REGIONAL INTEGRATION, PUBLIC HEALTH CAPABILITIES, AND THE PLACE OF THE WORLD HEALTH ORGANIZATION IN AFRICA

Smith Ouma and Oyeniyi Abe***

ABSTRACT

Many countries in Africa have recently embarked on fast-tracking connectivity with other African countries in a bid to, among other things, attract investments and skill power. The main front of these initiatives has been the move towards the elimination of visa requirements among African states. This move has been further justified by arguments that have been made on the global scene by development economists and by the vision of Pan-Africanism. Rapid globalization and increased border openness, however, pose several health hazards and increase the spread of infectious diseases. The recent wake of the Ebola virus, and the weak responses by the African countries that were the most affected by it, is illustrative of this. The spread of diseases across borders has a concomitant effect of increasing disease burdens in countries which are then forced to spend more money to combat these diseases. This resultantly increases health disparities in these countries, further entrenching inequity when it comes to access to healthcare. This is notwithstanding the fact that most African countries have strained public health systems that are already struggling to cope with local demands and mostly rely on charities to deal with emergencies. Therefore, globalization increases the call for the intensification of international cooperation among states to protect the health of their populations. This paper argues for increased cooperation, both regionally, among African states, and globally, to strengthen national detection systems, and to facilitate fast responses in lieu

* LL.M Candidate, Loyola University, Chicago
** PhD Candidate, Centre for Comparative Law in Africa, Faculty of Law, University of Cape Town, South Africa. oabe@luc.edu

of the increased movements of people and goods, which is likely to result from a visa-free Africa. The paper further calls on African states to be attentive to public health concerns that may arise from increased cross-border movements and take appropriate measures to improve detection and responses to any concerns that may arise.

INTRODUCTION

While growth in international travel and trade is laudable in the quest for global development, it comes with the emergence or re-emergence of international disease threats and other risks to public health. International trade and travel promotes connectivity, a critical element in the quest for globalization.[1] The concomitant increase in vulnerability to pandemics resulting from globalization is a threat to all gains that have been made, and, if unchecked, can lead to catastrophic consequences. Under the global health regime, "[n]ational public health systems are essential components of resilient health systems and the first line of defense against the threat of pandemic disease."[2] The World Health Organization (WHO) has taken cognizance of these realities and, in 1969, adopted the International Health Regulations (IHRs), which were subsequently revised and adopted

[1] *Global Business Environment: Chapter One: Globalization*, PEARSON EDUC., http://catalogue.pearsoned.co.uk/assets/hip/gb/hip_gb_pearsonhighered/samplechapter/0273752634.pdf (last visited Jan. 24, 2017).

[2] COMM'N ON A GLOB. HEALTH RISK FRAMEWORK FOR THE FUTURE, THE NEGLECTED DIMENSION OF GLOBAL SECURITY: A FRAMEWORK TO COUNTER INFECTIOUS DISEASE CRISES 23 (2016), https://nam.edu/wp-content/uploads/2016/01/Neglected-Dimension-of-Global-Security.pdf.

in 2005.[3] The purpose of these regulations is "to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade."[4] In order to achieve these objectives, the IHRs require that State parties develop certain minimum core public health capacities and notify the WHO whenever there are events that may constitute a public health emergency of international concern.[5]

Notwithstanding this, there still exists, in many countries, numerous public health threats that are of global concern. The world has been affected by "[a] series of global health crises . . . since 2000, ranging from Severe Acute Respiratory Syndrome (SARS), its phylogenetic cousin Middle East Respiratory Syndrome (MERS), to pandemic Influenza A (H1N1), Ebola, and the ongoing Zika virus epidemic."[6] The outbreak of these epidemics has particularly grave consequences for poor countries with weak national health systems. The severity of the Ebola outbreaks in Guinea, Liberia, and Sierra Leone has been particularly attributed to systemic deficiencies in national public health systems, especially the lack of functional disease surveillance and response systems.[7] This is indicative of the fact that most developing countries, especially in Sub-Saharan Africa (SSA), have not been able to build effective public health systems to enable them to effectively deal with such epidemics. Notwithstanding the glaring deficiencies, African countries have embarked on the elimination of visa requirements among African nations.[8] This will inevitably increase the movement of goods and people across borders, which is critical in the quest to speed up the development of African countries, but also puts many of the

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[3] WHO, INTERNATIONAL HEALTH REGULATIONS 36 (2nd ed. 2005) [hereinafter INTERNATIONAL HEALTH REGULATIONS].

[4] *Id.* at 10.

[5] COMM'N ON A GLOB. HEALTH RISK FRAMEWORK FOR THE FUTURE, *supra* note 2, at 24.

[6] Lawrence O. Gostin et al., *Toward a Common Secure Future: Four Global Commissions in the Wake of Ebola*, PLOS MED. 1, 1 (May 19, 2016), http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1002042 [hereinafter Gostin et al.].

[7] COMM'N ON A GLOB. HEALTH RISK FRAMEWORK FOR THE FUTURE, *supra* note 2, at vi–1.

[8] Michelle DeFreese, *Visa Free by 2018? Africa's Open Visa Policy*, THE WORLD POST (June 29, 2016), http://www.huffingtonpost.com/young-professionals-in-foreign-policy/visa-free-by-2018-africas_b_10745768.html.

countries with weak national health systems at a big risk.

The above concerns form the basis of this paper. We assess the move by African countries to eliminate visa requirements among African nations while examining the potential public health implications. Our analysis points at the inadequacies of frameworks within African countries to facilitate detection, reporting, and responses to public health epidemics in lieu of the likely increase of these epidemics. Our analysis also reveals that the existing public health systems are likely to be overstretched, given the increase in the number of people moving across borders within the African continent. This paper underscores the need for an integrated approach in the move to eliminate visa provisions. This integrated approach is meant to ensure that national health systems are strengthened by African countries with assistance from the WHO to make these systems more responsive and efficient. Subsequently, strengthened national health systems should be used as one of the criteria for establishing compliance by countries before they can eliminate visa requirements.

AFRICA'S OPEN VISA POLICIES

Africa is yet to fully realize the enormous trade potential that its 54 countries have, and this is partly attributable to the fact that most of these countries have strict visa requirements which limit the movement of people and goods. According to the Africa Visa Openness Index Report, most Africans need visas to travel to about 55% of the other countries within the same continent.[9] In its Agenda 2063,[10] African countries, through the African Union, came up with a strategic framework for the economic transformation of the continent. In Agenda 2063, African countries committed to growth and sustainable development by opening their borders under a visa policy that would see African countries integrate even deeper.[11]

The implementation of Agenda 2063 is to be carried out in three phases: showing one's visa upon arrival for all African nationals, the mandatory granting of a minimum thirty-day visa for African citizens visiting any African country, and the development of a

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[9] THE AFRICAN DEV. BANK GRP. & THE AFRICAN UNION, AFRICA VISA OPENNESS REPORT 2016, at IFC (2016), https://www.afdb.org/fileadmin/uploads/afdb/Documents/Generic-Documents/Africa_Visa_Openness_Report_2016.pdf.

