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African Agency in Practice: Acquiring Agency and Institutional Change in the West African Health Organisation

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Abstract

This article investigates how practitioners in the West African Health Organization (WAHO) obtain and exercise autonomous political agency in the development of regional health policy. While many process-driven accounts of African agency focus on the freedom and ability of African governments and regional organisations to act and not be acted upon, the article finds that it is necessary look within these agents to examine how they are constituted and the processes in which they acquire the capacity to be agents in their external interactions. This article shows that practitioners in WAHO rely on three institutional strategies that constitute them as agents within the organisation: networking with extra-regional partners; the inclusion of civil society in regional social policy; and the development of intra-organisational linkages to create insulation from political control. Through these strategic interactions, WAHO practitioners constitute themselves as agents within the organisation as well as autonomous agents in the broader global health theatre.

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Keywords

West Africa, agency, global health governance, ECOWAS, practices

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Introduction

Despite the co-ordinated multi-lateral effort by various actors in the international community, the response to the 2014–2015 Ebola virus disease (EVD) outbreak in West Africa was deemed a failure in global health governance (Busby et al., 2016; Patterson, 2018). Nonetheless, the outbreak caused analysts to revisit the capacity of African actors and the unevenness of their dependence on actors external to the region (Anderson and Patterson, 2017). Additionally, the Economic Community of West African States (ECOWAS) region faces a series of complicated security issues, namely, instability in the Sahel region, electoral crises in Cote d'Ivoire and Guinea, and political unrest in Togo and Nigeria, among others. Compounding these security issues is the novel coronavirus outbreak (COVID-19), which as of November 2020 has infected over 190,000 people in West Africa, with 2,769 deaths. The COVID-19 pandemic poses a significant challenge to fragile health systems in West Africa. However, despite the fragility of health systems, West Africa, along with the rest of the continent, has drawn from lessons in previous public health epidemics to respond to the outbreak and adopt measures to keep their societies safe.[1] The variation in response across the continent points to an increased awareness and a convergence between public health practitioners and political actors to develop responses to public health outbreaks in West Africa, highlighting the need to interrogate how policy officials acquire the capacity to influence and shape West African regional health policy

The exercise or practice of African agency often refers to the freedom and autonomy of African governments to define, act, lead, and control issues that affect them (Tieku, 2013). A focus on African agency requires a shift in understanding African actors not as passive recipients but rather as deliberate and intentional norm entrepreneurs in the international community (Coleman and Tieku, 2018). African agency is also framed as a response to its political and economic marginalisation in the practice and theorising of Africa and suggests that the drivers of economic, social, and political change on the continent are no longer extra-continental, but they arise from within (Brown and Harman, 2013; Shaw, 2015). Advancements in our understanding of African agency also separate the relationship of structure and agency and empirical questions about the ideas and material preferences of African actors (Murray-Evans, 2015).

This article examines the processes in which African actors acquire agency and how the acquisition of agency creates a context for the creation of practices that induce institutional change. While many process-driven accounts of African agency focus on the freedom and ability of African actors to act and not be acted upon, how African actors use their agency to induce institutional change is underexplored. For example, the African Union and its embrace of "African Solutions to African Problems" presupposes a "collective African voice" in areas such as peace and security, and advocates the need for self-sufficiency and sustainability of African-driven policies. In this collective voice, African actors rely on or "manipulate" their position as "weak" actors in order to acquire resources and assert their agency.

While ECOWAS may be considered a weak organisation or to have failed in conventional notions of market integration, the agency of ECOWAS practitioners, specifically

in the West African Health Organization (WAHO), through their "ability and capacity to create an inclusive mode of governance through the incorporation of regional stakeholders in regional governance," had a transformative effect on how we understand the processes of institutional development and change.[2] Displays of this agency are sometimes difficult to identify in practice, particularly given the insular structure of ECOWAS, budgetary constraints, and heterogeneity among officials. However, focusing on the actions and agency of WAHO practitioners provides insight into how practitioners acquire agency and use their agency to navigate across scales of governance and, in the acquisition of agency, are able to overcome real and perceived barriers to effecting change in WAHO and beyond.

