THE EBOLA PANDEMIC AND WEST AFRICAN INTEGRATION: AN IMPERATIVE FOR STRENGTHENING PUBLIC HEALTH CAPACITY

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Abstract: The paper examines the implications of the Ebola Virus Disease (EVD) in West Africa within the context of regional integration.The outbreak, which began in southern part of Guinea in December 2013, was unreported for about three months, leading to a spread especially in 2014 to the neighboring states of Sierra Leone and Liberia. The migratory pattern in West Africa and the challenges of porous borders provided a leeway for the spread of the disease to Senegal, Mali and Nigeria. The study reveals thatthe Ebola pandemic and the resultant mitigation measures of shutting down borders and travel bans have deep implications for the ECOWAS protocol of free movement of persons, goods, and services; and right of residence and establishment; socio-economic development; and also, the ECOWAS Trade Liberalisation Scheme (ETLS). The spread of the disease brought to the fore the inadequate capacity of health systems and resources in West Africa to respond to such a health pandemic in a proactive manner. The paper, therefore recommends the development of a Regional Public Health Action Framework for Member States, which will serve as a guide for Member States to review their existing public health capacities and services and to define country-specific policies to strengthen them. This will also require strengthening the governance system in all facets that relate to health and development.

INTRODUCTION

The Ebola Virus Disease (EVD) outbreak in West Africa in 2013-2015 has renewed debates about the response capacity of public health systems in the region and how best to galvanise collective regional action. It is no surprise that EVD related questions made the top 10 most searched topics on Google in 2014 (Nordrum, 2014). Although the EVD can be traced back to the Ebola River in the Democratic Republic of Congo in 1976, the outbreak in 2014 was unique in several ways (WHO-Regional Office for Africa, 2014). In his speech during the ECOWAS Ministerial Meeting on Ebola Outbreak in West Africa, Dr Luis Gomes Sambo, Regional Director WHO Regional Office for Africa, noted that it was the first outbreak of Ebola disease in West Africa. He also observed that it was the first time the region had simultaneous outbreaks in multiple countries, with urban, rural and cross border spread of the disease (WHO-Regional Office for Africa, 2014). The WHO Regional Director for Africa described the West African outbreak of EVD as the worst documented in history of mankind and declared the situation as an international health emergency. He summed up the situation as a preventable medical and public health crisis. The 2014 EVD outbreak in West Africa is the longest, deadliest and the most complex in history. Unlike past outbreaks, which lasted for a very short time, this outbreak has lasted for more than a year. As of 11 February 2015, there were 22,859 EVD cases and a total of 9,162 deaths. Compared to the cumulative sum of past episodes from 1976-2012, a period of 32 years, which had 2,232 infected people and 1,503 deaths. The particular strain of EVD, which at that time had no vaccine or cure, had a fatality rate of 50 to 90 percent and an incubation period of 2 to 21 days. Symptoms of the disease

include fever, headache, vomiting and bleeding from orifices. Ebola only becomes infectious when an individual is visibly sick, and is transmitted through contact of body fluids such as sweat, saliva, urine, semen and blood (Meseko, Egbetade, & Fagbo, 2015). More so, the Ebola virus remained communicable even through an infected corpse, which is why cremation was proposed to be the best method of disposal. It is worth noting that majority of infected people were in fact involved in cultural norms and burial practices. One of the practices that posed a high risk of contagion is the handing of the bodies of the deceased. In preparation for burial, the bodies of loved ones are often washed, touched, and kissed (Gassel, 2015, p.1). With bleeding, vomiting and diarrhea as some of the main symptoms of Ebola, persons in charge of funeral preparation were easily exposed to these and other bodily fluids (Meseko, Egbetade, & Fagbo, 2015). Other at-risk persons were the health personnel, support workers and caregivers (Bangura, 2014). A shortage of healthcare workers, and sanitary conditions made it easier for Ebola to spread. With more people becoming infected, fear became the most difficult barrier to overcome. Fear caused people who have had contact with infected persons to escape from the surveillance system and relatives to hide symptomatic family members or take them to traditional healers. The fact that Ebola is frequently fatal and has no cure further fuels fear and perpetuates these dangerous behaviors. The migratory pattern in West Africa made the containment of the epidemic challenging. In addition to spreading to several West African countries, the EVD was also detected in other parts of the world, including Spain, Italy, Germany and the United States of America (CDC, 2014). It was the first time that EVD was transmitted to other countries via air travels. It was first transmitted to Nigeria by a traveller from Liberia who flew into the country by air. Within a very short period, it was transported to Europe and America. This led to a pronounced international stigmatization against West Africa.

Due to the high transmission rate in some countries in West Africa, John Dramani Mahama, who was then Chairman, Economic Community of West African States (ECOWAS), noted that the EVD had progressed from a regional problem to an international problem (StarAfrica News, November 6, 2014). The World Health Organisation (WHO) also declared Ebola a 'Public Health Emergency of International Concern' (WHO-Regional Office for Africa, 2014). The ensuing results since the outbreak of the disease demonstrate that it is not only a health issue, but also, a security and an economic issue. The response to the Ebola outbreak from extant organizations along with newly created national and international bodies to contain the virus has been immense. Among such ad-hoc bodies are the United Nations Mission for Ebola Emergency Response (UNMEER), Sub Regional Ebola Outbreak Coordinating Center (SREOCC) and the African Union Support to Ebola Outbreak in West Africa (ASEOWA). The paper, which examines the Ebola pandemic in the context of regional integration in West African, is divided into seven sections. Following the introduction, section two examined the concept of regional integration. Section three focuses the Ebola crisis in West Africa and section four focused on the implications of the Ebola crisis on regional integration. While section five assesses the ECOWAS response to the Ebola crisis, section six examines the imperative for strengthening public health capacity in West Africa. Section seven is the conclusion. The paper argues that the public health system of countries in West Africa, particularly the worst-hit, were unprepared for the Ebola crisis. It concludes by recommending that member states of the ECOWAS should strengthen their public health capacities by developing and integrating health promotion and disease prevention with robust health protection services.