[10] AFRICAN UNION COMM'N, AGENDA 2063: THE AFRICA WE WANT 1–20 (2015), http://www.un.org/en/africa/osaa/pdf/au/agenda2063.pdf.

[11] *Id.* at 14.

single and unified African passport by 2018.[12] Numerous scholars have questioned the implementation of these proposals.[13] When compared to their European counterparts, with regards to socio-economic development, most African states are still in the doldrums, and this is evident from the fact that most states in Africa lack basic amenities and infrastructural development, i.e., poor existing roads, a lack of good schools and healthcare facilities, among others.[14] Opening up each country's borders could therefore lead to an array of developments, including economic migration, medical tourism, movement of illicit and illegal goods, and terrorism.[15] African countries find themselves between a rock and a hard place when they consider opening up their borders to citizens from other African countries. For instance, the richest man in Africa, according to Forbes,[16] Aliko Dangote, once lamented that he needs multiple visas to visit some countries in Africa.[17] This is illustrative of the helpless position where most people are placed when they want to visit other African countries for business and other purposes. As a result of this, numerous economic opportunities are missed.

Indeed, the visa-free proposal by the African Union presents tremendous challenges in the face of public health concerns that could hamper the successful take-off of the program. Even though

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12 THE AFRICAN DEV. BANK GRP. & THE AFRICAN UNION, *supra* note 9, at 7, 16.

13 *See* Emmanuel Ngwainmbi, *The US DV Visa Lottery Program and the African Experience: Cultural Mediation or Brain Drain?*, 3 J. DEV. & COMM. STUD. 35, 46 (2014) (discussing the impact of the exportation of "African" human capital on the capacity for poor African countries to implement their own development agenda for long-term and sustainable development); *see also* Luisa Feline Freier, *Open Doors (for Almost All): Visa Policies and Ethnic Selectivity in Ecuador* 10, 19–20 (Ctr. for Comp. Immigr. Stud., Working Paper No. 188, 2013), https://ccis.ucsd.edu/_files/wp188.pdf (justifying the introduction of visa policies on security policies closely intertwined with the ethnic prejudice of both domestic and international political actors).

14 THE INT'L BANK FOR RECONSTRUCTION & DEV. & THE WORLD BANK, AFRICA'S INFRASTRUCTURE: A TIME FOR TRANSFORMATION 2 (Vivien Foster & Cecilia Briceño-Garmendia eds., 2010), http://siteresources.worldbank.org/INTAFRICA/Resources/aicd_overview_english_no-embargo.pdf.

15 *See generally* Marc R. Rosenblum et al., *Border Security: Understanding Threats at U.S. Borders*, CONG. RES. SERV. 1 (Feb. 21, 2013), https://fas.org/sgp/crs/homesec/R42969.pdf (discussing the myriad of border risks faced by the United States, which are also border risks for African countries).

16 *Africa's Billionaires: #1 Aliko Dangote*, FORBES (Jan. 28, 2017), http://www.forbes.com/profile/aliko-dangote/?list=africa-billionaires.

17 Emmanuel Lala, *Aliko Dangote Laments His Struggle to Get Visas; Says He Needs 38 Visas to Move Around Africa*, 36NG (Sept. 18, 2016), http://www.36ng.com.ng/2016/09/18/aliko-dangote-laments-struggle-get-visas-says-needs-38-visas-move-around-africa/.

the current practices, by existing regions in the African continent, have shown greater benefits from the visa-free policy, the Ebola incident reflects health challenges faced by African countries, which has almost led to a challenge of the free movement of persons under regional protocols. The visa-free proposal aims to offer a socio-economic transformation of the African people, through the removal of trade barriers, job opportunities, and skills transfer.

Regional trade agreements encourage close-knit cooperation between the members of these agreements.[18] These agreements give members preferential treatment with regards to trade flow.[19] Regional trade agreements have been entered into by countries in various parts of Africa, especially where the countries are located in similar geographic regions.[20] Today, each region within the continent has a visa-free policy.[21] The Economic Community of West African States (ECOWAS), the East African Community (EAC), and the South African Development Community (SADC) operate either visa-free or single-visa policies amongst its member states.[22] In fact, ECOWAS has an "ECOWAS Passport" that allows citizens to move freely within the ECOWAS regions, without the necessity of obtaining a visa.[23] Quite a few countries within the continent have keyed into Agenda 2063 by adopting visa-free policies for African nationals.[24] The significant benefits of this cannot be overemphasized.[25] There are severe implications of the

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[18] Oyeniyi O. Abe, *Deepening Regional Integration and Organising* [sic] *World Trade: The Limits of ECOWAS*, 4 INT'L. J. PUBLIC LAW & POL'Y 71, 71 (2014).

[19] *Id.*

[20] *See generally id.* at 71–72 (discussing, at length, trade agreements in the West African region, as well as ECOWAS).

[21] *See* DeFreese, *supra* note 8 ("Thus far, regional communities within Africa have made variable progress towards the goal of a pan-African, visa-free policy with largely positive results. . . .").

[22] DeFreese, *supra* note 8.

[23] *See generally* Iwa Akinrinsola, *Legal and Institutional Requirements for West African Economic Integration*, 10 L. & BUS. REV. AM. 493, 498–99 (2004) (discussing the abolition of visas for ECOWAS' member states and the objective of the "ECOWAS Passport" in achieving the free movement of persons within the member states).

[24] *See* DeFreese, *supra* note 8 ("Ghana has adopted the 2063 Agenda's visa-free policy. . . . Rwanda in particular has made significant strides to ease visa restrictions for African nationals. . . .").

[25] *See id.* ("Rwanda's 2013 visa-free policy for African nationals resulted in several positive benefits in terms of economic development; these include an estimated 24% increase in tourism . . . and a 50% increase in intra-African trade. Trade with the Democratic Republic of the Congo alone increased by 73% since the implementation of the policy.").

visa-free policy on the healthcare industry within the continent. One likely effect of a visa-free regime within the African continent is increased movements across countries in search of better healthcare facilities and services. Very few countries within the continent offer this solution. In fact, the desire to seek better healthcare facilities led to the first incident of Ebola in Nigeria.[26]

ECOWAS' mission is to promote economic integration across the region.[27] It is considered as one of the pillars of the African Economic Community.[28] ECOWAS was founded in order to achieve a form of collective self-sufficiency for its member states by creating a single large trading bloc through an economic and trading union.[29] It was conceived initially for the economic integration and development of West African States.[30] The ECOWAS Treaty (Treaty) was revised on July 24th, 1993 in order to fasten the economic and political integration of the economic and trading union.[31] It was purely a regional economic agreement conceived initially for the economic integration and development of West African States.[32] The resultant effect, therefore, was to enhance economic stability and relations among its member states. Like the European Union (EU), ECOWAS is a treaty-based institutional framework that defines and manages economic and political cooperation among its fifteen member states.[33]

The ambitious aim of the Treaty was set to raise the living standards of people within the region, to maintain and enhance economic stability, foster relations among member states, and contribute to the progress and development of the African

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[26] Faisal Shuaib et al., *Ebola Virus Disease Outbreak – Nigeria, July–September 2014*, CENTERS FOR DISEASE CONTROL & PREVENTION (Oct. 3, 2014), https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6339a5.htm.

