Knowledge SUCCESS

REGIONAL ECONOMIC COMMUNITIES

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RESULTS FROM A LANDSCAPE ANALYSIS OF REGIONAL HEALTH SECTOR ACTORS IN AFRICA: AN UPDATE OF THE COMPARATIVE ADVANTAGES, CHALLENGES, AND OPPORTUNITIES

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About

Knowledge SUCCESS (Strengthening Use, Capacity, Collaboration, Exchange, Synthesis, and Sharing) is a five-year global project led by a consortium of partners and funded by USAID's Office of Population and Reproductive Health to support learning, and create opportunities for collaboration and knowledge exchange, within the family planning and reproductive health community. We use knowledge management to help programs and organizations working in family planning and reproductive health collect knowledge and information, organize it, connect others to it, and make it easier for people to use. Three core pillars that describe the work that we do include game-changing tools and approaches; meaningful and mutual connection; and relevant and easy-to-use technical content. Our partners comprise Johns Hopkins Center for Communication Programs, Amref Health Africa, Busara Center for Behavioral Economics, and FHI 360.

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Abbreviations

AEC	African Economic Community
AfCFTA	The African Continental Free Trade Area
AfDB	African Development Bank
AFENET	African Field Epidemiology Network
AfHEA	African Health Economics and Policy Association
Africa CDC	Africa Centers for Disease Control and Prevention
AFRO	Africa Regional Office
AIDS	Acquired Immune Deficiency Syndrome
ALM	African Leadership Meeting
AMA	Africa Medicines Authority
AMQF	African Medicines Quality Forum
Amref	Amref Health Africa
AMRH	African Medicines Regulatory Harmonization
AMU	Arab Maghreb Union
APEC	Asia Pacific Economic Cooperation
APHF	Africa Public Health Foundation
ARLA	Africa Regional Landscape Analysis
ASEAN	Association of Southeast Asian Nations
AU	African Union
AUC	African Union Commission
AUDA-NEPAD	Africa Union Development Agency
AVATT	African Vaccine Acquisition Task Team
BMGF	Bill and Melinda Gates Foundation
BSEC	Black Sea Economic Cooperation
CA	Central Africa
CEMAC	Central African Economic and Monetary Community
CEN-SAD	Community of Sahel-Saharan States
CEO	Chief Executive Officer
CEPGL	Economic Community of Great Lakes countries
CIS	Commonwealth of Independent States
COHRED	Council on Health Research for Development
COMESA	Common Market for Eastern and Southern Africa
COVAX	COVID-19 Vaccines Global Access
COVID	Coronavirus Disease
CRVS	Civil Registration and Vital Statistics
CSO	Civil Society Organization
DRC	Democratic Republic of Congo
EA	Eastern Africa
EAC	East African Community

EAEU	Eurasian Economic Union
ECCAS	Economic Community of Central African States
ECO	Economic Cooperation Organization
ECOWAS	Economic Community of West African States
ECSA-HC	East, Central and Southern African Health Community
EFTA	European Free Trade Association
EPD	Epidemic-prone Disease
EU	European Union
FCDO	Foreign Commonwealth Development Office
GAFTA	Greater Arab Free Trade Area
GDP	Gross Domestic Product
GHPI	Global Health for Peace Initiative
HIV	Human Immunodeficiency Virus
HRH	Human Resource for Health
HSS	Health Systems Strengthening
ICD	Institute of Capacity Development
IDA	International Development Association
IFHA	Investment Funds for Health in Africa
IGAD	Intergovernmental Authority on Development
IOC	Indian Ocean Commission
IOM	International Organization of Migration
IRB	Institutional Review Board
KII	Key Informant Interview
MCF	Mastercard Foundation
MCH	Maternal and Child Health
MRU	Mano River Union
NEPAD	New Partnership for African Development
OAU	Organization of African Unity
PACT	Partnership to Accelerate COVID-19 Testing
PAVM	Partnership for Vaccine Manufacture
PSC	Peace and Security Council
RCC	Regional Collaborating Center
RCDSC	Regional Center for Disease Surveillance and Control
REC	Regional Economic Community
RHFH	Regional Health Financing Hub
RICAS	Regional Integration and Cooperation Assistance Strategy
RLN	Regional Laboratory Networks
RMNCAH	Reproductive Maternal Newborn, Child, and Adolescent Health
RNA	Regional Network and Association
RRT	Regional Rapid Response Team
RSSH	Resilient and Sustainable Systems for Health

SA	Southern Africa
SACIDS	Southern African Center for Infectious Disease Surveillance
SACU	South African Customs Union
SADC	Southern African Development Community
SCO	Shanghai Cooperation Organization
SCOT	Strengths, Challenges, Opportunities, Threats
SDG	Sustainable Development Goal
Sida	Swedish International Development Cooperation Agency
SOP	Standard Operating Procedure
TARC	Training and Research Center
TB	Tuberculosis
TRIPS	Trade Related Aspects of Intellectual Property Rights
UEMOA	West African Economic and Monetary Union
UHC	Universal Health Coverage
UK	United Kingdom
UN	United Nations
UNECA	United Nations Economic Commission for Africa
UNFPA	United Nations Population Fund
US	United States
US$	United States Dollar
USAID	United States Agency for International Development
WA	Western Africa
WAEMU	West African Economic and Monetary Union
WAHO	West African Health Organization
WB	World Bank

1.0 Introduction

Globally and regionally, a trend has been growing 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 in isolation, but in strategic alliances with other like-minded nations[1]. Over the years, the African continent has perhaps seen the most pronounced movement towards regional integration. In Africa's health sector, regional bodies—such as regional economic communities (RECs) and inter-governmental institutions composed of groupings of member states, as well as regional associations and networks (RNAs)—have become active contributors and players in creating and directing the regional health sector agenda. RECs 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, structures such as the East, Central and Southern African Health Community (ECSA-HC) and the New Partnership for African Development (NEPAD) are active in the health sector. Most key African regional actors have a well-defined political mandate, administrative structure, and technical capabilities. These entities have established a range of relationships with governments and donor agencies, as well as amongst themselves. Some RECs have also received technical assistance from donors and UN agencies to implement specific health programs as well as build institutional capacity. Similar to other international institutions and networks, some of these regional bodies face complex challenges in relation to their mandates, organizational structure, coordination, and financial and human resources.

What is regional integration?

Regional integration is the process by which two or more nation-states agree to cooperate and work closely together to achieve peace, stability, and wealth. Usually, integration involves one or more written agreements that describe the areas of cooperation in detail, as well as some coordinating bodies representing the countries involved.

Source: https://carleton.ca/ces/eulearning/introduction/what-is-the-eu/extension-what-is-regional-integration/

Funded by USAID Africa Bureau and developed by African Strategies for Health, two landscape reports that focused on RECs and RNAs in Africa were completed in 2014: Regional Economic Communities (Results from a Landscape Analysis of Regional Health Sector Actors in Africa: Comparative Advantages, Challenges, and Opportunities) and Regional Networks and Associations (Results from a Landscape Analysis of Regional Health Sector Actors in Africa: Comparative Advantages, Challenges, and Opportunities). Since then, there have been significant global and regional changes. Health priorities—globally and throughout the African continent— have also changed. Relevant post-2014 global health priorities include the development of the Sustainable Development Goals (SDGs),

[1] https://carnegieeurope.eu/2022/02/17/from-local-to-global-politics-of-globalization-pub-86310

Universal Health Coverage (UHC), and the Global Health Security Agenda. The 2014–15 multi-nation Ebola outbreak in West Africa and recent COVID-19 pandemic also yielded many experiences and lessons on the importance of regional integration in health.

In Africa, the landscape of regional integration in the context of health systems strengthening has undergone policy and institutional changes in recent years. Key institutional changes include the launch of the Africa Health Strategy 2016–2030; the 2017 establishment of the Africa Centers for Disease Control and Prevention (Africa CDC), the public health agency of the AU; the launch of the African Continental Free Trade Area (AfCFTA) agreement in 2018; and the transformation of the New Partnership for Africa's Development Planning and Coordinating Agency (NEPAD Agency) into the African Union Development Agency (AUDA-NEPAD). These trends were spearheaded by the AU, which operates at the apex of African regional integration, with RECs overseeing the health agenda at the sub-regional level.

With the evolving paradigm of regionalism, and its intersectionality with global health security, it is fundamental to develop an in-depth understanding of power dynamics, relationships, strategic advantages, and the limitations of regional bodies. This publication builds on the 2014 report, focusing on integrating relevant emerging global and continental health issues into regional activities. The report provides a synthesis of the African integration context, plus the strategic advantages, challenges, and opportunities for promoting regional health integration. It concludes with a set of recommendations applicable to many actors, including the AU, RECs, and regional development and implementing partners that work with these communities.

2.0 Methodology

2.1 The Objective of the Landscape Analysis

The landscape analysis entailed a review of Africa's health sector organizations, including RECs and RNAs. As defined by the AU, RECs are regional groupings of African states generally established to facilitate economic integration among members of individual regions and throughout the wider African Economic Community (AEC). RECs were established under the Abuja Treaty of 1991[2]. RNAs, on the other hand, comprise umbrella organizations of local, national, or sub-regional civil society organizations (CSOs) or networks. Some RNAs convene individual health professionals, researchers, and policymakers. Others bring together a combination of these and/or provide a platform for exchange and collaboration between research or academic institutions[3]. We used the following inclusion criteria to conduct the landscape analysis:

- A group of individuals or organized entities structured around a common purpose
- Involved in health-related activities in two or more African countries
- Headquartered in one of the AU Member States

This being an updated landscape analysis, we based our thematic areas on the 2014 report, with additional details addressing post-2014 emerging health priorities and developments. Main themes include the concept of regional integration, the RECs and their roles, RECs and health, comparative advantages, challenges, and opportunities. To further understand the role of RECs in health, we used the WHO health systems building blocks approach to guide the discussions.

Given the distinctions between the two categories of regional health actors and in consideration of the interests of various users of this report, the landscape analysis has been divided into two. This publication covers the RNA landscape analysis. The REC landscape analysis is available in a separate report.

