1: Study Methods and Information Sources**

Methods	Information Sources
<b>Desk Review</b>	<p><b>137</b> documents were reviewed, including academic journal articles, technical reports, budgets, policy papers, strategy documents, press releases, and presentations.</p> <p><b>101</b> regional organizations with health programs identified, including:</p> <ul style="list-style-type: none"> <li>■ 11 regional economic communities</li> <li>■ 65 regional associations and networks</li> <li>■ 2 regional intergovernmental organizations</li> <li>■ 24 regional technical organizations</li> </ul>
<b>Key Informant Interviews</b>	<p><b>51</b> key informants were interviewed in person and via telephone in Africa, Europe, and the US.</p> <ul style="list-style-type: none"> <li>■ 38 interviews with key regional organizations</li> <li>■ 13 interviews with other key informants (e.g. int'l donors and NGOs) who have worked extensively with regional African organizations and with a REC from another region: the Caribbean Community (CARICOM)</li> </ul>
<b>Analysis</b>	Data triangulation, SCOT analysis, and quantitative analysis of financial data.

## FINDINGS

While the landscape analysis focused on regional associations and networks, regional technical organizations, Regional Economic Communities (RECs), and regional intergovernmental organizations, this paper focuses on the latter two types of regional organizations (i.e. regional bodies that are composed of member states). An analysis of regional networks and associations is presented in a separate report by ASH, and is available at [www.africanstrategies4health.org/resources](http://www.africanstrategies4health.org/resources).

The Findings section of this paper begins with a discussion on the concept of regionalization—focusing mainly on the African continent. The second part of this section presents an analysis of the comparative advantage of the RECs, as well as their challenges and opportunities in the health sector in Africa.

### Discussion on Regionalization

To shed light on the regional organizations as entities, findings from the desk review and interviews provided insight into the concept of regionalization. There is an extensive amount of published articles on regional integration in the academic literature. The amount of policy and strategy papers on this topic also abounds. In reviewing selected documents, the study team sought to answer the following critical questions:

1. What is regionalization? How is it defined?
2. Is regionalization a trend in Africa?
3. How can regional integration contribute to improving health outcomes?

### What is Regionalization?

An international region can be broadly defined as “a limited number of states linked by a geographical relationship and by a degree of mutual interdependence”.<sup>3</sup> Numerous definitions can be associated with the term regionalization. It is most commonly defined as the tendency to form decentralized regions and can more distinctly refer to “the growth of societal integration within a given region, including the undirected processes of social and economic interaction among the units (such as nations).” Regionalization and its derivative terms regionalism and regional integration cannot be defined in isolation but in the context of globalization and nationalism. Regional integration is the term endorsed by the African Union and most commonly in the literature. Regional integration can be defined as the process in which nations “enter into a regional agreement in order to enhance regional cooperation through regional structure and rules.”

Figure 1 presents some of the many definitions of the terms globalization, regional integration, regionalism, and nationalism.

Figure 1: Globalization, Regional Integration, Regionalism, and Nationalism

**Globalization:** “intensification of economic, political, social, and cultural relations across borders. *Globalization* is pushed by several factors, the most important among which is technological change.”

**Regional integration:** “process in which countries enter into a regional agreement in order to enhance regional cooperation through regional structure and rules.”

**Regional integration:** “phenomenon of territorial systems that increase the interactions between their components and create new forms of organization, co-existing with traditional forms of state-led organization at the national level.”

**Regionalism:** “proneness of the governments and peoples of two or more states to establish voluntary associations and to pool together resources (material and nonmaterial) in order to create common functional and institutional arrangements.”

**Regionalism:** “process occurring in a given geographical region by which different types of actors (states, regional institutions, societal organizations and other nonstate actors) come to share certain fundamental values and norms. These actors also participate in a growing network of economic, cultural, scientific, diplomatic, political, and military interactions.”

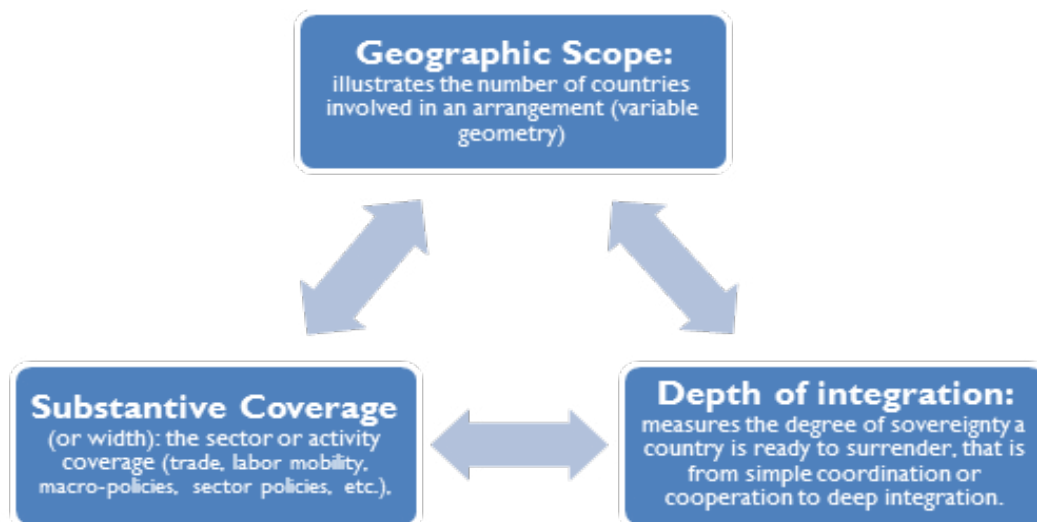
**Nationalism:** “an immediate derivative of the concept of nation. It refers to the feelings of attachment to one another that members of a nation have and to a sense of pride that a nation (or better, a nation-state) has in itself.”

Source: Adapted from an excerpt of Kacowicz, 1999<sup>4</sup>

3 Lombaerde, Philippe de, et al. “The problem of comparison in comparative regionalism.” *Review of International Studies* 36.03 (2010): 731-753.

4 Kacowicz, Arie M. “Regionalization, globalization, and nationalism: Convergent, divergent, or overlapping?” *Alternatives* (1999): 527-555.

Figure 2: The Three Dimensions of Regional Integration

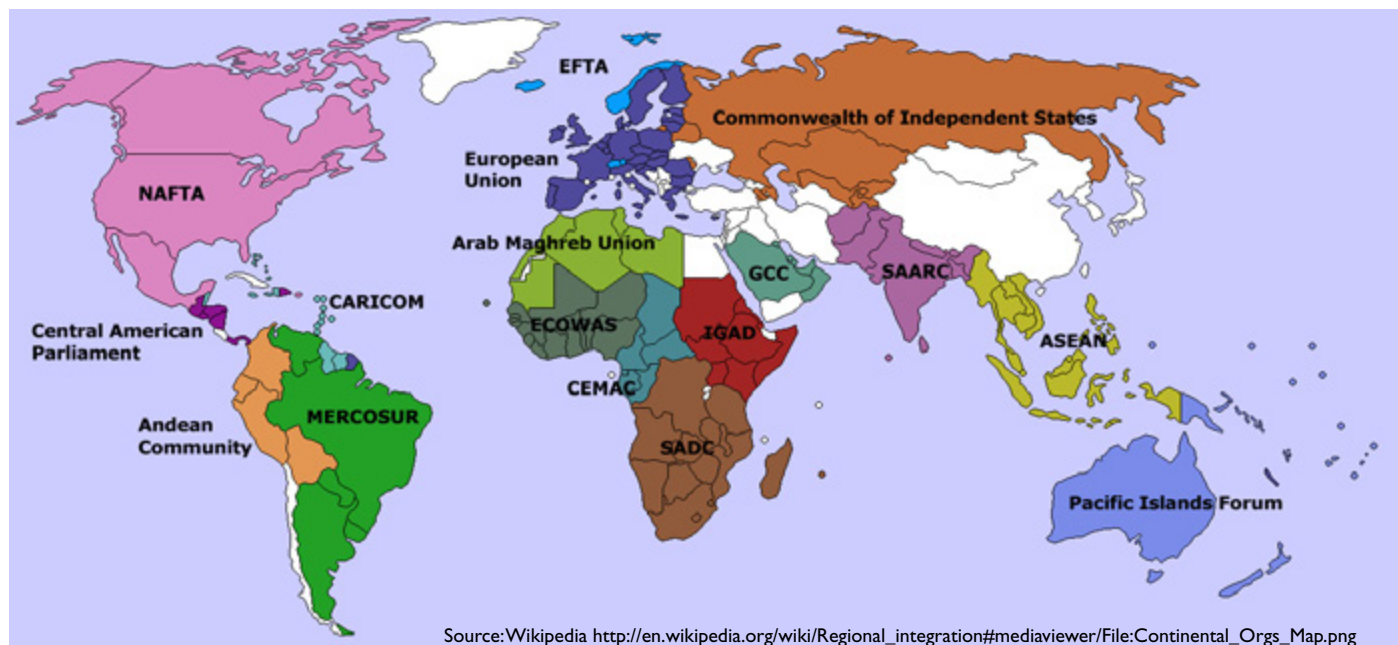


In the 2005 paper *Regional Integration: Concepts, Advantages, Disadvantages and Lessons of Experience*,<sup>5</sup> a World Bank senior economist describes regional integration as a three-dimensional process (Figure 2). The first dimension, geographic scope, refers to the nation states involved in the regional agreement. The second dimension, substantive coverage, relates to the activities and sectors (e.g. trade, health, security, labor mobility, macro-policies, sector policies, etc.) that are being integrated. The last dimension, depth of integration, “measures the degree of sovereignty a country is ready to surrender”.

### Global Trend and Rationale for Regional Integration

Within the context of globalization, regional integration is a global phenomenon taking place in various forms and shapes over all continents—with varying degrees of regional cohesion. There more now than 62 regional arrangements (RECs and others) exist globally. Two of most widely known regional integration agreements include the North American Free Trade Agreement (NAFTA) and the European Union. Most experts agree that “The European Union is the most formal and mature integration of states, with significant

Figure 3: Global Map of Regional Economic Communities



<sup>5</sup> Kritzing-van Niekerk, Lolette. “Regional Integration Concepts, Advantages, Disadvantages, and Lessons of Experience.” World Bank, Washington, DC. <http://siteresources.worldbank.org/EXTAFRREGINICOO/Resources/KritzingervanNiekerk.pdf> (2005)

## Expanding the Knowledge Base to Better Understand Regional Integration

Regional integration is such a prominent geopolitical trend that the United Nations is investing in mechanisms to research, track, and build capacity in this field:

- United Nations publishes, since 2006, the World Report on Regional Integration, and has established regionalization focus commissions, including the UN Economic Commission for Africa (UNECA) based in Ethiopia.
- United Nations University has, in 2001, created an Institute on Comparative Regional Integration Studies (UNU - CRIS). As a research and training institute specializing in studying the processes and consequences of regional integration and cooperation, UNU-CRIS offers short-term training programs and a Master of Science in Public Policy and Human Development and about the specialization in “Regional Integration and Multi-Level Governance”.
- UNU-CRIS hosts the Regional Integration Knowledge System—the most comprehensive database for qualitative and quantitative data relevant for the study of regional integration.

institutional capacity at a regional level. Other regions will be more informally arranged, with sheer power dynamics driving cohesion; in this regard, the Caucasus and broader Middle East regions come to mind. In some cases, unity will be more symbiotic with voluntary participation -- in other cases, a coercive local hegemony may impose integration on neighbors that do not have the capacity to hedge their bets against it.”<sup>6</sup>

According to the World Economic Forum's Global Agenda Council on Geopolitical Risk: “The dearth of truly effective global institutions [such as the G-20, World Bank, IMF, and U.N.] is part of a larger geopolitical trend, one in which the global agenda is increasingly influenced as much on a regional level as on a global one. To provide some leadership that extends beyond the national stage, there is a growing reliance on regionalism to stopgap this shortage of effective global decision-making.”<sup>7</sup>

Shortly after the 2012 World Economic Forum, Bremmer and Clemons argued the following: “This rise of regionalism, at its core, arises from an accepted truth: nations are selfish. They act in their own interests. But they also acknowledge that the unbridled pursuit of those interests produces sub-optimal results, and coordinated policies can help drive national agendas forward. In order to provide leadership that extends beyond the national stage. . . . Countries are already coming together in new ways on a regional level, filling the void left by global institutions with smaller-scale governance within limited spheres of influence. We will see new institutions, organized geographically that promote

and reflect regional interests, and new trends exposing the ascendancy of neighborhoods in a G-Zero world.”<sup>8</sup> While proponents of regional integration are many, some experts point to the E.U. as a reason why countries should not enter regional agreements. Given its very deep level of integration, the critical dynamic at stake in the E.U. seems to be the tension between national sovereignty and regional interest. In the midst of the Euro crisis, E.U. member countries are “divided into two classes—creditors and debtors—with the creditors in charge. . . . [and] debtor countries pay substantial risk premiums for financing their government debt.” As a result, pushed the “debtor countries into depression and put them at a substantial competitive disadvantage that threatens to become permanent.”<sup>9</sup> Although no member state has ever withdrawn from the E.U. (after 20 years of existence), the United Kingdom is now on the verge of a national referendum on E.U. withdrawal and political parties from Portugal, France, Greece, Finland, Italy, and The Netherlands are advocating for similar departure from the E.U.