WAHO practitioners rely on three pathways to acquire and use their agency. First, WAHO practitioners engage in networking with extra regional partners, such as the World Health Organization (WHO), development agencies, and extra-regional governments to strategically acquire resources that elevate the preferences of WAHO as an institution in ECOWAS. Second, WAHO practitioners align with ECOWAS' broader institutional practice of incorporating regional civil society actors into regional health governance as a way to make their agency more people-centric. Third, WAHO practitioners acquire agency by attempting to create intra-institutional linkages within ECOWAS in order to elevate the importance and relevance of West Africa's regional health practices within and beyond ECOWAS. Combined, these strategies represent the acquisition of agency through strategic engagement with a multitude of regional actors, overcoming barriers of action and leading to incremental shifts in organisational dynamics.

Focusing on a practitioner-led perspective of agency follows the recent trend of studying agency in African regionalism. That is, it focuses on the capacities of actors to determine the scope and intensity of their governance arrangements through the establishment, promotion, contestation, resisting, and modification of "conventional" norms and practices. As such, the focus on practitioner agency offers insight into how institutions can break from structural constraints and, instead, embrace and drive the dynamism of organisations. Put differently, an agentic turn in the study of African regionalism considers how an actor's agency also changes the structure of an institution to be more inclusive to non-member state actors, creating a relationship between regional stakeholders and the institution that is not conditioned on dependency or limited by a lack of political will by powerful member states. Embedded in this discussion of practitioner agency is a focus on the process of agency acquisition. This approach combines the logics of international practices and institutionalism to understand not only what bureaucrats do but also how their practices serve as sources of deep institutional memory and provide the background knowledge and conditions for competent governance performances. The convergence between practitioner agency and institutional change is necessary to understand the fluidness of rule interpretation and the ways in which practitioners access the background knowledge of ECOWAS to implement existing rules in new ways.

This article builds on the study of international practices in international relations (IR) as well as historical institutionalist (HI) approaches to empirically examine the relationship between how actors acquire agency through practice and how actor agency

drives institutional change. Drawing from thirty interviews with WAHO and ECOWAS officials, regional civil society officials, and officials from international development organisations and through archival document analysis, this work demonstrates how WAHO practitioners acquire their agency through three discrete and varied practices. Additional documentary evidence comes from archival research at the WAHO secretariat in Bobo-Dioulasso, Burkina Faso, and the ECOWAS Commission in Abuja, Nigeria.[3]

The article proceeds in three parts. First, it discusses how the intersection of international practices and incremental institutional change can be used to investigate how bureaucratic actors obtain agency. The next section "African Agency" explains the constitution of WAHO practitioners as key actors in regional health governance. This section highlights how practitioners obtain the institutional space to become activists and develop strategic institutional mechanisms to assert their agency within the organisation. The subsequent section emphasises how WAHO practitioners use strategic institutional mechanisms to leverage their comparative advantage of locality over international actors and international non-governmental organisations in facilitating responses to health crises in West Africa. By initiating these strategic interactions with international actors and actors within the region, WAHO practitioners are simultaneously agents within the organisation and autonomous agents in the broader global health theatre. Overall, the mechanisms that this article identifies to explain bureaucratic agency diverge from functional approaches to integration.

Acquiring Agency: Institutionalism and International Practices

Much has been made of the "practice-turn" in IR, with particular focus on diplomatic communities (Glas and Balogun, 2020) and actors' socially meaningful patterns of activity (Schatzki and Cetina, 2001). Practices are how we organise the world and its materials, to closing the divide between ideas and matter (Adler and Pouliot, 2011; Bueger and Gadinger, 2015). Practices, conceived as competent performances that are acted out by communities of practice, are agential. They are performed by individuals and communities but also frame how actors know who they are and how to act in a socially recognisable way (Adler and Pouliot, 2011: 15, 17). Practices are meaningful because they enable agency by transforming background knowledge into intentional acts with social meaning. Background knowledge and practices in general do not assume uniformity or monolithic understandings of actors within the community of practice, defined here as relatively bounded groups of actors united and observable through their shared repertoires of action, common enterprise, and dense interactions (Bueger, 2019; Glas, 2018; Glas and Balogun, 2020). Nonetheless, background knowledge provides a sense and understanding of how actors interpret their agency and also how they acquire agency.

