

Health Diplomacy and Regional Integration in West Africa: The West African Health Organization's Experience

Benjamin Uchenna Anaemene

Abstract

From the outset the founding fathers of Economic Community of West African States (ECOWAS) recognized the relevance of integration in the social sector based on the conviction that intense cooperation in the economic and political sectors alone will not bring about lasting regional integration. For instance, the ECOWAS treaty of 1975 and revised treaty of 1993 had the promotion of social progress and collaboration in the social field as one of the objectives of the community. Yet scholars have not given it the deserved attention. This paper therefore represents an attempt to assess the extent to which the West African Health Organization (WAHO), a specialized health agency of ECOWAS, has contributed to regional health integration in West Africa. It argues that regional integration and cooperation should not be geared solely towards economic and political purposes. It also examines the achievements as well as the major challenges confronting WAHO. It concludes that regional health integration is no longer an option but an imperative for West African countries to meet their common health challenges.

Keywords: *Health diplomacy, regional integration, West African Health Organization (WAHO), development, global health, West Africa.*

Introduction

Regional integration has been one of the foreign policy goals of African states since independence. This strategy was pursued as a means of promoting socioeconomic development and of reducing their dependence on the West. As Claude Ake aptly noted, 'even though individual states of Africa seemed content to surrender their development agenda to external development agencies they still groped collectively towards a vision of how to proceed' (Ake, 2001, p. 21). It was contended that such cooperative effort would serve as building blocks of a future African union. Consequently, the lure of regionalism has had a profound effect on the foreign policies of African states (Adejo, 2001, p. 120). The African continent was therefore subjected to waves of regional integration initiatives as a grand strategy of breaking out of underdevelopment and dependence.

West Africa was not left out in this quest for regional integration. It has been counted as one of the regions of the world with a certain experience in this area. Clear evidence is the existence of approximately 50 intergovernmental organizations in this area, some of which

trace their origin to the colonial era. Most of them are project specific or represent loose forms of regional cooperation. However, there are three economic communities pursuing the economic integration of its member countries. These include, the West African Economic Community (CEAO), established in 1972 which was disbanded in 1994 and supplanted by the West African Economic and Monetary Union (UEMOA), the Mano River (MRU) created in 1973 and the Economic Community of West African States (ECOWAS) formed in 1975.

Indeed, the inauguration of ECOWAS was a major breakthrough in the long series of efforts to institute some form of economic integration that would embrace the entire West African region. Ibrahim Gambari noted that the ECOWAS 'is a manifestation of the awareness of West African countries that they cannot reduce their dependency on the industrialized countries of the world without coming together' (Gambari, 1991, p. 14). Muny also contends that, 'the ECOWAS was created to end the subjugation of West African countries to colonial and neo-colonial forces and to alleviate and eliminate poverty' (Muny, 1989, p. 4).

Having said this, it is instructive to note that regional integration was hitherto identified with economic matters especially trade. However, it has been emphasized that regional integration should not be geared only towards economic or political purposes but also to the social sector as well. This was aptly demonstrated by the founding fathers of ECOWAS. In other words, they knew that intense cooperation in the economic and political sectors alone would not bring about lasting regional integration. For instance, the ECOWAS treaty of 1975 and the revised treaty of 1993 had the promotion of social progress and collaboration in the social field as one of the objectives of the community.

Article 2 of the treaty establishing ECOWAS stipulates:

It shall be the aim of the community to promote cooperation and development in all fields of economic activity particularly in the fields of industry, transport, telecommunications, energy, agriculture, natural resources, commerce, monetary and financial questions and in social and cultural matters for the standard of living of its peoples, of increasing and maintaining economic stability of fostering closer relations among its members and of contributing to the progress and development of the African continent (ECOWAS, 1975).

It was against this background that the West African Health Organization (WAHO) was created in 1987, as the specialized agency of ECOWAS saddled with the responsibility of promoting cooperation among its members in the field of health. The relevance of WAHO is based on the growing realization that many challenges are neglected at the global level, whereas the seriousness of certain health problems such as epidemics are harder to disregard on the regional level since many regional actors are immediately affected. However, existing studies have focused basically on international health relations in Africa through the analysis

of the activities of the continental body, the African Union and its socioeconomic agenda, the New Partnership for African Development (NEPAD). Hence, little or nothing is known about social (health) integration in West Africa. It is with this rather neglected aspect that this article is chiefly concerned. It seeks to examine the role of WAHO in the promotion of regional integration in West Africa.

