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Working Paper: ECOWAS and the Covid-19 pandemic: Regional responses and African inter-regional cooperation

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Introduction

Inspired by recent blog posts on the regional dimension of responses to the current pandemic of the Coronavirus Disease (Covid-19), this paper echoes the warning against methodological nationalism and the neglect of regional and inter-regional dimensions in the responses to the crisis (in particular Witt 2020; and Engel 2020). It does so by focusing on ECOWAS, as an example of the so-called regional economic communities (REC) that have remained rather neglected compared to the academic attention dedicated to the African Union, especially with regard to the African Peace and Security Architecture (APSA), but also considering other fields of cooperation, such as health (cf. Anaemene 2013, 60-61). Moreover, this paper centers on an issue that has been mentioned only in passing, namely intra- and inter-regional dynamics of competition and coordination, which become particularly visible from a socio-spatial perspective.

In her post on the blog of the Peace Research Institute Frankfurt (PRIF), Antonia Witt re-constructs the efforts by the African Union to fight Covid-19 to counter-balance a strong (re)emerging focus on national responses, largely focusing on isolation (e.g. closing borders, prohibiting travels). Highlighting in particular the agency of the Africa Center for Disease Control (Africa CDC), launched in January 2017 in response to the Ebola epidemic in West Africa in 2014/15, as an example of “internationalism”. A similar approach is taken by Ulf Engel (2020), comparing approaches by the World Health Organization’s (WHO) Regional Office for Africa, the Africa CDC, and the Ethiopian government. On this basis, Engel argues that while representing a case of internationalism, regional, trans- and inter-regional dimensions (i.e. different spatial scales) also play an important role in the efforts of different African actors, but in particular the African Union, to assume agency in international relations. Although Engel’s contribution explicitly refers to efforts by the African RECs, and the required coordination efforts between them and the African Union (as well as other spatial scales), his analysis does not go into detail about responses employed by those RECs, and how exactly they link (or not) with efforts by the African Union and Africa CDC.²

Academic literature on the topic of West African regional responses to epidemics or pandemics, as well as regional health cooperation more generally, is rather limited. So far, only very few publications have touched upon the subject. The few exceptions in this regard include the publications discussed in the following. Adopting an institutional-legal perspective,

² Moreover, a series of blog posts on the news, opinion and research platform African Arguments (www.africanarguments.org), have grappled with the implications of the Covid-19 pandemic for Africa, for example reflecting upon related politics (de Waal 2020) and potential negative side effects in already autocratic regimes (Seyhan 2020). However, the only contribution in this series focusing on crisis response by African RECs, so far, has been the post by Cedric de Coning (2020), discussing some of the problems linked to AU organs such as the Peace and Security Council pausing their work, due to the need to adapt to the new situation.

Onzivu (2006) considers four “regional integration schemes” – the African Union, ECOWAS, the Association of South East Asian Nations (ASEAN), and the Caribbean Community (CARICOM) – to analyze the emergence and development of regional health policies out of regional economic cooperation efforts. With regard to ECOWAS, Onzivu, provides a short overview of the founding protocol of ECOWAS’ West African Health Organization (WAHO), from 1987, and a short analysis of regional capacities. Anaemene (2013) analyzes the links between regional integration, security, development and health diplomacy. Focusing on WAHO, Anaemene provides a very brief overview and analysis of the organization’s setup, before reflecting upon its achievements and challenges. Two additional publications were triggered by the experience of West African responses to the Ebola epidemic in the region. In an academic commentary, Bappah (2015) argues that ECOWAS played a leading and proactive role in response to the Ebola outbreak in 2014/15, but initially depended too much on member state institutions, which mostly lacked capacities for effective responses. Later, the process of regionalizing the response, most notably through the agency of WAHO, was to slow (Bappah, 2015,191). Ifediora and Aning (2017) provide short overviews of the regional and international responses to the Ebola outbreak in West Africa, focusing in particular on the WHO, the African Union, and ECOWAS. The authors assess their respective takes on the emergency, reflecting a general lack of adequate resources and preparedness at all levels, and different degrees of ‘securitization’ of the crisis.

While all of these publications provide valuable insights and good starting points, much more academic research and discussion on the subject is required. Knowledge about ECOWAS health cooperation more generally and WAHO in particular is still very thin. Furthermore, in recent years the institutional landscape has become more complex with the emergence of a stronger regional actor at the continental scale since January 2017, the Africa CDC, and the creation of another specialized ECOWAS (sub)structure, the ECOWAS Regional Center for Surveillance and Disease Control (RCSDC) in 2015/16. Therefore, in this paper, after providing some background information on WAHO and the RCSDC – the two main ECOWAS specialized agencies established to respond to pandemics – I look at the responses by ECOWAS actors to the current Covid-19 pandemic.³ Finally, draw some tentative conclusions with regard to regional and inter-regional cooperation dynamics, and reflect on how the current crisis foregrounds ongoing issues of space-making, in particular the continuous construction (and re-construction) of different regional spaces and the organization of spatial order among them.

³ An overview of the responses by individual West African states is provided by the OECD’s Sahel and West Africa Club (see <http://www.oecd.org/coronavirus/en/#country-tracker>, accessed 21 April 2020), in addition to a collection of up-to-date data, analysis, and media reports regarding the Covid-19 situation (see <http://www.oecd.org/swac/coronavirus-west-africa/>, accessed 21 April 2020).