The Concept of Regional Integration

In the contemporary international system that is characterised by globalisation processes, regional integration has become a magnetic force especially in the global peripheries that are acutely aware of the ever increasing threat of marginalisation in the global economic and political 'high tables' and decision making processes. According to Sesay and Omotosho, regional integration refers to:

> ... harmonization policies – prevailing or proposed at both the continental i.e. African Economic Community, AEC, and regional such as ECOWAS, Southern Africa Development Community, SADC, levels among many others (Sesay and Omotosho, 2014, p.11).

According to Botlhale (2010, p.3), regional integration is aimed at achieving three basic goals; a) political stability, a prerequisite for national economic development, b) economic development, facilitated by the free movement of people, goods and services etc, as anticipated in the ECOWAS integration project, and c) regional public good, to be promoted by the collective desire of the integrating states to address matters and concerns of common interest, such as "food security, preservation of biodiversity and tackling climate change...", among others. Also, regional integration offers the prospect of pooling resources for enhanced individual and collective empowerment, especially for the smaller and weaker members. It also offers opportunities for collective problem solving, and in volatile regions, it is aimed at promoting peace among the member states through various mechanisms and institutions that are set up either especially for such purpose or indirectly to facilitate such a process. Put differently, regional integration programmes are aimed at solving directly and indirectly, the ever increasing challenge of development and peace among states and whose competing interests are not always the same or compatible.

Regional integration is a concept and movement that gained momentum with the establishment of the European Economic Community (EEC), now known as the European Union (EU), in 1957. Regional integration, as defined by the aforementioned Regional Economic Community (REC), is '...the process of overcoming, by common accord, political, physical, economic and social barriers that divide countries from their neighbours, and of collaborating in the management of shared resources and common national goals'(Niekerk, 2011, p.7). It is in light of these interpretations of regional integration that the paper will focus on the implications of EVD as it relates to the single most important REC in the region of West Africa, the Economic Community of West African States (ECOWAS). The ECOWAS, was founded on the 25th of May 1975, with the prime aim to "enable the member states to create an enlarged market to enhance their competiveness and development" in an increasingly globalized world (Sesay and Omotosho, 2014, p.13). Since its creation the organisation has recorded some significant achievements and has also grappled with numerous challenges. The ECOWAS agenda at inception was to establish appropriate institutional framework for the work of the organisation, for the development of an elaborate integration mechanism, the abolition of visas and the introduction of a protocol on the free movement of persons and goods, the regional industrialisation framework, the development of a regional monetary system, and movement towards a single currency, the Trade Liberalisation Scheme, development of transport and energy master plan, the ECOWAS power pool etc.

For more than two decades after its inception, ECOWAS was burdened by political crisis and security concerns, such that from 1990 and up till the moment, conflict management, conflict

resolution, peace-making, peace-keeping became major preoccupations for the organisation. A major development in this regard was the creation of the ECOWAS Monitoring Group (ECOMOG), which incidentally brought international recognition to the organisation and helped to establish it as an instrument for peace-making within the region and an example for the rest of the West African region, and other troubled regions around the world. The experience gathered from the different conflict resolution efforts in Liberia, Sierra Leone and other trouble spots in the region informed the adoption in 1999 of the Protocol relating to the Mechanism for Conflict Prevention Management, Resolution, Peacekeeping and Security (MCPMRPS). Indeed, the fragile political stability and porous interstate borders in the region have been rendered more vulnerable and volatile by new wave of security challenges including terrorism - particularly the Boko Haram terrorism in northern Nigeria, piracy, proliferation of small arms and light weapons, human and drug trafficking and other transnational organised crimes. Developments in the region such as the attempted unconstitutional changes of government in Niger, Mali, Guinea Bissau, amongst others, has seen Member States being the first to condemn such acts in addition to taking active steps as an organisation to restore democratically elected governments. At the same time, the region is still confronted with other developmental challenges including poverty, high rate of unemployment, diseases such as HIV/AIDS and malaria, amongst others, which have clogged the attainment of the Millennium Development Goals (MDGs) (Chan, 2014). The latest challenge which the region had to grapple with is the exponentially spread of Ebola Virus Disease (EVD), which has affected West African states such as Liberia, Sierra Leone, Guinea and Nigeria. The Ebola pandemic has not only exposed the fragility of national health systems, but also tested the capacity and capability of the ECOWAS organisation to handle such challenges in many ways. ECOWAS has responded in a number of ways to the pandemic. A treaty revision in 1993 led to the adoption of new protocols that would facilitate:

> liberalisation of trade by the abolition, among member States of customs duties levied on imports and exports and the removal of non-tariff barriers in order to establish a free trade area at the Community level; the adoption of a common external tariff and a common trade policy and finally, the removal of obstacles to the free movement of persons, goods services and capital and the right of residence and establishment (Sesay and Omotosho, 2014, p.14).