By focusing on international practices rather than on abstract criteria such as "the state" or "international institutions," we can isolate agency and understand how socially meaningful "ways of doing" are positioned in a local, social environment (Adler-Nissen and Drieschova, 2019). Understanding practices as both ideational and material, as well as acknowledging their reinforcing character, allows us to see how practices both shape

rules and institutions and can also transform those same rules and institutions (Best and Gheciu, 2014). Practices allow us to isolate and specify the unit of analysis, with the assumption that an actor's subjective experiences form the starting point of any analysis (Adler and Pouliot, 2011).

As such, practices such as diplomatic text production, networking, or non-intervention are often linked relationally with agency and structure. The relational dynamics of structure and agency are well documented in constructivist and practice theory literature; however, practice theory aims to liberate agency from the constrictions of structure (Bueger, 2019). A focus on practice and agency becomes a focus on the meaning of action. Put differently, by focusing on the meanings of actions, we can examine the acquisition and use of agency as its own entity. As Bueger (2019: 835) notes, this leads to an understanding of agency as distributed – agency dependent on webs of relations set up in and through practice and actors acquire their agency by participating in a practice.

Practices are an analytically useful tool to explain and understand African agency in WAHO for a number of reasons. First, a practice-oriented approach specifies the unit of analysis to be practitioners in a community of practice, but also requires us to consider how the actors contextualise their social environment, how actors adapt to political constraints, and how actors contribute to institutional change. Here, I am concerned with the everyday, routinised activities of stakeholders and WAHO practitioners, the decisions they make on whom to interact with, and the ways in which WAHO engages, develops, and prioritises public health. I further ask how engagement in public health becomes essential and normalised to the social fabric of the region. Embedding international practices into a conceptualisation of regional convergence allows us to better understand dynamics of order and change, see process, and appreciate collective knowledge.

Second, a practice-oriented approach allows us to look systematically at the intra-organisational dynamics of bureaucratic actor behaviour (Bauer et al., 2017). For instance, international public administration focuses on the role of bureaucratic autonomy and administrative expertise and practices to help make meaning out of how bureaucrats understand their institutional contexts and constraints (Venzke, 2008). For example, as a specialised agency of ECOWAS, WAHO enjoys a significant amount of autonomy in the shaping and development of its policies and agenda setting. Using a practice-oriented approach, this article emphasises and focuses on the ways in which WAHO practitioners use and understand this autonomy in the context of the broader structure of ECOWAS, particularly WAHO practitioners' ability to work with actors outside of ECOWAS.

Third, a practice-oriented approach calls for a focus on the embedding of practical sense into wider social contexts (Kratochwil, 2011). As a specialised agency, WAHO has the benefit of autonomy as well as superior technical expertise. A practice-oriented approach centres the practitioners' technical expertise and the process in which this technical expertise is embedded in a broader institutional context.

Put simply, practices help us understand the extent to which the community of practice in WAHO operates (to a degree) autonomously from the broader ECOWAS community of practice, by focusing on how historical experiences and shifting relationships with regional health stakeholders have transformative effects on ECOWAS as an institution. Investigating

practices in a particular community provides context for explaining and understanding how agents approach and engage in institutional change.

Combining the study of international practices and institutional analysis provides an opportunity to examine not just the acquisition of agency, but also how actors can use their agentic capacity to transform and evolve institutions. Institutional analysts ask what properties of institutions permit change and how institutions allow actors to carry out behaviours that foster change (Mahoney and Thelen, 2010). For them, part of what explains institutional change are problems of rule interpretation within institutions, which open up the space for actors to implement existing rules in new ways (Mahoney and Thelen, 2010).