ECOWAS, WAHO and the RCSDC

Technically, WAHO has existed for 33 years, originally coming into life as the result of efforts to avoid competition between anglophone and francophone states in West Africa, merging the Anglophone West African Health Community (WAHC, established in May 1972, based in Lagos, Nigeria) and the Francophone *Organisation de Coordination et de Cooperation pour la Lutte Contre les Grandes Endemies* (OCCGE, established in 1963, based in Yaoundé, Cameroon) (cf. ECOWAS Authority 1987, Preamble and Art. II).⁴ In November 1984, at its 16th session in Lomé, the ECOWAS Council of Ministers decided to merge the two organizations, following extended negotiations (cf. ECOWAS Council of Ministers 1984a, 1984b, 7). Three years later, the ECOWAS Authority of heads of state and government signed the protocol establishing WAHO as a specialized institution of ECOWAS, in July 1987 in Abuja (ECOWAS Authority 1987). The protocol entered into force in August 1989, and was subsequently revised only once, in January 2006 by a Supplementary Protocol (ECOWAS Authority 2006).⁵ Following a proposition of the ECOWAS Assembly of Health Ministers, meeting in Lomé in July 1998, and a request by the Burkinabé representative at the ECOWAS Council of Ministers (cf. ECOWAS Council of Ministers 1998b) to host the WAHO headquarters, in October 1998 in Abuja, ECOWAS heads of state decided to establish it in Bobo-Dioulasso (cf. ECOWAS Authority 1998a).

However, WAHO became fully operational and active only in 2000,⁶ 13 years after its formal establishment, as in 1998 negotiations between WAHC and OCCGE representatives were still ongoing, and staff still had to be recruited (cf. ECOWAS Council of Ministers 1998a, 19-20). The process also needs to be understood in the context of more general efforts by ECOWAS actors to “rationalize” inter-governmental organization in the West African region, during the 1980s and 1990s. For these efforts, the merger between WAHC and OCCGE became a key reference (e.g. cf. ECOWAS Authority 1998b, Art. 2).

The principal WAHO organs, unchanged since 1987, are the Assembly of ECOWAS Ministers of Health, a Committee of Experts (assisting and advising the Assembly), and the WAHO General Directorate, headed by a Director General as WAHO’s the chief technical, administrative and financial officer (ECOWAS Authority 1987, Arts. IV-IX). In principal, WAHO

⁴ Somehow, parallel efforts persist. The West African Economic and Monetary Union (UEMOA), although in a much less structured way than ECOWAS / WAHO, also convenes an Assembly of its health ministers, developing regional strategies, e.g. on pharmaceutical regulations and the control of HIV/AIDS and Sexually Transmitted Diseases (cf. Anaemene 2013, 67-68).

⁵ Most importantly the Supplementary Protocol reorganizes the specialized technical divisions of WAHO (Art. X.1-2), and changes the budgeting procedure (DG proposing to Health Assembly, for approval by CM) (Art. XII).

⁶ See <https://www.ecowas.int/life-in-the-community/325-2/> (accessed 23 April 2020).

has administrative and financial autonomy (cf. ECOWAS 2014). However, presentations of the organization on the ECOWAS and WAHO websites stress the role of the ECOWAS Authority as the Community's supreme political decision-making body, supported by the ECOWAS Council of Ministers.⁷ Whereas the foundational protocol mostly refers to the Council of Minister when it comes to appointing the Director General, its Deputy, and approving the WAHO budget (both on recommendation of the Assembly of Health Ministers), these presentations point out that the Assembly of Health Ministers was basically limited to "matters of health, and more particularly to the technical aspects therein", nevertheless determining general WAHO policies and making "other appropriate decisions to promote or advance the objectives of the Organisation".⁸ As the account below also suggest, in practice, WAHO actors appear to act relatively autonomously, and the WAHO Director General (DG), currently Prof. Dr. Stanley Okolo (from Nigeria),⁹ has assumed a particularly prominent role.¹⁰

WAHO's main objective, the "attainment of the highest possible standard and protection of health of the peoples in the sub-region", is to be achieved through policy harmonization, pooling of resources, and cooperation towards a "collective and strategic combat against the health problems of the sub-region" (ECOWAS Authority 1987, Art. III.1; see also Figure 1). Recognizing already in 1987 "that diseases know no boundaries and unequal development in different countries in the promotion of health and control of disease pose a common problem" (ECOWAS Authority 1987, Preamble), West African heads of state defined WAHO's functions to include (a) research; (b) training, (c) serve as a forum for collecting and disseminating relevant health information; (d) assist in setting up technical information centers; (e) promote and harmonize the production of vaccines, drugs, and quality control laboratories; (f) combating drug abuse; (g) promote exchange of "manpower" (later re-labeled 'human resources') and health technology; (h) advise on the health aspects of development projects; (i) assist in strengthening the health services and infrastructure of member states; (j) give active support to solving health problems in times of natural disasters or emergencies; (k) collaborate with international, regional and sub-regional organizations; (l) promote co-operation among scientific and professional groups; (m) propose conventions, agreements

⁷ See <https://www.ecowas.int/life-in-the-community/325-2/> and <https://www.wahooas.org/web-ooas/en/who-we-are> (both accessed 23 April 2020).