2.2 Data Collection Methods

This study employed a mixed-method data collection approach. We used stakeholder mapping, a review of key documents and literature (scientific and grey literature), and key informant interviews. The stakeholder mapping exercise sought to identify and analyze regional health actors. The mapping

[2] https://au.int/en/organs/recs
[3]http://www.africanstrategies4health.org/uploads/1/3/5/3/13538666/regional_networks_and_assocs_full_length_report_final.pdf

highlighted regional networks and technical institutions engaged in the health sector across the continent. The literature review entailed scoping the publications mentioned on the websites of relevant institutions. To achieve this, we searched terms such as “regional integration [and] health [in] Africa” and “Africa regional health actors and networks and associations [and] health” in scholarly engine databases including Science Direct, PubMed, Google Scholar, the Cochrane Library, the Web of Science, CINAHL EBSCO, EMBASE, and the WHO Depository Library. This strategy was limited to journal articles published between 2014 and 2022 (after the publication of the 2014 report). In the snowballing approach, a review of websites from the few identified organizations provided a list of regional partner institutions.

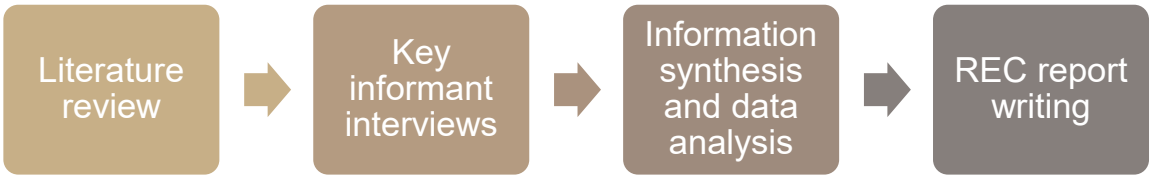

Figure 1: Data collection methods and approaches

We adopted a convenience sampling approach in selecting the key informant interview (KII) respondents. These included subject matter experts, senior officials and representatives from the RECs, plus partner organizations such as international donor agencies and civil society organizations. The KIIs with sampled respondents focused on organization data and working relationship with REC regional health focus of the organization, opinions on RECs role in health, opportunities, advantages and disadvantages and recommendations on how RECs can be strengthened to play a more critical role regional health agenda. The structured KIIs provided an opportunity to verify the information and findings generated from the literature review, which sought to understand each organization’s location and priority health focus. This information was then documented in a matrix that detailed the organization’s name and website, country, and focus. As part of updating the 2014 findings and to ensure alignment with global and regional agendas, we developed a list of pre-identified emerging and re-emerging issues to examine during the literature review and KIIs. These issues included UHC; the SDGs; New African Union Strategies, especially the AU’s Agenda 2063; public health emergencies, especially COVID-19; private sector involvement; and gender mainstreaming, among others.

A total of 85 documents, including technical reports, academic journals and articles, policy papers, media releases, and strategic plans were reviewed. In addition, 31 key informant respondents were interviewed. The KII guide and the list of experts interviewed is provided as an annex to this report. Table 1 presents the number of documents reviewed and respondents reached.

Table 1: Documents reviewed and key informant respondents

METHODS	INFORMATION SOURCES
Desk Review	85 documents, including technical reports, academic journal articles, strategy documents, policy papers, and media releases. 35 regional organizations with health programs identified via: • Regional economic communities • Regional associations and networks • Regional intergovernmental organizations • Regional technical organizations
Key Informant Interviews	31 key informants interviewed via virtual platforms
Analysis	Data triangulation Strengths, Challenges, Opportunities, and Threats (SCOT) analysis

Data collected from literature review and key informant interviews were thematically analyzed.

2.3 Ethical Consideration

Having no significant ethical sensitivities, this landscape analysis did not require any IRB approvals. However, throughout the analysis, the team endeavored to ensure that respondents understood the purpose, objectives, and the intended use of findings from the review; practice sensitivity to cultural norms during interactions with all respondents; and respect the rights of respondents by ensuring informed consent and confidentiality during interviews. The landscape report does not directly attach findings to respondents.

2.4 Landscape Analysis Limitations

This landscape analysis was not without limitations. Key limitations and how we addressed them are listed below:

- Lack of French-speaking interviewers among the landscape analysis team. The landscape analysis team used available resources to attempt language inclusion through competent translators. While we addressed this through interviews with English-speaking respondents from French-speaking regions and the literature review, it is possible that some relevant speakers were missed due to time constraints with back-translation. In future, we recommend careful consideration to include French speakers in the landscape analysis exercise. It may add further value to undertake a more detailed landscape analysis for the French-speaking region.

- Outdated websites and/or sometimes insufficient information. Where information was not available, respondents from targeted organizations (when possible) were requested to provide additional documentation. However, we recommend that regional organizations update their websites to ensure access.

- Organizational-level policies on information disclosure made some respondents hesitant to share certain requested information. This impacted the amount of detail that could be provided in this report.

- Technical experts were only able to provide information on their competency areas, necessitating multiple interview requests within one organization.

3.0 Key Findings

3.1 About This Report

This updated analysis adopts the 2014 report definition of Africa-based regional health actors as "organizations or institutions headquartered in Africa and comprised of groups of individuals or organized entities from more than one country with a relationship structured around a common purpose." As discussed earlier, these are grouped into two: Regional Economic Communities (RECs) and Regional Networks and Associations (RNAs). This publication discusses the first category of regional economic communities, the RECs. The RNAs are discussed in a separate report.

3.2 The Concept of Regional Integration

While the concept of regionalism has existed for centuries, it gained prominence in the aftermath of World War II and became a major trend during the twentieth century. Since its emergence in the 1950s, regional integration has evolved, shaping international relations and regional cooperation. This has resulted in the formation of advanced RECs, including the Association of Southeast Asian Nations (ASEAN) in 1967, the Asia Pacific Economic Cooperation (APEC) in 1989, the AU in 1991, and the European Union (EU) in 1993. Regional integration organizations vary in form and level of integration. They range from free-trade areas (at their most basic) to customs unions, common markets, and fully fledged economic and political unions. Regional organizations operate mainly on the basis of intergovernmental decision-making, in combination with supranational institutions in some cases. In economic terms, the EU is the largest regional bloc. Given its single market and the euro as its common currency, the EU exemplifies the most advanced form of regional integration. The EU's single market extends to cover the area of the European Free Trade Association (EFTA), a smaller bloc of four countries. At the intersection of Europe and Asia, the Eurasian Economic Union (EAEU) bridges parts of Eastern Europe and Central Asia in the world's newest regional economic bloc—with a tighter economic integration agenda compared with the looser political alliance of the Commonwealth of Independent States (CIS). The Organization of the Black Sea Economic Cooperation (BSEC), the Shanghai Cooperation Organization (SCO), and the Economic Cooperation Organization (ECO) are three other regional blocs in this geographical intersection. Outside the realm of economic integration, the North Atlantic Treaty Organization (NATO) is an example of political and military regional integration. The integration architecture is more complex in Africa and the Americas, with multiple layers (sub-regional, cross-regional, continental) and often overlapping memberships. In addition, some blocs contain smaller sub-groups that have a higher degree of integration in the form of customs and/or monetary unions.

Neighboring countries share common characteristics, and in many cases similar histories, cultures, geographic features, and especially challenges. These may affect governance, geo-political and

economic interests, and social issues, including health. Regional integration is key to addressing these shared problems in a more effective and efficient way. Public health emergencies and other humanitarian challenges that cut across neighboring countries have demonstrated the importance of regional integration. Cross-border outbreaks such as Ebola and COVID-19 have highlighted the urgent need for cooperation in research and technology, which benefit from significant economies of scale and may be too costly for individual states[4]. Regional integration comes with several benefits. It can help member countries improve market efficiency, share costs of public goods or large-scale infrastructure projects, and reap other non-economic benefits, such as peace and security[5]. By developing regional policies and strategies, regional integration can help prevent public health emergencies. Although the advantages outweigh the disadvantages, some regionalization-related challenges exist, and the right structures and policies must be put in place to address them. Member states may have different priorities, and inefficient outcomes resulting from lack of complementary policies and institutions can occur. Additionally, regional integration may create winners and losers among member states[6].

3.3 Progress Towards Africa Regionalization

Regional integration has remained an economic and political priority in the post-colonial era. Regionalization in Africa dates as far back as 1910 with the formation of the South African Customs Union (SACU), the world's oldest functioning regional integration agreement. Since then, the continent has witnessed an evolution of strategies and governance architectures that could accelerate regional development processes[7]. In May 1963, 32 signatory governments launched the Organization of African Unity (OAU), creating Africa's first post-independence continental institution aimed at eradicating all forms of colonialism and promoting political and economic integration among member states. Building on earlier development strategies and recognizing that integration is critical in growing Africa's economies, 1991's African Economic Community (AEC) Treaty (also known as the Abuja Treaty) established historical building blocks for continental integration and a framework for political, economic, and social integration[8]. Since independence in the 1960s, regional integration has been an integral part of Africa's development strategies; indeed, it has been one of the most important goals over the past six decades. The Africa-wide development agenda, as championed by the AU, is based on regional integration and the formation of an African Economic Community (AEC). This was laid out in the Abuja Treaty and now in Agenda 2063. The Africa regional integration roadmap considers RECs as building blocks of the AEC, which was planned to develop in six phases over a period of 34 years[9]. Figure 1

[4] https://au.int/sites/default/files/documents/41587-doc-African_Integration_Report_2021_-_Final_Design.pdf

[5] https://www.worldbank.org/en/topic/regional-integration/overview

[6] Ibid.

[7] https://au.int/en/overview

[8] Ibid.

[9] https://au.int/sites/default/files/documents/41587-doc-African_Integration_Report_2021_-_Final_Design.pdf

presents the continent's journey towards regional integration.

Figure 1: Six successive phases which should lead to the AEC in 2028

3.4 Regionalization in Africa

The economic benefits of regionalization and the challenges that come with fragmentation have become evident over time. Integration promotes trade between member states and creates a large market for favorable trade with other regional blocs. Research by the African Development Bank shows that intra-African trade is the lowest of all global regions, at approximately 15% compared to 70% within the European Union and 60% in Asia[10]. Regional integration is pivotal for Africa to narrow the economic and development gap between the continent and the rest of the world through eliminating trade barriers, developing integrated transport and energy infrastructure, promoting knowledge and technology transfer, cultivating human capital, and increasing industrial development[11].

Moreover, through regional integration, member states increasingly expand markets and input sources, which translate to higher economic growth and improved welfare.[12] Regional integration is key in repositioning the continent in the global market and away from the rigid world trade order. Stringent international health frameworks/guidelines include the Trade-Related Aspects of Intellectual Property Rights (TRIPS), which bars knowledge accumulation and transfer within the pharmaceutical space in Africa. Regional integration can play a critical role in providing a voice to negotiate these trade-related agreements and commitments.