Admittedly, there have been many obstructions to the realization of the ECOWAS protocols and institutions, which include competing national interests of member states; lack of ratification and implementation of prescribed protocols of 1993; bureaucratic bottlenecks; corruption; substandard port operations and physical infrastructure, but the one colossal impediment to regional integration in 2014 was the Ebola outbreak (Vickers & Games, 2015, p.1). It is against this background that we examined the Ebola pandemic in West Africa.

The Ebola Crisis in West Africa

The EVD outbreak was first reported in 1976 in Yambuku, a village in the Democratic Republic of the Congo. Since then, more than 20 Ebola outbreaks have occurred mainly in East and Central African countries. According to the WHO, the first case of the current Ebola epidemic began in southern part Guinea in December 2013. It was unreported for about three months, leading to wide spread to the neigbouring states of Sierra Leone and Liberia. Incidentally, these three states whose populations were most affected by the disease are among the world's 50 poorest. According to Oxfam, the three countries are in the bottom 7 percent of the "inequality adjusted Human Development Index (a measure of human development based

on country level inequalities in health, education and income)" (Galasso, 2014). The accelerating spread of the disease brought to the fore, not only the lack of resources and inadequate health systems in West Africa, but also revealed that by investing in the health system and being proactive, the disease can be curtailed – as was the case in Nigeria and Senegal, where EVD eventually spread to and was curbed on time. As at December 18th, 2014, Ebola had resulted in 6,928 dead in West Africa. As earlier stated, the spread of EVD is more than just a health problem. There are economic and security dimensions of the epidemic. The agricultural sector has been a major victim as a result of abandonment of farmlands with major implication for food security in the region. Restriction of trade and closure of establishments have adversely affected livelihoods in the countries affect. According to Wangalwa,

> Economic growth in Guinea, Liberia and Sierra Leone is forecasted to reduce by 2 percent as cross border markets have been shut down and farmers have fled affected zones, leaving decayed crops in fields, a significant contributor to the GDP [Gross domestic product] (Wangalwa, 2014).

Concerted efforts were made towards managing the EVD through financial contributions and donations, deployment of health workers and provision of food and other facilities to support health workers. The African Union (AU), United Nations Development Program (UNDP), Center for Disease Control and Prevention (CDC), African Federation of Public Health Association, WHO, Doctors without Borders/Medicins Sans Frontieres (MSF), West African Health Organization (WAHO) and ECOWAS member states showed serious commitment towards containing the further spread of the disease. National governments of some infected states closed their major borders to avoid further transmission of the Ebola virus, and other countries closed theirs to people coming from infected countries as a form of preventive measure. Quarantines were set up at entry points where frontiers remained open to test incoming travellers for the virus. Unfortunately, as was the case in Liberia and Sierra Leone, it has been pointed out that most of these isolation units are in fact breeding grounds for Ebola because of the poor sanitary conditions. A brief country-by-country overview of the Ebola crisis will be done in order to fully appreciate the implication of the disease for West Africa.

Guinea

On 28th December, 2013, a 2-year-old boy died of a fever accompanied by hemorrhage in the South Eastern Guinean village of Meliandou.[i] The village, Meliandou is located in the area that was later designated as the outbreak's "hot zone": a triangle-shaped forested area where the borders of Guinea, Liberia and Sierra Leone converge".[ii] WHO reported that unemployment and poverty exacerbated the spread of the disease within a short time.[iii] Owing to the disadvantaged populations in the three countries, citizens often travelled across borders to find work and because of the contagious nature of the disease, many people became infected very quickly. In March, 2014, hospitals in Guinea reported to the country's Ministry of Health and MSF that 59 people had died as a result of hemorrhagic fever in the neighboring towns of Gueckedou, Macenta, Nzerekore, and Kissidougou.[iv] On March 23rd, 2014, the WHO announced that the unidentified illness taking lives was the EVD, and deployed medical teams under the aegis of the WHO Global Outbreak Alert and Response Network (GOARN).[v] MSF personnel were also on ground to help contain the outbreak. A Regional Ebola Outbreak Coordinating Centre was established in Conakry. Unfortunately, cases flared up in Conakry and went on to reach other parts of Guinea. Every time it seemed like the disease had been managed in one part of the country, cases would appear again. Recurring incidents of violence against health workers and destruction of medicines and equipment buttress the submission

that fear and illiteracy were obstacles to combating the disease. In a country where the doctor patient ratio is 10 to 100,000 as compared to the WHO recommendation of 1 physician for 600 people, forcing health personnel to flee was unwise.[vi] The Guinean government earlier announced "a US$220 million financing gap because of the crisis".[vii] As at 10 November, 2015, Guinea was the only country yet to be declared free from the Ebola crisis.

Liberia

A mysterious disease was reported to be causing deaths in Lofa, northern Liberia in February 2014. In Lofa, EVD was initially misdiagnosed as Lassa fever, but subsequently blood samples were sent to France for testing by a team of Liberian Researchers (Epstein, 2014). The researchers got confirmation that Liberia indeed had cases of Ebola. There were few cases in March and April, and then none for over a month. However, by the end of May, 2014, there were reports of numerous cases in the capital city of Monrovia (Epstein, 2014). The Ebola Task Force in the country's Ministry of Health and Social Welfare, MSF and the CDC collaborated to halt the spread of disease. Public announcements were made to citizens to be wary of people with symptoms; a hotline was set up so the public could call in and report suspected cases; teams were trained to go to reported homes and make diagnoses; laboratories were equipped to test for the Ebola virus; isolation and treatment units were put in place in the form of tents; and thousands of contact tracers were hired to identify and isolate individuals who had been in contact with infected persons (Epstein, 2014). While these measures put in place towards containing previous Ebola outbreaks, they clearly were not working. According to Epstein (2014) the main reason for the non workability of the measures was the disillusionment of Liberians with their government. Even after official statements about EVD in Liberia, people thought the government made it up and so they went on with their lives with no regard or caution for the disease (Epstein, 2014). Burial practices of bathing corpses continued and patients were treated without the use of protective outfits. According to a nurse, villagers, "thought nurses had been given poison by the president to inject into people so they'd die and the UN would send money" (Epstein, 2014).