⁸ See <https://www.ecowas.int/life-in-the-community/325-2/> (accessed 23 April 2020). See also ECOWAS Authority (1987, Art. VI).

⁹ Stanley Okolo holds a postgraduate degree in Obstetrics & Gynaecology from the UK. He has a PhD in Endocrinology from the University College London. He also holds professorships at City University and Middlesex University, all in London, and is a fellow of both the West African College of Surgeons and the Royal College of Obstetricians and Gynaecologists in the UK (<https://wahooas.org/web-ooas/en/mediatheque/articles/handing-over-ceremony-professor-stanley-okolo-takes-office-waho-director>, accessed 23 April 2020).

¹⁰ Okolo took over from Dr. Xavier Crespin (from Niger) in March 2018. Crespin had been in office since February 2014. Previous WAHO DGs have been Dr. Placido Cardoso (2008-2013, from Guinea-Bissau) and Dr. Kaba Joiner (2000-2007, from Nigeria). For more information about WAHO DGs see <https://www.wahooas.org/web-ooas/en/a-propos/directeurs-generaux> (accessed 23 April 2020).

and regulations and make recommendations with respect to sub-regional health matters (ECOWAS Authority 1987, Art. III.2).

Figure 1: WAHO Logo



Source: <https://www.wahooas.org/web-ooas/en> (accessed 23 April 2020)

These objectives have later translated into several programs and projects, according to subsequent strategic plans (currently 2016-2020, with 13 programs and 13 projects).¹¹ To perform its functions, WAHO has partnered with various agencies, such as the WHO, USAID/West Africa, GIZ, UNAIDS, and UNICEF.¹² Especially, since the Ebola epidemic in 2014/15, donors have significantly increased their support to WAHO, specifically with regard to responding to epidemics and pandemics in West Africa.¹³

While it is beyond the scope of this paper to assess the work and effectiveness of the WAHO,¹⁴ the large consensus criticizing the 'weakness', 'unpreparedness' (etc.) of West African actors to respond to the Ebola epidemic in 2014/15 (e.g. cf. Bappah 2015; Ifediora and Aning 2017), appears to point to significant shortcomings, at least with regard to emergency management. Responding to these shortcomings, and heavily supported by donors, ECOWAS heads of state and government approved the establishment of the Regional Center for Surveillance and Disease Control (RCSDC) in May 2015 in Accra (ECOWAS Authority 2015, Par. 15). This decision followed a recommendation by the ECOWAS Assembly of Health Ministers from March 2015 (meeting in Niamey) and recognized a call by the African Union for the RECs to create regional *centers* for disease control.¹⁵ In December 2015, the ECOWAS

¹¹ See <https://www.wahooas.org/web-ooas/en/programmes> (accessed 23 April 2020).

¹² USAID – United States Agency for International Development; GIZ – German Corporation for International Cooperation; UNAIDS – Joint United Nations Programme on HIV/AIDS; UNICEF – United Nations Children's Fund.

¹³ E.g. see <https://www.giz.de/en/worldwide/62702.html> and https://eeas.europa.eu/headquarters/headquarters-Homepage/57588/eu-ecowas-giz-launch-regional-support-improve-surveillance-and-response-networks-against_nb (both accessed 23 April 2020).

¹⁴ For a brief assessment of achievements and challenges, see Anaemene (2013, 69ff). A short overview about WAHO's strategic plan for the period between 2009 and 2013 is given by Ifediora and Aning (2017, 230).

¹⁵ In fact, the need for such a center was first suggest in July 2009 by the Assembly of ECOWAS Health Ministers in Yamoussoukro (ECOWAS Council of Ministers 2015b, 2). At the African Union level, the process emerged more strongly in July 2013, at an African Union Special Summit on HIV,

Council of Ministers approved the regulations, adopted by the ECOWAS health ministers in Dakar in November 2015, regarding the setup and operation of the RCSDC, tasking the ECOWAS Commission and WAHO to mobilize external fund amounting to five million US Dollar, required for the operationalization of the Center to be setup in Abuja, Nigeria (cf. ECOWAS Council of Ministers 2015b, 2; ECOWAS Council of Ministers 2015a, Par. 55-59).

According to its Regulations (ECOWAS Council of Ministers 2015b), the Center was established as a “regional structure, responsible for prevention and control of disease across the ECOWAS region” (Art. 2). According to its statute, it is a Specialized Agency of ECOWAS with legal personality and financial autonomy (Art. 3.1), however, operating under the “supervision” of WAHO (Arts. 3.3 and 5.3) – this tension is present throughout the Center’s operating procedures. Despite the more narrowly defined purview (i.e. disease control), the Center’s mandate reads a lot like the more general one of WAHO (see the WAHO functions listed above). In addition to producing and distributing information, public communication, and regional capacity building, it is among other things mandated with the operation of a “dedicated regional surveillance network” (Par. 4.a), to perform early warning, and to support the creation of national emergency operating centers (Art. 5). The RCSDC structure consists of a Governing Board, comprising the WAHO DG (as chair), the WAHO Director of the Department of Disease and Epidemics Control, a representative each of the ECOWAS Commission, the Regional Animal Health Center, the WHO, as well as six member-state representatives of the national coordinating institutions (Art. 8). Under the oversight of the Governing Board work the Office of the Director (responsible for day-to-day operations, strategic planning, implementation and evaluation), supported by a Technical Advisory Committee (composed of regional and international experts). The RCSDC Executive Director is appointed by the ECOWAS Commission President (Arts. 9-11).