The African Continental Free Trade Area (AfCFTA) agreement launch, which created the largest free trade area in the world, is a huge step towards African integration. The agreement connects 1.3 billion people across 55 AU member states with a gross domestic product (GDP) estimated at US$3.4 trillion. The World Bank estimates that AfCFTA will raise the continent's real income by 7%—equivalent to

[10] https://www.afdb.org/en/news-and-events/importance-of-regional-and-continental-integration-for-africas-development-18773
[11] Ibid.
[12] Brenton, P., & Hoffman, B. (2016). Political Economy of Regional Integration in Sub-Saharan Africa. Political Economy of Regional Integration in Sub-Saharan Africa. https://doi.org/10.1596/24767

US$450 billion—by 2035, thus increasing Africa's exports by US$560 billion and lifting 30 million Africans out of extreme poverty while adding US$76 billion to the global income[13].

3.5 African Countries' Regional Integration Index

The level of integration in Africa varies highly across REC members, including depending on their degree of integration within their respective RECs. The 2019 Africa Regional Integration Index by the African Union Commission, the United Nations Economic Commission for Africa, and the African Development Bank highlights that African countries remain less integrated than others, with an average score of 0.327 out of a possible 1[14]. The index of 16 indicators is calculated on a linear scale from 0 to 1, where 0 denotes the lowest level of integration and 1 denotes the highest level. A score of 0.5 is considered moderate or average. The index ranks countries on five dimensions of integration: productive integration (including integration into regional value chains), free movement of people, trade integration (including tariffs and shares of intra-regional trade), infrastructural integration (including flight and road infrastructure), and macroeconomic integration (including investment treaties, currency convertibility, and regional inflation). According to the index, productive and infrastructural integration remain Africa's weakest areas of integration, with free movement of people being its strongest. The EAC recorded the highest regional integration score of any African regional group at 0.537, with the SADC being the most weakly integrated with an overall score of only 0.337.

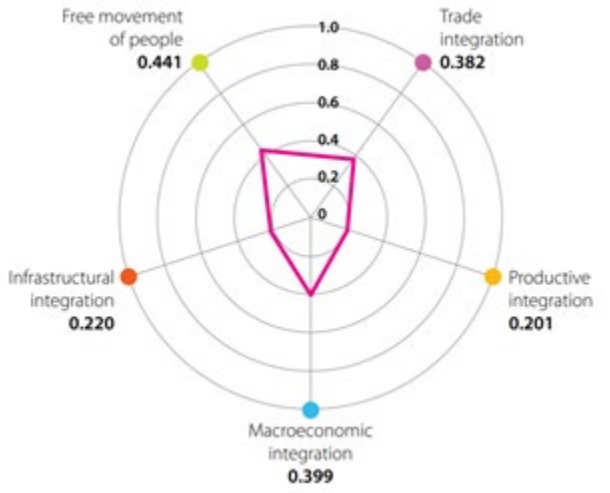

Figure 2: Africa Regional Integration Index

3.6 Mapping of Regional Economic Communities

Although the African continent has 14 inter-governmental organizations, each working on regional integration issues with numerous joint treaties and protocols, the AU recognizes only eight RECs[15]. These are the Common Market for Eastern and Southern Africa (COMESA), the Arab Maghreb Union (AMU), the East African Community (EAC), Community of Sahel-Saharan States (CEN-SAD), the

[13] Asche, H. (2021). On the African Continental Free Trade Area. In Advances in African Economic, Social and Political Development. https://doi.org/10.1007/978-3-030-75366-5_6

[14] https://au.int/sites/default/files/documents/38554-doc-arii-fr-report2019-fin-r14_21may20_french.pdf

[15] https://au.int/en/organs/recs

Economic Community of Central African States (ECCAS), the Intergovernmental Authority on Development (IGAD), the Economic Community of West African States (ECOWAS), and the Southern African Development Community (SADC). The additional six RECs identified in this report and classified as “others” are the Economic Community of the Great Lakes Countries (CEPGL), Southern African Customs Union (SACU), Mano River Union (MRU), West African Economic and Monetary Union (UEMOA), Central African Economic and Monetary Community (CEMAC), and Greater Arab Free Trade Area (GAFTA).

The RECs vary by their years of establishment, initiating logic, and focus areas. ECOWAS, established in 1975, is the oldest, with CEN-SAD being the youngest (1998). For instance, while SADC was born from a liberationist movement, COMESA was established for economic purposes. Most RECs have their overall objectives as trade, social and economic agendas, politics, and ensuring regional peace and security.

Figure 3 presents the eight AU-recognized RECs and their member states. Table 2 presents quick facts on the eight AU-recognized RECs and the six others.

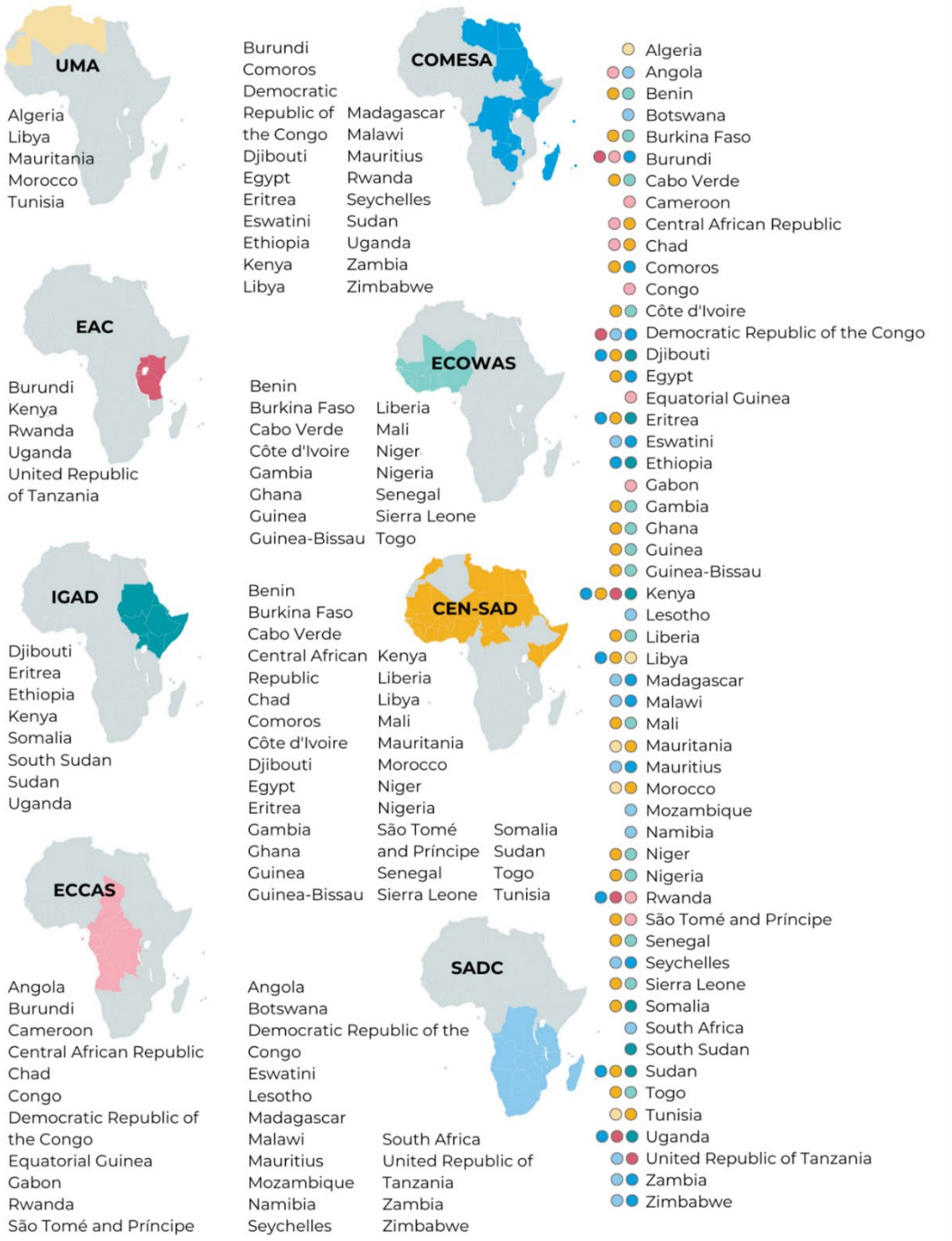

Figure 3: The AU-recognized RECs and their member states

Table 2: Quick Facts on RECs

REGIONAL ECONOMIC BLOC (REC)	MEMBER STATES	AREA (KM^2)	POPULATION	GDP (PPP) (US$) IN MILLIONS	GDP (PPP) (US$) PER CAPITA
Southern African Development Community (SADC)	16	9,672,702	363,222,621	597.8 billion	1,649
Economic Community of Central African States (ECCAS)	11	6.5 million	158.3 million	257.8 billion	1,631.4
Common Market for Eastern and Southern Africa (COMESA)	21	11.8 million	560 million	2.921 trillion	5,264
Economic Community of West African States (ECOWAS)	15	5,114,162	349,154,000	1.483 trillion	4,247
Community of Sahel Saharan States (CEN-SAD)	29	14.3 million	553 million	1,350.7 billion	1,363.80
East African Community (EAC)	6	2,467,202	183,625,246	602.584 billion	3,286
Intergovernmental Authority on Development (IGAD)	8	5,233,604	187,969,775	337.82 billion	888.5
Arab Maghreb Union (AMU)	5	6,046,441	102,877,547	$1.299173 trillion	12,628
West African Monetary Zone (WAMZ)	6	1,602,991	264,456,910	1,551,516	5,867
Southern African Customs Union (SACU)	5	2,693,418	51,055,878	541,433	10,605
Economic and Monetary Community of Central Africa (CEMAC)	6	3,020,142	34,970,529	85,136	2,435

West African Economic and Monetary Union (WAEMU/UEMOA)	8	3,505,375	80,865,222	101,640	1,257
Union du Maghreb Arabe (UMA)	5	5,782,140	84,185,073	491,276	5,836
Greater Arab Free Trade Area (GAFTA)	5	5,876,960	1,662,596	6,355	3,822

3.7 The Role of RECs

The Abuja Treaty (1991) recognizes the fundamental role of RECs as facilitating economic integration between respective regions and the envisioned Africa Economic Community (AEC)[16]. The Abuja Treaty and the AU Constitutive Act mandate RECs to work under the aegis of the African Union guided by the 2008 Protocol on Relations between RECs and the AU. The RECs were established by specific treaties ratified by individual members. While REC roles and mandates differ depending on the level of integration, common objectives include broadening and deepening regional cooperation and integration among member states and with other regional communities in political, economic, and social areas for mutual benefit.