According to Epstein (2014) Liberians in almost all the villages actually believed the rumour that President was spreading the disease to attract foreign aid. By early August, the treatment centres were full, the streets were strewn with bodies, and the Ebola hotline was receiving thousands of calls a week (Epstein, 2014). The Ebola outbreak prompted the shutting down of schools and markets. The closure of about 60 percent of market led to a reduction in the activities of miners and palm oil traders.[viii] Nevertheless, with the increased mobilization of funds, medicines, and equipment, the number of cases began to abate. Also, the villagers eventually realized they were wrong and set up their own quarantine system, and began to cooperate with health workers to contain the virus. As of January 9th 2015, CDC reported 3,515 cases out of 8, 263 cases were fatal[ix]. In addition to efforts of the Liberian government, the ECOWAS, AU and other international organisations, volunteers, local chiefs and leaders and religious organisations play important roles in ending the Ebola transmission in Liberia. On 9 May, 2015, WHO and the Liberian government declared Liberia free of Ebola virus transmission.

Sierra Leone

The first confirmed case of EVD in Sierra Leone was a young woman who was admitted to a government hospital in the eastern city of Kenema following a miscarriage on 24 May, 2014.[x] The lady was later isolated in the Lassa fever isolation ward in the country after testing positive

for Ebola. Following the discovery, the Ministry of Health and Sanitation were promptly alerted[xi]. The lady soon fully recovered without anyone at the hospital contracting the disease and explained how she had been to the funeral of a traditional healer who had consulted Ebola cases from Guinea.[xii] By June, the disease had swept through Kenema and taken root in Kailahun and spread to Freetown "where it took advantage of overcrowded living conditions and fluid population movements to grow in explosive numbers".[xiii] Sierra Leone as at January 2015 had the highest number of laboratory-confirmed and probable cases combined. The figure stood at 10,030 with 2,977 mortalities.[xiv] Owing to the seriousness of the Ebola epidemic, Sierra Leone like Liberia, ordered the closure of schools and markets after declaring a state of emergency (Mark, 2014). The epidemic was compounded in Sierra Leone by the death of many health workers including nurses, health support workers and Dr Sheik Humarr Khan, a virologist and world-renowned expert on viral haemorrhagic fevers" and "five co-authors of the Ebola study, who contributed greatly to public health and research in Sierra Leone".[xv] To compensate for lack of human resources, WHO and MSF deployed health care personnel and increased the treatment centres in Sierra Leone. National workers worked with their international counterparts to educate citizens about the disease, and traced contacts swiftly because the longer an infected person goes unidentified, the higher the risk of contagion. As a result of the Ebola crisis in Sierra Leone, not less than US$20 million meant for infrastructure development had to be redirected to containing the Ebola fight (UNECA, 2014). In Sierra Leone, only 1 in 5 people with the human immunodeficiency virus (HIV) are still receiving treatment. Both human and financial resources were redirected to contain the Ebola scourge leaving only few available for non-Ebola care.[xvi] The outbreak of EVD will be considered ended after 42 days have since passed the last confirmed case has tested positive. Following 42 days with no new cases in Sierra Leone, its declaration as free of Ebola by the WHO on Saturday, November 7, 2015, threw thousands of citizens into the streets in celebration.

Nigeria

Shortly after the revival of the Nigeria-Liberia Joint Commission (NLJC) and Nigeria's pledge of US$500,000 to fight the Ebola pandemic, Patrick Sawyer, a Liberian civil servant, brought the Ebola virus to Lagos by air (Ahmad, 2014). Sawyer collapsed on arrival at Murtala Muhammad International Airport in Lagos on July 20th 2014 and was quarantined at the First Consultants Hospital, Obalende, Lagos state (Cocks, 2014). He died five days later, but not before communicating the disease to several people he had come in contact with. Unfortunately, the disease spread to Port Harcourt and Enugu through persons that had contact with him, who out of fear sought treatment outside Lagos. The Nigerian government and health care workers responded with promptness creating quarantine and treatment centres all over Lagos, Port Harcourt and Enugu. Sensitization of the public on the EVD was adopted as a primary preventive measure by the government at federal, state and local levels. Various media sources were utilized to educate the public on hygiene and to inform them about the symptoms of Ebola and how it can be contracted. Despite the education of citizens, rumours of salt water being a vaccine of the disease became widespread. Many bathed with salt water, and death resulted in cases where some drank copious amounts. Public institutions as well as schools, banks and offices encouraged the use of hand sanitizer before entering and exiting the building leading to an exponential increase in the prices and proliferation sanitizers, including fake versions. Arik Air suspended travel between Nigeria to Liberia and Nigeria to Sierra Leone. Although Nigeria did not close its borders so as not to threaten regional integration, its airports, seaports and land frontiers were placed on red alert, with commuters being thoroughly

screened on entry and before exit. Schools in Lagos and other parts of the country were closed down until the end of the outbreak. The Nigerian government's efforts were complimented by other international organisations and groups that assisted in managing the EVD. These included WHO, the United States and Nigerian CDC, MSF, United Nations Children's Fund (UNICEF), the media, Non Governmental Organisations (NGOs) and religious bodies. As a result of concerted efforts by the government to manage the EVD, assisted by relevant stakeholders, nationally and internationally, the WHO declared Nigeria Ebola-free on 20th October (WHO, 2014).