Context of Regional Health Integration

A proper understanding of regional health integration would best be appreciated if the political, social, economic and health context in West African region is given a deserved attention. From a political perspective, West Africa has the largest number of rebuilding and developing countries in the world. The region is also marred by political instability. In addition, populations, infrastructures and institutions have been devastated by conflicts thereby creating a serious refugee situation in the region. Available records indicate that despite development interventions over the past several decades basic human needs remain unfulfilled across the region. Asante reports that in 1980, the average GNP for the whole sub region was around \$760 per capita and that 4 out of 16 West African countries were among the 30 least developed countries of the world (Asante, 1986). These countries were Benin, Gambia, Guinea and Niger. It was also recorded that 13 of the 16 countries of West Africa were among the world 42 most economically disadvantaged countries. It is noteworthy that the situation has not changed much since then. According to the United Nations Human Development Report of 2008, the six lowest ranked countries are in this region (UNDP, 2008). The major indicators describe a region that ranks as one of the poorest in the world, with the highest rate of population growth and one the lowest levels of human capital development. The natural resources base are deteriorating, corruption levels are high and a large part of the population does not have access to safe water, sanitation, basic education or healthcare services, adequate housing and job opportunities.

The countries in the region do not generate enough income for the average person to avoid a \$2 per day poverty line. More than 45% of the population in the region is below 15 years old and state expenditures on health and education are far below 15% (USAID, 2011). The major health problems in the region include HIV/AIDS, high child and infant mortality and high maternal mortality. The child infant and maternal mortality rates in West Africa are among the highest in the world. For instance 20% of annual worldwide maternal deaths occur in West Africa (USAID, 2011).

It is pertinent at this point to offer some insights into the linkages between health, security and development in the region in order to provide a useful background for our discussion on health diplomacy and regional integration in West Africa. The importance of health is underscored by the growing attention given to the issue in both global and regional political agendas. The consequence of this development is the frequency with which states addressed health issues through their foreign policies. This development can be traced to the collapse

of the Cold War and globalization which brought about transformations in international health which are revolutionary. The importance of health is further underscored by the redefinition of national security to include issues of health to make the concept of health security more relevant to challenges states face in the post Cold War era. For instance, in 2000 the United Nations Security Council adopted a resolution identifying HIV/AIDS as a threat to international peace and security. Health is also the subject of three of the millennium development goals. Health has also achieved an unprecedented recognition as a key driver of socioeconomic development. The protection and promotion of health has also become an independent marker of good government at national, regional and international level.

According to Javier Solana, ‘a society which is not physically healthy cannot be politically healthy. When large parts of the population suffer from a disease it has an impact on the economy and on governance’ (Solana, 2006, p.10). In recent years infectious disease has gained recognition as a threat to both development and to national security, spurring the development of the nascent field of health security (Price-Smith, 2002; Elbe, 2002; Ostregard, 2002). Using the rubric of health security, advocates assert that a population’s health is of utmost importance to the state’s ability to survive within the international system (Younde, 2004). One of the prolific authors within the health security paradigm is Andrew Price-Smith. He has demonstrated that acute and chronic changes in health status have direct and indirect impacts on security and that epidemics may lead to destabilization, political unrest, civil disorder, or long term deterioration of the economic viability of a country or region (Price-Smith, 2002). The more developed countries such as the United States, Canada and Denmark have explicitly included issues of health security in their national foreign policies but the same cannot be said of West Africa. One reason is that health has not been securitized in the region. To securitize an issue is to frame and present it as susceptible to threats. When something is securitized, exceptional measures are taken to secure the issue that faces existential threats. The argument for the securitization of health becomes more pertinent if one examines the state of health within the West African context. In a rapidly global environment, access to healthcare is considered a basic feature of a modernized world. Yet, the sad reality is that health like most basic human needs such as food and shelter is still unavailable to many in the region.