Notably, REC structures mirror those of a national government and include directorates, departments, committees, and secretariats, which are usually staffed. They mainly focus 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, migration, labor and employment, sports, and culture)
- Human resources, science, and technology (education, information and communication

[16] https://au.int/sites/default/files/treaties/37636-treaty-0016_-_treaty_establishing_the_african_economic_community_e.pdf

technology, youth, human resources, science, and technology)

- Trade and industry (trade, industry, and 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, private sector development, investment, and resource mobilization)

3.8 Collaboration Between RECs and Partners

The role of RECs

"The RECs are regional groupings of African states. The RECs have developed individually and have differing roles and structures. Generally, the purpose of the RECs is to facilitate regional economic integration between members of the individual regions and through the wider African Economic Community (AEC), which was established under the Abuja Treaty (1991). The 1980 Lagos Plan of Action for the Development of Africa and the Abuja Treaty proposed the creation of RECs as the basis for wider African integration, with a view to regional and eventual continental integration. The RECS are increasingly involved in coordinating AU Member States' interests in wider areas such as peace and security, development and governance."

Through collaboration with regional health partners, RECs potentially (and ideally) provide a foundation for a region's engagement in global diplomacy and governance for health. This can ensure that health is not edged out by the various political, trade, economic, and security agendas that primarily drive regional integration processes. RECs are able to spearhead the adoption of high-level health declarations, strategies, and action plans at summits convened by the highest governing bodies. As an example, the AU's Africa Health Strategy 2016–2030 calls for regular meetings of health ministers and establishes ministerial-level councils/committees/assemblies.

RECs also serve as recipients of major regional health grants (as in the case of IGAD and its role as the principal recipient of the Global Fund's grant on cross-border measures in the fight against tuberculosis). They can also coordinate Africa's voice at WHO, helping to foster formal cooperation agreements. In 2017, for instance, the WHO and the African Union Commission held a high-level meeting to discuss areas of partnership in health. During this meeting, a joint workplan (2017–2018) including high-impact health activities was adopted[17]. A coordinated approach would ensure that RECs' political stance is instrumental in putting Africa's health issues at the top of the global agenda[18]. Through the Regional Integration and Cooperation Assistance Strategy (RICAS) 2021–2023, the World

[17] https://www.afro.who.int/news/who-and-african-union-commission-map-way-forward-stronger-partnership
[18] Nikogosian H (2020) Regional integration, health policy and global health. Global Policy. Epub ahead of print 9 June 2020. DOI: 10.1111/1758-5899.12835.

Bank reinforced its support for Africa's integration agenda by agreeing to promote greater continental connectivity in energy, transport, and digital infrastructure[19]. In addition, the EU-Africa Strategy, launched at the 2021 AU-EU summit, aimed to collaborate on addressing converging interests in multiple areas such as climate change, security, agriculture, and health, with a special focus on sexual and reproductive health and rights[20].

3.9 Health and RECs

This section of the landscape analysis discusses the position of health in the eight AU-recognized regional economic communities. As described earlier in the methodology section, in order to guide discussions and to better understand the role of RECs in health, we used the six WHO health systems building blocks for our analysis[21]. Figure 4 depicts this.

Figure 4: RECs and resilient sustainable systems for health

[19] The World Bank. (2021). Regional Integration and Cooperation Assistance Strategy (RICAS 2021-2023)

[20] European Parliament. (2021). European Parliament Resolution of 25 March 2021 on a new EU-Africa Strategy – a partnership for sustainable and inclusive development (2020/2041(INI)). March, 1–35.

[21] https://extranet.who.int/nhptool/BuildingBlock.aspx

Health leadership and governance

African RECs, including the AU, have implemented various leadership and governance initiatives to strengthen regional health integration. To effectively guide member states and RECs in health systems strengthening, increasing investments, improving equity, and addressing social determinants of health to reduce the disease burden by 2030, the AU developed the Africa Health Strategy 2016–2030. The Africa CDC, an agency entirely dedicated to health, was established in January 2016 and officially launched in January 2017[22]. At the REC level, ECOWAS established WAHO to lead and coordinate health initiatives in the region. In an effort to provide policy guidance, some RECs have integrated health into their treaties and protocols or developed specific health plans and policies. SADC has developed a health policy protocol and regional indicative strategic plan[23]. The AU demonstrated leadership in response to the COVID-19 pandemic by establishing various structures, including the Partnership to Accelerate COVID-19 Testing (PACT), the African Vaccine Acquisition Task Team (AVATT), the AU COVID-19 Response Fund, the Africa Medical Supplies Platform, and the Partnership for Vaccine Manufacture (PAVM). WAHO has successfully demonstrated that a regional health institution can integrate research promotion to address health concerns, particularly maternal and infant mortality. In 2016, for instance, WAHO created a unique program aimed at improving the generation, dissemination, and evidence-based use of research results in programming for improved population health. This highlighted the need for collaboration and coordination among member states, the importance of commitments on the part of country leadership, and cohesion among in-country actors. Overall, it provided a good learning opportunity on steering such initiatives.

Service delivery

Disease-specific programs, including epidemic control, are common across almost all RECs and the AU. Understandably, due to their disease burden, communicable diseases such as malaria, TB, and HIV/AIDS feature prominently. Guidelines, SOPs, minimum standards, strategic frameworks, and service delivery plans are all well established. For instance, SADC has developed minimum standards for TB, HIV, and malaria to guide harmonization in service delivery across member states. The AU quickly created a

USAID praises IGAD HIV/TB/Malaria strategic plan (2018–2025)

USAID Kenya and East Africa Office Deputy Director Wairimu Gakuo congratulated IGAD on its participatory approach to the development of a comprehensive HIV, TB, and malaria strategy on that includes refugees and cross-border populations. She highlighted the support provided by the US Government to the Global Fund for such endeavors and the strong partnership between USAID and IGAD in various intervention areas.

[22] https://africacdc.org/about-us/
[23] https://www.sadc.int/pillars/health-and-nutrition

Division of AIDS, TB, Malaria and Other Infectious Diseases within its Department of Social Affairs. Most RECs hold annual activities to raise public health awareness around these three leading diseases. Examples include the SADC's Annual Malaria Day and ECOWAS' synchronized campaigns for seasonal malaria prevention. Some RECs are addressing cross-border challenges related to prevention and the promotion of access to services, especially by mobile populations including transport workers, sex workers, refugees, internally displaced persons, and those living in close proximity to borders.

Through the SRHR-HIV Knows No Borders project, supported by partners including Save the Children, the International Organization of Migration (IOM), and the United Nations Populations Fund (UNFPA), SADC member states established cross-border sexual and reproductive health (SRH) clinics that provide HIV, TB, and reproductive health services to migrant populations and nearby host communities[24]. With assistance from the Global Fund, IGAD developed a strategic plan for HIV, TB, and malaria and supports member states in implementing service delivery programs targeting these three diseases[25]. At the height of the Ebola epidemic, IGAD established state-of-the-art health facilities at the borders of three ECOWAS member countries.

Health care commodities and supplies

The East African Community, SADC, and ECOWAS have integrated commodities and supplies into their strategies or even developed stand-alone pharmaceutical plans. The EAC has developed the 2nd EAC Pharmaceutical Manufacturing Plan of Action 2017–2027, which serves as a roadmap to guide the community towards "evolving an efficient and effective regional pharmaceutical industry that can supply national, regional and international markets with efficacious and quality medicines[26]." Full implementation of the plan is expected to decrease dependence on imported pharmaceuticals, while at the same time protecting and supporting the local pharmaceutical industry. ECOWAS has also developed a Pharmaceutical Good Manufacturing Practices Roadmap, which defines which medicines are produced and by which manufacturers.

To provide continental support for regulating medical products, the AU established the Africa Medicines Authority (AMA). By the end of May 2022, 31 of the African Union's 55 member states had signed and/or ratified the AMA Treaty, with Ethiopia being the most recent. Rwanda has been selected to host the AMA headquarters.

[24] https://ropretoria.iom.int/sites/g/files/tmzbdl691/files/documents/SRHR-HIV%20KNB%20Phase%20II%20-%20final.pdf
[25] https://igad.int/igad-member-states-to-validate-their-8-year-strategy-against-hiv-tb-and-malaria/
[26] http://repository.eac.int/handle/11671/24343

To address funding gaps, the AU launched its COVID-19 Response Fund in March 2020[27]. The fund has two key functions: to support procurement of critical medical supplies for distribution by the Africa CDC, and to mitigate the socio-economic impacts of the COVID-19 pandemic. According to a key informant who specializes in regulatory reforms in the region, "The whole issue of regulatory transformation should be taken seriously, not just for the health workforce training but also with regard to regulation and manufacture of medicines. There exists an opportunity to leverage a country's strengths to ensure certain standards and to take advantage of the entire regional market."

Human resources for health

With recent global as well as regional human resource reforms, Human Resources for Health (HRH) is becoming an important regional integration priority. To address the issue of brain drain while simultaneously responding to inadequate numbers of health workers in member states, ECOWAS and EAC negotiated for specialized training of their doctors and nurses in Brazil and South Korea, respectively. To address HRH gaps specifically during public health emergencies, the AU established an Africa CDC Mobile Response Team. In collaboration with Africa CDC, WHO facilitated training-of-trainers events across member states to enhance COVID-19 surveillance at points of entry. Africa CDC has held numerous virtual training events for policymakers, clinicians, journalists, and other interested parties. In addition, with support from various donors, including Seed Global Health and the World Bank, the AU (through Africa CDC) is implementing a health workforce initiative for member states[28]. On behalf of RECs, the East, Central and Southern Africa Health Community (ECSA-HC) is investing in various initiatives for education and labor markets for health care workers, especially nurses[29].