> According to WHO recommendations, the end of an Ebola virus disease outbreak in a country can be declared once 42 days have passed and no new cases have been detected. The 42 days represents twice the maximum incubation period for Ebola (21 days). This 42-day period starts from the last day that any person in the country had contact with a confirmed or probable Ebola case.

Nigerian officials, especially the Lagos state government and then Minister of Health, Professor Onyebuchi Chukwu were greatly commended. In the end, 8 individuals out of 20 infected people died including the pioneer doctor, Stella Adadevoh who attended to the index case[xvii]. Stella Adadevoh sacrificed herself for the country that others may live (Mugele & Priest, 2014:1). Even with the declaration by the WHO that Nigeria was an Ebola free country, epidemiological surveillance remained in place as a preventive measure, particularly at entry points such as Nigeria's airports around the country.

Senegal

Senegal was among the last countries that the 2014 wave of Ebola in West Africa reached. This might be because of the proactive measures taken by the Senegalese government, particularly, banning air and land travel between Senegal and the three most affected countries of Guinea, Liberia and Sierra Leone. Senegal's Health Minister Dr Awa Marie Colle Seck noted that the 'travel ban would not affect humanitarian flights and Senegal had a duty to prevent further spread of the EVD" (BBC, August 22, 2014). In August, a carrier of the Ebola virus flew into Senegal from Guinea. Since the confirmation of the index case in Dakar, a vigilante border patrol force was organized to apprehend and deport Guineans crossing the border into Senegal (Ba, Malick, 2014). There were reported cases of Ebola patients being attacked while hospitalized. This prompted the President of Senegal, Macky Sall to denounce the stigmatization of infected people (Ba, Malick, 2014). The index case in Senegal made a full recovery, and Senegal's Ebola case did not result in fatality. The WHO has also declared Senegal free of the EVD on 17 October.

Mali

A laboratory in Kayes, Western Mali confirmed the first Ebola case in Mali on October 23rd 2014 and it proved fatal the following day.[xviii] The patient was a two-year-old girl who had travelled through Mali with her grandmother seeking treatment. The child's travel history increased the risk of contagion in the country as the grandmother admits she was symptomatic during the journeys. Subsequent cases were identified in Mali. Malian authorities in conjunction with WHO and MSF personnel worked hard to ensure containment of the disease. As at January, 2015, CDC reported that 8 cases were confirmed and 6 were reported dead.[xix] Mali is a landlocked country that heavily depends on products from Senegal, Guinea and Cote d'Ivoire, thus President Ibrahim Boubacar Keita maintained that Mali would not close its borders.[xx]

Implications of the Ebola Crisis for Regional Integration

The Ebola pandemic and the resultant mitigation measures of shutting down borders have hampered the ECOWAS protocol of free movement of persons, goods, and services; and right of residence and establishment; socio-economic development; and also, the ECOWAS Trade Liberalisation Scheme (ETLS). To contain the spread of the epidemic, the affected countries had to close their own borders with each other and most of their neighbours. Many countries within Africa banned citizens from the three most affected countries from entering their borders as well as travellers who had been to the affected areas. The majority of airlines stopped flights into the affected countries, mostly to Liberia and Sierra Leone. Only two airlines, SN Brussels and Royal Air Maroc, continued flights to these countries, although more airlines have since resumed flights. Concerns about the spread of Ebola through cargo movements were disruptive, with increased scrutiny on cargo shipments from West Africa and screening crew members for possible infection. Despite these concerns, the ports remain open and sea traffic continues to provide a crucial channel for trade. Visitors from other parts of Africa and other parts of the world avoided the West African region for fear of contamination, resulting in reduced demand for hotels, airlines and service providers with links to international business. Conferences and international meetings were canceled. There was a general slowdown in business activities particularly in the areas of tourism, hospitality and aviation. The Third India-Africa Forum Summit (IAFS III) that eventually held from 26-30 October, 2015, was one of the major meetings canceled in 2014 due to concerns over Ebola. Closed borders results frustration of the integration process because free movement of people and goods and services becomes impossible. The "ripple effect" of Ebola on economies is profound, with establishments having to close down and sources of income being lost (Galasso, 2014, p.2).