The lack of access to and deprivation of healthcare are vivid examples of human insecurities. These insecurities if not addressed pose fundamental threats to the survival and wellbeing of individuals. Moreover, they debase human dignity and deprive human beings of their freedom. When a core human need like health becomes a scarce resource, the situation becomes a breeding ground for discontent and conflict among those individuals and communities that are affected. More importantly, it also causes the spread and cross infection of complex diseases and worst of all – death. As many of us know, pandemic diseases like HIV/AIDS have become more devastating than wars. The effect of such diseases seriously undermines the social, economic and political structures of states not to mention the tremendous toll they take on human lives. Experience has shown that epidemics can reach crisis proportions

beyond the capabilities of the state to handle. The devastating effects brought about by neglect not only drain the resources of states, they can also reverse the gains from economic growth and development. When health issues are ignored or sacrificed for other types of issues, the social and economic consequences can destabilize societies and threaten political stability. In worst case scenarios, such crises could have devastating effects such as complex emergencies and failed states. However, Ban has argued that ‘while it is clear that health issues often intersect with security issues, not all health challenges represent security concerns’ (Ban, 2003, p.19). Rebecca Katz and Daniel Singer also warned that ‘health issues that do not pose security threats should not be conceptualized as such, since doing so may detract from overarching public health and foreign policy objectives’ (Katz & Singer, 2007). Thus, cooperation and assistance targeted at public health challenges that are put in the context of foreign policy may broaden partnerships and build diplomatic relationships. In this way, the act of promoting global health enhances the security of countries (Katz & Singer, 2007).

It is significant to note that there is an increasing range of health issues that transcend national boundaries and require action both at the regional and global levels. Viewed against this background, it goes without saying that no country in the region can effectively handle such health issues on its own. Consequently, the broad political, social and economic implications of health issues have brought more diplomats into the health arena and more public health experts into the world of diplomacy. The emergence of ECOWAS and its specialized agencies such as WAHO is extremely encouraging. Increasingly, these institutions are windows of opportunities for collaboration and harmonization of regional initiatives that can reduce the gridlock to social (health) development in the region.

Benefits of Regional Health Integration

It is a truism that regional integration arrangement is principally a preferential agreement among countries with the aim of reducing barriers to economic and non-economic transactions (Agu et al., 2007). It has been observed that such cooperation among countries has potential benefits for the health sector as well. Regional integration arrangements can benefit member countries especially those with small populations as do most West African countries, through increased scale and competition (World Bank, 2000). Regional health integration can provide Member states the opportunity of reduced cost of medical technology through bulk purchase mechanisms (Agu et al., 2007). In the same way, expensive high medical equipment and infrastructure that require large populations can become viable if regionalized and made simultaneously available to populations within the bloc. It can also ensure the continuity of health reforms in member countries (Agu et al., 2007). Such measures 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. Regional health integration makes this possible even in the face of the frequent changes of Ministers of Health experienced by various countries.

Another derivable benefit from regional health integration include resource pooling for the purpose of promoting regional goods and combating regional public bads (World Bank, 2000). Such arrangements can provide a framework for resource sharing or for dealing with cross border problems, such as HIV/AIDS, pollution among others.

Regional integration and cooperation arrangements also strengthen enforceability (Agu et al., 2007). In addition, the regular contact and relationship between policy makers that regional integration arrangements demand can strengthen support and integration arrangement. Also, activities can be undertaken which member states cannot implement on their own due to strictures in both human and financial resources (Agu et al., 2007).

Conceptual Clarifications

Perhaps a much more rewarding way to address the subject matter of this article is to confront and objectively analyze the core concepts. These include regional integration and health diplomacy.

Regional Integration

Integration is one of the most controversial concepts in international relations. Hodge has attributed this definitional chaos to the strong normative element which is present in most, if not all, of the various attempts to describe, explain and predict regional integration (Hodge, 1978). Haas holds that integration is a strengthening of ties reflected through a process in which national political actors shift their expectations, loyalties and political activities from the nation state level to a larger centre with institutions possessing or demanding authority over the nation state (Haas, 1958).