Incorporating practices into an institutionalist perspective offers an opportunity to highlight how practitioners acquire and use their agency to change institutions in gradual ways, rather than explaining institutional changes as an episodic moment. Thus, practitioners in a community of practice become important not as merely historic agents that use political moments as opportunities to change the trajectory of institutional development, but, rather, as actors who are constantly negotiating and re-defining their constitution and agency in an institution. Focusing on the relationship between practices and institutional change emphasises the combined effects of institutions and processes which are lost in examining one institution or process at a time (Skocpol and Pierson, 2002). The incorporation of practice bolsters the explanatory power of studying how actors acquire and use agency to change their positions and effectiveness within an institution and potentially transform or change an institution. Practices and institutional change focus on the struggles over what rules mean, how rules are applied, and how rules are enforced and informed by an actor's social context.

Understanding how actors acquire agency through practices is fundamental to understanding the dynamism of institutions. Take, for instance, how actors understand the rules of an institution. Institutional actors might face information processing limitations and uncertainty over ambiguous rules (Fioretos et al., 2016); however, they rely on their shared contexts and understanding about institutional rules over time to know how much space they have to alter and enforce new rules, navigate entrenched power dynamics and political constraints and, ultimately, transformative actors in the institution. Focusing on the practices of a community of practice allows us to analytically explain not only how institutions change but also what drives institutional change (Thelen, 2009).

African Agency

Much of the existing works on African agency focuses on the autonomy of African citizens, through their governments and their ability to define, act, and control issues that affect them (Brown and Harman, 2013; Coleman and Tieku, 2018; Tieku, 2013). Following calls to privilege and consider regional norms to understand the differences in agency (Witt, 2019), African agency is often framed as a mode of contestation – African actors resist the external imposition of norms and values. Existing studies on African agency bring to light the many ways in which African actors are shaping global norms,

particularly in the areas of international peace and security and global health (Coleman and Tieku, 2018). For instance, the African Union (AU) Constitutive Act, which allows for the intervention of the AU in the event of an unconstitutional change in government serves as a primary example of the ways in which African countries, collectively, are agentic actors. Similarly, in the arena of global health, African states are both dependent on global aid, trade, and security and agentic in their manoeuvres within international structures (Anderson and Patterson, 2017; Patterson, 2018).

While African agency is often framed as a mode of resistance or contestation, it can also be as emancipatory. The optimistic "Africa Rising" narrative, which points to the economic progress of African countries, is often used to highlight how African governments are positioning themselves in the global economy to rely less on actors external to the region to improve their development. The emancipatory nature of African agency is also tied to increased South–South co-operation, and specifically China's growing economic partnerships with African countries (Lopes, 2010). These notions of African agency almost entirely focus on the state as the driver of agency and see agency as merely about Africa's growing influence in the world or how Africa resists or contests top-down norm diffusion dynamics, which omits the ways in which actor preferences can be diminished by national preferences (Murray-Evans, 2015).

The conflation of African agency with resistance and influence is highly present in the discussion of global health governance. For example, Dionne (2017) argues that there is a fundamental disconnect between global and local responses to HIV/AIDS interventions in Africa, particularly those that require African states to partner with international organisations, development partners, or international NGOs. Dionne (2017) uses a principal agent framework to argue that, beyond co-ordination issues, there is a global-to-local hierarchy of AIDS intervention that favours powerful actors and not the intended beneficiaries, concluding that agent preferences matter. This approach to actor agency emphasises the capability of actors to act freely despite constraining contexts (Anderson and Patterson, 2017: 8). African agency then is cast as a way to highlight that African actors have a choice in the matter – that there ought to be a recognition of their ability to make a choice or indicate and act on their interests and preferences. African agency, then, ought to move beyond the binaries of resistance and influence and centre any discussion about agency on the preferences of agents.