Regional Action through Data Goals

- Assist WAHO in consolidation of the regional health data warehouse
- Integrate all data sources into a single database
- Support the improvement of the production, dissemination, and use of health information (weekly and quarterly epidemiological bulletins, regional health profile, regional statistical yearbook)
- Strengthen cross-border health and epidemiological surveillance
- Facilitate cross-border health mapping, monitoring of EPDs, vaccination, HIV, cross-border collaboration

[27] https://au.int/en/AUCOVID19ResponseFund
[28]https://seedglobalhealth.org/2022/07/27/seed-named-major-partner-in-ground-breaking-initiative-led-by-the-african-union-to-build-a-fit-for-purpose-health-workforce-that-can-sustain-universal-health-coverage-in-africa-with-inaugur/
[29] https://ecsahc.org/colleges/

Health information

Quality data, including its availability and use for decision-making, is an important agenda for countries and regions. The AU Africa Health Strategy identifies health information and use of data for decision-making as an important investment area for RECs and member states. With funding from USAID, IGAD and WAHO implemented (2016–2021) a health information and research strengthening project dubbed Regional Action through Data[30]. The EAC noted that "the agenda that [we have] on digital health by developing a cloud where [we] can store health data is an area that should be explored if member countries can overcome issues of data insecurity to support disease surveillance and intelligence." The COVID-19 pandemic demonstrated the importance of data and information sharing among member states and regions. In the wake of the pandemic, several REC member states established regional data hubs for the purpose of sharing COVID-19 data with each other. Projects such as the Bill & Melinda Gates Foundation Africa data hubs were initiated to further strengthen the region's capacity to manage health information[31].

Health care financing

With the drive towards UHC, health care financing is increasingly becoming an important issue for regional economic blocs. Several regional initiatives have been implemented to improve investments for health. During the 2015 Addis Ababa Action Agenda of the Third International Conference on Financing for Development, African leaders committed to raising the level of per capita spending to at least US$44 and allocating at least 15% of government budgets to health. The 2019 Africa Scorecard on Domestic Financing for Health reports that only two AU member states dedicate 15% of the government budget to health; five dedicate 12%; 12 dedicate 10%; 20 dedicate 8%; and 29 spend less than 7%. Out-of-pocket spending on health exceeds 20% in 41 AU member states[32]. In all RECs, there is a strong policy direction towards partnership with the private sector. IGAD, for instance, heavily recognizes the need to partner with the private sector to achieve its mandate. Similarly, the Africa CDC is pursuing a mechanism for sustainable financing through businesses, the private sector, and African philanthropy.

More recently, in *April 2022, AUDA-NEPAD, in collaboration with SADC, hosted the African Leadership Meeting (ALM) Regional Health* Financing Hubs (RHFH) Technical Meeting. The meeting had five interlinked objectives:

[30] https://www.wahooas.org/web-ooas/en/projets/rad-action-through-data
[31] https://www.africadatahub.org/about
[32] https://aidswatchafrica.net/alm-declaration/

1. To support member states in driving and harnessing health financing mechanisms
2. To strengthen health systems within the Southern African region
3. For member states to contribute to the full operationalization of the SADC Health Financing Hub
4. Provide member states with a progress update on the overarching ALM activities, offering them a platform for sharing the current health financing landscape at the national level and indicating their support requirements from the RHFH
5. Outline next steps in the full operationalization of the hub within the SADC region

Participating member states comprised Eswatini, Lesotho, Madagascar, Mauritius, Mozambique, Namibia, South Africa, and Zambia. A key outcome from the meeting was the consensus on the need to strengthen collaboration between ministries of health and finance, building the capacity of focal points within the two ministries to ensure increased financing and efficiency[33].

Based on the foregoing discussion, this landscape analysis identifies that RECs have, to some extent, integrated the six health system building blocks within their operations.

3.10 Comparative Advantages, Challenges, Opportunities, and Threats

3.10.1 Comparative Advantages

The RECs' convening power. Given their mandates, RECs have the ability to convene member countries' heads of state to discuss high-level political, social, economic, and security issues. They have a significant influence on their member states, donors, and key stakeholders in the region. At the height of the COVID-19 pandemic, one of the RECs we studied was able to organize a regional heads of state and government meeting in a week, followed by a finance ministerial meeting in the following three days, and a health ministers' meeting within another two days. Within two weeks, member countries had developed a response framework to the pandemic[34]. All respondents agreed that RECs have a unique ability to serve as platforms for convening high-level officials to discuss political, economic, social, and development issues, including health. For instance, NEPAD routinely gathers ministers of health to discuss their health priorities. Under WAHO, its specialized health agency, ECOWAS regularly convenes its 15 member countries to discuss joint strategies towards the achievement of UHC. SADC and EAC also routinely convene health ministers from member states to discuss health issues of regional concern. Such platforms present an opportunity to discuss, advocate, and prioritize the health agenda within the RECs[35].

[33] https://www.nepad.org/news/alm-regional-health-financing-hubs-strengthening-health-systems-southern-africa
[34] https://www.eac.int/press-releases/147-health/1721-eac-unveils-covid-19-response-plan
[35]https://issafrica.org/pscreport/psc-insights/regional-coordination-against-covid-19-what-role-for-the-recs

Gender mainstreaming. RECs have attempted to mainstream gender in their work, with most developing the necessary policy instruments and structures. Regional economic blocs such as ECOWAS, EAC, IGAD, SADC, and COMESA have established explicit gender equality frameworks. Some, like SADC, have created monitoring plans to assess progress in implementing gender commitments; others, like COMESA, EAC, and IGAD, are in the process of developing theirs. Literature reviews and interviews with stakeholders identified that financing gender structures and activities is a key challenge in gender mainstreaming[36]. Through its Gender Development Center, and with funding from donors including the Government of Canada, ECOWAS has implemented various initiatives, including strengthening the capacity of RECs and other partners (CSOs) to advocate with their member states to meet their commitments to gender equality and women's empowerment in the context of achieving Agenda 2063[37].

Ready market for medical commodities and supplies. RECs can and do create ready markets for health products, especially commodities and supplies. On their own, only a few countries have an adequate market for health commodities. The cooperation of member states creates a large market that can ensure economies of scale to sustain pharmaceutical products manufacturing. The market can also provide an opportunity to negotiate with multinational companies as a stronger bloc. As described earlier, RECs can facilitate joint procurement of essential medicines, medical supplies, and other equipment through pooled purchasing. In addition to securing lower prices through bulk purchasing, it also equalizes the negotiating power of member states, especially those with lower incomes.

Harmonization of medicine regulations. Joint, centralized, and regional regulation, licensing, registration, and accreditation of health commodities can help improve efficiency and reduce the cost of doing business. Additionally, centralized regulation, licensing, and accreditation of health products can help improve the availability of quality assured medicines for member states who may otherwise not have the regulation capacity. For instance, through its existing EAC Free Trade Agreement, the EAC has implemented a regional medicines regulation harmonization since 2010[38.] At a higher level, the AU established the African Medicines Agency to enhance member states' and RECs' capacity to regulate medical products, improving access to quality, safe, and efficacious products[39]. Working under AUDA-NEPAD, the African Medicines Regulatory Harmonization (AMRH) initiative helps to facilitate and coordinate the harmonization of medicines regulation. To achieve this, AMRH works towards improving registration processes and operational inefficiencies, reducing registration times while enhancing the

[36]https://africa.ippf.org/sites/africa/files/2018-09/SOAW-Report-Chapter-4-Regional-Economic-Communities.pdf
[37] https://ccdg.ecowas.int
[38] Dansie LS, Odoch WD, Årdal C (2019) Industrial perceptions of medicines regulatory harmonization in the East African Community. PLoS ONE 14(6): e0218617. https://doi.org/10.1371/journal.pone.0218617
[39] https://au.int/sites/default/files/treaties/36892-treaty-0069_-_ama_treaty_e.pdf

quality of the registration decision[40]. As part of improving quality, the AU established the African Medicines Quality Forum (AMQF) in 2017. Its role is to strengthen the capacity of national quality control laboratories in medicines quality testing and support countries to institute programs that prevent falsified and substandard medicines from reaching consumers[41]. Through its Collaborating Centers and Regional Centers of Regulatory Excellence, WHO AFRO provides support to AMQF and AMRH in improving regulation and harmonization.

Coordination with other RECs and global, regional, and national actors. RECs can serve as a bridge between other RECs and actors at the global, regional, and national levels. At the global level, they can help member states take positions and translate agreements and guidelines, such as the SDGs and the UHC agenda to contextualize national policies and targets. In line with these, WAHO has developed its UHC Vision 2030. Given the importance of a COVID-19 vaccine, the AU was able to take a position on the COVAX facility, a mechanism that aims to pool the procurement and distribution of vaccines, on behalf of member states. These regional positions are useful in helping negotiate on the basis of strength in numbers[42]. As observed by a key informant, “In principle, the regional platforms can and should have the ability to leverage the strengths and opportunities across different areas in the health sector in different countries.” Additionally, regional economic blocs can play an important role of coordinating the work of donors and partners. At the height of the COVID-19 pandemic, the AU coordinated the donation of medical supplies from the Jack Ma Foundation on behalf of member states[43].

Capacity to influence legal, regulatory, and policy reforms across the region. A core mandate of the RECs is to promote regional standards and harmonize legal frameworks and policies. RECs use their political influence, resources, technical savvy, and collective bargaining powers to influence reforms. For example, WAHO was established against the backdrop of intergovernmental health organizations pursuing conflicting agendas. The organization has supported Benin, Nigeria, and Ghana by harmonizing the process of producing HIV/AIDS drugs for the region. WAHO also helped promote trade in health commodities by contributing to the reduction of taxes and tariffs on commodities for malaria control and decreasing regional trade barriers to encourage the purchase of mosquito nets.

[40] https://www.nepad.org/content/about-amrh
[41] https://www.usp-pqm.org/content/african-medicines-quality-forum-africa-led-network-protecting-consumers-poor-quality
[42] https://au.int/en/pressreleases/20210322/statement-member-states-deployment-astrazeneca
[43]https://africacdc.org/news-item/africa-cdc-receives-third-donation-of-medical-supplies-from-jack-ma-foundation-co-hosts-global-medixchange-webinar-on-covid-19/

Mobilization capacity to coordinate a unified response in Africa during public health emergencies. Using lessons from the Ebola epidemic (2014–2016) and now the COVID-19 pandemic, RECs have made efforts to use regional integration to prevent the spread of contagious diseases. The extract (see text box) from the 2014 Landscape Analysis report highlights WAHO's role in the Ebola response[44]. Combined, interlocking efforts have permitted many African governments to respond to the COVID-19 pandemic earlier than other regions in the world[45]. ECOWAS (through WAHO) and the AU (through Africa CDC) played key roles in collecting and disseminating information and practical knowledge to member states and their citizens, building capacities and coordinating responses at different levels. In addition, they have undertaken efforts to mobilize international financial support[46]. The AU rapidly responded to the COVID-19 pandemic through the unanimous adoption of a continental strategy that focused on preventive measures and timely information.