### Regionalization in Africa

In Africa, regional integration efforts have a long history—dating back to the early 1900s (see Figure 4). In fact, although it is not one of the recognized building blocks of the African Economic Community, the world's oldest functioning regional integration agreement is the Southern African Customs Union, which was established in 1910. Adopted almost three decades ago, the Lagos Plan of Action and the Final Act of Lagos was the “first major blueprint” outlining a “vision of an integrated African market by the year 2000. It was given further impetus by the Abuja Treaty, which was approved in

6 Ian Bremmer and Steve Clemons (January 24, 2012). Davos 2012: The Rise of Regions in a G-Zero World. *The Atlantic*. Retrieved from: <http://www.theatlantic.com/international/archive/2012/01/davos-2012-the-rise-of-regions-in-a-g-zero-world/251912/>

7 World Economic Forum. Global Institutions Ineffective Amid Rise Regionalism. Davos-Klosters, (2012) Retrieved from: <http://www.weforum.org/content/global-institutions-ineffective-amid-rise-regionalism>

8 Ian Bremmer and Steve Clemons, “Davos 2012: The Rise of Regions in a G-Zero World,” *The Atlantic*, January 2012.

9 George Soros. *The New York Review of Books*. The Tragedy of the European Union and How to Resolve It (2014). Retrieved from: <http://www.nybooks.com/articles/archives/2012/sep/27/tragedy-european-union-and-how-resolve-it/>

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## Africa's unique population and geographical characteristics make regional integration more urgent on this continent than any other. These countries face colossal challenges in accessing regional and global markets.

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1991 and came into force in 1994. According to this Treaty, the African Economic Community (AEC) would be in place by 2028<sup>10</sup> through a gradual process over 34 years (i.e. by 2028). Milestones from the Abuja Treaty include: "creation of new regional economic communities in regions without one and strengthening of existing ones (between 1994 and 1999); stabilization of existing tariffs, and integration and harmonization of economic sectors (1999 to 2007); establishment of a free trade area and customs union (2007 to 2017); harmonization of tariff systems across various regional economic communities (RECs) (2017 to 2019); the creation of a common African market and harmonization of monetary, financial, and fiscal policies; and the establishment of a pan-African economic and monetary union (2023 to 2028)."<sup>10</sup> The plan adopted through the Abuja Treaty ultimately seeks to solve, through the RECs, deep-seated challenges of poverty and underdevelopment and creates a vision for the 'United States of Africa'.

With the ultimate goal being for the continent to operationalize the African Economic Community (AEC) by 2028, the push for regional integration in Africa is gaining increasing attention and financial support from key international donor institutions. This process is being led "by African for Africans". In response to the African-led push and strong commitment by African nations to regional integration, the World Bank has developed an overall Regional Integration Assistance Strategy, and the African Development Bank has developed distinct Regional Integration Strategies for West Africa, East Africa, and Southern Africa in order to guide their multi-million dollar investments in the regionalization process.

In 2013, prominent reports from both the World Bank and the World Economic Forum made the case for regional integration as the key to increasing Africa's competitiveness. Moreover, regional integration was the theme of the 2013 African Economic Conference organized by the AfDB and UNDP. At the country-level, more than a dozen of African nations have created ministries<sup>11</sup> of regional integration

and regional cooperation to handle regional affairs and interactions with their RECs. Most countries have designated points-of-contact, within each of their line ministries (including health), with the responsibility to liaise with their regional bloc.

### **Why is Africa Regionalizing?**

Africa's unique population and geographical characteristics make regional integration more urgent on this continent than any other. Africa is home to more countries with low population densities than other developing regions. Besides the one country (Nigeria) with a population of more than 100 million, 19 African countries have fewer than five million people. The combination of small population size and very low income levels across countries results in a continent with small domestic markets with low purchasing power. Africa contains more landlocked countries than any other continent. Fifteen African countries (representing approximately one-third of Africa's population) are landlocked. These countries face colossal challenges in accessing regional and global markets. Most African countries are far from major markets of Europe and the US, as well as from commonly used shipping routes to these markets.<sup>12</sup>

### **Mapping Regional Economic Communities**

In Africa, the RECs group together individual countries in sub-regions for the purposes of achieving greater economic integration. They are described as the 'building blocks' of the African Union (AU) and are also central to the strategy for implementing the New Partnership for Africa's Development (NEPAD).<sup>13</sup>

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10 Qobo, Mzukisi. The challenges of regional integration in Africa in the context of globalisation and the prospects for a United States of Africa. Institute for Security Studies (ISS). ISS Paper 145 (2011).

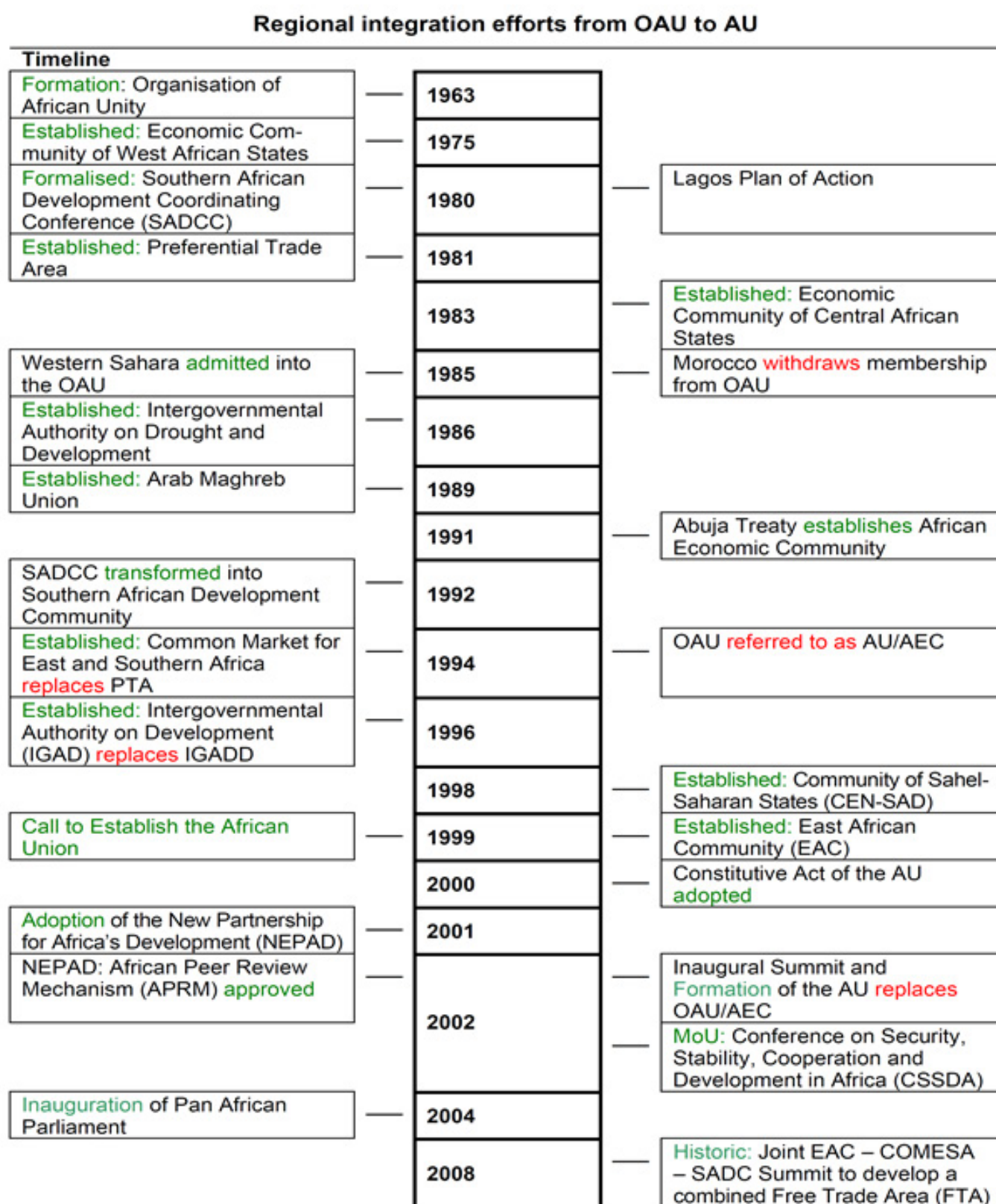
11 Member states of the East African Commission have created ministries of East African affairs.

12 Vinaye Ancharaz, Kennedy Mbekeani and Zuzana Brixiova. Impediments to Regional Trade Integration in Africa. Africa Economic Brief. Chief Economist Complex. African Development Bank. Volume 2, Issue 11. September 2011

13 In accordance with Article 88 of the Abuja Treaty, the foundation of the Treaty is that the African Economic Community must be established mainly through the coordination, harmonization and progressive integration of the activities of the RECs. To this end, member states are expected to promote the coordination and harmonization of the integration activities of the RECs of which they are members with the activities of the AEC, it being understood that the establishment of the latter is the final objective towards which the activities of existing and future RECs must be geared.



Figure 4: Timeline of Key Regional Integration Events in Africa<sup>14</sup>



<sup>14</sup> Masalila, Kealeboga. Overview of initiatives to promote convergence in the context of regional integration: an African perspective. Irving Fisher Committee on Central Bank Statistics. IFC Bulletin No 32, October 2005.

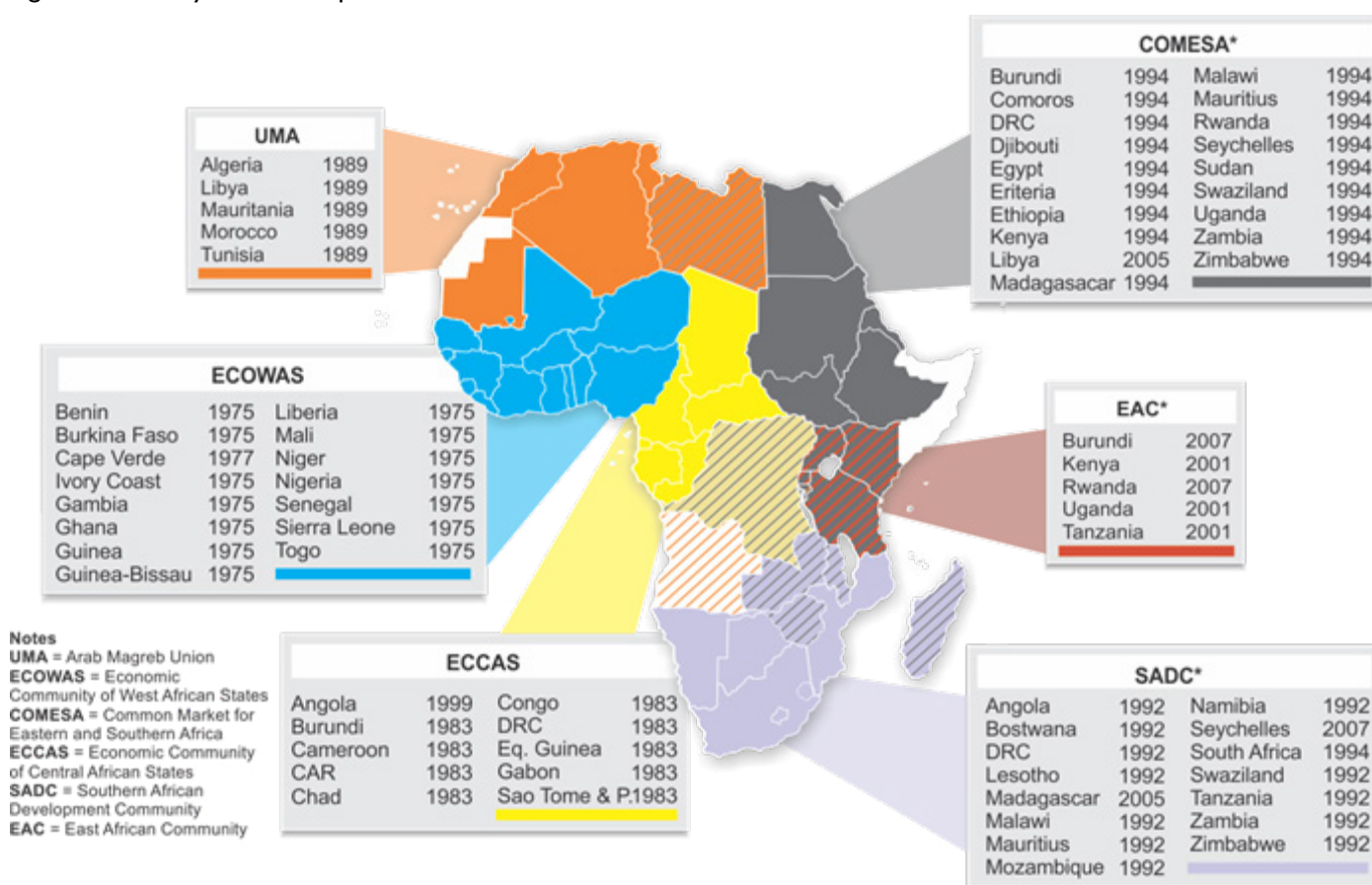
There are eight pillar RECs currently recognized by the African Union, each established under a separate regional treaty. Figure 5 presents country membership for six of the eight pillar RECs.

1. Arab Maghreb Union (UMA)
2. Common Market for Eastern and Southern Africa (COMESA)
3. Community of Sahel-Saharan States (CEN-SAD)
4. East African Community (EAC)
5. Economic Community of Central African States (ECCAS)
6. Economic Community of West African States (ECOWAS)
7. Intergovernmental Authority on Development (IGAD)
8. Southern Africa Development Community (SADC)

There are additional regional economic cooperation bodies not officially recognized by the African Union as RECs, including:

1. Economic and Monetary Community of Central Africa (CEMAC)
2. West African Economic and Monetary Union (UEMOA/WAEMU)
3. Economic Community of the Great Lakes Countries (CEPGL)
4. Indian Ocean Commission (IOC)
5. Mano River Union (MRU)
6. Southern African Customs Union (SACU)

Figure 5: Country Membership for Six Pillar RECs





As shown in Table 2, RECs have varying levels of economic development, population, geographical coverage. COMESA

spreads across central, southern and eastern Africa and has the highest population size.