[27] *Regional Partner in Economic Growth: ECOWAS*, USAID, https://www.usaid.gov/west-africa-regional/fact-sheets/regional-partner-economic-growth-ecowas (last updated Sept. 23, 2016).

[28] *Economic Community of West African States*, INT'L DEMOCRACY WATCH, http://www.internationaldemocracywatch.org/index.php/economic-community-of-west-african-states- (last visited Jan. 16, 2017).

[29] *Id.*

[30] *Treaty*, ECON. COMMUNITY OF WEST AFRICAN STATES (ECOWAS), http://www.ecowas.int/ecowas-law/treaties/ (last visited Jan. 28, 2017).

[31] *Id.*

[32] *Id.*

[33] *See* Michael M. Ogbeidi, *Comparative Integration: A Brief Analysis of the European Union (EU) and the Economic Community of West African States (ECOWAS)*, 3 J. INT'L SOC. RES. 478, 478–86 (2010) (comparing the founding and subsequent progress of both the EU and ECOWAS).

continent.[34] In order to achieve the foregoing aim, Article 3(2) of the Treaty provided for its attainment in stages.[35] Of particular importance is "the removal, between [m]ember [s]tates, of obstacles to the free movement of persons, goods, services and capital, and to the right of residence and establishment."[36] However, suffice it to say that the implementation of the Treaty by the member states begs questioning. Has it gone way beyond the free trade agreement that the Treaty envisaged in 1993 when the Treaty came into force? There is deemed to be unrestricted freedom of movement of persons and goods across the borders of the member states.[37] However, the Ebola outbreak brought forth the concern that free movement, as practiced under the Treaty and envisaged under the African Union visa policy, could lead to health disasters. Besides, WHO's hesitancy in declaring the Ebola outbreak a Public Health Emergency of International Concern (PHEIC) was a result of its experience in the H1N1 pandemic, where critics believed that WHO declared the virus an emergency of international concern prematurely.[38] The organization's hesitation to lead in the Ebola case left the weak and impoverished nations to tackle the quickly spreading disease themselves. Needless to say, the countries who had this virus had just emerged from civil conflicts, experiencing a deep and widening distrust of their authorities and economic disadvantage.[39]

Furthermore, the ECOWAS Protocol on the Free Movement of Persons and Goods,[40] enhances the free movement of persons,

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[34] ECOWAS Revised Treaty art. 3, July 24, 1993, http://www.ecowas.int/wp-content/uploads/2015/01/Revised-treaty.pdf [hereinafter ECOWAS Revised Treaty].

[35] *See id.* (listing the stages by which ECOWAS wanted to achieve its objectives).

[36] *Id.*

[37] *Id.*

[38] Mathilde Bourrier et al., *Lessons from the A(H1N1) Pandemic to the Ebola Epidemic*, UNIVERSITÉ DE GENEVE, https://www.unige.ch/sciences-societe/socio/fr/recherche/irs/thematiques/risque/h1n1/#Summary (last visited Jan. 28, 2017).

[39] Barbara McPake et al., *Ebola in the Context of Conflict Affected States and Health Systems: Case Studies of Northern Uganda and Sierra Leone*, BIOMED CENT. (Aug. 8, 2015), https://conflictandhealth.biomedcentral.com/articles/10.1186/s13031-015-0052-7.

[40] Protocol A/P.1/5/79 Relating to Free Movement of Persons, Residence and Establishment, May 29, 1979, http://documentation.ecowas.int/download/en/legal_documents/protocols/PROTOCOL%20RELATING%20TO%20%20FREE%20MOVEMENT%20OF%20PERSONS.pdf [hereinafter Protocol A/P.1/5/79]; Supplementary Protocol A/SP.1/7/86 On the Second Phase (Right of Residence) of the Protocol on Free Movement of Persons, the Right of Residence and Establishment, Jan. 7, 1986, http://documentation.ecowas.int/download/en/

residences, and establishments within the ECOWAS' sub-region.[41] The challenge here is mapping these rights with the challenges faced when an international health disaster, like the Ebola crisis, appears. The European experience has demonstrated that the existence of a large free market zone has the capacity and potential to enhance the flow of investments, increase economic productivity, provide consumers with options, generate prosperity and employment, and uplift the living standards of the people.[42] Unfortunately, the 2014 Ebola outbreak has critically damaged the political, institutional, and legal pillars of the approach in elevating global health in the international political agenda.[43]

CAPABILITY ASSESSMENT OF NATIONAL PUBLIC HEALTH SYSTEMS IN AFRICAN COUNTRIES

National public health systems play a critical role in promoting resilience in the global public health framework.[44] Of particular importance in this broad goal is the need to strengthen the primary healthcare systems within the African states to ensure that these systems are effective, as these primary healthcare

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legal_documents/protocols/Supplementary%20Protocol%20on%20the%20Second%20Phase%20(Right%20of%20Residence)%20of%20the%20Protocol%20on%20Free%20Movement%20of%20Persons,%20Right%20of%20Residence%20and%20Establishment.pdf; ECOWAS Revised Treaty, *supra* note 34.

41 Protocol A/P.1/5/79, *supra* note 40.

42 *The European Single Market*, EUROPEAN COMMISSION, https://ec.europa.eu/growth/single-market_en (last visited Mar. 3, 2017).

43 *See* Sara Louise Dominey, Note, *Ebola, Experimental Medicine, Economics, and Ethics: An Evaluation of International Disease Outbreak Law*, 44 GA. J. INT'L & COMP. L. 133, 138 (2015) ("Those local governments, in conjunction with foreign governments and international aid groups, have taken steps to contain the virus, including: limiting or restricting international travel to and from countries with high infection rates, making donations of monetary aid and experimental vaccines, sending medical experts to provide guidance and training to local medical aid workers, and even sending troops to increase manpower. However, due to poor healthcare systems, lack of governmental capacity to control the virus, and fear, the virus continues to spread."); Janet E. Mosher, *Accessing Justice Amid Threats of Contagion*, 51 OSGOODE HALL L.J. 919, 920 (2014); *see also* David P. Fidler, The Challenges of Global Health Governance 5–6 (May 2010) (file:///C:/Users/alex%20husain/Downloads/IIGG_WorkingPaper4_Global Health.pdf) (discussing the economic burden of various global diseases). *See generally* David P. Fidler, *From International Sanitary Conventions to Global Health Security: The New International Health Regulations*, 4 CHINESE J. INT'L. L. 325, 325 (2005) (explaining the history of the IHRs); David P. Fidler, *Governing Catastrophes: Security, Health and Humanitarian Assistance*, 89 INT'L. REV. RED CROSS 247, 247 (2007) (discussing how globalization affects catastrophes).