Integration can also be viewed as a phenomenon reflected by transactions coupled with cooperative decision making among states. It could therefore be taken as a process of linking an existing system with a future system. If the present international scene represents a series of different nations with their different political environments, the future of these nations if involved in integration, would be the type that would lead to greater interaction and cooperation. The nation state through integration, are brought together for common purposes within the same institutional structures.

Amitai Etzioni has argued that integration is a condition. He opined that a political entity which possesses effective control over the use of the means of violence is integrated. This is because such community has a centre for decision making with the power for allocating resources and rewards throughout the community. The community also becomes the dominant focus of political identification for the large majority of the politically aware citizens and, logically, political unification is produced through political unification (Etzioni, 1965). Conversely, Lindberg sees integration as a process whereby nations forgo

the desire and ability to conduct foreign and key domestic policies independent of each other. Instead of doing them independently, they seek to make joint decisions or to delegate the decision making process to new central organization. Lindberg contends that integration is the process whereby political actors in several distinct settings are persuaded to shift their expectations and political activities to a new centre (Lindberg, 1963).

Deutsch posits that it is a condition (Deutsch, 1957). It is a situation which a people have attained within a territory. It is manifested by a 'sense of community and the growth of institutions and practices strong enough and widespread enough among the people involved to assure for a long time dependable expectation of peaceful change' (Deutsch, 1957). By this definition, integration is a matter of fact and not of time i.e. what it is, rather than what it would be. Adeniran commenting on the position taken by Deutsch states that his approach tends to watch and measure integration by the flow of international transactions, the movement of trade among others (Adeniran, 1982). On the other hand, scholars such as Haas and Lindberg are concerned with the formal institutions that are established for purposes of integration. It is through these that they determine the extent to which certain functions are carried out so as to determine the extent of integration. From the foregoing, it is apposite to agree with Hodge that there are two major approaches to integration theory namely: the transaction approach, which emphasizes the role of transactions between people as both an indicator of their attitude towards each other and as the begetters of interdependence within the community (Hodge, 1978). The major exponent of this approach is Karl Deutsch; and the neo functionalist approach which stresses the way in which supranational institution possessing binding decision making power emerge from a convergence of self interest on the part of various significant groups in society. The major proponents include Ernst Haas, Inis Claude, Joseph Nye among others.

In the general sense, therefore, integration involves the coming together at a higher level, within the international system, of certain units from a lower level. Integration implies the shifting of allegiance from one's tribe or ethnic group to the nation or from one's nation to an international community or regional association. This occurs mostly in expectation of joint rewards or for fear of likely penalties (Adeniran, 1982).

Integration has been identified by statesmen and leaders as well as scholars around the world as a strategy for development, the evidence being the proliferation of regional groups since the wake of the 1970s. Marvin Leshaba asserts that 'throughout the world, regional integration has gained momentum and is seen as the panacea to dealing with the shortcomings of the state' (Leshaba, 2009). Even the largest world economic power, the United States finds it necessary to integrate by creating the North American Free Trade Association (NAFTA) and the erstwhile atomistic European countries are also rushing for cover under the European Union. This means that the benefits of integration cannot be overemphasized. As I mentioned earlier, integration has been proposed in the developing countries as a major response to the problems of underdevelopment (Segal, 1967). Omitola and Jiboku argues that as the gap between the developed and the underdeveloped countries

increases, integration is conceived as a defensive reaction by the developing countries to harness their limited resources for development purposes as well as a source of bargaining power in their relations with the developed world (Omitola & Jiboku, 2009). This gap has become more widened with intensification of economic, political, social and cultural relations across international boundaries and especially the current economic dominance in form of globalization.

The trend towards regionalism in the 1980s has been characterized by headlong rush, involving qualitative and quantitative changes in regional integration schemes (World Bank, 2000). One of the important lessons arising from this period is that effective integration requires more than reducing tariffs and quotas (World Bank, 2000). Thus, an enabling environment for regional integration and collaboration in the social (health) sector in West Africa beyond the traditional economic, trade, and political fields has been facilitated by the several positive integrative policies of the West African Health Organization.