**Table 2: Pillar African RECs and Other African Blocs**

<b>African Economic Community</b>					
<b>Pillars regional blocs (REC)</b>	<b>Member states</b>	<b>Area (km<sup>2</sup>)</b>	<b>Population</b>	<b>GDP (PPP) (\$US)</b>	
				<b>in millions</b>	<b>per capita</b>
<a href="#">AUC</a> – Africa-wide	53	29,910,442	997,875,000	2,233,830	2,878
<a href="#">ECOWAS</a> – West Africa	15	5,112,903	301,477,000	675,048	1,151
<a href="#">ECCAS</a> – Central Africa	10	6,667,421	134,210,000	248,614	4,601
<a href="#">SADC</a> – Southern Africa	15	9,882,959	273,192,000	647,790	3,833
<a href="#">EAC</a> – East Africa	5	1,817,945	139,939,000	108,979	632
<a href="#">COMESA</a> – East and Southern Africa	20	12,873,957	446,123,000	653,269	2,729
<a href="#">IGAD</a> – North Eastern Africa	8	5,233,604	223,795,000	197,698	1,036
<b>Other African blocs</b>	<b>Member states</b>	<b>Area (km<sup>2</sup>)</b>	<b>Population</b>	<b>GDP (PPP) (\$US)</b>	
				<b>in millions</b>	<b>per capita</b>
<a href="#">CEMAC</a>	6	3,020,142	43,059,000	93,252	6,335
<a href="#">SACU</a>	5	2,693,418	58,802,000	384,019	4,701
<a href="#">UEMOA</a>	8	3,505,375	94,751,000	89,440	793
<a href="#">UMA</a>	5	5,782,140	58,576,000	348,869	6,427
<a href="#">GAFTA</a>	6	5,876,960	199,106,000	775,663	5,006

## Role of Regional Economic Communities

Established by a treaty ratified by the member states within a sub-region, a REC is the institution responsible for the planning, coordination, and monitoring of the integration or regionalization process. Their individual mandates aim at widening and deepening regional cooperation and integration among their member states and with other regional economic communities in political, economic and social areas for their mutual benefit. As building blocks of the African Union, and the sub-regional bodies responsible for the implementation of New Partnership for Africa's Development (NEPAD)<sup>15</sup> programs and projects. Each REC organizes high-level annual meetings or summits of Heads of States and other meetings of the council of ministers (including annual meetings of ministers of health). The organizational structure<sup>16</sup> of RECs typically resembles that of a national government

and includes directorates, departments, committees and secretariats staffed with focusing on the following targeted areas:

- Peace and Security (Conflict Prevention, Management and Resolution, and Combating Terrorism)
- Political Affairs (Human Rights, Democracy, Good Governance, Electoral Institutions, Civil Society Organizations, Humanitarian Affairs, Refugees and Internally Displaced Persons)
- Infrastructure and Energy (Energy, Transport, Communications, Infrastructure and Tourism)
- Social Affairs (Health, Education, Children, Drug Control, Population, Migration, Labor and Employment, Sports and Culture)
- Human Resources, Science and Technology (Education, Information Communication Technology, Youth, Human Resources, Science and Technology)
- Trade and Industry (Trade, Industry, Customs and Immigration Matters)
- Rural Economy and Agriculture (Rural Economy, Agriculture and Food Security, Livestock, Environment, Water and Natural Resources and Desertification)
- Economic Affairs (Economic Integration, Monetary Affairs, Private Sector Development, Investment and Resource Mobilization)

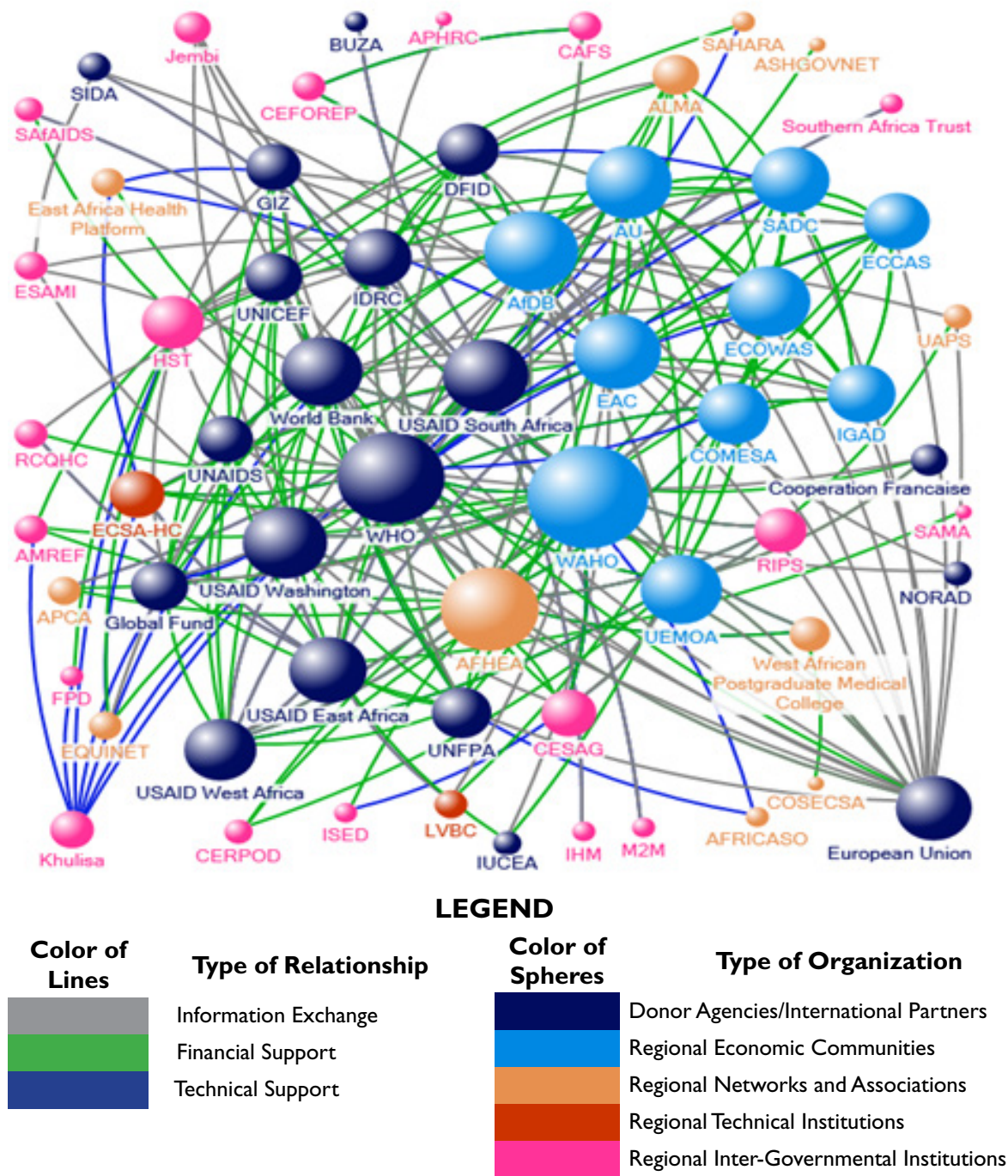
<sup>15</sup> New Partnership for Africa's Development (NEPAD), an African Union strategic framework for pan-African socio-economic development, is both a vision and a policy framework for Africa in the twenty-first century. NEPAD is a radically new intervention, spearheaded by African leaders, to address critical challenges facing the continent: poverty, development and Africa's marginalization internationally. NEPAD areas of focus are: 1) Agriculture and Food Security; 2) Climate Change and Natural Resource Management; 3) Regional Integration and Infrastructure; 4) Human Development; 5) Economic and Corporate Governance, and; 6) Cross-cutting Issues, including Gender, Capacity Development and ICT.

<sup>16</sup> For example, the organizational structures for SADC and EAC are publicly available online at:  
EAC - [http://www.eac.int/index.php?option=com\\_docman&task=doc\\_view&gid=4&Itemid=163](http://www.eac.int/index.php?option=com_docman&task=doc_view&gid=4&Itemid=163)  
SADC - <http://www.sadc.net/editorial/sadctoday/documents/center.pdf>

Despite the formally recognized role of RECs and their importance in achieving the global goals of the AU, the capacity of each REC to achieve its mandate largely depends

on the level of resources and political commitment from its member states.

Figure 6: Relationships Between Regional Organizations in Africa



### Collaboration between Regional Economic Communities and Other Partners

Regional blocs collaborate with a number of other regional organizations and international donors. Regional-level collaboration typically consists of technical assistance, financial

assistance, and/or information exchange. Figure 6 presents results from a social network analysis of data collected as part of this study.

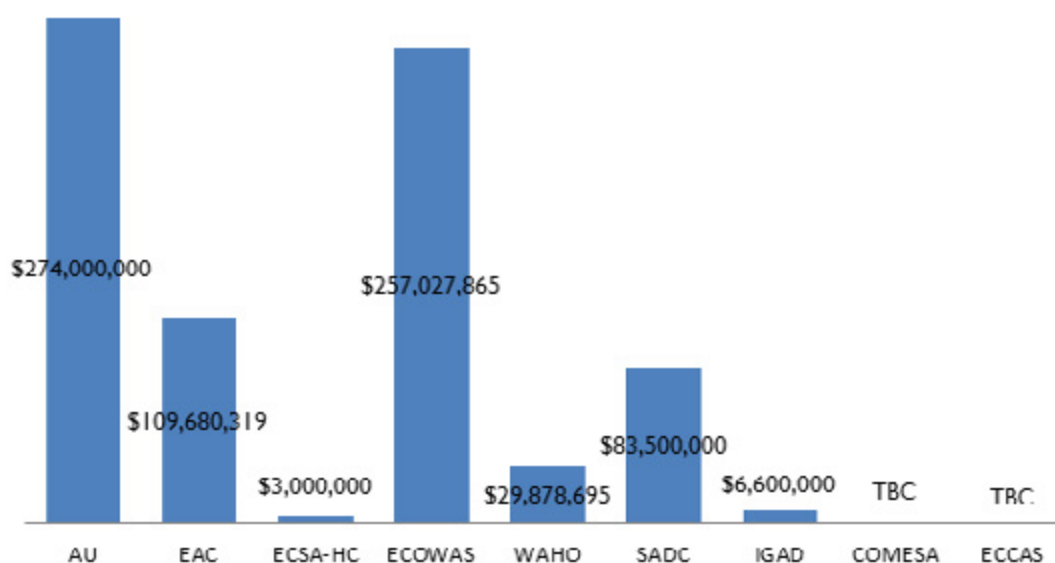
## Financial Sustainability of Regional Economic Communities

Sub-regional RECs are financed mainly through annual assessments provided by their member states. In addition to these annual contributions from African governments, the RECs receive institutional grants from bilateral and multilateral donors, such as the World Bank, the African Development Bank, the European Union, the Global Fund, the UK Department for International Development (DFID), German bank KfW, GIZ, the Canadian International Development Agency, the French Development Agency (AFD), AusAID,

Canadian International Development Research Center (IDRC), as well as private foundations, including the Bill and Melinda Gates Foundation and Rockefeller Foundation. The World Bank and the African Development Bank are the two largest external sources of financial contributions for the RECs. According to data available the institutions' website, the World Bank's [active regional integration projects](#) in Africa total \$6 billion USD.

The graph below shows 2012 funding levels for five of the RECs, as well as for WAHO, the health secretariat of ECOWAS, and for regional intergovernmental organization ECSA-HC.

Figure 7: 2012 Budget Levels of African Economic Communities



## U.S. Foreign Policy and Regionalization in Africa

The U.S. Government has supported the regional integration process in Africa with different mechanisms and in various sub-regions for at least three decades. For example, USAID support to SADC dates as far back as the 1980s. In his testimony to the Senate Foreign Relations Committee Subcommittee, former USAID Assistant Administrator for Africa Lloyd O. Pierson commented that:

"Each of these regional (economic communities) has assumed a critical coordination and technical role to advance economic development and trade, improve conditions conducive to democracy and good governance, and to bring about an end to violent conflict and to secure peace in Africa. By supporting activities to increase institutional effectiveness and improve the enabling environment in which they operate, USAID support enables these regional partners to fulfill the missions that their members have laid out for them."

Administrator Pierson concluded that:

"As the largest bilateral donor in sub-Saharan Africa, we must actively collaborate with our African counterparts in order to achieve our common goal of a better quality of life for all Africans. Regional organizations are key development actors in the countries they serve. Their successes contribute to overall levels of peace and security, and economic development. As they strengthen their institutional and technical capacity, their potential impact will only increase. By supporting discrete regional activities and by helping to strengthen these regional organizations through training and well-targeted technical assistance, USAID will continue to play a leadership role in this process."<sup>17</sup>

<sup>17</sup> Lloyd O. Pierson, USAID Assistant Administrator for Africa. "African Organizations and Institutions: Positive Cross-Continental Progress". Written Testimony to the Senate Foreign Relations Committee Subcommittee On African Affairs. November 17, 2005. Accessed at: <http://iipdigital.usembassy.gov/st/english/texttrans/2005/11/20051117171838wcyeroc0.8282129.html#ixzz39b51ixOA>

**Table 3: Trade Agreements Signed Between the U.S. and African Regional Blocs**

Regional Body	Year	Agreement Type
East African Community (EAC)	2008	Trade and Investment Framework Agreement (TIFA)
Southern African Customs Union (SACU)	2008	Trade, Investment, and Development Cooperative Agreement (TIDCA)
Common Market for Eastern and Southern Africa (COMESA)	2001	Trade and Investment Framework Agreement (TIFA)
West African Economic and Monetary Union (UEMOA)	2002	Trade and Investment Framework Agreement (TIFA)

Other US Government agencies have worked closely with RECs in Africa, including the Department of State, which continues to post U.S. Ambassadors to the AU, ECOWAS, EAC, and ECCAS, and the U.S. Department of Defense has seconded staff to ECOWAS and the AU. Together with the World Bank and WHO/AFRO, the U.S. Centers for Disease Control and Prevention has supported the EAC to establish the East African Public Health Laboratory Networking Project. In light of President Obama's Power Africa initiative for broadening access to electricity, the Millennium Challenge Corporation (MCC)'s "programmatic efforts to coordinate cross-border initiatives (in infrastructure and transportation) will provide the bridge between MCC's country-focused design and the trans-boundary problems countries face".<sup>18,19</sup> The Executive Office of the President's Office of the US Trade Representative (USTR) has signed regional trade agreements with four of the RECs to provide strategic frameworks and principles for dialogue on trade and investment issues (such as reducing trade barriers, improving the business environment, encouraging open investment regimes, and enhancing two-way trade) between the United States and the other parties to the trade agreements.