44 COMM'N ON A GLOB. HEALTH RISK FRAMEWORK FOR THE FUTURE, *supra* note 2, at 23.

systems are essential in detecting initial cases of outbreaks. Strong primary healthcare systems have been hailed as essential in acting as "radar screens" to pick up the initial cases of outbreaks and as the delivery systems used to execute effective response strategies.[45] These "radar screens" feed into the broader public health frameworks that may exist in countries and contribute towards ensuring that appropriate responses to disease outbreaks are found.[46] Primary healthcare systems, therefore, are essential anchors to public health systems in African countries. It is on this premise that this article examines the national healthcare systems in African countries, with particular emphasis on the effectiveness of the public health system. Therefore, the question entails how weak primary healthcare systems are contributing to unresponsive public health systems, which are not able to effectively deal with disease outbreaks, leaving large percentages of the populace in grave danger.

In April 2008, African countries met in Ouagadougou, Burkina Faso, for the International Conference on Primary Health Care and Health Systems in Africa (Conference), and adopted the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa (Declaration).[47] The Conference, in adopting the Declaration, expressed the need for accelerated action by African governments, partners, and communities to improve health.[48] In particular, the Conference noted the importance of African countries creating an enabling environment by, among others, incrementally funding health services and strengthening health systems to achieve the Millennium Development Goals.[49] The African Health Strategy 2007–2015 (Strategy) has also been adopted by African countries at the auspices of the African Union.[50] The Strategy notes, with concern, that health systems in African countries are too weak and services too under-resourced to support a targeted reduction in disease burdens and achieve

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[45] *Id.*

[46] *Id.*

[47] WHO Regional Off. Afr., *The Ouagadougou Declaration on Primary Health Care and Health Systems in Africa: Achieving Better Health for Africa in the New Millennium*, THE AFRICAN HEALTH MONITOR, Apr.–June 2010, at 10.

[48] Ouagadougou Declaration on Primary Health Care and Health Systems in Africa: Achieving Better Health for Africa in the New Millennium, Apr. 30, 2008, http://www.who.int/management/OuagadougouDeclarationEN.pdf.

[49] *Id.*

[50] Africa Health Strategy: 2007–2015, ¶ 1, Apr. 9–13, 2007, file:///C:/Users/alex%20husain/Downloads/AFRICA_HEALTH_STRATEGY(health).pdf.

universal access to healthcare.[51] Further, these national health systems lack adequate safeguards to cushion vulnerable groups, especially during catastrophic situations.[52] The Strategy notes the importance of strengthening health systems within African countries in a bid to promote health equity and reduce disease burdens through the use of improved resources.[53] With regards to early detection and responses by public health systems, the Strategy notes that all African countries should have a "community based [sic], clinic and district hospital mechanism of monitoring and rapid reporting in place."[54] These mechanisms are meant to "ensure that outbreaks are identified and acted upon up the line as appropriate at the district, regional and national and continental levels."[55] These systems guarantee vigilance at all levels and ensure effective responses to any public health concerns that may arise. Notwithstanding the numerous commitments that African countries have made to improve their public health systems over the years, much is yet to be seen in terms of any actual realization of these goals, as national public health systems within many African countries continue to be overwhelmed with disease burdens. Detection systems in many African countries are in a sorry state, and this, in effect, weakens the broad public health systems.

One key area where many African countries have performed dismally is with regards to the strengthening of public health laboratories. Public health laboratories are critical in "providing timely and reliable results primarily for the purpose of disease control and prevention."[56] Laboratories, at the local level, play a key role in the quick detection of disease outbreaks and these results prompt appropriate measures by relevant authorities. Therefore, there cannot be proper responses where effective detection systems do not exist. Most countries in Africa, however, lack proper laboratory "services [which are] characterized by inadequate staffing, equipment and supplies."[57] The Ebola outbreak in West Africa exposed the weaknesses in the detection

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[51] *Id.* at ¶ 10.
[52] *Id.* at ¶ 12.
[53] *Id.* at ¶ 4.
[54] *Id.* at ¶ 91.
[55] *Id.*
[56] Jean Bosco Ndihokubwayo et al., *Strengthening Public Health Laboratories in the WHO African Region: A Critical Need for Disease Control*, 12 AFR. HEALTH MONITOR 47, 47 (2010) [hereinafter Ndihokubwayo et al.].
[57] *Id.*

systems in African countries, especially in Sierra Leone which, despite being heavily affected by the outbreak, only had one laboratory capable of testing for Ebola.[58] Further, most countries in Africa have not been found to have national policies and strategies for laboratory services, and to be lacking the proper funding for such services, which are usually given low priority and recognition in most national health delivery systems.[59] In Uganda, it has been established that there are poor surveillance systems, and that the capacity for laboratory testing activities is very centralized.[60] The fact that most African countries still rely on fee-for-service systems to access healthcare services discourages many people from accessing laboratory services, making it difficult for diseases to be detected early.[61] It has also been noted that within African countries, capabilities of laboratory services vary and are determined by factors such as access to piped water and a constant water supply.[62]

Coordination of responses to public health epidemics is also another area of concern for African national public health systems. This is partly attributable to a lack of proper health information systems in most African nations. It is notable that health information systems in most African countries have faced serious constraints, including the lack of written health information policies, scanty or unevenly-distributed resources, fragmentation and a lack of standards, and the fact that most information systems tend to be "data-driven" instead of "action-driven."[63] This, in effect, means that where health information systems are available, the systems may not work effectively to deliver results, as critical health information may be "siloed" by various entities tasked with data collection. At the global level, the WHO has done a dismal job in ensuring the effective coordination in detection of responses to public health emergencies. The delayed response by

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[58] Kim Yi Dionne, *Why West African Governments are Struggling In Response to Ebola*, THE WASH. POST: THE MONKEY CAGE (July 15, 2014), https://www.washingtonpost.com/news/monkey-cage/wp/2014/07/15/why-west-african-governments-are-struggling-in-response-to-ebola/?utm_term=.a2494a65ed16.

[59] Ndihokubwayo et al., *supra* note 56, at 49.

[60] GLOB. HEALTH SEC. AGENDA, GLOBAL HEALTH SECURITY AGENDA PILOT ASSESSMENT OF UGANDA 8 (2015).

[61] Cathy A. Petti et al., *Laboratory Medicine in Africa: A Barrier to Effective Health Care*, 42 CLINICAL INFECTIOUS DISEASES 377, 379 (2006).

[62] *Id.*

[63] Priority Interventions for Strengthening National Health Information Systems, Sept. 2, 2004, http://apps.who.int/iris/bitstream/10665/93130/1/AFR.RC54.R3%20Priority.pdf.

the WHO in the wake of the outbreak of the Ebola virus is illustrative of this. Despite the fact that Guinea had identified cases of the Ebola virus disease (EVD) and reported this to international health agencies, there was a delayed response by the WHO, and this led to the spread of the disease into Sierra Leone and Liberia.[64] The fact that healthcare delivery, in many African states, is a responsibility borne by a multitude of stakeholders ranging from governments, non-profit organizations, private entities, and religious institutions may also lead to a lack of coordination where each of these entities pull in different directions.