In order to setup the ECOWAS RCSDC, the Council of Ministers tasked WAHO to work with the Nigerian Center for Disease Control (NCDC) and WAHO should propose to the ECOWAS Commission President an Acting Executive Director for the Center (ECOWAS Council of Ministers 2015b, Arts. 15-16). In June 2016, the Center’s Governing Board held its inaugural meeting in Abuja. At the time, the NCDC hosted the RCSDC in its own facilities, before it eventually moved into a separate office, starting operations with the first batch of dedicated staff in February 2018.¹⁶ The choice of Abuja; Nigeria, as headquarter of the RCSDC contrasts with WAHO being based in Bobo-Dioulasso, Burkina Faso. According to the NCDC the “choice of Nigeria [as headquarter] was based on the country’s successful Ebola response

TB and Malaria that took place in Abuja. However, it took until January 2016, for the AU Assembly to approve the statutes of the Africa CDC (cf. AU Assembly 2016, Preamble; see also Engel 2020).

¹⁶ See <https://nigeriahealthwatch.com/ecowas-regional-centre-for-surveillance-and-disease-control-starts-operations/#.Xpgjzy-nnBI> (accessed 16 April 2020)

which evidently informed other West African states' strategies towards the ultimate containment of the outbreak, the human capital base and most importantly leadership commitment".¹⁷ Nevertheless, the Nigerian offer to provide building, staff and funding probably played an important role, too. Since 2016, several Chief Executive Officers of the NCDC have doubled as Acting Executive Director of the RCSDC.¹⁸ All this, appears to point once more to the tension of the Center being imagined as a relatively autonomous structure – a specialized agency itself – and being under the “close supervision” of WAHO (ECOWAS Council of Ministers 2015b, Art. 5; see also organizational chart under Art. 7), indeed rather a sub-structure of WAHO – another specialized ECOWAS agency.¹⁹

In any case, staffing of the Center appears to have been a challenge, particularly with regard to its Executive Director. Since initial recruitment in early 2017, the job has been repeatedly posted as vacant on the ECOWAS website (in March 2018; and again, in May 2019, this time with an indicated salary that had almost doubled), and continues to be so.²⁰ What is more, despite some activity²¹ and donor support, the available sources do not allow for an assessment of the Center's actual state of operationalization.²² WAHO continues to be the main actor; in particular its current Director General, Stanley Okolo, being very visible in the general public (see also below). This assessment is also supported by observing the social media accounts of WAHO (@oaswaho, active since February 2016) and the ECOWAS RCSDC (@ecowas_cdc, active since May 2018). Whereas content of the latter primarily, and almost exclusively refers to WAHO, the WAHO account does not refer to the Center at all (at least not during the last six months).²³ Interestingly, for example, the five million Euros of EU support labelled ‘to the ECOWAS RCSDC’ – implemented by the GIZ and the *Agence Française de Développement* – does mostly not go directly to the Center, instead being directed largely towards capacity building in West African member states (cf. EU External Action Service 2017, 11ff.).

¹⁷ <https://ncdc.gov.ng/news/49/ecowas-regional-center-for-surveillance-and-disease-control-kicks-off-in-abuja-nigeria> (accessed 23 April 2020).

¹⁸ In 2016 this was Dr. Abdusalami Nasidi; in 2018 it was Dr. Chikwe Ihekweazu.

¹⁹ For the WAHO organogram, see <https://www.wahooas.org/web-oas/en/waho-organogram> (accessed 23 April 2020).

²⁰ Phone Interview, ECOWAS Commission Staff, 24 April 2020; see also

<https://www.ecowas.int/director-regional-centre-for-surveillance-disease-and-control-d1/>;
<https://www.ecowas.int/executive-director-of-the-ecowas-regional-centre-for-disease-surveillance-and-control/>; and <https://www.ecowas.int/executive-director-of-the-ecowas-regional-centre-for-disease-surveillance-and-control/> (all accessed 23 April 2020).

²¹ For a list of “achievements”, see <https://frontview.com.ng/waho-d-g-others-list-achievements-of-ecowas-rcsdc-as-governing-board-meets-in-abuja/> (accessed 24 April 2020).

²² At least in February 2019, WAHO DG Okolo still spoke about the need to “expedite” the Center's operationalization (https://eeas.europa.eu/headquarters/headquarters-homepage/57588/eu-ecowas-giz-launch-regional-support-improve-surveillance-and-response-networks-against_nb, accessed 23 April 2020).

²³ See https://twitter.com/ecowas_cdc?lang=de and <https://twitter.com/oaswaho>, as well as <https://www.facebook.com/pg/oaswaho/posts/>.