WAHO and the Ebola Response

In response to the 2014 Ebola outbreak in Guinea, Liberia, and Sierra Leone, WAHO provided these three neighboring countries—all ECOWAS member states—with technical and financial assistance through the creation of an Ebola Solidarity Pooled Fund, dubbed the ECOWAS Special Fund for the Fight against Ebola. WAHO organized regional meetings of health ministers, coordinated the regional response in close collaboration with international partners, and advocated for the filling of critical gaps in local health worker capacity, training, and incentive provision in order to improve the outbreak response.

To respond to the COVID-19 crisis, SADC developed guidance for its member states, based primarily on WHO recommendations, and established regional measures to respond to the pandemic. There is, however, no documentation on the measures' effectiveness.

Health research and development for evidence-based decision-making. African RECs have the potential to define the agenda for regional health research, including approval, funding, and ensuring the use of data to influence policy and inform decision-making[47]. Regional health research would provide useful data and information on critical issues and provide evidence-based solutions. During the COVID-19 outbreak, WAHO provided support to ECOWAS member states in promoting data sharing and evidence-based decision-making. The agency organized trainings on evidence-based decision-making, surveillance and supported synthesis, and sharing evidence to support the COVID-19

[44] https://msh.org/wp-content/uploads/2016/03/regional_economic_communities_full_length_report_final.pdf
[45] Engel, U., & Herpolsheimer, J. (2021). African Regional and Inter-Regional Health Governance: Early Responses to the COVID-19 Pandemic by ECOWAS and the African Union. African Security, 00(00), 1–23. https://doi.org/10.1080/19392206.2021.1982240
[46] Engel, U., & Herpolsheimer, J. (2021). African Regional and Inter-Regional Health Governance: Early Responses to the COVID-19 Pandemic by ECOWAS and the African Union. African Security, 14(4), 318–340. https://doi.org/10.1080/19392206.2021.1982240
[47] https://www.ijhpm.com/article_4213_37a2adda3a90b4552da62064356a9134.pdf

response[48]. The Council for Health Research for Development (COHRED) works with WAHO to provide technical assistance in areas such as policy development, health research systems, capacity building, and developing regional information platforms[49]. To improve collaboration between participants, WAHO facilitated the launch of a regional network of health research institutions.

One Health approach to address health insecurity. One Health is a collaborative, multidisciplinary effort to attain optimal health for people, animals, and the environment[50]. With the heightened risk of transmission of zoonotic diseases from one country to another as result of regional animal trade and other factors, the One Health approach has gained traction in recent years. In 2014, the EAC adopted a One Health disease management strategy for the control of infectious diseases: The EAC Regional One Health Platform covers human, animal, and environmental health sectors. In 2017, ECOWAS established a secretariat to implement One Health and adopted strategic regional documents. Institutional structures established to govern and coordinate One Health include the ECOWAS Department of Environment, Regional Center for Disease Surveillance and Control (RCDSC), Regional Laboratory Networks, Early Warning Department, Regional Animal Health Center (RAHC), the Regional Rapid Response Team, and the West African Network of Infectious Disease Surveillance. A partners' forum mobilizing technical and financial resources has also been established. While ECOWAS has conducted limited reviews of One Health's impact, the EAC has not yet done so. In ECOWAS, key achievements include increased political commitment and leadership, demonstrated by functionality and established structures and financing from donors and member states[51].

3.10.2 Challenges

Multiplicity of African RECs and overlapping membership. Out of the 54 African nations that belong to an REC, 11 countries have membership in one REC, 35 countries hold membership in two RECs, seven are official members of three RECs, and one has membership in four RECs. Multiple REC membership poses the challenge of institutional proliferation, which makes integration efforts costly and cumbersome. Countries with overlapping membership often experience conflicting decisions due to differing REC procedures, schedules, and strategies. Although countries may view multiple membership as an enthusiastic strategy to fill existing gaps and serve their health needs in an effective manner, it may also be perceived as a waste of effort and resources. Moreover, it complicates the REC role of harmonization, coordination, regional integration, and cooperation in the health sector.

Perceived hegemony among member states. As identified from key informant interviews, African

[48] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7733344/
[49] https://www.cohred.org
[50] https://www.sciencedirect.com/science/article/pii/S2352771421001154
[51] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8287219/

regionalisms remain subject to substantial power asymmetries among states, with some perceived as hegemonic by other member states within their own region. As evidenced by the Africa Regional Integration Report, integration within the continent is sub-optimal, with RECs existing at different levels[52]. The East African Community scored highest for overall integration, with the SADC coming last. The implication of this low level of integration, coupled with perceived hegemony, is that most states are reluctant to delegate authority to regional organizations.

Lack of evidence-based analysis on the link between health and RECs' main objectives. As reported earlier, most RECs were formed to address economic, security, or political agendas. As presented in the text box on WHO's statement on the link between health and peace, health and most objectives for the establishment of RECs are intrinsically linked. Health can have a negative or positive impact on socio-economic development, peace, and politics. Despite this recognition, data remains insufficient and in forms that are not useful to support evidence-based advocacy with RECs' political leadership. The growing interest in health and peace presents an opportunity for advocacy with regional economic blocs, with significant focus on the regional peace agenda. Examples include the WHO Global Health and Peace Initiative[53]. Article 6 of the AU Peace and Security Protocol lists one of the functions of the PSC as "humanitarian action and disaster management," which includes responses to public health emergencies[54]. Further, as part of appreciating the link between peace, security, and public health crises, the Africa CDC and the Operations Divisions of the AU Peace and Security Department deployed COVID-19 responders to member states[55]. In addition to actual service delivery for COVID-19 cases and educating communities on COVID-19 prevention, the responders helped build the capacity of local response teams through on-the-job training.

WHO Global Health for Peace Initiative

In the words of the Director-General of WHO, Dr. Tedros, "There cannot be health without peace, and there cannot be peace without health." Conflicts are a major obstacle to health, while a lack of access to health and basic social services can lead to feelings of exclusion, which is a major driver of conflict and violence. Delivering health care can help to prevent this vicious circle, if done in a way that is specific to the context, sensitive to the triggers of the conflict, and delivers health benefits and contributes to the peace process. The WHO's Global Health for Peace Initiative (GHPI) involves WHO building on its technical competencies, legitimacy, relationships, and convening power in health to develop innovative ways to address conflict, strengthen resilience to violence, and empower people to (re)build peaceful relations with each other.

[52] https://au.int/en/documents/african-integration-report-2021
[53] https://www.who.int/initiatives/who-health-and-peace-initiative
[54] https://au.int/en/treaties/protocol-relating-establishment-peace-and-security-council-african-union
[55] https://reliefweb.int/report/burkina-faso/africa-cdc-deploys-28-frontline-responders-burkina-faso-cameroon-mali-and-niger

Vertical, disease-specific, and fragmented health responses. Strengthening the broader health systems and ensuring that they are robust and resilient is a more effective and sustainable approach to improving health outcomes than implementing vertical programs. Led by the AU, most regional economic blocs have developed plans and strategies focused on specific diseases such as malaria, HIV and tuberculosis, but are not focused on the overall health systems. For example, both the EAC and SADC have developed disease-specific strategies and plans. In most cases, RECs' health programs and agendas are driven by piecemeal and vertical donor funding from major global partners such as the Global Fund, USAID, Sida, and FCDO, among others. Newer developments, including the SDGs and UHC, have demonstrated the need to move from vertical strategies to a more integrated health systems approach.

Weak institutional capacity to implement integration agenda. Most RECs lack a dedicated health directorate with the authority to drive the integration agenda. Even where health directorates and units exist, these are under-resourced, both in terms of finances and human resources. Some RECs—for example, MU, CEN-SAD, and ECCAS—have little or no indication of regional activities focused on health. COMESA's health and HIV/AIDS programs fall under its Gender and Social Affairs Directorate.

Financial unsustainability. Key informant interviews and a review of governance documents revealed that the financial landscape of most RECs is characterized by unpredictability and volatility of revenues, dependence on external partners, and weak accountability and oversight mechanisms. Most RECs rely heavily on unreliable and unsustainable donor funding for implementation of their health programs. For example, funding for most of the One Health initiatives across Africa (>90%) comes primarily from donors, with little co-funding by member states. The AU policy on financial self-reliance is not practiced. Key informants noted that over 40% of member states do not pay their annual contributions to the AU and to their RECs on time[56]. There was no evidence from those interviewed on the availability of a dedicated health vote line in REC budgets.

Weak coordination and implementation of regional health initiatives. Key informant interviews revealed that RECs face various challenges in effectively coordinating and implementing regional initiatives. With no physical presence in member states, RECs rely on states' infrastructure to implement and coordinate regional health actions. Human resources, infrastructural, and funding challenges among member states make it difficult to effectively coordinate activities. Sometimes there is competition for the same health donors by RECs, member states, and national CSOs, resulting in similar initiatives that are poorly coordinated. To highlight this weak coordination, a key informant observed: "Coordination is challenging, particularly in the health sector. For instance, there was a recent communication from one continental partner to support an initiative in vaccine programming. However, the way it was communicated to the broader community was rather uncoordinated and the

[56] https://au.int/en/pressreleases/20220622/africas-financial-self-reliance-not-self-isolation-commitment-base

result was a reallocation of resources that had already been allocated, owing to politics and bureaucratic processes."

Sub-optimal knowledge and information management systems in RECs. While there has been some effort, for instance through the USAID-funded Regional Action through Data (RAD) project, this landscape analysis identified weak knowledge and information management among RECs.[57] Information flows between regional and national bodies are limited, and the quality and reliability of data is hampered by individual member states' weak information systems. Limited disaggregation of data by wealth quintiles across members states, which is important for targeting key actions to ensure equity, is also lacking. The Southern African Center for Infectious Disease Surveillance (SACIDS) has no formal institutional arrangements that would support data and information sharing in a systematic way. Civil registration and vital statistics (CRVS) systems in Africa remain weak: In 47 countries, civil registration systems do not have fully functional capabilities to record vital statistics and are unable to provide real-time data required to measure mortality[58].