A majority of African countries also suffer from already-burdened public health systems. Diseases such as HIV/AIDS, Tuberculosis, and Malaria continue to drain the scarce public health resources that African countries have, leaving these countries vulnerable to any major epidemics.[65] The challenges that public health systems in African countries continue to experience forms part of the wider developmental challenges facing African countries as a result of the financial constraints facing many African governments. Moreover, healthcare is always in a state of competition for limited resources with other public services, and, as a result, the health sector is often ranked relatively low among national development priorities.[66] Resource imbalance is also evident when it comes to allocations made to healthcare services in urban and rural areas. It is notable that most governments in Africa give preferential treatment to public health infrastructure in urban areas as opposed to those in rural areas.[67] This, in effect, makes it difficult to detect any public health emergencies that may emerge in remote areas. This leaves the populace, in these remote areas, vulnerable to any epidemic outbreaks that may eventually spread to other parts of the African countries. Nonetheless, most governments in Africa have failed to prioritize the health sector in

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[64] Mark J. Siedner et al., *Strengthening the Detection of and Early Response to Public Health Emergencies: Lessons from the West African Ebola Epidemic*, PLOS MED. 1, 1 (2015), http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001804 [hereinafter Siedner et al.].

[65] BD. ON GLOB. HEALTH: INST. OF MED. OF THE NAT'L ACADEMIES, COMMITTEE ON ENVISIONING A STRATEGY TO PREPARE FOR THE LONG-TERM BURDEN OF HIV/AIDS: AFRICAN NEEDS AND U.S. INTERESTS 1 (Rona Briere ed., 2011).

[66] Dan Kaseje, *Health Care in Africa: Challenges, Opportunities and an Emerging Model for Improvement*, THE WOODROW WILSON INT'L CTR. FOR SCHOLARS, 4 (Nov. 2, 2006), https://www.wilsoncenter.org/sites/default/files/Kaseje2.pdf.

[67] *Id.* at 7.

budgetary allocations, and funding to the health sector has been relatively low in most of these countries, especially when compared to other sectors like security and defense.

Countries in SSA also suffer from a health workforce crisis. This crisis is caused by a multitude of factors ranging from inadequate production in some countries, an inability to hire, brain drain, a lack of or poor motivation, corruption, and the misuse of resources.[68] Population increases, in most African countries, means that the shortage in healthcare professionals will continue to persist unless proper measures are taken to address this shortage.[69] The WHO estimates that the current healthcare workforce, in most SSA countries, would need to be scaled-up by as much as 140% in order to attain international health development targets.[70] The shortage of healthcare professionals means that most of the countries are not able to deal with public health emergencies whenever they arise. The outbreak of Ebola in West Africa was illustrative of this, as most of the countries affected relied heavily on volunteer health workers from other countries.[71] The table below illustrates how African countries compare with other countries globally when it comes to the number of healthcare professionals.

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[68] *Id.*

[69] Yohannes Kinfu et al., *The Health Worker Shortage in Africa: Are Enough Physicians and Nurses Being Trained?*, BULL. OF THE WHO (Feb. 10, 2009), http://www.who.int/bulletin/volumes/87/3/08-051599/en/.

[70] *Id.*

[71] U.N. Security Council, With Spread of Ebola Outpacing Response, Security Council Adopts Resolution 2177 (2014) Urging Immediate Action, End to Isolation of Affected States (Sept. 18, 2014), https://www.un.org/press/en/2014/sc11566.

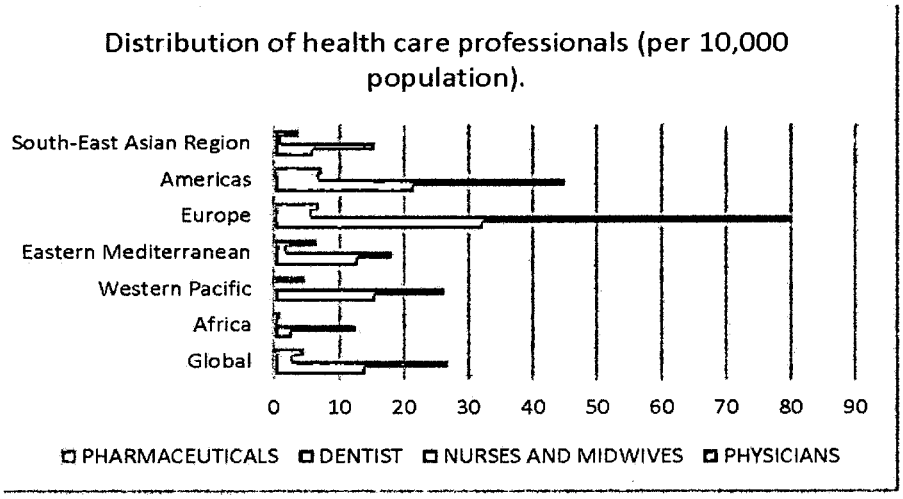

Table 1: Figures adopted from WHO (2016)[72]

THE WORLD HEALTH ORGANIZATION AND PUBLIC HEALTH EMERGENCIES

At the global level, the WHO is tasked with momentous responsibilities in controlling the international spread of diseases.[73] The WHO has taken cognizance of this role, and this is what led to the adoption of the IHRs.[74] The IHRs were adopted by the Health Assembly "[i]n consideration of the growth in international travel and trade, and the emergence or re-emergence of international disease threats and other public health risks."[75] The IHRs outline their purpose and scope as "to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade."[76] The IHRs require states to establish focal points which shall be the points of contact with the WHO and responsible for disseminating information to the relevant stakeholders.[77]

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[72] AFRICAN HEALTH OBSERVATORY, ATLAS OF AFRICAN HEALTH STATISTICS 2016: HEALTH SITUATION ANALYSIS OF THE AFRICAN REGION 69 (2015), https://www.aho.afro.who.int/sites/default/files/publications/5266/Atlas-2016-en.pdf.

[73] *About WHO*, WHO, http://www.who.int/about/en/ (last visited Feb. 13, 2017).

[74] INTERNATIONAL HEALTH REGULATIONS, *supra* note 3, at 1.

[75] *Id.*

[76] *Id.*

[77] *Id.* at 11.

State parties are required to develop, strengthen, and maintain the capacity to detect, assess, notify, and report events to the WHO, in accordance with the IHRs, and to do so within five years of the IHRs coming into effect, which was by 2010.[78] The WHO is required to "collect information regarding events through its surveillance activities [to] assess their potential to cause international disease spread and possible interference with international traffic."[79] Any outbreaks within states are to be immediately reported to the WHO by state parties.[80] The Director-General of the WHO is to make an assessment based on information received from a state, and determine whether an occurring event constitutes a public health emergency of international concern.[81] The IHRs also required that each state, within a period of five years from when the IHRs came into effect, to develop, strengthen, and maintain the capacity to respond promptly and effectively to public health risks and public health concerns.[82] These measures are to be taken at different levels, including at the local community level.[83] At the local or primary public health response level, states are required to maintain the capacity to detect and report events, and this is to be done through, among others, maintaining laboratories in these areas to facilitate early detection and ensure that appropriate responses are deployed.[84]

The WHO has, in the recent past, performed dismally in dealing with public health emergencies that are of international concern. The Ebola virus epidemic, that was witnessed in West Africa, revealed a lack of coordination and poor leadership by the WHO.[85] It is notable that, despite the fact that forty-nine cases of the EVD had been identified by Guinea and reported to international health agencies, and despite the quick spread of the virus, it took a while before the WHO laid out a roadmap to deal with the outbreak.[86] The WHO also requires states to conduct annual self-assessments,

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[78] *Id.*

[79] *Id.*

[80] INTERNATIONAL HEALTH REGULATIONS, *supra* note 3, at 12.