The impact of the Ebola crisis on regional integration is almost invariably tantamount to socio-economic consequences (UNECA, 2014, p.2). National development, which is an objective of regional integration, has also been impeded by the outbreak. UNDP reports a likely 2 to 3.5 percent GDP loss in Guinea, Liberia and Sierra Leone; and a 90 percent "decrease in fruit and vegetable exports from the Northeast of Guinea to neighbouring countries".[xxi] Liberia, Sierra Leone and Guinea are all least developed countries (LDCs) that confront extreme poverty and socioeconomic challenges. Poverty ranged from 2.25 percent in 2014 to 7.9 percent in 2015; between 13.8 percent and 14.1 percent for Sierra Leone; and between 5.5 percent and 17.6 percent during 2014-2015 (UNDG-WCA, 2015, p.iv). Although these countries experienced high growth rates in recent times, buoyed by favourable commodity prices and post-conflict assistance, the gains of the past decade were quickly eroded due to the Ebola crisis. The World Bank estimated that the virus had cost Liberia, Sierra Leone and Guinea more than US$2 billion from 2014-15. Since mid-2014, the three worst affected countries experienced flat or negative income growth as cross-border markets were shut down and farmers fled affected zones, leaving decayed crops in fields, a significant contributor to the GDP (Wangalwa, 2014). The World Bank lowered the prognosis for 2015 on the basis of continuing new infections, second-round effects and investor aversion: -0.2 percent in Guinea, 3 percent in Liberia and -2.0 percent in Sierra Leone (down from pre-Ebola estimates of 4.3 percent, 6.8 percent and 8.9 percent respectively). The World Bank also estimates foregone income in 2015 of about US$1.6 billion: US$540 million in Guinea, US$180 million in Liberia, and US$920 million in Sierra Leone (World Bank, January 2015). This is more than 12 percent of their combined GDPs. Multinational companies (MNCs) operating in the three most affected countries pulled

back new investments, particularly in the areas of mining, oil and gas; repatriated many foreign workers; and cut production of critical revenue generating exports (Vickers & Games, 2015, p.2). Their economic plight was exacerbated by the simultaneous drop in the prices of iron ore on international markets, adding to the revenue decline of these mining economies.

Regional trade in West Africa is largely informal and inundated with considerable insecurity to traders and goods from corrupt law enforcement agencies and/or cross-border challenges. The insecurity of traders is compounded by inadequate border infrastructure such as warehousing facilities and reliable transport system. Traders often do not have valid travel documents or certificates of origin for their wares. Overall, aggregate levels of intra-regional trade are typically low relative to other regions of the world economy due to the prevalence of trade barriers, undiversified and underdeveloped production structures and poor infrastructure. According to UNCTAD data, in 2007-2011, the share of regional trade of the 15-member ECOWAS was only 9 percent, down on previous years. Regional integration in West Africa has made some significant progress. In January 2015, ECOWAS launched the long awaited common external tariff (CET) (Vickers & Games, 2015, p.3). Although the CET includes protection for agricultural products, it raised the tariff on rice, which is zero in many countries, to 10 percent with a view to increase over time. However, this may also provide a regional export opportunity for rice producing countries in the region, which include the Ebola-hit economies. There are other examples of trade policies that may, if carefully negotiated and managed, form part of the post-Ebola strategy. Ironically, this deepening of regional integration comes at a time when the region has shut down borders and is focusing more than ever on national priorities. The Ebola-induced suspension of formal and informal intra-regional trade in goods and services could lead traditional West African trading partners to seek alternative suppliers, even from outside Africa, thereby undermining regional integration and potential trade-led regional value chains in ECOWAS. The decimation of manpower in the various countries plagued by Ebola also thwarted regional integration, in the sense that market size shrunk. As a result of the Ebola menace, intra-regional trade that stood at about 10 to 12 percent before the Ebola outbreak has further dropped (Hartzenberg, 2011, p.3). Sesay and Omotosho have argued that among the cornerstones of a successful regional integration arrangements (RIA) are:

> i) domestic peace and security in the integrating states because apart from the destruction of infrastructure such as road networks, telecommunications and other important facilities, conflict diverts attention from regional integration projects as was the case with Liberia, Sierra Leone and Cote d'Ivoire while their civil wars lasted; ii) enhancing political and civic commitment and mutual trust among the members, and (iii) there must be a minimum threshold of macro- economic stability and good financial management in member countries(Sesay and Omotosho, 2014, p.12).

It can therefore be inferred from this submission that since the governments of Guinea, Sierra Leone and Liberia have been preoccupied with handling the Ebola epidemic, which is both a health and security issue, they have not been fully committed to regional integration projects. With most of their time, energy and resources channelled to preventing further spread of Ebola infections, the governments were too stretched out to address issues impeding the ELTS. Again, in regards to the third cornerstone, the closure of businesses and borders due to Ebola had encouraged disequilibrium, which negatively impacts on economies of West African states, and hence undermines regional integration.