ECOWAS/WAHO responses to the Covid-19 pandemic

In response to the Covid-19 outbreak in China, WAHO started to prepare for potential consequences in West Africa already in January 2020. Since 13 January, it prepared and distributed a weekly Epidemiological Bulletin, including information on the Covid-19 outbreak, to regional health ministries, directors of national public health institutes (NPHIs), and partners. In addition, WAHO staff initiated weekly online meetings with NPHI directors and directors of national laboratory services to discuss situation updates, challenges, as well as country needs. They also put the so-called Regional Rapid Response Team on standby to allow in case of need for active communication and “real-time collaboration” (cf. ECOWAS Commission 2020c, 1-2). On 27 January, WAHO issued its first public statement on the “Outbreak of Novel Coronavirus in China”, to “inform the general public of ongoing measures to protect the region and what people should do to protect themselves” (WAHO 2020a, 1). The statement referred to the WHO risk assessment of the WHO for regions outside China as “moderate”, including West Africa, and highlighted first WAHO efforts, aiming at regional coordination towards the timely sharing of information, strengthen surveillance capacities in members states, and networking among laboratories to allow all West African states access to testing. At the time, only one suspected case (fever detected at Abidjan airport, promptly isolated, and later tested negatively) existed in the ECOWAS region (WAHO 2020a).

Throughout February 2020, WAHO issued several public statements (1 February, 13 February, and 28 February), the WAHO Director General, Stanley Okolo, held a joint press briefing (17 February) with the Nigerian State Minister for Health, Olurunnimbe Mamora, and convened an emergency meeting of the Assembly of ECOWAS Health Ministers (14 February). Already on 1 February, WAHO had reported that the WHO had declared the Covid-19 outbreak a “public health emergency of international concern” updating the WHO risk assessment outside China to “high” (being “very high” in China). WAHO staff continued to work with member states towards strengthening airport surveillance, especially with regard to direct flights from and to China. Moreover, together with the Africa CDC, it began to support the increase of “regional reference laboratories” dedicated to testing for Covid-19 from two to five (WAHO 2020b). On 14 February, WAHO convened a “high-level regional coordination meeting” in Bamako, for the Assembly of ECOWAS Health Ministers to urgently discuss, coordinate and harmonize regional preparations and responses, especially “in terms of surveillance, case management, infection prevention and control, laboratory and risk communication”. Based on joint assessments of needs and challenges, WAHO staff was tasked to work towards developing common regional guidelines (cf. WAHO 2020c), and

develop a strategic costed regional preparedness plan (based on member states' priorities) for governments, partners, and the private sector to support (cf. ECOWAS Health Ministers 2020).

In an effort to popularize the results of the ministerial emergency meeting, Okolo and Mamora held a joint press briefing on 17 February 2020, calling for collective action in West Africa. Referring to the first confirmed case in Africa, reported on 14 February in Egypt, Okolo argued to draw on lessons learned during the Ebola outbreak in 2014/15. He stated that testing capacities now were available in Nigeria, Ghana, Côte d'Ivoire, Sierra Leone, and Senegal (ECOWAS Commission 2020a). With the confirmed arrival of the virus in Africa, and subsequently in West Africa on 28 February, with a first confirmed case reported from Nigeria (cf. ECOWAS Commission 2020c, 2), WAHO dropped the reference "in China" from subsequent statements. Also in February, WAHO staff organized diagnosis training of laboratory personnel from Gambia, Ghana, Côte d'Ivoire and Nigeria in collaboration with the Pasteur Institute in Dakar (WAHO 2020c), providing the participants with 100 test kits each, only Nigeria receiving 200 (cf. ECOWAS Commission 2020c, 2). Moreover, throughout February 2020, WAHO staff also engaged in several (previously scheduled) activities more or less explicitly involving Covid-19 (among other diseases). For example, it organized a twelve-weeks field epidemiology training, starting in Gambia on 11 February.²⁴ Between 12 and 14 February they held a workshop in Liberia, supporting the establishment of medical emergency teams, though this one was not specifically on the Coronavirus.²⁵

During March 2020, WAHO staff sought to further strengthen individual capacities in member states to prepare and respond to the pandemic. It organized a simulation exercise in Abuja on 5 March, and rehearsed and practiced the deployment of the ECOWAS Regional Rapid Response Teams. It increased the procurement of critical supplies, such as diagnosis kits, specimen transportation kits, and personal protective equipment (PPEs). The ECOWAS Commission provided additional funds for an "emergency basis" of 50.000 test kits and equipment for member states (ECOWAS Commission 2020c, 2). On 16 March, a technical working group of reference laboratories, on response to Coronavirus outbreak, met with the Africa Task Force for Novel Coronavirus (AFCOR), an effort of actors at the Africa CDC to coordinate support for laboratory testing and supply chains in member states (cf. ECOWAS Commission 2020c, 2).

Also on 16 March 2020, through its President, Jean-Claude Kassai Brou, the ECOWAS Commission issued its first pronouncement on "measures to prevent and contain the spread"

²⁴ See <https://www.wahooas.org/web-ooas/en/actualites/gambia/waho-afenet-and-gambian-ministry-health-are-strengthening-field-epidemiology> (accessed 17 April 2020).