The White House's most recent U.S. Strategy for Sub-Saharan Africa (2012) prioritizes:

"Promoting Regional Integration. Increased African regional integration would create larger markets, improve economies of scale, and reduce transaction costs for local, regional, and global trade. We will work with regional economic communities... to reduce the barriers to trade and investment flows across the continent. In particular, we will promote... standards harmonization; support regulatory coherence and transparency; improve infrastructure that

strengthens regional trade and access to global markets; and explore ways to remove impediments to efficient operation of supply chains in the region."

"An increasing number of African governments and regional organizations are taking a lead role in addressing the security and political challenges within their borders and beyond and are increasingly influential players in international fora."<sup>20</sup>

A 2014 report from the Center for Global Development recommends "increasing USAID support for regional bodies that are supporting integration and harmonized policies" as a way of supporting trade-based growth in Africa. The report says:

US assistance for regional economic community (REC) secretariats has been modest, despite their central role in facilitating regional integration. RECs play an important facilitative role for harmonizing policies and regulations, reducing non-tariff barriers, liberalizing trade, and developing transport corridors. The effectiveness of the individual African RECs has varied over time, however, largely due to differences in member governments' political will and capacity. While USAID support for the EAC has been more robust, it has provided only token assistance to other RECs. For example, US support for SADC and COMESA has totaled only \$32 million since 2000 – or roughly \$1.3 million per year for each respective REC secretariat.<sup>21</sup>

18 Michael Igwe. MCC's board seeks open data, borders. DEVEX. September 2013. Web access: <https://www.devex.com/en/news/mcc-s-board-seeks-open-data-borders/81800>

19 Sarah Rose. Regional and Sub-National Compact Considerations for the Millennium Challenge Corporation. September 2014. Web access: <http://www.cgdev.org/publication/regional-and-sub-national-compact-considerations-millennium-challenge-corporation>.

20 The White House. U.S. Strategy toward Sub-Saharan Africa. The White House. June 2012.

21 Benjamin Leo and Vijaya Ramachandran. Getting Serious about Underperformance of the African Growth and Opportunity Act: Policy Options for Supporting Trade Potential in Africa. Center for Global Development. Washington, DC. February 2014.



## Comparative Advantage, Challenges and Opportunities of the Regional Blocs in the Health Sector

The SCOT analysis sought to identifying key strengths, challenges, opportunities and threats for regional institutions and for their health programs and initiatives. This analysis identified the internal and external factors that are favorable and unfavorable to achieving organizational objectives set for the organization.

- Strengths: characteristics of the organization that give it an advantage over others
- Challenges: are characteristics that place the organization at a disadvantage relative to others
- Opportunities: elements that the organization could exploit to its advantage
- Threats: elements in the environment that could cause trouble for the organization or its programs

Figure 8: Key Strengths, Challenges, Opportunities and Threats



## Strengths

The comparative advantages of regional organizations can be organized in three main categories: political leadership, enabling economies of scale, and technical leadership.

**Very influential players with high-level convening power** While other health sector actors (such as WHO, the UN and the World Bank) have strong regional level convening power, it is difficult finding organizations with the level of influence of the RECs. At the highest level, RECs organize annual meetings of Heads of State during which high-level negotiations take place and decisions are made on political, economic, security, and social issues including health. Given their political mandate to foster regional cooperation, regional economic communities have the clout to influence their member states, donors, and other key stakeholders in the region. As a senior official from Nigeria pointed out: “If I don’t go back to my country and implement this new regional HIS policy (adopted under WAHO’s leadership), my Minister will ask me about it, because he signed the resolution at the last Annual Health Ministers meeting and our President is putting pressure on him to make sure these resolutions get implemented.” Another key informant from USAID noted that: “You need a coordinating body. If SADC didn’t exist, we’d have to create a SADC!”

Recognizing their unique convening power, a number of international organizations have funded and partnered with the RECs including USAID, the World Bank, the Global Fund, the European Union, CIDA, IDRC, German KfW, WHO, UNICEF, UNAIDS, and UNFPA. The following diagram shows the self-reported relationships between the RECs and their partners. ASH generated the diagram based on the social network analysis conducted as part of this study. The nodes represent individual actors within the network, and lines represent relationships between the individuals. It is important to emphasize that the social network analysis is not exhaustive as it was performed based on self-reported information shared by the regional organizations interviewed. Organizations (nodes) included in the diagram may have relationships (lines) with other organizations not included here.

**Keen understanding of political environment** Regional blocs have a firm grasp of the power dynamics, forces at play, and mechanisms to effect policy change. These institutions understand the political landscape—the state, government, institutions and laws together with the public and private stakeholders who operate and influence the political system—as well as political culture (i.e. views held about what governments should act with relation to its citizens). In the health sector, for example, RECs such as ECOWAS, WAHO and intergovernmental organizations such as

ECSA-HC typically pay close attention to how government actions affects health and are able to navigate the political environment to effectively influence policy reform.

An interviewee from USAID emphasized that “countries can face difficulty in taking decisions. A regional approach to a policy issue is streamlined through a regional body and countries can ratify the new policies”. RECs have used their influence to persuade governments to adopt resolutions and to commit various calls to action, such as the following:

- Adoption of mandatory food fortification in all 15 ECOWAS countries at the 2008 Health Ministers Assembly
- Elimination of taxes and customs tariffs on insecticide-treated mosquito nets, insecticides, equipment and anti-malaria medicines in ECOWAS countries in 2006
- Harmonization of 34 medical and preventive health specialization fields, among which 14 curricula have been edited, translated, and published in the three ECOWAS languages making graduates subsequently eligible to work in any of the ECOWAS countries
- Passage of the EAC HIV/AIDS Prevention and Management Bill in March 2012
- Development of regional prototype policies on sexual- and gender-based violence, child sexual abuse, and obstetric fistula by ECSA countries
- Adoption of pro-poor and equitable health insurance schemes tailored to their unique demographic, economic, and health system circumstances and integrated with their broader health financing policy in ECSA countries in 2010

**Strong sense of ownership and belonging** Governments have vested interest in their regional bloc. Much of the RECs influence stems from the fact that their respective Member States “buy into” their regional organization via annual contributions (also known as assessments). In health, senior representatives from Ministries of Health have emphasized that they are more inclined to listen to and work with their REC than with international organizations because their regional body works with and for them and represents their interest. During the interview with the African Development Bank, the key informant commented that “being regional gives lots of credibility and legitimacy” and that countries “recognize [the Bank] as ‘their bank’ which allows to engage in more effective policy dialogue because financing guarantees are contributed by member states”. Likewise, a key informant from a donor organization stated that countries are beginning to listen to their REC more than they listen to international organizations because their regional body “belongs to them”. Testifying to the Senate Foreign Relations Committee Subcommittee, former USAID Assistant Administrator for Africa Lloyd O. Pierson stressed that: “Because regional

(economic communities) are backed by national African leadership, they provide a level of local legitimacy to critical issues in ways that global or bilateral institutions cannot. For example, the African Union (AU) and the Economic Community of West African States (ECOWAS) have played pivotal roles in mediating conflict and securing peace in the Sudan and Liberia.”

**Regional legal and regulatory reform** A core function of regional economic communities is the harmonization of legal frameworks and policies, and the promotion of regional standards. RECs use their convening power, political influence, and in some instances technical savvy to influence, facilitate and guide regional legal and regulatory reform. For example, the dearth in highly specialized healthcare expertise in Africa negatively affects the continent’s health systems. When healthcare professionals migrate out of their country, governments that who subsidize the education of health workers not only suffer lose skilled labor; they also lose their financial ‘investment’. Regional economic communities are playing a lead role in standardizing the curriculums to improve the quality of education for health professionals and enable graduates to work in any member states in their sub-region. To address well-known and documented health data deficiencies in the region, WAHO led the development of a regional Health Information Systems (HIS) policy, which was adopted by the 15 ECOWAS Member States at the 13th Assembly of Health Ministers in 2012. This adoption by the 16 Health Ministers represents a significant commitment to implementing the policy, which sets high regional standards for data collection and reporting, as well as data quality and utilization. Other examples include the EAC’s East African Anti Counterfeit Bill (2010), ECOWAS’ mandatory food fortification (2008), and its elimination of taxes and customs tariffs on insecticide-treated mosquito nets, insecticides, equipment and anti-malaria medicines (2006).

**Enhanced regional cooperation and integration can provide sub-regions with a platform for effective participation in international negotiations** Due to their relatively small economies, perhaps with the exception of Nigeria and South Africa, most African countries have limited leverage and influence at the international level, when they engage as an individual nation. However, by strategically aligning themselves on key policy issues, countries that are grouped together under a regional bloc, can have a stronger voice international negotiations. As shown in Table 2, regional blocs such as ECOWAS represent populations on par with that of the United States, and economies as large as either Switzerland or Saudi Arabia. At the World Health Assembly, African countries have developed have united around shared positions on critical health issues including strategies for HIV response, access to essential medicines, global recruitment and migration of skilled African health workers, control

of breast milk substitutes, food security, debt cancellation, and fair trade. Other examples provided by Loewenson et al. in the peer-reviewed article “African perspectives in global health diplomacy” (2014) help to illustrate the role of regional organizations in international negotiations:

- With the Global Fund, African countries demanded to include funding for TB and malaria and for African representation on the Global Fund’s Board.
- South Africa sought to negotiate for and protect wider African and regional interests during its two terms as a non-permanent member of the UN Security Council (Kagwanja, 2008).
- Seeing the overriding of African peoples’ access to antiretrovirals as a clear example of the injustice of the Trade Related Aspects of Intellectual Property Rights (TRIPS) trade system being crafted at the World Trade Organization, African countries united and successfully pushed for the inclusion of language protecting public health. The language states that the Trade Agreement “can and should be interpreted and implemented in a manner supportive of WTO Members’ right to protect public health and, in particular, access to medicines for all.” (Article 4, WTO, 2001).<sup>22</sup>

**Regional bargaining power and pooling of expertise** As countries assume responsibility for procuring health commodities, they often face an additional challenge in taxes on imported goods—tariffs, duties, and value-added taxes—that can represent a sizeable proportion of total costs.<sup>23</sup> SADC countries have entered into a pooled procurement arrangement whereby Member States purchase directly from prequalified regional suppliers, to improve availability and affordability of health commodities. Since regional blocs represent more sizeable markets than individual countries, these pooled procurement mechanism can help countries negotiate better prices for commodities on the international market. Through WAHO’s coordinated informed buying, the regional bloc is facilitating the sharing of information about prices and suppliers among countries.<sup>24</sup> WAHO is also developing an early warning system with a dashboard for preventing stock-outs of essential medicines in the region.

Regional economic communities support a number of regional centers of excellence in various areas, including health, agriculture, and science, technology, engineering, and mathematics (STEM)-related disciplines, as well as in agriculture and health. Selected for their existing advanced specialized expertise, these regional centers of excellence

22 Loewenson, R., M. Modisenyane, and M. Pearcey. “African perspectives in global health diplomacy.” *Journal of Health Diplomacy* online. 2014

23 David Sarley et al., *Options for Contraceptive Procurement: Lessons Learned From Latin America and the Caribbean* (Arlington, VA: DELIVER; and Washington, DC: USAID | Health Policy Initiative, 2006).

24 Gribble, James. “Procuring contraceptives: options for countries.” (2010). Washington, DC. Population Reference Bureau.



are often associated with universities and typically seek to address the need for highly specialized expertise in the region by serving as “go-to” regional hubs for capacity building, service provision, and advisory services. A similar regional leadership model is also being used by WAHO as part of its Young Professional Internship Program (YPIP). Developed in 2005 by WAHO and its partner USAID in recognition of the lack of adequate human resources for health in the West African sub-region, YPIP has provided nearly 100 young professionals with knowledge, practical skills and experience for sustainable management of health issues in West Africa.<sup>25</sup>

**Region-specific technical expertise** Technical specialists employed by RECs are from the sub-region. They are typically qualified individuals who understand technical issues and complexities unique to their region, and can contextualize international standards related to the sector they cover. In the case of health, levels of technical expertise within RECs appear to vary greatly. While WAHO is made up of a sizeable team of more than 50 qualified experts from the region, other RECs have much smaller teams (e.g. SADC has four officers focusing on health issues). WAHO maintains a database of health experts in various technical areas in the sub-region. ECSA is developing a database of pharmaceutical experts.<sup>26</sup>

**Cross-border disease surveillance, prevention and emergency response** Disease outbreaks and epidemics are not contained by national boundaries. To improve coordination and timeliness of the responses to disease outbreaks and other public health emergencies in their subregion, RECs facilitate and coordinate cross-border inter-ministerial meetings and provide technical and financial assistance to countries. Regional blocs such as WAHO have established subregional “common basket” public health emergency funds to enable countries and donors to pool financial resources. In collaboration with WHO/AFRO, WAHO is the main implementing agency of the \$10 million World Bank-funded West Africa Regional Disease Surveillance Project which aims to (i) develop a framework and operational strategy for a regional disease surveillance and response system, including specimen management; (ii) develop an integrated regional health information management system; (iii) develop a resource mobilization strategy, and (4; increase the quantity and quality of human resources for field epidemiology and laboratory diagnostics in the region.<sup>27</sup> With funding from

Rockefeller Foundation, the EAC established the East African Integrated Disease Surveillance Network (EAIDSNet)—a collaborative effort of the health ministries of Kenya, Tanzania, and Uganda as well as national health research, and academic institutions. An important aspect of the Network is to improve the quality of data on communicable diseases and the flow and sharing of information to improve the health of the East African population. One USAID interviewee commented that “particularly in health sector, things don't stop at the border. You lose impact if things are not coordinated across the borders for polio or MDR-TB outbreaks. Borders serve as a draw or escape route and necessarily affect how diseases will spread. If you address in isolation, you aren't dealing with dynamic movement of people and how that affects spread of disease. Using RECs to get governments to agree is powerful – to extend services to border areas.”