Measuring impact of regional health programs and initiatives. Unlike health-specific country programs implemented within member states, regional programs, by their very nature, may not follow the known cause-and-effect relationship., This makes measuring their impact challenging. Most regional health programs focus on advocacy for policy change, replication of best practices, and coordination. These are naturally more difficult to measure, requiring the use of rigorous qualitative evaluation methods. Additionally, given their nature, regional integrated health programs usually take longer to realize the desired impact. The difficulties in measuring the impact of these programs makes them less attractive for funding by traditional donors.

3.10.3 Opportunities

Sustainable Development Goals. RECs are a crucial vehicle for Africa's realization of the global 2030 sustainable development agenda. They are pivotal in pooling and strengthening efficient resource allocation, enhancing economic diversification, encouraging market expansion, and addressing trans-boundary issues and challenges that would likely risk the continent falling behind in realizing the SDGs. In addition, RECs are key in providing institutional frameworks for SDG monitoring and reporting.

One Health has been embraced by many African countries. One Health has been championed by regional blocs including ECOWAS, MRU, IGAD, CEMAC, EAC, ACDC, COMESA, SADC, WAEMU, AU, ECCAS, SACU, AMU, and CILSS. This growing political interest and goodwill, including by member states, presents a good opportunity for allocation of funds and resources by member states towards

[57] https://2017-2020.usaid.gov/sites/default/files/documents/1864/Fact_Sheet_RAD_IGAD_WAHO_508.pdf
[58] https://reliefweb.int/report/world/crvs-systems-fragilized-covid-19-across-africa-says-eca-s-chinganya

implementation of the initiative.

Strengthening role of RECs in defining African health priorities. Given their presence in the continent and through their networks, RECs understand the health challenges facing the African continent. With strengthened capacity, they have an opportunity to play a leading role in defining and ensuring implementation actions that respond to African health priorities. WAHO has been able to work with the donor community and other partners in helping ECOWAS member states define health priorities of regional interest. Given RECs' autonomous nature, the officials are well positioned to engineer regional health policies and strategies and create networks to facilitate the development of regional health standards, responses, and epidemic prevention strategies.

Manufacturing of local health commodities. Most African countries have limited pharmaceutical manufacturing capacity and rely on imported commodities. To counter this, the majority of RECs have established policies that discourage dependence on imported pharmaceuticals. The intention is to promote the production of indigenous medicines through the development of regional and national private-sector bodies that manufacture and supply pharmaceuticals, thereby encouraging continent-wide trade. A regional roadmap for the development of an effective and efficient regional pharmaceutical industry to supply medicines to national, regional, and international markets is outlined in the 2nd EAC Pharmaceutical Manufacturing Plan of Action 2017–2027. The establishment of AMA and recent developments around the birth of the African Pharmaceutical Technology Foundation (to be headquartered in Rwanda) emphasize the opportunity for the continent to manufacture its own drugs[59].

The African Pharmaceutical Technology Foundation

When fully established, it will be staffed with world-class experts on pharmaceutical innovation and development, intellectual property rights, and health policy. It will act as a transparent intermediary, advancing and brokering the interests of the African pharmaceutical sector with global and other Southern Hemisphere pharmaceutical companies to share technologies, skills, and patented processes. WHO Director-General Dr. Tedros Ghebreyesus said, "Establishing the African Pharmaceutical Technology Foundation, by the African Development Bank, is a game changer in accelerating access of African pharmaceutical companies to IP-protected technologies and know-how in Africa."

RECs offer a platform for data and evidence generation. REC websites present a good opportunity to access regional data from one site without having to visit the websites of different member states. Some RECs, such as ECOWAS (through WAHO), have been able to provide regional data in one place. During the post-Ebola and COVID-19 epidemics, interest in data-sharing to promote regional

[59]https://www.afdb.org/en/news-and-events/press-releases/african-development-banks-board-approves-landmark-institution-establishment-african-pharmaceutical-technology-foundation-transform-africas-pharmaceutical-industry-52727

coordination has grown throughout neighboring countries, a role that RECs can effectively play.

3.10.4 Threats

Political instability and conflicts. Civil wars and political unrest usually compound health challenges. Peace and security issues tend to take precedence over social and economic development concerns. Thus, conflict and political unrest hinder regional health integration by weakening already overburdened national health systems. Consequently, the functioning of RECs and health actors can be undermined by conflict. In addition, military and political tensions between REC members of a REC can also derail integration efforts. Several studies have documented the negative impact of conflicts on population health: Countries that experience conflict report poorer health outcomes, including maternal mortality ratio and under-five mortality rate[60].

Competition for resources. Foreign assistance offered by donors across all sectors—including global health—is narrowing, and RECs are likely to experience changes in donor funding from donor[61]. Donor funding is usually unsustainable due to future inconsistencies and uncertainties. Moreover, the tough economic crises facing member states could trigger countries with multiple REC memberships to withdraw or forego their contributions. It is worth noting that donor funding is mostly directed to projects that can be taken to scale. Additionally, with most donor funding being bilateral, there is inadequate financial assistance to support regional health initiatives through RECs.

Stringent international health frameworks/guidelines, such as TRIPS, that bar knowledge accumulation and transfer within the African pharmaceutical space. The Agreement on Trade and Related Aspects of Intellectual Property Rights (TRIPS), which includes patenting, continues to create challenges in access to quality medicines, especially in Africa. This has become more visible with the HIV burden and public health emergencies such as Ebola, Marburg virus disease, monkeypox, and COVID-19. South Africa, for example, was denied waivers of certain TRIPS obligations in the context of COVID-19 following opposition by high-income countries (Australia, Brazil, Canada, the EU, Japan, Norway, Switzerland, the UK, and the US). Although this has not completely solved the problem of access to medicines SADC was able to use TRIPS' flexibility that facilitates the production or procurement of generic medicines to the benefit of the entire region. It is, therefore, possible to utilize the same flexibilities to ensure access to medicines for other diseases[62].

[60] https://www.ajol.info/index.php/mjas/article/view/187375
[61] https://devinit.org/resources/aid-data-2019-2020-analysis-trends-before-during-covid/
[62] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6277991/

4.0 Conclusion and Recommendations

4.1 Conclusion

This landscape analysis acknowledges that African RECs present a significant opportunity to accelerate their member states' achievement of health goals, including UHC and global health security. Across all the six health systems building blocks, innovative experiences testify to how regional integration has contributed to creating robust, resilient, and sustainable health systems. However, in most cases, these initiatives have been piecemeal, vertical, and reliant on unsustainable donor funding.

The COVID-19 outbreak and previous public health emergencies, such as Ebola and Marburg virus disease in the western Africa region, have also shown the importance of a coordinated and regional approach to promoting early outbreak detection, prevention, and response. There is an urgent need to scale up, formalize, and sustain various health integration initiatives, including data sharing during the COVID-19 pandemic and joint HRH accreditation and regulation. However, various challenges exist, ranging from bureaucratic delays and inadequate funding to low prioritization of the health agenda. These need to be addressed.

4.2 Recommendations

We discuss priority recommendations below.

Recommendation #1: Conduct analysis on link between health and broader REC agendas, then develop tools and advocate for stronger health integration. Almost all RECs were established on the philosophy of economic integration, security, and political interests. Policymakers may not understand the link between health, economic development, peace and security, and politics; therefore, they may not see the need to prioritize health in the regional integration agenda. As part of their advocacy work, RECs need to prove the link between health and their broader mandates. This landscape analysis recommends that cooperating partners support RECs to conduct a landscape analysis, using what they learn to better communicate the link between health and their overall agendas. These will then be included in policy briefs and disseminated to policymakers through regular REC, AU, and member states meetings.

Recommendation #2: Strengthen existing REC health-specific organizations and establish new ones. The AU established the Africa CDC in 2017. To ensure continental reach, the Africa CDC has established five Regional Collaborating Centres (RCCs) as hubs for surveillance, preparedness, and emergency response activities and to coordinate member states' regional public health initiatives in consultation with headquarters. According to our literature review and key informant interviews, ECOWAS' establishment of WAHO has been associated with better health integration in the West

African region compared to others. This landscape analysis recommends a study on the need for health-focused organizations within the other RECs. On a need-by-need and REC-by-REC basis, and learning from WAHO, we recommend the formation of health-focused agencies to drive the health agenda within RECs. Systems should, however, be put in place to ensure funding and sustainability of these agencies.

Recommendation #3: Strengthen health diplomacy across RECs and member states. Regional integration activities are common among ministries of foreign affairs and trade, but rarely involve ministries of health. The COVID-19 pandemic demonstrated the need for skills in international cooperation and negotiation on matters related to health, including for financial assistance, vaccines, and commodities. SADC has implemented health diplomacy activities, including training their diplomats on health issues. This is an ongoing process that requires more investment and attention. This landscape analysis identifies the need to strengthen the health diplomacy capacities of both RECs and relevant departments within member states, which will support their engagement with Ministries of Health as well as health development partners.

Recommendation #4: Strengthen RECs' health knowledge management and learning architecture. Despite the strategic value of data and evidence in health programming, RECs' open data sources provide outdated information, with websites not providing program or budgetary data. RECs must prioritize capacity strengthening initiatives to facilitate data generation, communication, and documentation of key learnings. This support should include appropriate training to build capacity in data interpretation and use for evidence-informed decision-making. The knowledge management architecture should also aim to strategically communicate the importance of integrating the health agenda in regionalization, plus regional programming among RECs and development partners.

Recommendation #5: Strengthen resource mobilization, efficiency and accountability. With most RECs lacking health-dedicated budget lines, as reported through key informant interviews, they often lack the requisite financial and human resources to fully implement their health mandates. Given shrinking donor funding, the challenge of resource constraints will persist; therefore, it is critical that RECs build their internal capacities for diversified and sustainable resource mobilization. Additionally, RECs must develop robust systems to ensure efficiency and accountability. With the right accountability mechanisms, RECs could attract more donor funding and increased membership from both states and individuals, thus boosting their financial sustainability.

Recommendation #6: Scale up existing efforts to strengthen RECs' organizational capacity, especially regarding health integration. RECs continue to experience operational challenges; this extends to their health directorates, which encounter difficulties providing leadership for health integration and coordinating stakeholders, including development partners and CSOs. With partner support, RECs could consider commissioning capacity assessments, from which capacity building

plans will be developed and implemented.