²⁵ See <https://www.wahooas.org/web-ooas/en/actualites/liberia/west-african-health-organization-waho-supports-liberia-towards-establishment> (accessed 17 April 2020).

of Covid-19 (ECOWAS Commission 2020b).²⁶ Advised by the WAHO, the Commission President instructed the commission leadership to approve only critical missions, and requested fourteen days of self-isolation for staff that had traveled to “any high burden country or country with local transmissions” within the last two weeks, as well as voluntary home office for commission staff. Furthermore, all meetings requiring international air travel were suspended; local meetings of more than 50 people “discouraged”, requesting social distancing and the use communication technologies. Brou also informed about the establishment of a Committee on Corona Virus Management (a help desk basically) at the ECOWAS Commission, and tasked all other ECOWAS institutions and agencies to do the same. In addition, he instructed WAHO to continue to provide advice and guidance as well as regular updates on the management of Covid-19 in the region. All measures were put in place initially for four weeks (ECOWAS Commission 2020b), but prolonged and updated subsequently on 22 March and 14 April (cf. ECOWAS Commission 2020f), referring ECOWAS staff to risk communication advice and material prepared by WAHO,²⁷ strongly encouraging home office for staff potentially at risk, and further reducing the allowed maximum number of participants for local/internal meetings 25 (with mandatory attendance lists). All private visits to ECOWAS institutions and agencies were prohibited during the next 14 days; except security personnel, staff reduced to a bare minimum (cf. ECOWAS Commission 2020d).

Following Commission President Brou’s request, on 18 March, WAHO began publishing regular situation reports. However, the last such report available online dates from 29 March.²⁸ It appears that since then, updates by WAHO have been posted primarily on its social media channels on Twitter and Facebook, limited to a table stating the current numbers of confirmed cases, deaths and recovered (see Figure 2 below).²⁹ On 21 March, in a first statement directed towards the broader public, followed by another ‘message’ on 23 March,³⁰ Commission President Brou highlighted the efforts of the Commission and WAHO so far. He stressed that they had been “very active in ensuring that the region is epidemic-free” (ECOWAS Commission 2020c, 1), working together with member states and partners (at this point mentioning only the WHO). In the meantime, the Assembly of the ECOWAS Health Ministers had adopted a Regional Strategic Plan for Preparedness and Response to

²⁶ At this point, only 38 cases (and zero deaths) had been reported across West Africa according to the WHO, 26 of which in Senegal, with a “hotspot” of “local transmissions” in Touba (ECOWAS Commission 2020b, 1).

²⁷ See <https://www.wahooas.org/web-ooas/en/actualites/benin-burkina-faso-cabo-verde-cote-divoire-gambia-ghana-guinee-guinee-bissau-liberia-24> (accessed 24 April 2020).

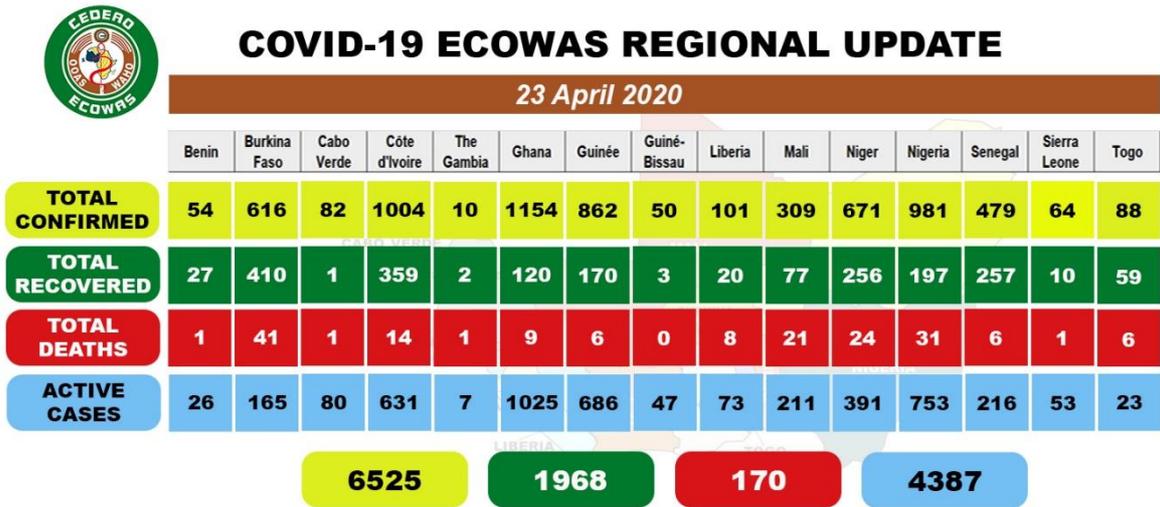
²⁸ See <https://www.wahooas.org/web-ooas/en/actualites/benin-burkina-faso-cabo-verde-cote-divoire-gambia-ghana-guinee-guinee-bissau-liberia-28> (accessed 16 April 2020).

²⁹ See Twitter (<https://twitter.com/ooaswaho>) and Facebook (www.facebook.com/ooaswaho/) respectively.

³⁰ See <https://www.ecowas.int/message-by-the-president-of-the-ecowas-commission-on-the-coronavirus-outbreak/> (accessed 16 April 2020).

Pandemics – calculated to cost about 51 million US dollars, resources to be mobilized from partners (ECOWAS Commission 2020c, 2) – as well as a Strategic Plan for Institutional Communication and manual procedures. With regular support and evaluations, WAHO staff had managed to set up National Coordination Institutions in all fifteen member states, and initiated a weekly communication process among them (ECOWAS Commission 2020c, 2).