In response to the 2014 Ebola outbreak in neighboring countries Guinea, Liberia, and Sierra Leone, WAHO provided these three ECOWAS member states<sup>28</sup> technical and financial assistance through the creation of an Ebola Solidarity Pooled Fund called the ECOWAS Special Fund for the Fight against Ebola. WAHO's role includes organizing Ebola-focused regional meetings of health ministers, coordinating the regional response in close collaboration with international partners, and advocating for the filling of critical gaps in medical human resource capacity, training and provision of incentives to local health workers in order to improve response to the Ebola outbreak. From a financial perspective, WAHO was one of the first African organizations to disburse funds with its \$250,000 contribution in March 2014 to deal with the outbreak. In response to the creation of the ECOWAS Ebola Solidarity Pooled Fund, in July 2014 the Nigerian government donated us\$3.5 million to Liberia, Guinea, Sierra Leone, the West African Health Organization, and the ECOWAS Pool Fund for the response. Other African regional organizations are also playing a role in the Ebola response. The African Development Bank has contributed more than \$220 million in grants and loans to WHO and WAHO, as well as affected and non-affected countries. The funds are to be used to help recruit and train health workers, purchase equipment and medicine, and ensure that the necessary logistics are in place at the local level to provide emergency health services to Ebola patients. The African Union released \$1 million from the Union's Special Emergency Assistance Fund for Drought and Famine in Africa in August 2014 and appealed in October for its members to send health-care workers to the three West African countries. To date more than 2,000 volunteers have been pledged by AU member states, including 1,000

25 Amadou Moreau and Jennifer Pierre. Young Professional Internship Programme (YPIP): Evaluation of the First Five YPIP Cohorts (2005-2010). February 2011. Accessed from: [http://www.globalresearchandadvocacygroup.org/sites/default/files/images/publication/2011/final\\_English\\_YPIP\\_evaluation\\_report\\_Feb%2016\\_2011.pdf](http://www.globalresearchandadvocacygroup.org/sites/default/files/images/publication/2011/final_English_YPIP_evaluation_report_Feb%2016_2011.pdf)

26 Technical Report of the 9th Meeting of the Regional Pharmaceutical Forum, May 2014 - Nairobi, Kenya [www.ecsahc.org/download/?file=rpf\\_report\\_nine.pdf](http://www.ecsahc.org/download/?file=rpf_report_nine.pdf)

27 Project Information Document (PID) [www-wds.worldbank.org/external/.../WARDS2PID2april2011.doc](http://www-wds.worldbank.org/external/.../WARDS2PID2april2011.doc)

28 ECOWAS Working with Member States, Partners to Defeat Ebola. Press Release. 1 August 2014 [Abuja-Nigeria] <http://news.ecowas.int/presseshow.php?nb=145&lang=en&annee=2014>

from Congo, 600 from the East African Community, 500 from Ethiopia and 506 from Nigeria.<sup>29</sup> Critics have argued that the AU's response is unacceptably slow and inadequate.<sup>30</sup>

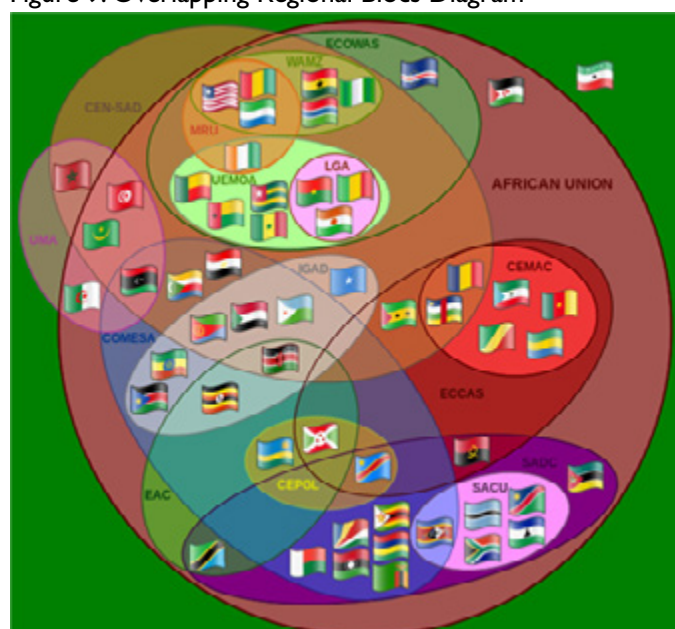
**Promoting the replication of best practices and regional priority-setting in health** Explaining why he is optimistic for Africa's future in July 2014, Bill Gates said: "Africa is now in an incredible position to shape its own destiny for the better for one very simple and powerful reason: the countries of Africa are learning from each other." Instead of wasting scarce resources to reinvent ways to address public health issues, proven interventions and promising or best practices implemented in one country can often be adapted and replicated in other neighboring countries. ECSA-HC, EAC, SADC and WAHO have co-facilitated a regional consensus building meetings to identify and prioritize best practices and identify action at national levels. In most cases, these meetings have resulted in the production of criteria that must be met for a program or an approach to qualify as a best practice and guidance to member states on how to take advantage of best practices.<sup>31</sup> To identify best practices and inform the priority-setting process, ECSA-HC conducted a study on resource allocation, waivers and exemptions in Zambia, Malawi, Tanzania and Uganda. ECSA-HC also has, for the past eight years, organized an annual Best Practices Forum which brings together senior MOH, researchers, heads of training institutions, and international experts to identify best practices and key policy issues which feed into a set of annual recommendations to the Ministers of Health. In partnership with USAID's Action for West Africa Region project, WAHO organized regional consultative meetings with MOH technical officers and experts from its 15 member states to review health statistics and evidence from identified best practices to build consensus on a regional vision and priorities for the region.

## Challenges

**Overlapping mandates** Africa currently contains 14 regional blocs—eight officially recognized by the AU plus six other regional integration arrangements—with two or more in each of the five sub-regions. As shown in Figure 9 and detailed in Annex 1, out of 53 African nations, 11 countries hold membership with only one of the pillar REC, 35 are members of two official RECs, seven are members of three RECs, and one (Kenya) is a member of four or more RECs. For countries, membership in more than one REC means having to pay annual contributions to multiple regional blocs, and attending multiple regional meetings every year. It may also mean agreeing to implement different regional policies and programs that may, at times, contradict each other. The extent to which countries calculate the costs (political and economic) and benefits of holding membership with multiple RECs is unclear.

**Slower processes** Policy reform and program implementation typically necessitate longer timeframes at regional levels than at national levels. Regional level consensus building requires inter-country negotiations that can drag on if a few countries oppose the policy reform or proposed program. For a country to adopt a resolution, the proposed policy has to be approved by the technical department of a ministry and moved on to the Minister for approval. For RECs such as ECOWAS and COMESA, having more than a dozen member states go through this approval process can often take much longer than a year.

Figure 9: Overlapping Regional Blocs Diagram



Source: Wikipedia [http://en.wikipedia.org/wiki/African\\_Economic\\_Community](http://en.wikipedia.org/wiki/African_Economic_Community)

29 Fact Sheet: African Union Response to Ebola Epidemic in West Africa <http://pages.au.int/ebola/documents/fact-sheet-african-union-response-ebola-epidemic-west-africa>

30 Alex Thurston. Ebola Tests Regional Cooperation in West Africa. IPI Global Observatory. October 28, 2014 <http://theglobalobservatory.org/2014/10/ebola-regional-cooperation-west-africa/>

31 For example, SADC and its partners have developed a SADC Framework for Developing and Sharing Best Practices on HIV and AIDS<sup>31</sup>, available here: <https://www.k4health.org/sites/default/files/SADC%20FRAMEWORK%20FOR%20DEVELOPMENT.pdf>

**Perception of weak capacity in the area of organizational management** Several of the key stakeholders interviewed as part of this study pointed to weaknesses in the area of management (general management, financial management and human resources). It is important to note that this Landscape Analysis was not designed to perform in-depth institutional capacity assessments for each of the RECs. Instead, the study team relied on perceptions shared by key informants during interviews and the review of grey and white literature that discuss this topic. These perceived weaknesses applied to some but not all of the RECs. Regional bodies for which management-related institutional capacity is a challenge; mandates/activities have grown so much that structures cannot cope.

**Multiplicity of programs and players** In each region, REC-supported regional health programs compete with programs funded by bilateral and multilateral donors for resources and for the attention of MOHs. Within each regional bloc, there are multiple international development partners and global health initiatives. This multiplicity of programs and players complicates the coordination and harmonization role of RECs. Overlaying these multiple regional actors with the national-level actors makes it all the more confusing.

**Communication, dissemination of information** To effectively assume their regional coordination function, RECs must lead the dissemination of information not only on regional and country level health issues, but also on their own activities. Regional blocs are expected to serve as regional hubs that provide countries in their sub-region with a forum for collective participation in knowledge sharing. Doing so requires making sure that member states and development partners know what their sub-regional REC are doing. To enhance their ability to perform this role, regional organizations such as WAHO have organized regional knowledge sharing workshops and have sought to establish and maintain comprehensive health information management system that include a document repository containing cutting edge health information from countries in the region and elsewhere in Africa that can be accessed through their website. However, key informants interviewed as part of this study expressed the need for better information sharing. Some interviews revealed limited knowledge of the work of RECs. While we did not systematically interview government officials, other than the few MOHs officers who are directly involved in regional meetings and workshops, the limited knowledge of RECs also appears to be ubiquitous within MOHs. A senior MOH official from Burkina Faso also noted his limited knowledge of his REC's programs and functions despite the fact that it (WAHO) is headquartered in his country.

**Varying levels of transparency** Limited information on the RECs' programs and budgets is publically available. Throughout this Landscape Analysis of regional health sector actors in Africa, the study team faced greater difficulty in accessing information on the RECs health programs and funding levels. Regional blocs do not publish up-to-date information in a common, open format that makes it easy for stakeholders to find and use. From the literature, there are examples in the Ugandan education sector and the Argentinian health sector that increasing access to information has positive impacts on reducing corruption.<sup>32</sup> Given that they are publicly funded organizations and sub-regional building blocks of the African Union, the study team would have expected the RECs adhere to the AU's founding Constitutive Act, which requires that the organization to "promote democratic principles and institutions, popular participation and good governance", and its Charter on Democracy, Elections and Governance, which obligates the organization to "establish transparency and access to information among member states".<sup>33</sup> Instead, information on the RECs budget and other critical documents is either not publicly available or very difficult to find. As regional information hubs, RECs should lead the way in ensuring information on its programs and funding sources and levels is publically available, as this type of open data can improve governance, increase civic engagement, and promote innovation.

**Measuring the effect of regional work on health outcomes** Unlike the effect of programs and policies implemented by organizations that deliver services, the effect of activities implemented by RECs will not necessarily follow a linear cause-effect paradigm. Given the nature of regional interventions in the realms of coordination, best practice replication, knowledge sharing, and advocacy for policy change, measuring the effect of regional work on health outcomes is a challenge. As a USAID interviewee emphasized: "For RECs, donors want to hear about specific impact (i.e. how many people served)—but most operate in the realm of policy and knowledge exchange, which are harder to justify and advocate for." One of the few quantitative studies on regional health programs in Africa—a 1998 cost-effectiveness analysis by Shepard et. al—found that, taking into account all external financing for population and family planning, the USAID West Africa regional approach generated women-years of protection at one-third the cost of the programs supported by bilateral missions.<sup>34</sup> In a foreign assistance environment where 'what gets measured, gets funded', it may

32 [http://www.cgdev.org/blog/building-evidence-base-open-data?utm\\_source=140610&utm\\_medium=cgd\\_email&utm\\_campaign=cgd\\_weekly&utm\\_&&&](http://www.cgdev.org/blog/building-evidence-base-open-data?utm_source=140610&utm_medium=cgd_email&utm_campaign=cgd_weekly&utm_&&&)

33 Brett Schaefer and Morgan Lorraine Roach, "African Union: Transparency and Accountability Needed," Heritage Foundation Issue Brief No. 3535, March 8, 2012

34 Shepard, Donald S., Richard N. Bail, and C. Gary Merritt. "Cost-effectiveness of USAID's Regional Program for Family Planning in West Africa." *Studies in family planning* 34.2 (2003): 117-126.

ultimately behoove the RECs and their development partners to strengthen their value proposition by building performance management systems that include systematic evaluation of impact. For regional blocs, a significant purpose of evaluation will seek to demonstrate the influence their regional programs and policies have on individuals and organizations within their sphere of influence (e.g. MOHs and development partners).

**Limited authority to enforce policy implementation** The RECs have successfully brokered, negotiated, and influenced Ministers of Health and partners to adopt resolutions which *if implemented* can increase access to health services, improve quality of care, and ultimately improve health outcomes in their region. However, the RECs lack the authority to enforce country-level implementation of resolutions adopted at the regional level because such enforcement is beyond their mandate. While RECs can urge, demonstrate evidence, recommend, and advise countries to adopt and implement new policies, they cannot force them to implement these policies. What the RECs can do—and need to do a lot more—is monitor and assess the implementation of previously adopted resolutions.