The ECOWAS Response to the Ebola Crisis

To halt the Ebola epidemic, ECOWAS took several significant steps. The first was setting up a Regional Solidarity Fund (RSF) to fight Ebola, to which Nigeria contributed US$4.5 million, Cote d'Ivoire and Senegal US$1 million each, Benin Republic US$400,000, Sierra Leone US$250,000, Burkina Faso US$150,000 and Niger Republic and Mali US$200,000 each[xxii]. ECOWAS collectively donated US$1 million to the three worst affected countries, and the West African Economic Monetary Union US$1.5 million.[xxiii] Also, conferences were held among ECOWAS member Heads of State and Government, and, Health Ministers met twice in Accra, Ghana, to assess the epidemic. Recommendations were made to strengthen health structures, intensify communication and cooperation; and an operational plan involving the alliance of WAHO, Nigeria CDC, WHO and the ECOWAS commission itself to tackle EVD was developed (Shittu, 2014). Speaking at the Health Partners Coordinating Committee (HPPC) meeting in Abuja, the President of the ECOWAS Commission, Mr. Kadre Desire Quedraogo, made a strong case for non-closure of borders, but rather recommended that surveillance measures be put in place.[xxiv] The ECOWAS suggested that affected countries should choose one land, sea and air entry point that will be monitored by ECOWAS.[xxv] Affected states were encouraged to consult with concerned neighbouring countries, WHO and WAHO, before closing their borders. In making such recommendations, the ECOWAS took cognisance of the implications of border closure. The point must be made that apprehension to the closure of borders is predicated on the assertion that it is counter-productive. Sambo buttresses this point by explaining that "closed borders and entry points and banned flights to and from the affected countries, isolate and stigmatize them, making it difficult to transport supplies, personnel and other resources".[xxvi] Health personnel were also volunteered by ECOWAS member states to fight Ebola. The Chief Executive of the health arm of ECOWAS, WAHO disbursed US$400,000 to Guinea, Liberia and Sierra Leone to enhance their response capacity, and asked for a supplemental annual amount of 'US$2.5 million to the institution to strengthen its capacity to fight epidemics".[xxvii] The WAHO also sent teams of health workers to the various affected countries of West Africa. Regarded as a full-scale war on the disease, ECOWAS Chief of Defense Staff "met in Ghana to work out modalities that will facilitate the deployment of the Regions' Armed Forces to tackle the Ebola Virus Disease ravaging the region".[xxviii] It is evident that the Ebola virus disease affected cardinal prongs of regional integration in West Africa, namely trade, free movement of people and goods, threatened by the wave of border closings and travel bans. It is also evident from the discussion that the Ebola crisis provided opportunity for the pooling of resources by states, regional, continental and international organisations and bodies to contain the epidemic and help fight it in countries to avoid spread.

The Imperative for Strengthening Public Health Capacity in West Africa

Public health has been defined as the art and science of preventing disease, prolonging life and promoting health through the organized efforts of society (Acheson, 1988). The definition suggests that the success of public health is a function of involving the whole of society. Public health is to be achieved through society's "organized efforts" (Marks, Hunter & Alderslade, 2011, p.14). Arguably, a public health system is considered as more inclusive than any other health system. Indeed the Ebola crisis has shed more light on the public health capacity challenges that West African countries are facing. These are primarily at two levels namely, human – inadequate trained personnel, and institutional - weak public health infrastructure. Most hospitals in West Africa lack quarantine units or holding centres. Even the Doctor-

Patient ratio is below the WHO recommendation of 1 physician for 600 people in the majority of West African countries. Numerous reports have shown that ECOWAS member states "perform worst on the [Global competitiveness Index] GCI indicators in comparison to other RIAs", and healthcare is one of its weakest areas (Hartzenberg, 2011). Ebola thrived on abysmal health system, poverty and illiteracy, therefore ECOWAS strategy from here on should be to draw up a "strategy that pools state resources that will help increase provision where there are regional imbalances and address under-capacity" (Yeates, 2014). The most affected countries, Guinea, Liberia, and Sierra Leone, are among the poorest in the world. The health systems in these countries were unprepared for Ebola at the onset of the epidemic. They lacked sufficient amounts of all that was required to contain the epidemic - drugs, ambulances, facilities, trained health personnel, and even the technical knowhow to manage such emergencies. These countries have only recently emerged from years of conflict and civil wars that have left their health systems largely destroyed or severely disabled. Moreover, impoverished rural areas have more limited access to services than relatively well-off urban areas. As shown in Table 1, the poor state of the health systems in these countries is revealed by the population living on less than 1 dollar daily, number of health personnel per 10,000 population, per capita government health spending and government health budget as percentage of total government spending.

Table 1: Selected Health System Financing Statistics in 2011

	% of Population Living on < $1 Daily	Health Personnel per 10,000 Pop.	Per Capita Gov. Health Spending	Gov. Health Budget as % of Total Gov. Spending
Guinea	43.3%	not available	$15	6.8%
Liberia	83.8%	2.8	$27	19.1%
Sierra Leone	51.7%	1.9	$31	12.3%
Nigeria	68.0%	20.2	$49	6.7%
Africa	51.5%	14.6	$76	9.7%
World	21.5%	43.3	$619	15.2%

Source: WHO, World Health Statistics Report, 2014

Note: Health personnel refers to doctors, nurses and midwives

Indeed, before the EVD epidemic in 2011, Liberia had only 2.8 healthcare workers per 10,000 people and 51 medical doctors serving its population of 4.29 million (UNDP, 2014a). The situation is the same in Sierra Leone and very similar in Guinea. Most countries in the region were not better-off than the three most affected countries (UNECA, 2014). For instance, only Nigeria had a greater number of health personnel of 20.2 per 10,000 populations. Even so, the government health budget as percentage of total government spending, which stood at 6.7 percent in 2011 was significantly low for a country with more than 170 million people. Most other countries in the entire West Africa are in the same health sector conditions as those in Guinea, Liberia and Sierra Leone. They are not prepared for any serious public health crisis such as the EVD outbreak. Isolation wards and even hospital capacity for infection control are virtually nonexistent. Contacts of infected persons were being traced but not consistently isolated for monitoring. These are only some of the many challenges that had to be overcome in the worst Ebola outbreak in the nearly four-decade history of this disease. While the needs were enormous; the prospects for rapid containment were quite slim.