While agent preferences matter, to fully grasp how actors determine or consider how to use their agency, it is important to understand the processes through which agents form their preferences. How do background knowledge and social context inform a community of practice? How do practitioners consider existing rules of an institution, and how do they make new rules to reflect their current context? If new rules are not created or if there are structural constraints that would presumably limit agentic capacity, how do agents manoeuvre an institution to demonstrate their capacity and autonomy to act? I argue that it is crucial to examine the acquisition of agency to understand the relationship between practice and institutional change.

In the following sections, I explore the institutional transformation of ECOWAS broadly and the creation of WAHO specifically. I highlight how the community of

practice emerges and transforms overtime and illuminate the practices of WAHO practitioners to show how their quest for agency shapes their institutions.

ECOWAS' Institutional Transformation

WAHO was established as a specialised agency in ECOWAS in 1987, twelve years after the creation of ECOWAS. WAHO's creation merged Anglophone and Francophone West African health communities into one, under an Assembly of Health Ministers, made up of the ministers of health from member states. WAHO conferred decision-making power on the Assembly of Health Ministers, giving them autonomy to co-ordinate and harmonise health practices in West Africa. As ECOWAS expanded its mandate towards peace and security and responding to civil conflicts, the Assembly of Health Ministers continued to meet WAHO bi-annually and often discussed matters through the WHO Regional Office for Africa (AFRO) (Balogun, forthcoming). In these early years, WAHO as a community of practice was inherently insular and elite – characteristics shared by other departments across ECOWAS – and WAHO had limited engagement with the full range of health stakeholders across the region. WAHO also had little presence across ECOWAS as the institution expanded its mandate. As one current WAHO official notes, the issue of health was "not a mainstream issue" in ECOWAS, which has dealt with transitions from civil war in Liberia, Sierra Leone, Guinea-Bissau, and Cote D'Ivorie.[4] Further, from 1993 to 2005, ECOWAS did not include health as a priority for the organisation in its strategic plan.

However, from 2005 to 2007, as part of a broad organisational reorganisation in ECOWAS, the Assembly of Health Ministers came together to augment WAHO's original mandate. An official in the Social and Humanitarian Affairs directorate in ECOWAS notes that the organisational shift was meant to orient the region "more towards the people" and "rely on the expertise of those who make up the region" as a means to "further and deepen the regional project."[5] Under this expanded mandate, WAHO expanded the power of the Director-General to appoint all WAHO staff and officials, a duty formerly given to the Assembly of Health Ministers. In addition, WAHO expanded to have six administrative units made up of health practitioners from around West Africa.

In addition to these changes in WAHO, the broader organisation of ECOWAS transformed its institutional structure from the ECOWAS Secretariat to the ECOWAS Commission. Led by Mohammed Ibn Chambas, the ECOWAS Commission created a Commission President and would be divided into seven sub-commissions, with relevant departments therein. Public health was included in the mandate of two units, namely, Human Development and Gender and Agriculture, Environment, and Water Resources. Broadly, the transformation from the Secretariat to the Commission shifted the dynamics and constitution of the community of practice in ECOWAS and WAHO.

For ECOWAS, and WAHO specifically, these institutional transformations were significant for two key reasons. First, the Director-General position (as well as the Commission President) obtained more power and agency to not only improve the technical capacity of the organisation but to also use political capital to incorporate WAHO

into the strategic vision of ECOWAS more broadly. Second, redefining the role of the Director-General and the scope of WAHO overall entrenched WAHO's autonomous status within ECOWAS; it also put the onus on WAHO officials to determine the scope of their capacity as actors within the larger ECOWAS organisation. The re-configuring of ECOWAS and WAHO provided the institutional space for officials to operate autonomously and provided the conditions for practitioners to acquire agency.

Whereas officials who previously worked in the ECOWAS Secretariat were primarily political appointees who worked on behalf of their home country, the community of practice in the commission consists of officials who are procured from a professional, civil servant class, to fill organisational roles. Specifically, for WAHO, practitioners come primarily from the health and international development sector. Most members of the WAHO community of practice have medical degrees, from African universities and abroad. Other members of WAHO have worked on health policy in the United Nations, the WHO, and for health-focused NGOs. WAHO draws from the revenue from the community levy, which funds the salaries of WAHO practitioners.