**Dearth of expertise in eHealth/mHealth to advise countries** Mobile phones, computers and internet connectivity are allowing unprecedented changes in the way health care is delivered. Africa has the highest rate of expansion of cell phones and internet connectivity putting it in a unique position to revolutionize the health sector. As of late 2013, of the nine markets already having more registered mobile money accounts than bank accounts, three are East African: Kenya, Tanzania, Uganda, with the other six being Cameroon, DRC, Gabon, Madagascar, Zambia, and Zimbabwe. The emergence of mobile diagnostic tools and bundled mHealth services (i.e. mobile apps that not only provide health information, appointment reminders or medication adherence messages, but also financial services like credit or insurance) are game changers and transformative for the health systems.

As investments in digital solutions for health (or eHealth) by international partners and MOHs increases, the dearth of locally available subject matter expertise in software development, change management, health informatics, enterprise architecture becomes all the more prominent. African governments are left with making decisions on how to choose between a variety of attractive but often costly digital solutions without the appropriate expertise to guide their selection. Since most ministries do not have the in-house eHealth expertise, there is a serious need for this expertise to be available at the regional level. Unfortunately, the RECs lack this type of expertise and thus also have to rely on international eHealth experts.

## Opportunities

**MDG 2015 deadline** The RECs have successfully influenced Ministries of Health to adopt resolutions. When implemented most of these resolutions can help countries make significant progress towards achieving Millennium Development Goals. A key challenge associated with resolutions advocated for by the RECs is country-level implementation. The quickly approaching 2015 deadline for countries to achieve the MDGs can provide an incentive for implementation of resolutions.

**Increased focus on Global Health Security** The importance of Global Health Security has never been more conspicuous. Drug resistance is on the rise, new pathogens are emerging and spreading, and laboratories around the world could release dangerous pathogen either unintentionally or intentionally. As a result of globalization, the likelihood and speed of spreading infectious diseases is multiplied due to increases in travel and trade. Since the RECs already play a led political and technical role in cross-border disease surveillance, prevention and emergency response, it behooves the U.S. government, WHO and other global partners to engage these regional bodies to accelerate progress toward a safe world and promote global health security as an international priority.

**New emphasis on Global Health Diplomacy** Global Health Diplomacy (GHD) focuses on negotiations that shape and manage the global policy environment for health in health and non-health fora. As discussed in the “Strengths” section of this report, enhanced regional cooperation and integration can provide subregions with a platform for effective participation in international negotiations. The RECs can facilitate greater policy coherence between national health policies, commitment to development, and the need to define collective action in an interdependent world. For foreign governments seeking to forge diplomatic relations with specific countries or simply understand the policy environment of an African subregion, the RECs can serve as an entry-point—either as a relationship broker and a knowledge hub—by providing insights on dynamics, institutions, and mechanisms shaping regional policies and frameworks. RECs can also play a key role in facilitating negotiations on health issues that cross national boundaries, are global in nature and require global agreements to address them.

**Healthy competition** Annual gatherings of Ministers of Health and other senior MOH directors to share best practices, discuss key issues and present country-level results promotes healthy competition between countries, because Ministers and directors of invariably weigh their national programs against those of other countries, and sets the stage for greater



inter-country accountability. RECs could do more to stimulate friendly competition with respect to specific programs and policies.

**Local manufacturing of health commodities** In many African countries, national competitive bidding for health commodities (contraceptives and basic medicines) is not an option for procurement because they lack the manufacturing capacity. Over time, as countries develop greater manufacturing capacities, the local production of generic health products, could improve access to contraceptives and other medicines.<sup>35</sup> Regional blocs EAC, SADC and WAHO are actively promoting and supporting local manufacturing of pharmaceuticals in their respective regions. Efforts to enable local African Medicines Regulatory Harmonization (AMRH) operationalizes the African Union's Pharmaceutical Manufacturing Plan for Africa (PMPA) which seeks to enable African countries to fulfill their national obligations to provide all citizens with safe, quality and efficacious essential medicines. The AMRH program is being implemented through the RECs in collaboration with partners namely the AU, WHO, World Bank, Bill and Melinda Gates Foundation, DFID and Clinton Health Access Initiative (CHAI).

## Threats

**Lack of understanding of mandates and core functions** A number of key informants from donor agencies expressed the need to better understand the work of the RECs in the health sector. Senior MOHs officials also indicated that they have limited knowledge of what their REC's mandates and core functions. As long as key stakeholders are unaware of the role of the RECs and how they can collaborate to address public health issues, the regional bodies will not be able to optimally fulfill their mandates.

**Competing interests (country versus region)** In addition to the cost of annual membership dues, participation in regional meetings and implementation of regional policies and programs diverts scarce human, financial, and technical resources away from in-country programs. Oftentimes, most senior and best-qualified government officials are appointed to represent their country in regional policy dialogue. While there are benefits to learn about experiences, exchanging ideas, and exploring collaboration with one's peers in the region, this focus on regional issues can take a senior official away from his normal duties for a considerable amount of time.

One interviewee from a donor agency commented that: "There are too many meetings and too many organizations trying to convene leaders. They want high-level representation so ministers are forced to shoot from meeting to meeting." The interests of a subregion can also, at times, compete with pan-African cooperation. In a 2013 article for The Africa Report, Comfort Ero, director of the International Crisis Group's Africa programme, said: "What we have noticed in the past six months has been a degree of reluctance by ECOWAS to give way to the AU. What [AU Chairwoman Nkosazana] Dlamini-Zuma needs to do is to reassure ECOWAS that it is very much the AU supporting ECOWAS".<sup>36</sup>

**Competition for resources** As foreign assistance across most sectors, including global health, continues to flat line, the RECs will likely see changes in their funding levels from donor agencies. With more restrained budgets, donors who historically provided financial assistance to health programs at both regional and country levels may have to make the difficult decision between these two levels. Likewise, a member state facing economic crises may decide to reduce or forgo contributions to its regional body, especially if the country holds membership with multiple RECs. When asked about emerging trends for the next two years, an interviewee from a donor agency predicted that "international organizations will fund less and less" and will become "more and more catalytic—providing initial funding for projects that can be taken to scale by countries".

<sup>35</sup> source: <http://www.prb.org/pdf10/toolkit-procuring.pdf>

<sup>36</sup> Theafricareport.com: African Union: It's never too late to avoid war! - Dlamini Zuma Dec 2012

## CONCLUSIONS AND RECOMMENDATIONS

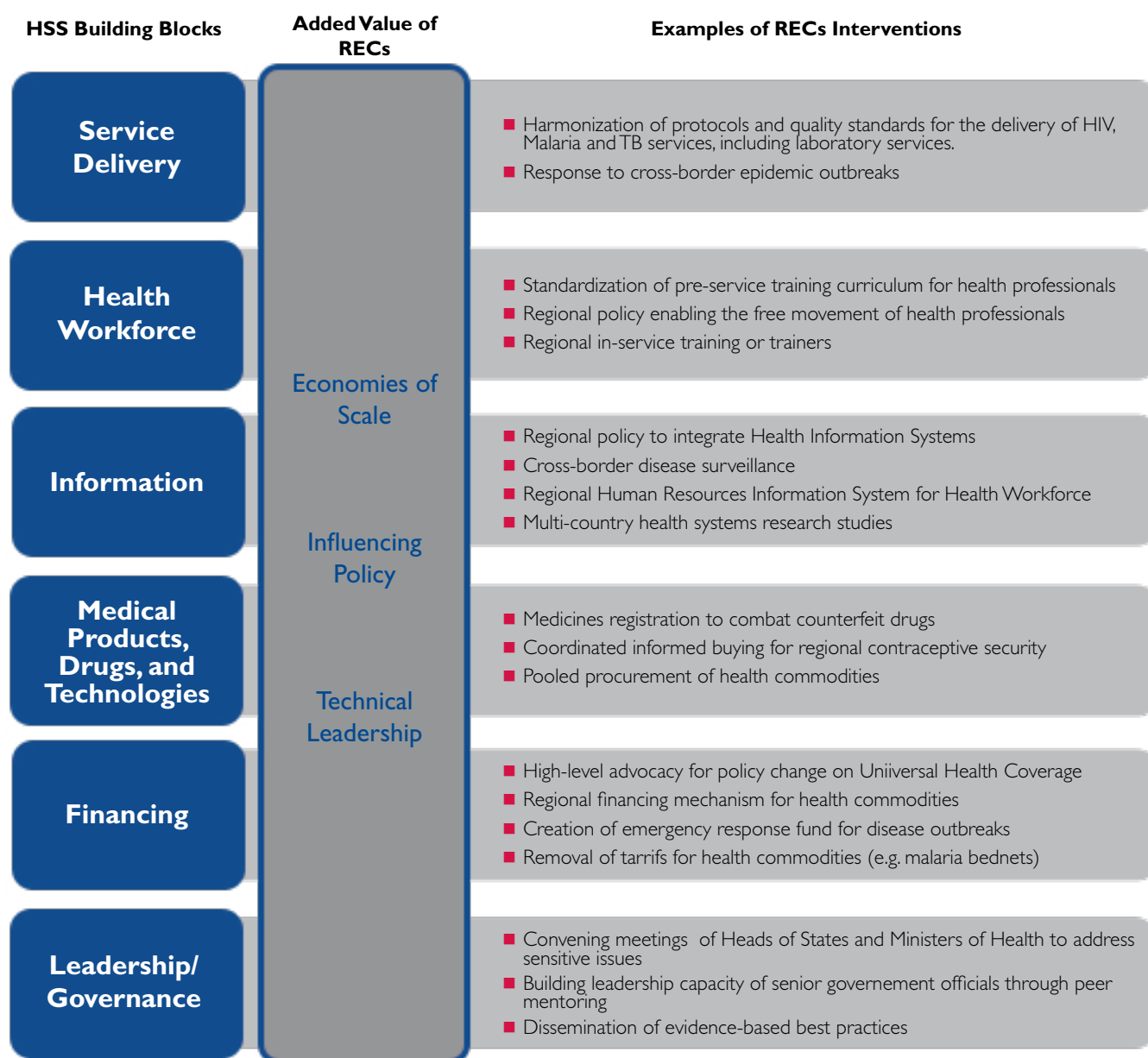
Regional integration is an important trend that is gaining momentum in Africa and regional economic communities are the key drivers of this process. Regional integration has been a continental objective since independence. Many of Africa's trade blocs have been in existence since the 1970s. Despite its prominence in the African policy dialogue, the regionalization process and the role of the RECs remain economic and social development-related topics that are misunderstood by international partners.

Senior officials at both USAID and other donors continue to express their need to learn more about the power dynamics, limitations and strategic advantages of regional

bodies and of the regionalization process to better inform regional and bilateral programming on the continent. As one interviewee noted: "Even internally within USG, there's not a good understanding of or appreciation for the comparative advantages of regional work and regional activities. People assume that bilateral is the way to go – and for many things this is true, but not all."

Results from previously conducted evaluations and special studies that sought to determine the effect of regional programs are promising. However, more evaluations are needed to clearly make the case for regional programming.

Figure 10: Contributions of RECs to Strengthening Health Systems



## Benefits of Regional Integration and Collaboration in the Health Field

The 2007 paper “Strengthening international health co-operation in Africa through the regional economic communities” published by WHO officers in the African Journal of Health Sciences outlines five potential benefits of regional integration and collaboration for the health sector:

1. Regional integration among developing countries in the past has been mainly aimed at encouraging industrial development. There is, therefore, relatively little direct evidence on its impact on health. However, economic theory predicts that regional integration promotes increased intra-regional trade, which fosters economic growth and increases employment prospects and the income-earning capacities of the poor. It is, therefore, tempting to conclude that regional integration arrangements will generate health and welfare gains.
2. Regional integration arrangements can benefit member countries (with small populations like most African countries) through increased scale and competition. Member states can benefit from reduced cost of medical technology through bulk procurement mechanisms. Similarly, expensive high-technology medical equipment and infrastructure that require large populations can become viable if regionalized and made simultaneously available to populations of several countries within the bloc.
3. In the health sector, regional integration can ensure the continuity of health reforms in member countries, because such arrangements (even in the face of the frequent changes of ministers of health experienced by various countries) have the potential of bringing about commitment of those countries to decisions taken collectively, and for providing a framework for improving coordination and achieving better harmonization of policies and regulations.
4. Countries in the bloc can benefit from cooperation -- including resource pooling -- to promote regional public goods and combat regional public bads. Such arrangements can provide a framework for resource-sharing or for dealing with cross-border problems, such as pollution, HIV/AIDS, etc.
5. Regional integration and cooperation arrangements also strengthen enforceability. Furthermore, the regular contact and collaboration among policymakers that regional integration arrangements entail can strengthen support and integration arrangement, activities can be undertaken which member states cannot implement on their own due to strictures in both human and financial resources.

(excerpt from Agu et al., 2007)

This landscape analysis shed light on the concept of regionalization and the role played by key regional health sector actors in Africa. In terms of answering the question: “How do the RECs contribute to improving health outcomes in Africa?”, based on the literature review, interviews, and SCOT analysis conducted as part of this study, the RECs offer strategic value in three core areas enabling economies of scale, influencing policy, and providing technical leadership. The study team developed Figure 10 to illustrate the contribution of the RECs in strengthening health systems.

While nearly all interviewees recognized that the RECs are country-owned and possess tremendous influence over their member states—and therefore have great potential for contributing to improving health outcomes—they also acknowledged that these regional bodies have a limited ability to follow-up and enforce policies at country level. As one USAID key informant stated, “Efforts at the regional level can be undermined by the country level; it’s possible to have conversations at the regional level but the power is at the

country level. Donor organizations (like AfDB, World Bank) can move very far at the regional level but things will not move until countries sign on at the country level.”