[81] *Id.* at 14.

[82] *Id.* at 15.

[83] *Id.* at 40–41.

[84] *Id.* at 40.

[85] John Maurice, *Expert Panel Slams WHO's Poor Showing Against Ebola*, THE LANCET (July 10, 2015), http://thelancet.com/journals/lancet/article/PIIS0140-6736(15)61253-3/fulltext.

[86] Siedner et al., *supra* note 64, at 1–2.

under the IHRs, and report the findings to the WHO.[87] Most states have, however, missed the reporting deadlines over the years. The 2014 deadline for reporting was extended to 2016 for eighty-one states.[88] Only sixty-four states reported meeting core capacities while forty-eight failed to even respond.[89] This low level of compliance by states is worrisome and highlights the importance of the WHO in guiding states to comply with these requirements. This is particularly critical in light of the emergence of new public health emergencies, like the spread of the Zika virus.

The WHO has also established the African Public Health Emergency Fund (APHEF), which is used to mobilize, manage, and disburse additional resources from member states for providing rapid and effective responses to public health emergencies of national and international concern, including epidemic and pandemic-prone diseases, natural and man-made disasters, and humanitarian crises.[90] The establishment of APHEF is justified by the lack of adequate resources to respond to the frequent epidemics and public health emergencies in the African region.[91] Funding to the APHEF is to be primarily made by member states on a voluntary basis.[92] APHEF has approved $50 million American dollars as the total annual recommended voluntary contribution by member states.[93] A member state can request assistance from APHEF to support investigation and response activities subject to a formal declaration of an outbreak of a public health emergency by the state, the UN Secretary-General appointing a Humanitarian Coordinator for the emergency, or the launch of a humanitarian appeal by the member state.[94]

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87 INTERNATIONAL HEALTH REGULATIONS, *supra* note 3, at 11.

88 Gostin et al., *supra* note 6, at 2.

89 Director-General, WHO, Implementation of the International Health Regulations (2005): Report of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation, at 4 (2015).

90 WHO, AFRICAN PUBLIC HEALTH EMERGENCY FUND (APHEF): OPERATIONS MANUAL 6 (2013), http://www.afro.who.int/index.php?option=com_docman&task=doc_download&gid=9139&Itemid=2593.

91 *Id.* at 9.

92 *See id.* at 20 ("APHEF shall be funded largely by the Member States. The Regional Committee has approved the amount of US$ 50 million as the total annual recommended voluntary contribution by Member States to APHEF.").

93 *Id.*

94 *Id.* at 10.

Administration of APHEF has been made as little bureaucratic as possible to ensure quick disbursement when requested and approved. It is estimated that it takes a total of forty-eight hours between the time a member state requests the funds and the time the funds are disbursed.[95] It is, however, not clear whether member states are required to have plans of actions whenever the funds are disbursed to ensure that the funds reach the targeted area within the shortest time possible. It is, however, worth noting that the funds may not be adequate in dealing with public health emergencies of great magnitudes like the Ebola crisis that West African countries faced. During the Ebola outbreak, the WHO estimated that it needed at least $1 billion American dollars to contain the outbreak.[96] Therefore, the $50 million American dollars proposed by the APHEF is a drop in the ocean where funds are needed to contain a public health emergency of the same magnitude as the Ebola virus outbreak. Furthermore, the fact that contribution to the fund is voluntary means that some states may choose not to make any contributions, but may still ask the WHO for assistance when they have to deal with public health emergencies.

Article 43 of the IHRs requires the state party to disclose their public health concerns and scientific information to the WHO.[97] During the Ebola outbreak, this disclosure requirement ended up serving three main purposes. First, countries affected took excessive precautionary measures, which hindered the flow of international traffics unnecessarily.[98] Most African airlines, for instance, closed their commercial routes to affected countries in West Africa.[99] Secondly, health and aid workers were prevented

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[95] *Id.* at 23.

[96] *See generally UN: Nearly $1 Billion Needed to Combat Ebola Outbreak*, U.N. NEWS CTR. (Sept. 16, 2014), http://www.un.org/apps/news/story.asp?NewsID=48728#.WJTrwVMrLIU ("The United Nations announced today that it would need nearly $1 billion for an exceptional, international response to Ebola outbreak in West Africa. . . .").

[97] *See* INTERNATIONAL HEALTH REGULATIONS, *supra* note 3, at 29 ("A State Party . . . shall provide to WHO the public health rationale and relevant scientific information for it. WHO shall share this information with other States [sic] Parties and shall share information regarding the health measures implemented.").

[98] Tsung-Ling Lee, *Making International Health Regulations Work: Lessons from the 2014 Ebola Outbreak*, 49 VAND. J. TRANSNAT'L L. 931, 965–66 (2016).

[99] BD Reporter, *Kenya Airways Suspends Flights to Liberia, Sierra Leone*, BUS. DAILY (Aug. 16, 2014), http://www.businessdailyafrica.com/Corporate-News/Kenya-Airways-suspends-flights-to-Liberia--Sierra-Leone/-/539550/2421364/-/7anrao/-/index.html.

from traveling to the affected countries due to these travel restrictions placed on the region. Third, the affected countries were unjustly stigmatized.[100] This explains why the affected countries were initially reluctant in responding to the outbreak of the disease. It is notable that excessive and unjustifiable measures interfere with international travel, an important factor when considering international response time.[101] Most developed countries placed travel restrictions on their citizens, which prevented them from traveling to and from the affected region, against WHO's recommendations.[102]

More precarious is the fact that the IHRs lack enforceable mechanisms.[103] This fundamentally undermines the overall effectiveness of the IHRs.[104] When nations violate the IHRs, they do so because non-compliance does not result in enforceable legal sanctions and states do not incur high political costs for their non-compliance. Some other reasons for non-compliance include strained healthcare facilities, poverty, and fear of severe political and social repercussions from notifying the WHO of an outbreak epidemic, for instance.[105] To circumvent non-compliance, incentives should be used to encourage compliance with the IHRs.

Incentives for the early reporting of outbreaks could help prevent trade and travel restrictions. Furthermore, access to care, isolating patients, contact tracing, raising community awareness, conducting alerts and surveillance, supporting safe burials and decontamination, and providing healthcare for non-Ebola patients are essential in showing a commitment to the IHRs' standards.[106] There is no doubt that the Ebola epidemic tested the new IHRs developed in 2005, highlighting the persisting problems inherent in enforcement paradigms and fulfilling the core obligations of the WHO.

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[100] Lee, *supra* note 98.

[101] *Id.* at 966.