Health Diplomacy

Health diplomacy dates back to the middle of the 19th century and at the same time it is a recent diplomatic innovation (Youde, 2004). In the past, health diplomacy focused primarily on international collaboration to protect human and commercial interest against the spread of particular diseases (Youde, 2004). It materialized first by the creation of international public health institutions as from 1838 and by a succession of international conferences which started in 1851 and the drafting of international sanitary conventions (Beigbeder, 1998). It is important to state that these early efforts represented a narrow conceptualization of health diplomacy and one quite different from what we have today. The distinction is based on the fact that health diplomacy during the early period focused on diseases rather than health. Thus, international collaboration in the field of health focused on those diseases that threatened to interrupt commerce rather than a general concern for human wellbeing.

Health diplomacy has conjured disparate interpretations in the contemporary period. A proper understanding of health diplomacy is best done by a meticulous survey of its two broad conceptions. First, are those definitions focusing on the field being driven by globalization, diverse actors beyond nation states, health negotiations and health impact of non-health negotiations. For example, Kickbusch et al. (2007) defined health diplomacy as the ‘multi-level and multi-actor negotiation processes that shape and manage the global policy environment for health’. Second, are conceptions that deemphasize both negotiations and the primary role of global health. They dwell basically on efforts aimed at improving health of a receiving country within the larger context of supporting the providing country’s national interest. In other words, they emphasize the use of health interventions as instruments to advance foreign policy interests. For example, Fauci defines health diplomacy as ‘winning the hearts and minds of people in poor countries by exporting medical care expertise and personnel to those who need it most’ (Fauci, 2007, p. 171). Tommy Thompson, the former United States Secretary and Human Services, promoted the use of what he termed ‘medical

diplomacy' as an important element of the government's anti-terrorism strategy. Thompson remarked that 'what better way to knock down the hatred, the barriers of ethnic and religious groups that are afraid of America, and hate America, than to offer good medical policy and good health to these countries' (Thompson, 2005; http://www.boston.com/news/globe/editorial_opinion/oped/articles/2005/10/24/the_cure_for_tyranny_/).

These definitions take a more holistic view of both health and the international community. It moves beyond an explicit focus on particular disease and instead recognizes how various manifestation of ill health can have negative consequences for international community. It would be wise to agree with Buss and Ferreira that health diplomacy addresses health issues that transcend national borders and expose countries to global influences (Buss & Ferreira, 2010). It also ensure a better, more coherent coordination between the government's health policies and external relations sector, not only in advocating the acceptance of health related goals in the millennium development goals but also ensuring that those are incorporated into the countries health and development plans.

Today, health diplomacy manifests itself in three ways. First, as disaster diplomacy it involves providing relief to areas ravaged by natural disasters like earthquakes, tsunamis and drought (Ratzen, 2005). The second form, deals with one country or a group of countries engaged in developing healthcare infrastructure in a country or a group of countries (Youde, 2004). The third form and the one that is the focus of this article concerns international agreements and conventions designed to bring many parties together to address health concerns (Youde, 2004). An important part of health diplomacy takes place within the West African Health Organization. This article is therefore an analysis of the collaborative diplomacy of health in West Africa, in this case the West African Health Organization.

WAHO: Its Emergence and Institutional Organization

The models of international health cooperation in the West African region are divided into two categories (Agu et al., 2007). The first category is organisations that established specialized health communities and also created capacity within existing communities to undertake work in health. Apparently, ECOWAS stand out as the only community in West Africa that established a specialized health agency known as WAHO, which was created in 1987 to handle cooperation on health matters among the 15 member states.