Figure 2



Source: <https://twitter.com/ooaswaho> (accessed 24 April 2020)

On 1 April 2020, WAHO Director-General Okolo held an online press conference and issued another press release, reflecting upon the current situation in the ECOWAS region, with 1077 confirmed cases and 31 deaths (as of 31 March), by now across all 15 member states. WAHO staff continued to distribute essential materials, including 30.000 test kits (for most member states the first they had received), 50.000 specimen transportation kits, 10.000 PPEs and some medications (about 740.000 prescription tablets of Chloroquine and Azithromycin, cf. ECOWAS Commission 2020e) – additional orders had been placed and were expected to arrive within the next two weeks, and “sourcing” for ventilators was ongoing (WAHO 2020d). All these efforts were in addition to those employed individual member states, and potential supply shortages addressed through partnerships with other agencies (though not mentioning which exactly). Finally, WAHO staff were still in the process of developing instructional Operation Guides and preparing an online training for health care workers, scheduled for 6-12 April 2020 (WAHO 2020d).

In second communiqué on 6 April 2020, taking stock of efforts employed by ECOWAS so far, Commission President Brou declared that, in addition to the materials already delivered

by WAHO to Benin, Burkina Faso, Cabo Verde, Gambia, Ghana, Guinea, Sierra Leone, Togo, additional 240.000 test kits, 240.000 extraction kits, 250.000 viral sample transport kits, 285.100 PPEs; 268.100 masks for medical personnel, 120 ventilators, several thousand liters of disinfectants had been ordered. Grateful for financial and technical support by partners (mentioning none of them specifically), the Commission and WAHO continued to mobilize resources ‘internally’ and ‘externally’. Moreover, they had started working on a Short and Medium Term State Assistance Plan (including humanitarian assistance and economic recovery support), to complement current interventions (ECOWAS Commission 2020e, 2). Developing a new dimension to the regional response to the Covid-19 epidemic, the latter had already been introduced by WAHO Director General Okolo in a TV interview, referring to WAHO support to member states in preparing strategies, also to transition back out of measures, and alleviating socio-economic damage.³¹

A response driven more directly by state actors within ECOWAS has emerged only on 21/23 April. Following a meeting by the ECOWAS Ministers in charge of Finance and Governors of Central Banks, on 21 April 2020 (cf. ECOWAS Commission 2020g), the ECOWAS Authority convened a virtual extraordinary summit on 23 April 2020, the first to touch upon the issue of Covid-19 in West Africa (cf. ECOWAS Authority 2020). At the summit mainly concerned with the socio-economic impact of the crisis, ECOWAS heads of state decided on several initiative towards “stabilization and economic recovery”, putting President Buhari of Nigeria in charge (as “Champion”) of coordinating regional efforts to contain the pandemic and to supervise newly set-up ministerial committees on health, finance and transport (ECOWAS Authority 2020, 5-6).

ECOWAS / WAHO and continental coordination and ordering efforts

The accounts provided so far – of the emergence and functioning of WAHO and the ECOWAS-RCSDC, as well as the concrete efforts employed by ECOWAS actors in response to the Covid-19 pandemic – allow for several interesting observations regarding regional and inter-regional coordination, pointing to more general dynamics around efforts and ambitions to organize space, and potentially construct spatial order in Africa.

First, agency in response to the crisis on behalf of ECOWAS has been most visible in the personality of the WAHO Director-General (DG), Stanley Okolo, and his staff, as well as to a lesser extent the ECOWAS Commission President, Jean-Claude Kassai Brou. At least publicly, these two figures have become the faces of regional responses to the Covid-19

³¹ See Okolo interview on TVC News, 4 April 2020, https://www.youtube.com/watch?v=OaMkqWHHY58&feature=emb_logo (accessed 16 April 2020).

pandemic, delivering public messages, answering at press conferences and in tv and newspaper interviews.³² In this, although in principal an ECOWAS institution, it appears that WAHO actors (specifically its DG and the Assembly of ECOWAS Health Ministers) have developed significant initiative and autonomy in their approach towards the Covid-19 pandemic. Actors at the ECOWAS Commission appear to have mainly sought to closely associate themselves with actions taken by WAHO.³³ To assess to what extent other actors at the ECOWAS Commission, such as the Early Warning Department (recently moved to the Office of the Deputy Commission President, to develop a broader outlook beyond conventional notions of ‘security’), have been active and involved in formulating and implementing responses will have to be subject to further research. This picture may begin to change, however, in the aftermath of the extraordinary session of the ECOWAS Authority on 23 April 2020, the first to deal with the Covid-19 pandemic.