[102] Nick Thompson & Inez Torre, *Ebola Virus: Countries with Travel Restrictions in Place*, CNN (Nov. 14, 2014), http://edition.cnn.com/2014/11/04/world/ebola-virus-restrictions-map/; *Statement on Travel and Transport In Relation to Ebola Virus Disease Outbreak*, WHO (Aug. 18, 2014), http://www.who.int/mediacentre/news/statements/2014/ebola-travel-trasport/en/.

[103] Lee, *supra* note 98, at 968.

[104] *Id.* at 966–67.

[105] *Id.* at 984–85.

[106] *Id.* at 941–42, 945–46.

IMPORTANT LESSONS AND SOME THOUGHTS ON THE WAY FORWARD

The EVD outbreak in West Africa offered some important lessons on dealing with public health emergencies within states where such outbreaks have global implications. While much effort was made to curb the outbreak and to eventually stop its spread, the global community needs to be on the lookout for any other outbreaks that may occur and deal with such outbreaks effectively. The emergence of the Zika virus in South America is illustrative of the need to avoid complacency, which is to be achieved through, among others, the establishment of mechanisms to ensure early detection and responses to any outbreaks. Also important is the need to ensure collective action at regional and global levels in dealing with such challenges when they arise.

Though laudable, the move by African states to eliminate visa requirements for citizens in the African states needs to be alert to the numerous public health challenges that may present themselves. While the African leaders have been so proactive in speeding up the implementation of the visa-free entry and visa on arrival systems for Africans, the same action has not been evident in ensuring an improved access to healthcare delivery within the continent. The initial response to the Ebola outbreak in West Africa was compounded by the despicable healthcare facilities within the affected countries.[107] When the WHO was slow to respond, African countries could have rallied around the affected countries and assisted with logistics such as medical personnel, drugs, and technology transfers with regards to contact tracing. Instead, some African countries were busy reeling out visa restrictions for travelers from the affected region.[108] As a result, the epidemic in West Africa took thousands of lives, with a significant number of them being healthcare workers.[109] The reasons are, in part, due to weak or non-existent healthcare facilities available to cope with the sudden and rampant cases of the virus.[110] The Ebola response shows that contact tracing, immediate responses to patients and the community, and

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[107] *Id.* at 942–44.

[108] *Update - the Ebola Virus Disease*, FLIGHT CTR., http://www.flightcentre.co.za/company/about/ebola-travel-updates (last visited Feb. 4, 2017).

[109] Thomas R. Frieden et al., *Ebola 2014 – New Challenges, New Global Response and Responsibility*, N. ENG. J. MED. 1177, 1177 (2014), http://www.nejm.org/doi/pdf/10.1056/NEJMp1409903.

[110] *Id.*

preventive measures could go a long way in stopping another outbreak of the virus or any other virus.[111] However, the key question is whether the affected countries are prepared to commit resources towards ensuring that the capacity of their public health infrastructures is improved.

Mr. Siedner and others argue that there is no substitute for prevention in dealing with public health emergencies.[112] Prevention is an important measure that can help reduce the costs associated with dealing with an outbreak, and such funds can be used to strengthen the existing facilities and improve public health resources. National Health Systems have been identified as important links in the global health mesh.[113] The IHRs have taken cognizance of this by requiring state parties to develop and maintain health capacities to enable detection, assessment, and reporting and to be able to respond to any potential PHEICs.[114] The WHO has developed a checklist to determine compliance with IHRs' national core capacity requirements, which include legislation, coordination, surveillance, preparedness, responses, risk communications, human resources, and laboratories.[115] As noted earlier, compliance with the WHO requirements has been wanting based on the fact that it is voluntary, and that there are no incentives for states to comply.

Many reports have criticized the WHO of complacency in responding to the EVD outbreak in West Africa. These reports have attributed the high number of lives lost during the outbreak in part to the slow response by the WHO and other international bodies.[116] Therefore, it has been argued that the WHO needs to revise the IHRs' criterion to take cognizance of the fact that some countries may need external assistance in dealing with public health emergencies.[117] This is meant to ensure that countries with such needs get assistance at the earliest possible opportunity in order to contain the spread of epidemics.[118] WHO should, particularly, draw lessons from the Zika virus epidemic, which

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111 *Id.* at 1178.

112 Siedner et al., *supra* note 64, at 5.

113 *Id.* at 5–6.

114 INTERNATIONAL HEALTH REGULATIONS, *supra* note 3, at 30.

115 *Guide for Acceleration of IHR Implementation in States Parties*, WHO, at 13–14 (Feb. 2013), http://www.who.int/ihr/publications/WHO_HSE_GCR_LYO_2013.1.pdf.

116 Siedner et al., *supra* note 64, at 2.

117 *Id.* at 3.

118 *Id.*

was declared a public health emergency of international concern before conclusive tests were made to determine the causal relationship between the Zika infection during pregnancy and microcephaly.[119] This enables a collective approach to dealing with such emergencies when they occur in a given state.

Mr. Siedner and others have proposed mechanisms that can ensure that states will comply with IHRs' requirements, with one way involving asking the International Monetary Fund (IMF) to link IHRs' pandemic preparedness evaluations to its evaluation of macroeconomic stability.[120] This is particularly important because of the economic impact of public health emergencies. The EVD outbreak in West Africa nearly crippled the economies of the countries affected as a result of decreased trade, the closing of borders, flight cancellations, and reduced investments.[121] In Guinea, infrastructural projects that relied on foreigners were stopped and abandoned as construction workers were repatriated due to Ebola.[122] Further, the outbreak of the virus led to increased poverty in the countries that were hit most as economic activities, like farming, were affected.[123] It is therefore of importance that African states become aware that not investing in critical public health infrastructures may eventually have a high cost to be borne when epidemics strike. Individual countries can, therefore, mitigate the potential losses before they occur by investing in public health infrastructures and resources that facilitate early detection and responses. Needless to say, African countries need to put money where their mouths are.

The spread of the EVD virus, and now the Zika virus, demonstrate how truly globalized the world has become. The Ebola virus epidemic was particularly indicative of how the omissions in one country can easily have a spillover effect in a neighboring country. The epidemic underscored the importance of the adoption

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[119] Michael Pearson, *Zika Virus Sparks "Public Health Emergency"*, CNN (Feb. 2, 2016), http://edition.cnn.com/2016/02/01/health/zika-virus-public-health-emergency/.

[120] Gostin et al., *supra* note 6, at 2.

[121] Nicolas Douillet, *West African Economies Feeling Ripple Effects of Ebola, says UN*, U.N. DEV. PROGRAMME [sic] (Mar. 12, 2015), http://www.undp.org/content/undp/en/home/presscenter/pressreleases/2015/03/12/west-african-economies-feeling-ripple-effects-of-ebola-says-un.html.

[122] *See* U.N. DEV. GRP., SOCIO-ECONOMIC IMPACT OF EBOLA VIRUS DISEASE IN WEST AFRICAN COUNTRIES: A CALL FOR NATIONAL AND REGIONAL CONTAINMENT, RECOVERY AND PREVENTION 5 (2015) (discussing a company that left Guinea due to Ebola).