The second category is organizations that did not establish specialized health agencies but have decided to increase their capacity to undertake work on specific health issues. For instance, UEMOA does not have a protocol on health, but its ministers of health have approved a plan for future cooperation in health (UNECA, 2004). Such policy initiatives include, the adoption by UEMOA Ministers of Health, in the 3rd Ordinary Meeting of their Assembly in January 2005, of a communiqué on Harmonization of Pharmaceutical Regulation among member states. Similarly, in the 4th Ordinary Meeting of their Assembly

in September 2005 in Ouagadougou, Burkina Faso, they recommended and elaborated on Regional Strategy on HIV/AIDS Control, in recognition of the fact that the annual increase in AIDS is higher in the UEMOA region. One remarkable achievement was the adoption of the Regional Strategy Paper on HIV/AIDS and STD Control by a session of the Statutory Ministers Council held in December 2005. Apparently, the UEMOA Commission is gradually organizing the implementation of the Regional Strategy for HIV/AIDS Control, including the establishment of a regional fund to support the global response to HIV/AIDS, and the launching of important projects on HIV vaccine research and development.

WAHO was established in 1987 as a specialized agency of ECOWAS. The protocol creating the organization was adopted by the Heads of States and Governments from the 15 countries in the ECOWAS that is, Benin, Burkina Faso, Cape Verde, Cote d'Ivoire, The Gambia, Ghana, Guinea, Guinea Bissau, Liberia, Mali, Niger, Nigeria, Senegal, Sierra Leone, and Togo. The protocol was further ratified by each government. The overall objective was:

the attainment of the highest possible standard and protection of health of the people in the sub region through the harmonization of the policies of the member states, pooling of resources and cooperation with one another and with others for a collective and strategic combat against the health problems of the subregion (http://www.wahooas.org/spip.php?page=rubriqueS&id_rubrique=24).

WAHO was created against the backdrop of conflicting agendas that were being pursued at the time by the existing intergovernmental health organizations in the sub region: the Francophone organization de coordination et de cooperation pour la lutte contres les Grandes Endemies (OCCGE) and the Anglophone West African Health Community (WAHC) (<http://aros.trustafrica.org/index.php/>). It was later resolved that since health matters are not bound by linguistic difference, it would be of great advantage to the organizations to harmonize their efforts and combine resources to enhance the impact of their programmes in West Africa. Consequently, the OCCGE and WAHC merged to form WAHO, an organization committed to transcending linguistic borders in the sub region. In October 1998, the ECOWAS Heads of State and government established Bobo-Dioulasso Burkina Faso as the headquarters of WAHO. In March 2000, WAHO began active operations as a leading health authority in the sub region serving the ECOWAS member states.

The main functions of WAHO include: cost effective interventions through maintaining sustainable partnerships, strengthening capacity building, collecting, interpreting and disseminating information, promoting cooperation and ensuring coordination and advocacy and exploiting information communication technologies. These functions have served the organization well since its inception. The institutions of the West African Health Organisation are:

1. The Authority of Heads of State and Government of member states. This is the principal governing institution of the community. The Authority is responsible for

the general direction and control over the performance of executive functions of the community. It is also the supreme decision making body of WAHO.

2. The Council of Ministers. It is a rotating panel of Ministers from ECOWAS members that can include Ministers of integration, Economic Planning and Finance, and Foreign Affairs. The Council is responsible for the functioning and development of the community and makes recommendations to The Authority of ECOWAS on any action related to the objectives of the community.
3. The jurisdiction of the Assembly of Health Ministers. This is basically limited to matters of health and more particularly to the technical aspects. The Assembly determines the general policies of WAHO and makes other appropriate decisions to promote or advance the objectives of the organization.

It is significant to point out that WAHO enjoys administrative and financial autonomy (<http://aros.trustafrica.org/index.php/>). This autonomy is maintained through the General Directorate of WAHO. The Directorate is responsible for the execution of the organisation's programmes and activities. It is headed by a Director General and assisted by a deputy Director General. Current WAHO activities include: preparedness for responses to epidemics of meningitis, measles, cholera and yellow fever, support to country prevention of blindness programmes, support for the creation of network of National Health Information Systems, and Research Centers and Institutes of ECOWAS, young professional training, support to Research Centers by allocating funds for operational research etc. and the organisation of nutrition focal point.

Achievements So Far

The case of regional integration, although clear in theory, is difficult to achieve in practice. Nevertheless, several health initiatives have been undertaken by WAHO in the West African sub region with some notable successes.