Recommendation #7: Prioritize REC-specific regional health agendas. To ensure efficiency, this analysis recommends that RECs identify and define the priority health issues that are relevant to all member states for joint implementation. The prioritized agenda will then guide partnerships, including those with cooperating agencies and CSOs.

Recommendation #8: Cluster and strengthen joint learning between member states and RECs. Even within a single REC, diversity exists between member states based on health systems and disease epidemiologies. Where necessary, this landscape analysis recommends inter-REC clustering of member states for purposes of joint learning. We further recommend establishing opportunities for learning between member states belonging to different RECs. These could comprise routine in-person meetings or online knowledge exchange forums. Innovative approaches, such as twinning of member states, can also be explored. With the leadership of the AU, we also recommend establishing inter-REC learning forums.

Recommendation #9: Establish an emergency fund among RECs, including within the AU. The COVID-19 pandemic revealed the importance of regional preparedness in the event of a public health emergency. As part of this, we recommend that all RECs, including the AU, establish an emergency fund. This could be supported by member state contributions or resource mobilization from partners.

Recommendation #10: Develop harmonized standards and tools for measuring the impact of integrated regional health programs. With support from regional technical agencies such as WHO AFRO, this landscape analysis recommends the development of regional guidance and tools for measuring integrated regional health programs. This could include a regional health scorecard, with a compendium of health indicators for monitoring progress towards achieving performance goals. As an example, the EAC has developed a Regional Integrated RMNCAH and HIV Scorecard Indicators Booklet[63]. There is a need to strengthen and scale up similar initiatives to support member states' monitoring of regional health projects.

Recommendation #11: As an imperative to ensure sustainability of the world trade regime within Africa, RECs should be supported to facilitate a more active role in engaging the WTO. This will build their capacity to influence WTO negotiations and multilateral commitments.

In general, this landscape analysis observes that if the AU, RECs, and development and implementing partners carefully review, prioritize, support, and implement these recommendations, Africa will be better placed to achieve its SDG, UHC, and global health security goals in a timely manner.

[63] https://health.eac.int/publications/approved-eac-regional-integrated-rmncah-and-hivaids-scorecard-indicators-booklet-2021#gsc.tab=0

5.0 Annexes

5.1 Country-by-Country Membership in the Pillar RECs

Country	The RECs								TOTAL
	UMA	COMESA	CEN-SAD	EAC	ECCAS	ECOWAS	IGAD	SADC	
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
São Tomé and Príncipe									2
Senegal									2
Seychelles									2
Sierra Leone									2
Somalia									2
South Sudan									2
Eswatini									2
Tanzania		Left in 1997							2
Togo									2
Tunisia									2
Zambia									2
Zimbabwe									2
Burundi									3
Congo, DR				Joined in 2022					3
Djibouti									3
Eritrea									3
Libya									3
Sudan									3
Uganda									3
Kenya									4
Total	5	20	28	7	10	15	8	15	

5.2 List of Respondents

S/NO	NAME OF ORGANIZATION	HQ LOCATION
United States Agency for International Development (USAID) (5 interviewees)		
1	USAID West Africa Regional	Accra, Ghana
2	USAID Sahel Regional	Dakar, Senegal
3	USAID East Africa Regional	Nairobi, Kenya
4	USAID Southern Africa Regional	Pretoria, South Africa
5	USAID DRC/Central Africa Regional	Kinshasa, DRC
Regional Economic Communities (RECs) recognized by the African Union (9 organizations)		
6	African Union (AU)	Libreville, Gabon
7	East African Community (EAC)	Arusha, Tanzania
8	Southern Africa Development Community (SADC)	Gaborone, Botswana
9	Common Market for Eastern and Southern Africa (COMESA)	Lusaka, Zambia
10	Economic Community of West African States (ECOWAS)	Dioulasso, Burkina Faso

11	Intergovernmental Authority on Development (IGAD)	Nairobi, Kenya Djibouti, Djibouti
12	Economic Community of Central African States (ECCAS)	Libreville, Gabon
13	Arab Maghreb Union (UMA)	Rabat, Morocco
14	Community of Sahel–Saharan States (CEN–SAD)	Tripoli, Libya
Regional Network Actors: Organization's mandate and work cut across multiple countries within the region; therefore, possess some depth in regional operational knowledge to supplement information gaps and enrich the SCOT and recommendations identified in the literature review (14 organizations)		
15	ECSA-HC: East, Central and Southern African Health Community	Arusha, Tanzania
16	AfCDC Eastern Africa Regional Collaborating Center (EA-RCC)	Nairobi, Kenya
17	AfCDC Central Africa Regional Collaborating Center (CA-RCC)	Libreville, Gabon
18	AfCDC Western Africa Regional Collaborating Center (WA-RCC)	Abuja, Nigeria
19	AfCDC Southern Africa Regional Collaborating Center (SA-RCC)	Lusaka, Zambia
20	West African Health Organization (WAHO)	Dioulasso, Burkina Faso
21	WHO Africa Regional Office	Congo Brazzaville
22	Investment Funds for Health in Africa (IFHA)	Nairobi Kenya

23	Amref Health Africa (Amref)	Nairobi, Kenya
24	African Field Epidemiology Network (AFENET)	Kampala, Uganda
25	East African Health Platform	Arusha, Tanzania
26	EQUINET: The Regional Network on Equity in Health in Southern Africa	Harare, Zimbabwe
27	Africa Capacity Alliance	Nairobi, Kenya
28	AfHEA: African Health Economics and Policy Association	Accra, Ghana
Others: Key agencies that work with RECs and RNAs to support health systems strengthening in Africa (9 organizations)		
29	Health in Africa Fund by Africa Development Bank (AfDB)	Tunis, Tunisia
30	Swedish International Development Cooperation Agency (Sida)	Lusaka
31	International Development Association (IDA) by the World Bank Group (WB)	Nairobi, Kenya
32	European Union (EU)	Brussels, Belgium
33	Bill & Melinda Gates Foundation (BMGF)	Johannesburg, SA
34	MasterCard Foundation (MCF)	Nairobi, Kenya
35	United Nations Economic Commission for Africa (UNECA)	Addis Ababa, Ethiopia

36	Africa Public Health Foundation (APHF)	Nairobi, Kenya
37	The African Union Development Agency (AUDA-NEPAD)	Midrand, South Africa

5.3 Key Informant Interview Guide

Interview Protocol: Regional African Networks
Africa Regional Landscape Analysis (ARLA)
November 2021

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 in these documents will be used to enrich the analysis

Informed Consent:

- Thank you for taking time to hold a discussion with me regarding your organization.
- I am from Amref Health Africa and supported by USAID's Africa Bureau.
- The information from this project will help USAID and partners to better understand how regional organizations work in Africa.
- 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.
- To prepare for this interview, we 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.

- USAID intends to use this information to help guide their future plans.
- The main output will be an analytical document, which 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.

Organizational Data

Introduction: ** I would like to start by asking you to confirm the information we gathered through our desk review concerning your organization. (NOTE: Interviewer states the information gathered for each question and asks the interviewee to confirm).

1. What is the mandate and/or mission of your organization?
2. Does any part of your mandate or mission take into account gender or apply a gender lens to programming?
3. In what year was your organization established?
4. Where is your headquarters/head office located?
5. Does your organization have satellite offices in other countries?
   a. If yes, where?

Membership

Introduction: ** We would also like to know about your members. (NOTE: Interviewer states the information gathered for each question and asks the interviewee to confirm).

6. How many organizations are officially part of your network?
7. How does an organization become part of your network?
   a. What criteria do they have to meet?
   b. Who makes the decision on whether an organization can join your network?
8. What is the role of your network organization in working with its member organizations?

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)

Contextual Factors

Introduction: ** We would like to better understand some of the context within which your organization operates.

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 organization in the next two 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
n. None

15. Which other regional organization do you collaborate with the on a regular basis?
(Please complete the collaboration matrix)
a. What is the nature of your collaboration?
- Information exchange
- Technical assistance
- Financial support
- Gender and development, women's empowerment

Governance and Structure

Introduction: ** Now I would like to talk about how your organization is organized and how it makes decisions. (NOTE: Interviewer states the information gathered, if available, for each question and asks the interviewee to confirm).

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

17. Could you please describe your organizational structure?
    a. What are the names of the various departments and/or units within your organization?
    b. Could we please have a copy of your organizational chart?
18. How are important decisions made within your organization?
19. What is the gender breakdown of those with decision-making power at your organization?
20. What type of 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
21. What mechanisms does your organization utilize in order to push for health policy change?

Health Programming

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

22. 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

23. Which areas of health does your organization focus on? (e.g., HIV, MCH, Malaria, TB, HSS, etc.) Is this data disaggregated by sex?

24. Who is the primary audience or beneficiary, of your programming?

25. Does your organization have safeguarding and sexual harassment and discrimination policies and/or other policies in place to protect staff and program recipients from discrimination?

Policies and Planning

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

26. What is your overall strategy for the development and sustainability of your organization?

27. How do you plan for the organization?

28. Is there an overarching policy document or legislation by which your organization was established?

    a. If yes, where could we get a copy of that document?

29. Does your organization currently have a strategic plan to guide its health programs?

    a. If yes, how many years does it cover?
    b. What year does it end?
    c. Could we have a copy of your strategic plan?
    d. Is gender part of the organization's strategic plan?
    e. Does this strategic plan address equity issues? If so, how?

30. Does your organization produce an annual report?

31. Has your health program been evaluated in the past five years?

    a. If yes, could we have a copy of the evaluation report?

32. Do you hold annual events such as an annual conference or annual meetings?
    a. If yes, when do these events typically take place?
    b. Who attends these meetings?

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*

33. Do you receive non-financial technical assistance from partners?
    a. If yes, who are some of the partners from whom you receive technical assistance?
34. How many staff members does your organization currently have?
35. What is the gender breakdown of your staff?
36. 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?
37. How much funding did your organization receive in total from external donors in 2021?
    a. How much funding did your organization receive in total in 2020?
    b. How much funding did your organization receive in total in 2019?
38. Does your organization generate financial assets from sources other than funders/donors?

39. How much did your organization receive in total financial contributions from sources other than external funders/donors in 2021?
    a. For Associations: How much did you receive from your members?
40. What is your vision for the future of your organization?
41. Is there a plan for addressing gender and other equity issues within the 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. May I please have a copy of this document?