[123] *Id.* at 71.

of regional and continental approaches in dealing with challenges faced in the respective countries. The quest towards regional integration, which has gotten a big boost with the move towards eliminating visa requirements, needs to go hand-in-hand with a push for the improvement of public health resources. Regional bodies, like ECOWAS, have taken cognizance of this, and this was seen through the increased cooperation during the EVD outbreak where the political leadership in the West African region, including the Heads of State and Government, mobilized and met severally in a bid to find solutions to the epidemic.[124] This move was important in recognizing that such epidemics not only present challenges nationally, but also at the regional and global levels. It is also notable that a Regional Solidarity Fund was established by ECOWAS during the EVD virus outbreak, and the countries in the regional block reaffirmed their commitments to the Abuja Declaration, which requires the allocation of 15% of the total budget to the health sector.[125] ECOWAS, through the West African Health Organization (WAHO), also trained medical personnel who were deployed to the affected West African states, and provided $400,000 in American dollars to Guinea, Liberia, and Sierra Leone to strengthen their epidemiological surveillance and response capacities.[126]

The move by other African countries, like Burundi, the Democratic Republic of the Congo, Kenya, Rwanda, and Uganda, to send health personnel to the affected West African countries also underscores the importance of regional cooperation and peer-review. Initiatives taken by African States collectively, such as the ones taken during the Abuja Declaration in 2001, are meant to ensure that the continent collectively reviews the progress made by individual states towards meeting their commitments.[127] It is also notable that such commitments have seen increased allocations to the health sector since 2001, which is a step in the right direction of ensuring that proper resources are available to deal with health concerns.[128] A report, released jointly by UNAIDS

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[124] *Id.* at 27.

[125] *Id.*

[126] *Id.*

[127] *The Abuja Declaration: Ten Years On*, WHO, at 1 (2011), http://www.who.int/healthsystems/publications/abuja_report_aug_2011.pdf?ua=1.

[128] *See Abuja +12: Shaping the Future of Health in Africa*, U.N. AIDS, at 7, http://www.unaids.org/sites/default/files/media_asset/JC2524_Abuja_report_en_0.pdf (last visited Mar. 5, 2017) (demonstrating, graphically, the increased expenditures made by African countries to the health sector).

and the African Union, indicates that health spending by governments in the African Union has increased exponentially, from just $30.7 billion in 2001 to $106.6 billion in 2011.[129] This progress is indicative of how commitments made at the regional level are useful in ensuring that states meet their goals. Notwithstanding this progress, certain countries in the African Union are still performing dismally, and countries like Mozambique and Chad have, in recent years, cut their spending in the health sector.[130] Important, however, is the need of African countries to constantly remind each other of their commitments and to work collectively towards them.

Public health emergency preparedness cannot work effectively without the involvement of local communities. Local communities are the first points of contact whenever public health emergencies occur, and they are the ones that are mostly affected by slow responses from authorities.[131] During the EVD outbreak, it was reported that suspicions between local communities and public health authorities played a big role in the spread of the virus.[132] It is therefore of importance that local communities are involved in all aspects of public health and are properly educated on how to detect and report any suspicious public health concerns. Involving local communities will ensure that public health responses are culturally appropriate and will encourage further participation of local communities. To achieve this, it has been suggested that community advisory bodies be formed, which would represent the views of a large section of the communities and also provide assistance to overstretched public health resources.[133]

The public health emergencies that have arisen in recent years have also highlighted the manner in which global inequity continues to prevail, where the poorest of the poor are the ones that are most affected when epidemics strike. For the poor, health emergencies always drain the little resources they have and

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[129] *Id.* at 8.

[130] Aimee Rae Ocampo, *Health Funding in Africa: How Close is the AU to meeting Abuja Targets?*, DEVEX (Aug. 5, 2013), https://www.devex.com/news/health-funding-in-africa-how-close-is-the-au-to-meeting-abuja-targets-81567.

[131] Elizabeth Ferris, *Natural Disasters, Conflict, and Human Rights: Tracing the Connections*, BROOKINGS INST. (Mar. 3, 2010), https://www.brookings.edu/on-the-record/natural-disasters-conflict-and-human-rights-tracing-the-connections/.

[132] *Factors that Contributed to Undetected Spread of the Ebola Virus and Impeded Rapid Containment*, WHO (Jan. 2015), http://www.who.int/csr/disease/ebola/one-year-report/factors/en/.

[133] Siedner et al., *supra* note 64, at 4.

disrupt their livelihoods. Such disruptions are not easy to recover from, for the poor, and health emergencies therefore entrench poverty among these persons.[134] It is also notable that epidemics facing the poor are usually slowly responded to and not given much importance until they morph and become uncontainable.[135] This is not to say that the global community has totally turned a blind eye tó problems affecting developing countries. Fairness has been forthcoming in certain cases, as was seen when the Obama administration announced a $6.2 billion fund to combat Ebola in West Africa.[136] As of May 2015, the World Bank Group had mobilized $1.62 billion American dollars to finance post-Ebola recovery efforts in countries hit by the Ebola virus the worst.[137] In the same vein, the WHO announced, at the WHA, the creation of a $100 million American dollar contingency fund, aimed at financing its newly established health emergency program.[138] There is, however, a need for a change in attitude in addressing emergencies that arise in SSA and the Global South to ensure that bodies, like the WHO, uphold equity at all times in dealing with matters under its domain.

CONCLUSION

The authors have attempted to discuss an issue that may escape African countries and bureaucrats in their moves towards eliminating visa requirements for visitors from other African countries and towards further integration. The importance of regional integration cannot be overstated, and this paper appreciates the gains to be made by an increased mobility within the African continent. The paper, however, cautions African states to be alert to the potential threats that may be occasioned by increased movements, with the main focus being concerns about the likelihood of the increased spread of diseases. The deficiencies

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134 WHO & OECD, DAC GUIDELINES AND REFERENCE SERIES: POVERTY AND HEALTH 59–60 (2003).

135 *Id.* at 39.

136 Patricia Zengerle & Richard Cowan, *Obama Seeks $6.2 Billion to Combat Ebola: Officials*, REUTERS (Nov. 5, 2014), http://www.reuters.com/article/us-health-ebola-obama-idUSKBN0IP2EE20141105.

137 Melanie Mayhew, *World Bank Group Ebola Response Fact Sheet*, THE WORLD BANK (Apr. 6, 2016), http://www.worldbank.org/en/topic/health/brief/world-bank-group-ebola-fact-sheet.

138 *Contingency Fund for Emergencies*, WHO (Oct. 13, 2015), http://www.who.int/about/who_reform/emergency-capacities/contingency-fund/Contingency-Fund-Emergencies.pdf?ua=1.

in the public health infrastructures within most African countries underscore the urgent need of African countries to mobilize their resources to make the health sector resilient and responsive to any threats that may emerge. This paper has also reiterated the importance of peer-review within the African Union to ensure that individual countries uphold their commitments to strengthen their public health infrastructures. The WHO has also been highlighted as an important player in this discourse, and there is need to reform the body to make it more responsive to public health concerns that may arise in countries lacking adequate capacities to address those concerns.