With dwindling foreign assistance budgets,<sup>37</sup> the need for international partners to seriously consider proven and innovative ways of taking advantage of the economies of scale, policy influence, and technical leadership offered by regional bodies intensifies. Efforts to strengthen the institutional capacity of these regional bodies to fulfil their mandates should integrate robust performance metrics and systematic evaluation of impact.

Ultimately, international partners ought to select which organization to work with and how to work with them based on intended outcomes. As a key informant from USAID stated:

37 Amy Lieberman. Analysis: Obama's 2014 foreign aid budget request. DEVEX. April 2013. Web access: <https://www.devex.com/news/analysis-obama-s-2014-foreign-aid-budget-request-80681>



"If our aim is to strengthen governance structures, then we should work regionally. If it's only to strengthen service delivery, then we should work at the bilateral level. Systems, policy and research make most sense at regional level (pooled procurement, accreditations, etc.). If we want to look at health outcomes of economic growth and integration, we must look at the regional level – it's being driven by the regional economic agenda. If we're focusing on CHW meets the patient (how we measure) then we should focus on bilateral." ... "Things that are politically sensitive but are needed for public health are better addressed at a regional level, e.g. services and policy change for key populations (MSM, sex workers)."

**Recommendation #1: Develop a strategic communication plan for raising awareness of the importance of regionalization and regional programming within USAID Washington and bilateral missions.** Regional organizations are recognized by African governments and international donors as key players with strong policy influence. And the regional integration process will help Africa address its unique population and geographical characteristics. It is therefore paramount for USAID to continue supporting targeted initiatives of the RECs and the regional integration process in Africa. Developing a plan detailing communications strategies and tools (e.g. briefs, interactive presentations, stakeholders meetings, brownbag discussions) will help get that message across to relevant decision-makers within USAID. An overall better understanding, within the Agency, of the strategic value of the RECs and of their regional initiatives can help avoid missed opportunities and duplication of effort. For example, it would be important for bilateral USAID missions in West Africa to know about and understand the WAHO-led regional HIS policy adopted by the region's 15 Health Ministers in order to ensure that USAID implementing partners are using health information systems that are interoperable and avoid funding parallel or duplicative systems.

**Recommendation #2: Commission economic evaluations to determine the cost and impact of regional programming.** In a foreign assistance environment where 'what gets measured, gets funded', it may ultimately behoove the RECs and their development partners to strengthen their value proposition by building performance management systems that include systematic evaluation of impact. USAID Operating Units that have historically funded regional programs in support of the RECs (i.e. Africa Bureau and regional missions) should consider commissioning economic evaluations to assess the effect of past regional projects through using ex-post impact evaluation design to examine and quantify the effects of regional interventions targeting the RECs. This would involve tracing the effects of the implementation of country-level

policies adopted, through the work of the RECs, at the regional level. Other types of special studies, similar to the 1998 analysis quantifying the cost and effectiveness of regional USAID-family planning programs, could also be commissioned to further build the evidence base.<sup>38</sup>

**Recommendation #3: Support in-house eHealth capacity within the RECs.** In view of the rapid expansion of eHealth (including mobile technology) and the dearth of related expertise at country levels, it is strategically critical to ensure that experts is quickly developed and made available at the regional level (while the longer process of building a critical mass of eHealth experts at national levels also takes place). Given their high level of influence on policy and technical matters, the RECs are well positioned to serve as honest brokers and advisors to MOHs—who are routinely offered to invest in eHealth solutions but (in most cases) do not have the in-house expertise to lead the selection, deployment, and maintenance of these solutions. The RECs need in-house expertise to play a leadership role in help member states select appropriate solutions and scale up successful pilots. To maximize its own investments in eHealth, USAID and its private sector alliance partners should conduct needs assessments of eHealth capabilities within selected regional blocs and take action to ensure adequate expertise is available at the RECs to support countries, promote south-to-south learning and synergize use of local resources (reduce duplicative efforts in the sub-regions).<sup>39</sup>

**Recommendation #4: Encourage RECs to provide budget information and other documents to the public in order to increase transparency and accountability.** Limited information on the RECs' programs and budgets is publically available. Given that they are publicly funded organizations, the regional blocs ought to publish up-to-date information in a common, easy-to-find-and-use, open formats. In the past five years, USAID has made great strides in opening its own programmatic and financial data, including every individual transactions, on [foreignassistance.gov](http://foreignassistance.gov) and the Open Data Listing—a repository<sup>40</sup> of datasets from USAID analyses and evaluations—while maintaining protections for national and operational security, and individual privacy. The Agency should consider sharing lessons learned from its own open data

38 Shepard, Donald S., Richard N. Bail, and C. Gary Merritt. "Cost effectiveness of USAID's Regional Program for Family Planning in West Africa." *Studies in family planning* 34.2 (2003): 117-126.

39 Significant regional level efforts are already taking place under the leadership of the RECs. The EAC recently established an East African Community Science and Technology Commission in Kigali to serve as the hub for the promotion and coordination of the development, management and application of science and technology in the five member states. WAHO and ECSA are already planning for the development of their regional eHealth policies to be adopted by their member states. SADC has requested technical assistance from USAID and the U.S. Federal Communications Commission (FCC) to build national capacity in broadband plan development and spectrum management.

40 <http://www.usaid.gov/data>

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“It was not about what we saw on the ground – that is, broken buildings and an embryonic staff – but about the idea of a WAHO and the role it can play in improving the quality of life in West Africa... But today, the founding fathers of ECOWAS and WAHO and the ideas that these institutions represent for the development of the peoples in the region can take pride in some of the palpable achievements to date. We have come a long way in these past 7-8 years. There is still a long way to go.”

~Felix Awantang, USAID Deputy Mission Director (excerpt from speech given at ECOWAS Health Ministers' Meeting; Yamoussoukro, Ivory Coast, July 2009)

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initiative with the RECs. This type of collaboration will help the RECs become stronger information hubs and champions for transparency, accountability, collaboration and innovation.

***Recommendation #5: Continue efforts to strengthen the organizational capacity of regional economic organizations.***

The health secretariats of RECs still have significant organizational weaknesses. Stronger RECs can more effectively fulfill their mandates to harmonize policies and programs, and coordinate the efforts of the various actors in their region. With targeted RECs in-depth organizational capacity assessments could be conducted to identify capacity gaps and facilitate organizational capacity development interventions in the identified areas. Past USAID-funded efforts have had success catalyzing organizational change by seconding a long-term organizational development expert within the headquarters instead of short-term technical assistance.

***Recommendation #6: Support the RECs efforts to assess policy implementation.*** The RECs lack the authority to require country-level implementation of resolutions adopted at the regional level. While enforcement is beyond their mandate, the RECs can monitor and assess the implementation of previously adopted resolutions. They do already do this to some extent but could use technical assistance in developing an evidence-based methodology for assessing policy implementation, and building in-house capacity for policy analysis within the RECs (perhaps through existing USAID mechanisms such as the Health Policy Project). The policy implementation assessment methodology would also help identify approaches for overcoming barriers to implementation. This type of technical assistance would help the RECs and their member states better understand policy implementation dynamics and identify recommendations for translating health policies into action. Through regular check-ups and renewed commitment, policies can keep on track toward achieving policy goals.

***Recommendation #7: Explore ways to link the new USAID Regional Leadership Centers with the RECs.*** Building on the successes of WAHO and USAID/West Africa's Young Professional Internship Program (YPIP) in health, it would also be important to explore ways to partner with the RECs in the newly announced USAID Regional Leadership Centers program which will be established to train thousands of Africa's emerging leaders and foster connections, creativity and collaboration in sectors critical to Africa's growth and development.<sup>41</sup>

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41 Source: USAID Invests \$38 million in New YALI Centers to Support Young, Emerging Leaders in Africa : President Obama Announces Four Regional Centers in Town. USAID Press Office. Press Release. Monday, July 28, 2014. Accessed from: <http://www.usaid.gov/news-information/press-releases/july-28-2014-usaid-invests-38-million-new-yali-centers-support-young-emerging-leaders-africa>

## ANNEX I: Country-by-country membership in the pillar RECs

Country	UMA	COMESA	CEN-SAD	EAC	ECCAS	ECOWAS	IGAD	SADC	TOTAL
Algeria									1
Botswana									1
Cameroon									1
Cape Verde									1
Congo, Rep									1
Equatorial Guinea									1
Gabon									1
Lesotho		left in 1997							1
Mozambique		left in 1997							1
Namibia		left in 1997							1
South Africa									1
Angola		suspended itself in 2007							2
Benin									2
Burkina Faso									2
Centrafrique									2
Chad									2
Comoros									2
Côte D'Ivoire									2
Egypt									2
Ethiopia									2
Gambia									2
Ghana									2
Guinea									2
Guinea-Bissau									2
Liberia									2
Madagascar									2
Malawi									2
Mali									2
Mauritania						left in 2002			2
Mauritius									2
Morocco									2
Niger									2
Nigeria									2
Rwanda					left in 2007				2
Sao Tome & Princ.									2
Senegal									2
Seychelles									2
Sierra Leone									2
Somalia									2
South Sudan									2
Swaziland									2

Country	UMA	COMESA	CEN-SAD	EAC	ECCAS	ECOWAS	IGAD	SADC	TOTAL
Tanzania		left in 1997							2
Togo									2
Tunisia									2
Zambia									2
Zimbabwe									2
Burundi									3
Congo, DR									3
Djibouti									3
Eritrea									3
Libya									3
Sudan									3
Uganda									3
Kenya									4
<b>TOTAL</b>	<b>5</b>	<b>20</b>	<b>28</b>	<b>5</b>	<b>10</b>	<b>15</b>	<b>8</b>	<b>15</b>	

## ANNEX 2: Questionnaire for Key Informant Interviews

### Interview Protocol – Regional Economic Communities Regional Landscape Analysis July 15, 2013

Name of Organization Interviewed:	
Name of Interviewee:	
Title of Interviewee:	
Email address of Interviewee:	
Date of Interview:	
Key Informant: Ideally, the interview will be conducted with the Executive Director or the most senior official available.	
Duration: 2 hours maximum	
Requesting documents: For a number of questions, electronic copies of documents are requested. Information available in these documents will be used to enrich the analysis.	
<b>Informed Consent:</b> <ul style="list-style-type: none"> <li>• <i>Thank you for taking the time to hold a discussion with me regarding your organization.</i></li> <li>• <i>I am with the African Strategies for Health (ASH) Project, which is a five-year contract funded by USAID's Africa Bureau.</i></li> <li>• <i>The information from this project will help the WHO's Harmonizing for Health in Africa (HHA), to better understand how regional organizations work in Africa.</i></li> <li>• <i>We will be interviewing about 50 key regional organizations with health programs, including regional economic communities, regional networks, regional professional associations, and regional technical institutions.</i></li> <li>• <i>The answers provided during this interview will help to enhance HHA's understanding of the relationships, power dynamics, limitations and strategic advantages of regional bodies in Africa.</i></li> <li>• <i>To prepare for this interview, we have conducted a desk review to gather information about your organization. Sources of information included your organization's website, reports and other documents available online. On questions for which our team was able to find an answer, the interviewer will simply ask you to confirm that what we found is accurate.</i></li> <li>• <i>The main output will be an analytical document which the ASH project, HHA and other development partners will be able to utilize, as part of their planning process, to identify optimal areas of strategic cooperation with key regional entities.</i></li> </ul>	
<b>Organizational Data:</b> <p><i>Introduction: **I'd like to begin by asking you to confirm the information we gathered through our desk review concerning your organization. (NOTE: Interviewer states the information gathered for each questions and asks the interviewee to confirm.)</i></p> <ol style="list-style-type: none"> <li>1. What is the Mandate and/or Mission of your organization?</li> <li>2. In what year was your organization established?</li> <li>3. Where is your headquarter/head office located?</li> <li>4. Does your organization have satellite offices in other countries?             <ol style="list-style-type: none"> <li>a. If yes, where?</li> </ol> </li> </ol>	
<b>Membership:</b> <p><i>Introduction: We would also like to know about your members. (NOTE: Interviewer states the information gathered, if</i></p> <ol style="list-style-type: none"> <li>5. How many member states are officially part of your community?             <ol style="list-style-type: none"> <li>a. Who are your member states? Please provide a current list of your member states.</li> </ol> </li> </ol>	



6.	How does a country become a member of your organization?
a.	What criteria do they have to meet?
b.	Who makes the decision on whether a country can become a member?
7.	What is the role of your organization in working with its member states? (check all that apply)
a.	Collaborate on project/program implementation
b.	Provide training
c.	Provide technical assistance (other than training)
d.	Provide financial assistance
e.	Facilitate information exchange
f.	Disseminate best practices
g.	Monitor and/or evaluate programs
h.	Support and/or conduct research
i.	Convene regional stakeholders meetings
j.	Define, oversee and reinforce standards of practice
k.	Foster partnerships
l.	Advocate for health policy change
m.	Other (List them)
n.	None
8.	Can your organization impose sanctions on its members?
a.	If yes, what are some of the reasons why sanctions would be imposed on a member?
b.	What kind of sanctions would be imposed?
c.	How would your organization impose the sanctions?
<b>Contextual Factors:</b>	
<i>Introduction: We would like to better understand some of the context within which your organization operates.</i>	
9.	In your opinion, why is it important to have a regional health organization such as yours?
10.	What is your comparative advantage (compared to other organizations? And compared to country-level organizations?
11.	What emerging trends and opportunities do you see for your organizations in the next 2 years?
12.	What kinds of challenges are unique to the regional nature of your organization?
a.	Which of these unique challenges does your organization face?
13.	If you had to improve two things about your organization, what would they be?
14.	If your organization could receive technical assistance, what area would this technical assistance cover? (check all that apply)
a.	Management practices
b.	Human resources management
c.	Financial management
d.	Coordination
e.	Communication
f.	Technical skills in public health
g.	Leadership
h.	Governance
i.	Resource mobilization
j.	Monitoring and evaluation
k.	Advocacy for policy change
l.	Marketing
m.	Other (List them)
n.	None

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15. Which other regional organization do you collaborate with the most? (Please complete the Collaboration Matrix)

a. What is the nature of your collaboration?