The outbreak, in all its unprecedented dimensions, assumed an emergency of international concern and a medical and public health crisis. With the virus taking root in a setting of extreme poverty and dysfunctional health systems in West Africa, the most affected countries witnessed multiple human tragedies. These included abandoned rural villages and orphaned children, economic and social disruption in capital cities, extreme daily hardship in the quarantine zones, riots, uncollected bodies, and above all, the unprecedented number of medical staff who risked their lives and lost them. According to Chan (2014) about 160 health care workers were infected, and more than 80 have died. Given the situation, especially in 2014 and early 2015, the Heads of State of Guinea, Liberia, and Sierra Leone were frank in their assessment that the outbreak far outstrips the capacity of their health systems to respond. According to Osterholm, Moore & Gostin, (2014), the WHO was established in 1948 as the lead organization to coordinate the international response to infectious disease outbreaks of global importance. In 2005, the WHO revised the International Health Regulations, which were intended to form the basis for a rapid and effective response to what are known as public health emergencies of international concern (Harman, 2012). The International Health Regulations require 196 countries to develop public health capacities to detect and respond to outbreaks. Guided by International Health Regulations, it took the WHO five months after the international spread of the virus disease had occurred to declare a public health emergency of international concern. The WHO took several more weeks to issue an Ebola Response Roadmap to stop Ebola transmission in affected countries within 6 to 9 months and to prevent international spread. As of October 2014, however, the WHO was not been able to mobilize sufficient funding to implement the response plan that the roadmap calls for.

The response of the WHO to the Ebola crisis in West Africa was slow, with attention towards the outbreak in West Africa only gaining momentum once the first cases of the disease were identified in the US and Europe (Harman, 2014, p.1). In October 2014, World Bank President Jim Kim acknowledged the global response was coming too late and that the Bank had argued with WHO over the response (Elliott, 2014). Funding and personnel support to help stem Ebola in West Africa has been predominantly bilateral, with states giving to specific countries and financing specific areas, rather than contributing money to the global funding facility. As of October 2014, only US$100,000 of the $1 billion required had been contributed to the UN's Ebola Fund (Harman, 2014a, p.2), and the sending of medical personnel was quite contentious. Europe and the US had divided-up responsibility along old colonial ties and strategic interests, with the UK taking a lead in Sierra Leone, the US in Liberia, and France in Guinea. According to (Harman & Rushton (2014), what played out was a familiar pattern to global health governance: bilateral and earmarked financing over multilateral processes, a weakened WHO, and a lack of leadership in motivating and coordinating the international community to effectively respond to a very real health crisis. Despite the global politics that characterized the handling of the Ebola crisis in West Africa, eventually, a combination of national, regional and international support, were deployed to contain the Ebola scourge. These included a combination of bilateral aid from individual countries, and multilateral support from the World Bank. The World Food Program, with its unparalleled logistic capabilities addressing daily material needs in the quarantine zones. The WHO eventually played a major role in mapping the outbreak to pinpoint areas of transmission and the location of facilities and supplies to ensure that assistance is coordinated and rapidly and rationally distributed. Personal protective equipment was also dispatched on a nearly daily basis. The Centers for Disease Control and Prevention (CDC) provided a robust on-the-ground support,

including contact tracing in Lagos. The CDC also equipped the most affected countries with computer hardware and software that allowed real-time reporting of cases.

While international effort was critical in overcoming the Ebola crisis in the most affected states in West Africa, the reality remains that the public health systems in these countries still lack the capacity to respond to pandemics of this nature. The West African region faces multiple health challenges, which the outbreak of Ebola further exacerbated. While the level and distribution of public health capacities vary within and across countries in West Africa, the reality remains that health system capacities of the countries of the region are weak as exposed by the outbreak of Ebola. In most ECOWAS countries, it is not only the health professionals that are inadequate, but also, infrastructure in public health sector. For most Member States of the ECOWAS, public health development suffers on account of lack of political will to provide adequate budget to the health sector. Hence, the capacity to meet emergent public health challenges such as the Ebola case remains at best limited if not completely lacking. Consequently, the public health policies, functions and governance arrangements affecting health sectors of Member States of the ECOWAS need to be strengthened and made more coherent. This should be done with a view to increasing levels of access to health care; increasing the number and quality of healthcare personal; and improving quality and affordability of health care services.

The paper therefore recommends the development of a Regional Public Health Action Framework for Member States. This, the paper suggest, will serve as a guide for Member States to review their existing public health capacities and services and to define country-specific policies to strengthen them. ECOWAS Member States should strengthen the delivery of public health services by developing and integrating health promotion and disease prevention with robust health protection services, particularly through consistent and continues education of the public. Member states should be urged to ensure sustainable financing of public health services for long term efficiency in planning and delivery. This will also require strengthening the governance system in all facets that relate to health and development. No doubt, public health clearly is a function of the whole society, and members of the society need to be involved through education, support and public-private partnerships.

CONCLUDING REMARKS

The EVD has, by and large, slowed down economic growth and progress in the Member States. Thus, the Ebola pandemic has detrimental to the actualization of the ECOWAS objectives and, by extension, regional economic integration (UNECA, 2014). As argued by the President of the ECOWAS Commission, Mr. Kadre Desire Quedraogo, there was no quick fix to the Ebola crisis and neither did the answer rest in the closure of borders and secluding others. The ECOWAS Member States realised the greater need to work together to overcome the Ebola pandemic in West Africa. A strong recommend has been made for strengthening regional integration, for surveillance measures to be put in place, and heavy investment in public health capacity development. ECOWAS member states should invest in training and fund research that will yield vaccines and cures for such diseases. Regional cooperation can, after all galvanise support for higher social standards on health, labour, social protection and education in the region.

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