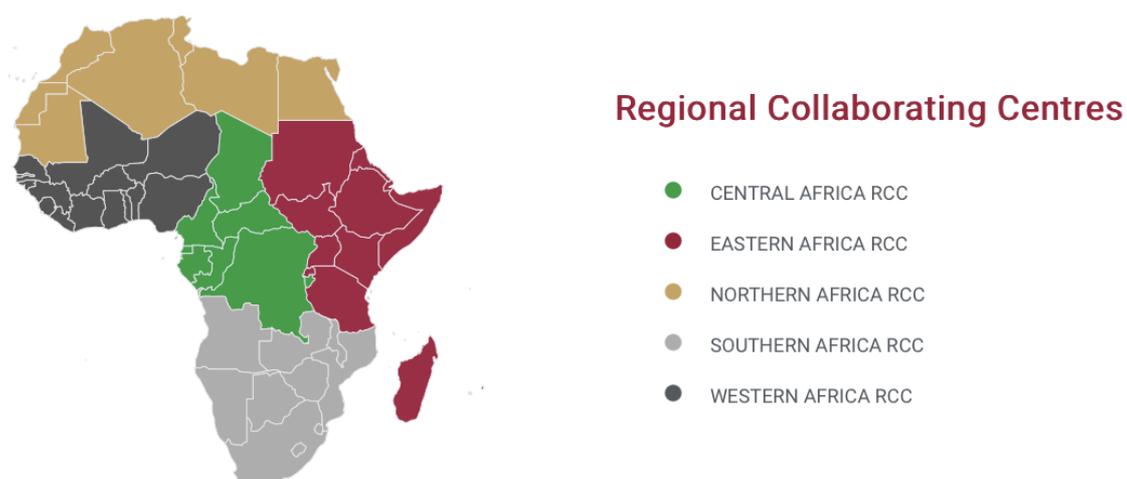
Second, the ECOWAS-RCSDC, established specifically for the purpose of responding to situations like the current Covid-19 outbreak in West Africa, is nowhere mentioned in the available material documenting the ECOWAS responses. If active at all in response to Covid-19, its actions have been completely subsumed under the WAHO efforts, more generally. Incipient research suggests that rather than becoming a more autonomous Specialized Agency of ECOWAS, the Center has become absorbed into the WAHO organization structure. Lack of visibility and leadership of the RCSDC may be explained by the position of Executive Director remaining vacant, which can be explained partly by a slow recruiting process at the ECOWAS Commission. However, it may also be explained by a lack of interest by the WAHO DG to see a stronger and more autonomous disease control center emerging, even if ultimately remaining under the formal authority of the WAHO DG.³⁴ Another explanation would relate to efforts aiming to avoid institutional proliferation (cf. Anaemene 2013, 70), which have also been at the heart of the creation of WAHO about 33 years ago. Further research into this direction might reveal interesting insights into dynamics among different West African regional actors.

³² E.g. see <https://www.ecowas.int/covid-19/> and <https://www.wahooas.org/web-ooas/en/actualites> (both accessed 17 April 2020).

³³ For example, on 8 April 2020, a post on the main ECOWAS website re-introduced general information about WAHO (cf. <https://www.ecowas.int/covid-19/west-african-health-organization/>). The statement of the ECOWAS Commission of 21 March 2020, stresses that the 28 February WAHO statement was delivered in “clos[e] collaboration with ECOWAS Commission”, and that the accelerated procurement of critical supplies was done by the ECOWAS Commission “through WAHO” accelerated (cf. ECOWAS Commission 2020c, 2).

³⁴ Phone Interview, ECOWAS Commission Staff, 24 April 2020.

Figure 3: Regional Collaborating Centers of the Africa CDC



Source: <https://africacdc.org> (accessed 16 April 2020)

Third, and closely related, the unclear state of operationalization of the ECOWAS-RCSDC also raises questions with regard to the inter-regional coordination and cooperation of West African regional health actors and the Africa CDC. As explained above, the RCSDC emerged in direct relation to the African Union's initiative to establish regional branches of the Africa CDC (see Figure 3). Therefore, another (admittedly speculative) possibility is that West African actors (in health or otherwise) are not too interested in empowering an institution somehow subordinate to its African Union counterpart, even less so with a similar agency (i.e. WAHO) already existing for a much longer time. In any case, with the RCSDC apparently out of the picture, the question emerges about the actual extent of coordination and cooperation between the Africa CDC and ECOWAS/WAHO. In the available material only very few references exist hinting at much interaction in that regard.³⁵ Conversely, documentation on the website of the Africa CDC refers to cooperation with ECOWAS and WAHO only in three cases, two prior to the Covid-19 outbreak (in May and June 2019, respectively), and one with regard to the simulation exercise referred to above.³⁶ At their extraordinary summit on 23 April 2020, ECOWAS heads of state called for the strengthening of cooperation between the Africa CDC and WAHO (ECOWAS Authority 2020, 4).³⁷

³⁵ On (non)congruence of the regional RCCs with existing regional divisions in the context of the African Peace and Security Architecture, see Engel (2020).

³⁶ See <https://africacdc.org/?s=waho> and <https://africacdc.org/?s=ecowas> (accessed 23 April 2020).

³⁷ Differences between the approaches of ECOWAS and the African Union are observable in the (non)securitization of the current pandemic, something already observed during the Ebola epidemic (cf. Anaemene 2013, 62; see also Ifedior and Aning 2017). Whereas, the AU Peace and Security Council has concerned itself with Covid-19 (cf. Engel 2020), the ECOWAS Mediation and Security Council has not.

Putting these observations into a larger context, they seem to point back to more general dynamics of (lacking) cooperation and contestation between the African Union and the RECs, as observed for example with regard to their interactions in response to conflicts on the continent (e.g. cf. Döring and Herpolsheimer 2018). Therefore, clarifying the relationship between the Africa CDC and its West African counterpart requires further research, promising to better understand efforts and ambitions to order relations among different spaces in and beyond Africa.

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