- Information exchange
- Technical assistance
- Financial support

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**Governance and Structure:**

*Introduction: Now, I would like to talk about how your organization is organized and how it makes decision. (NOTE:*

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16. What is the legal status of your organization? (check all that apply)

- a. Regional Economic Community
- b. Intergovernmental technical agency
- c. Non-governmental organization
- d. Public academic institution
- e. Private technical organization
- f. Professional association
- g. Network
- h. Other (List them)
- i. None

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17. Could you please describe your organizational structure?

a. What are the names of the various departments and/or units within your organization?

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b. Could we please have a copy of your organizational chart?

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18. How are important decisions made within your organization?

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19. What type of a governance structure does your organization have? (check all that apply)

- a. Board of Directors/Trustees
- b. Advisory Councils
- c. Steering Committees
- d. General Assembly
- e. Other (List them)
- f. None

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20. What mechanisms does your organization utilize in order to push for health policy change? (or to have a regional policy, a regional strategy or a resolution adopted by the Health Ministers or other political leaders)?

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21. What happens after a regional policy, a regional strategy or a resolution is adopted?

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**Health Programming:**

*Introduction: With regards to your health programs... (NOTE: Interviewer states the information gathered, if available, for each questions and asks the interviewee to confirm.)*

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22. What year was your health program established within the organization?

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23. How is your health program structured?

- a. By disease area (e.g. HIV, malaria, TB)
- b. By technical area (e.g. epidemiology, policy analysis)
- c. By geographic area
- d. By specific project
- e. Other (List them)

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24. Which areas of health does your organization focus on? (e.g. HIV, MCH, Malaria, TB, HSS, etc.)

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25. Why did your Regional Economic Community decide to incorporate health as one of its programs?

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26. Where does your health program reside within the overall organizational structure of the regional economic community?

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27. Do you require your members to routinely report data on standard indicators?

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#### ***Policies and Planning:***

*Introduction: And in terms of policies developed by your organization to guide your health programs...*

28. What is your overall strategy for the development and sustainability of your organization?
29. How do you do planning for the organization?
30. Is there an overarching policy document or a legislation by which your organization was established?
  - a. Where could we get a copy of that document?
31. Does your organization currently have a strategic plan to guide its health programs?
  - b. How many years does it cover?
  - c. What year does it end?
  - d. Could we have a copy of your strategic plan?
32. Does your organization produce an annual report?
33. Has your health program been evaluated in the past 5 years?
  - e. Could we have a copy of the evaluation report?
34. Do you hold annual events such as an annual conference or annual meetings?
  - a. When do these events typically take place?

#### ***Technical, Financial and Human Resources:***

*Introduction: To help us understand the size and scope of your organization, we would like to ask you a few questions concerning your financial and human resources.*

35. Do you receive non-financial technical assistance from partners?
  - a. Who are some of the partners from whom you receive technical assistance?
36. How many staff members does your organization currently have?
37. How are your health programs funded?
  - a. Do you receive funds from USAID?
  - b. Have you received funds from USAID in the past?
  - c. Could you please tell us who some of your other funders are?
38. How much funding did your organization received in total from external donors in 2012?
  - c. How much funding did your organization received in total in 2011?
  - d. How much funding did your organization received in total in 2010?
39. Does your organization generate financial assets from sources other than funders/donors?
40. How much did your organization received in total financial contributions from sources other than external funders/donors in 2012?
  - e. How much did you receive from your member states?
41. What is your vision for the future of your organization?
42. What do you hope to achieve in the next year?
  - a. Three years?
  - b. Five years?

#### ***Reference Documents:***

43. Are there any key documents you would suggest we use as key reference documents to learn more about your organization?
  - a. Might I please have a copy of this document?

## ANNEX 3: List of Key Informants

Name Of The Organization	Name Of Interviewee	Title	Headquarter Location	Email
<b>Regional Economic Communities/Intergovernmental Organizations</b>				
EAC : East African Community	Dr. Stanley Sonoiya,	Principal Health Officer	Arusha, Tanzania	Ssonoia@Eacq.Org
UEMOA: West African Economic And Monetary Union (In French)	Dr. Bakery Siriki Kone	Acting Director Of Health	Bskone@Uemoa.Int	
SADC: Southern Africa Development Community	Joseph Mithetwa	Senior Programme Officer For Health And Pharmaceuticals, Directorate Of Social, Human Development And Special Programmes	Gaborone, Dotswana	Jmthetwa@Sadc.Int, Josephmthetwa@Yahoo.Co.Uk
ECSA-HC: East, Central And Southern African Health Community (ECSA-HC)	Ernest T. Manyawu	Director Of Operations And Institutional Development	Arusha, Tanzania	Emanyawu@Ecsa.Or.Tz
ECSA-HC: East, Central And Southern African Health Community (ECSA-HC)	Dr. Odungu Odiyu	Manager Family Planning And RH	Arusha, Tanzania	Odungu@Ecsa.Or.Tz
African Development Bank	Fabrice Sergent	Chief Health Analyst	Tunis, Tunisia	F.SERGENT@Afdb.Org
<b>Regional Associations And Networks</b>				
African Field Epidemiology Network (AFENET)	Sheba Gitta	Acting Executive Director	Kampala, Uganda	Sgitta@Afenet.Net
ANECCA - African Network For Care Of Children Affected By HIV/ AIDS	Denis Tindyebwa	Executive Director	Kampala, Uganda	Dtindyebwa@Gmail.Com ; Mail@Anecca.Org
ASHGOVNFT - African Health Systems Governance Network	Francis Omaswa	Executive Director	Kampala, Uganda	Omaswaf@Achest.Org
College Of Surgeons Of East, Central And Southern Africa	Prof. Chris Samkange	President Cosecsa-Asea	Arusha, Tanzania (ECSA)	Registrar_Cosecsa@Ecsa.Or.Tz
East African Health Platform	Joyce K. Abalo	Coordinator	Arusha, Tanzania	Eahp.Coordinator@Gmail.Com
East, Central And Southern African College Of Nursing	Prof. Chris Samkange	Professor	Arusha, Tanzania (ECSA)	Registrar_Cosecsa@Ecsa.Or.Tz
EQUINET - The Regional Network On Equity In Health In Southern Africa	Dr. Rene Loewesen	Executive Director, Training And Research Center (TARC)	Harare, Zimbabwe	Rene@Tarsc.Org
HEALTH Alliance - Higher Education Alliance For Leadership Through Health	William Bazeyu	Dean, Makerere	Kampala, Uganda (Makerere Univ.)	Wbazeyu@Musph.Ac.Ug
Pan-African Health Journalism Network	Joy Wanjia	Secretary (Report At Daily Nation Newspaper)	Nairobi, Kenya	Wanjia@Ke.Nationmedia.Com
RATN- Regional AIDS Training Network	Mr. Kevin Storey	Executive Director	Nairobi, Kenya	Storeyk@Ratn.Org
AFHEA - African Health Economics And Policy Association	Pascal Ndiaye	Athea II-COM & Program Manager	Accra, Ghana	Pascalndi@Gmail.Com
AFRICASO - African Council For AIDS Service Organizations	INNOCEHT LAISON	Executive Director	Dakar, Senegal	Ilaisun@Africaso.Net
West African Postgraduate Medical College (Physicians, Nurses, Surgeons And Pharmacists)	Mr. Abraham Oklety	Principal Administrative Officer	Accra, Ghana	Abrahamoklety@Ymail.Com
ALMA - African Leaders Malaria Alliance (ALMA)	Melanie Renshaw	Chief Technical Advisor		Melanie@Alma2015.Org
<b>Regional Technical Organizations</b>				
ACHEST - African Centre For Global Health And Social Transformation	Francis Omaswa	Executive Director	Kampala, Uganda	Omaswaf@Achest.Org
AMREF - African Medical And Research Foundation	Ieguest Guerma	Director General	Nairobi, Kenya	Ieguest.Guerma@Amref.Org, Melle.Kjaer@Amref.Org



Name Of The Organization	Name Of Interviewee	Title	Headquarter Location	Email
APHRC - African Population And Health Research Center	Alex Ezeh	Executive Director	Nairobi, Kenya	Aezeh@Aphrc.Org
CAFS - Centre For African Family Studies	John R. Batten	Executive Director	Nairobi, Kenya	Jspangler@Cafs.Org
ESAMI - Eastern And Southern African Management Institute	Mr. Martin A. Lyewe	Director	Arusha, Tanzania	Martinlyewe@Ecamihq.Ac.Tz
Infectious Diseases Institute (IDI)	Alex Coutinho	Executive Director	Kampala, Uganda	Acoutinho@Idi.Co.Ug
Joint Clinical Research Centre (JCRC)	Peter Mugenyi	Executive Director	Kampala, Uganda	Pmugenyi@Jcrr.Co.Ug
PPD ARO - Partners In Population And Development Africa Regional Office	Jotham Musinguzi	Regional Director	Kampala, Uganda	Jmusinguzi@Ppdsec.Org
RCQHC - Regional Center For Quality Of Health Care	Fred Wabwire-Mangon	Director		Fwabwire@Rcqhcc.Org
Safais - Southern Africa HIV And AIDS Information Dissemination Service	Lois Chigandu	Executive Director	Harare, Zimbabwe	Lois@Safais.Net
CESAG - Centre Africain d'Etudes Supérieures En Gestion	Dr. Amani Koffi	Director, Health Management Institute	Dakar, Senegal	Amani.Koffi@Cesag.Sn; Kofrente@Yahoo.Fr
CAFS - Centre d'Etudes De La Famille Africaine (CEFA/CAFS)	LAMEGA Paulin	Assistant Du Bureau Régional	Accra, Ghana	Plamega@Cafs.Org
ISED - Institut De Santé Et Développement	PROF IBRAHIM SECK	DIRECTEUR DES ÉTUDES	Dakar, Senegal	Iseck@Ised.Sn
ISED - Institut De Santé Et Développement	MME FATOU DIAKHATE	RESPONSABLE DE L'ADMINISTRATION ET DES FINANCES	Dakar, Senegal	Fdiakhate@Ised.Sn
MWANGAZA Action	Ruger B. THIOMBIANO	Coordination		Mwangaz@Fasonet.Bf
RIPS - Regional Institute For Population Studies (RIPS) At The University Of Ghana	Prof Samuel Codjoe	Director	Accra, Ghana	Scodjoe@Ug.Edu.Gh
Union For African Population Studies	Prof Samuel Codjoe	Director	Accra, Ghana	Scodjoe@Ug.Edu.Gh
Khulisa Management Services	Salome Omolo	Associate Director Of Health		Somolo@Khulisa.Com
Health Systems Trust	Ronel Visser	Director - Programmes	Durban, South Africa	Ronel.Visser@Hst.Org.Za
Jembi Health Systems	Christopher Socbrogts, PhD	CEO And Ehealth Director	Cape Town, South Africa	Chris@Jembi.Org; Socbrogts@Ukzn.Ac.Za
Jembi Health Systems	Jonnea Smith	Director Of Corporate Services	Cape Town, South Africa	Jonnea@Jembi.Org
<b>International Organizations</b>				
World Bank	Miriam Schneidman	Lead Health Specialist, E&S Africa	Washington, DC	Mschneidman@Worldbank.Org
World Bank	Meera Shekar	Lead Health&Nutrition Specialist, Africa Health, Nutrition& Population	Washington, DC	Mshekar@Worldbank.Org
World Bank	Dun Bundy	Lead Health Specialist/VAPOC Coordinator	Washington, DC	Dbundy@Worldbank.Org
DFID	Jane Miller	MDG Team Leader And Senior Regional Health Advisor, Africa		J-Miller@Dfid.Gov.Uk
IDRC/Canada	Sue Godt	Senior Program Specialist	Ottawa, Canada	Sgodt@Idrc.Org.Sn
Tulane	Sambe Duale	Consultant (Former Technical Director Of Africa's Health In 2010)	Washington, DC	Sduale20@Gmail.Com

Name Of The Organization	Name Of Interviewee	Title	Headquarter Location	Email
USAID/DRC	Monica Carlson	Project Development Officer (Former WAHO Project Coordinator)	Kinshasa, DRC	Mcarlson@Usaid.Gov
USAID/GH/PRH	Carmen Tull	Technical Advisor	Washington, DC	Ctull@Usaid.Gov
USAID/M	Roy Miller	Information Architect	Washington, DC	Wallen@Usaid.Gov
USAID/East Africa	Julia Hcnn	Director, Health Office	Nairobi, Kenya	Jhcnn@Usaid.Gov
USAID/East Africa	Peter Anmi	HSS Advisor	Nairobi, Kenya	Panmi@Usaid.Gov
USAID/SA/RHAP	Karen Kasan	Director, Regional HIV & AIDS Program (RHAP)	Pretoria, South Africa	Kkasan@Usaid.Gov
USAID/West Africa	Danielle Nyirandutiye	Director Of Health Office	Accra, Ghana	Dnyirandutiye@Usaid.Gov
USAID/West Africa	Sheila Mensah	M&E Advisor	Accra, Ghana	Smensah@Usaid.Gov
MSII (Former CARICOM Officer)	Navindra Persaud	Senior M&E Lead (Former CARICOM Officer)		Mingabire@Idrc.Ca
<b>Other Key Informants</b>				
Consultant (Formerly From MSH)	Issakha Diallo	Former AWARE Project Director	Dakar, Senegal	Issakha.Diallo@Gmail.Com
Former WAHO DG	Kabba Joiner	Consultant	Accra, Ghana	Kabajoiner@Hotmail.Com

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