In the area of infectious disease control, WAHO has supported West African neighbours, Benin, Nigeria and Ghana to harmonize the process of producing the HIV/AIDS drugs for the region, where the drugs are currently being imported. It has also encouraged cross border cooperation on infectious disease control. The organization was also instrumental in the reduction of taxes and tariffs on commodities for malaria control. In other words, it decreased regional trade barriers to mosquito nets.

WAHO in collaboration with all its partners was involved in blindness prevention specifically in the area of coordination. They created a forum for discussion, exchange of views and sharing of experience on VISION 2020 for West Africa known as Advocacy Forum For Vision 2020 in West Africa (http://www.wahooas.org/spip.php?page=rubriqueS& id_

rubrique=24). In addition, WAHO in collaboration with the University of Marseille in France and IOTA (Institut d'Ophthalmologie tropicale de l'Afrique) in Mali, as well as with the support of its partners, organized a training of the trainers in Sutureless IOL surgery for Francophone Ophthalmologist. In 2005, a similar training session was also organized for all Anglophone Ophthalmologists in Nigeria. This training provided an alternative solution to the difficulties faced by cataract surgeons in WAHO countries (<http://www.wahooas.org/>). WAHO is also contributing to the attainment of the health related millenium development goals (MDGs) through the strategic orientation of ECOWAS health ministers concerning regional health priorities (Johnson & Keita, 2010). WAHO organizes the annual Assembly of ECOWAS Health Ministers and experts on MDG related themes, scaling up tried and tested cost effective interventions for women and children. It offers technical and financial support to countries and particular emphasis is placed on developing human resources for health including the harmonization of curricular for basic training of various categories of health workers.

In the area of improved nutritional conditions in the sub region, WAHO developed a consensual document through the ECOWAS Nutrition Forum (http://strategicplan_en_07.pdf). The ECOWAS Nutrition Forum was formed in 1995 as the West African nutrition focal point. It brings together nutrition actors from the commission 15 member states. The forum is coordinated by the West African Health Organization. It has enabled partners to contribute to the control of malnutrition through support to member states in a number of ways, using a synergistic approach and conforming to national and sub regional priorities. These collaborative efforts between partners and members of the forum have yielded encouraging results on the fight against vitamin A deficiency, promotion of exclusive breastfeeding, advocacy for nutrition and the adoption of the Essential Nutrition Action approach for promoting child survival (http://strategicplan_en_07.pdf). Indeed, the forum has contributed to a reduction in malnutrition through the implementation of identified priority strategies in a concerted and efficient manner in West African countries.

Another notable achievement of WAHO regional health integration is in the area of reproductive health. This was achieved by WAHO in concert with the United States Agency for International Development (USAID) through the agency's several regional projects such as 'Action for West African Region Reproductive Health and HIV/AIDS (AWARE-RH/AWARE-HIV from 2004 to 2008, and AWARE2, 2009-2012) (Johnson & Keita, 2010). This project aims at promoting best practices in RH/FP, maternal and child health, HIV/AIDS, as well as supporting countries in establishing legal and regulatory frameworks conducive to their replication and also raise fund for their implementation work. As part of AWARE-RH's efforts to strengthen partnerships for better health, AWARE-RH responded to WAHO's request for data on each country's respective efforts to improve maternal health. AWARE-RH joined WAHO in creating a cohesive questionnaire that could assist in identifying policy gaps advocacy efforts and moving the policy agenda in maternal and neonatal health. With technical support from AWARE-RH, WAHO organized a sub regional advocacy training featuring AWARE-RH's computer based advocacy tools

(Johnson & Keita, 2010). The partnership has also brought about the development of a sub regional strategy for Reproductive Health Commodity Security.

WAHO also supported health research development in the sub region. To this end, WAHO signed a cooperation agreement with the Council for Health Research for Development (COHRED) an international non governmental organization on January 20, 2010 (http://COHRED_WAHO_PRESS_RELEASE_EN_FINAL.pdf). The agreement is aimed at improving the quality and relevance of research for health of member states, and towards increasing the capacity of their research organizations to produce the evidence that meets their priority health needs. An important focus is the development of national policies, governance structures and priorities for health research to support goals for national public health and economic development. This is imperative in view of the fact that most West African states such as Liberia and Sierra Leone have recently emerged from long conflicts and are rebuilding their structures from the ground up. WAHO in partnership with COHRED provides support for countries' action plans by providing them with services to strengthen their system for health research. The goal of system development brings two long term benefits to the countries (http://COHRED_WAHO_PRESS_RELEASE_EN_FINAL.pdf). First, a country with a strong health research will better manage its research to meet the country's development goals. Second, it will also be able to engage with donors and research funders on its terms.

Consequently, the countries in the region collectively requested WAHO to serve as the regional hub for system strengthening and linking useful information between countries. COHRED supports WAHO in this role by offering technical assistance in areas such as health research system, policy development, building capacity and skills for research management communication and developing information platforms including web service in the region. WAHO in conjunction with USAID launched an Applied Research Small Grant Program under which five West Africa research institutions have each received the first installment of a small grant to conduct key research into key health challenges in the region and to propose solutions that can be implemented.

Challenges

The above examination of WAHO in the sub region illustrate that contrary to established opinions, significant strides have been made during the past decade. However, they could be considered limited when compared with set objectives and schedules. Experience with regional integration and collaboration in the field of health is bedeviled by various challenges.

One major problem facing WAHO is the lack of adequate human and fiscal resources to pursue even their priority activities relating to health integration (Guy, 2002). This is due mainly to the absence of a self financing mechanism which has been a major obstacle. It is also symptomatic of an overall lack of political will to mainstream regional commitments

and agreements into the national plans to ensure the success of the process as well as the low priority given to social (and health) issues within ECOWAS.

The effectiveness of WAHO is also limited by institutional proliferation. This makes integration efforts costly and cumbersome and resulted in overlapping membership of several countries in several organisations pursuing similar objectives but with different procedures and schedules which ultimately lead to conflicting decisions (Soumana, 2006). For instance, within ECOWAS we have multiplicity of players in the health sector. There are; the AFRO Intercountry Team in Burkina Faso, UEMOA with its own health strategy, and WAHO-the specialized health institution of ECOWAS. However, these organizations may be seen as an embodiment of enthusiastic policy response to fill existing gaps and serve a felt need in the field of health, but the overlapping membership are perceived as wasting both efforts and resources thereby complicating the work of harmonization and coordination. The impact has important implications for the capacity of WAHO to undertake the important work of regional integration and cooperation in the health sector.

The integration process in West Africa is constrained by conflicts in some member states. Conflicts and political unrest hinder regional health integration by weakening the already overburdened national health system. About 50% of the countries in the West African region have experienced situations of instability during the last 15 years. The conflicts have negatively affected the normal functioning of WAHO. As a corollary, peace and security issues tend to take precedence over social and economic development concerns in the region.

Conclusion

So far we have shown that regional integration in the field of health is no longer an option but an imperative for West African countries as well as the developing countries to meet their common health challenges. WAHO represents for the member states a way to increase regional health integration linkages. The consolidation and sustenance of the integration process in the field of health remains a key factor in the promotion of regional integration in West Africa.

However, there is the need to work towards the eventual rationalization of the myriad of disparate regional health groupings which have served more to distract the member states than help the integration process. Regional health integration should move more towards the sharing of experiences and best practices and increased coordination of activities. There is also the need for WAHO to address the issue of manpower development in West Africa. This can be achieved through the establishment and strengthening of public health schools, with world class facilities in West Africa (WHO, 1969). These specialized schools could also become the loci within the sub region for fellowships training by various UN agencies, including WHO. There are several derivable benefits from this arrangement: the training received will address the local health needs of populations in the sub region; it will be

more cost effective compared to training conducted outside the West African region and it will stem the outflow of trained professional and technical personnel from the sub region to the developed countries (Agu et al., 2007). The organization should also strengthen emergency preparedness and response. Moreover, in order to be effective, WAHO must serve the collective interests of the constituent states rather than being an expression of their conceived interest, in which case they will be working at cross-purpose to solve problems and respond to regional health challenges. It is therefore safe to conclude that regional health integration in West Africa is absolutely imperative not only for development but for the survival of West African countries.

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