While WAHO has officials from each ECOWAS member state, these officials often state that they pursued the position not because they wanted to work on behalf of their governments but because they wanted to work for the betterment of the region. For example, when discussing how they obtained their position at WAHO, one official noted that they became disillusioned working with their national government and sought out a position in WAHO.[6] A chief accountant from WAHO notes that in the ten years of being in the position, the biggest advantage they have is their "multi-national and multi-cultural" experience, having worked in the private sector and with various national government officials prior to working with WAHO.[7]

Part of what binds the WAHO community of practice together is how the practitioners understand their competencies and see them as both constraining and complementary. On different occasions, WAHO officials mentioned their experiences working with and appreciating different cultures within the organisation and how their interactions with practitioners from different backgrounds affects how they perceive their agentic capacity. One insight by a WAHO official from Sierra Leone working in Health Data administration sums up the sentiments of many, the belief that there are different competencies between practitioners from Anglophone and Francophone countries. The practitioner suggests that those who come from Francophone countries are "culturally" more susceptible to "do as they are told," while those from Anglophone countries tend to question. According to this practitioner, their colleagues from Francophone countries tend to be very dogmatic in their day-to-day interactions, which makes their behaviour hard to change.[8] These ideas that practitioners hold about themselves and their peers are important to understanding how practitioners in WAHO acquire their agency. The extent to which they view themselves as constrained or autonomous often conditions how they choose to interact with external actors and the scope to which they will pursue relationships with actors that will alter or retain the status quo. These "cultural" differences condition the organisational practices and also how individual practitioners feel empowered to assert themselves in their networked interaction.

Similarly, other WAHO officials from Anglophone member states often speak about how officials from Francophone member states always want to "liaise" or "do exploration" before making decisions, whereas officials from Francophone member states characterise their Anglophone counterparts as hasty. While these critiques create conditions for long meetings, they also provide context to how WAHO officials understand their practical sense as well as how they acquire their agency. However, it is important to not view these cultural perceptions purely as limitations. How WAHO officials understand each other becomes essential when engaging in external relations with donors or with the Assembly of Health Ministers, in that WAHO officials rely on their background knowledge of each other and take this into consideration when they are seeking relationships or funding from projects.

Pathways to Agency

Networking

How does a community of practitioners within a larger organisational framework acquire and exercise agency in global health governance? First, they acquire agency by re-framing the donor–agent dynamic. As mentioned, conventional understandings of African agency often characterise Africa as a "weak" actor internationally, and agency is acquired by African actors leveraging their weak position to demonstrate agentic capacity. However, for officials in the WAHO community of practice, they acquire and use agency by re-framing the relationship between WAHO and its donor partners and through networking. The networking dynamic here refers to the ways in which WAHO officials are able to transcend the bounds of the organisation and serve as the interlocutor between international actor priorities and local actor needs and priorities. Put differently, WAHO officials, through their autonomous position, contrive regional health policy and strategies and create networks to facilitate the development of regional health standards, responses, and epidemic prevention strategies.

WAHO officials fundamentally understand that health systems across West Africa are weak. While some health systems, like Nigeria's and Ghana's are stronger, there are significant disparities in the West African health systems' effectiveness and capacities. In addition, WAHO has to contend with what they call a "lack of political will" by elected and appointed officials in member states to accomplish wide-ranging health goals.[9] As such, many would consider the policy domain of WAHO officials to be constraining. However, WAHO officials note that they actively recognise potential constraining factors and use these factors to their advantage in seeking resources for WAHO. A key component of networking as a practice for WAHO officials is their relationship with external donors. While WAHO officials are cognisant of external actors' agendas, they are quick to point out that they do not view their relationship with external donors as dependent; rather, they see the relationship as an opportunity to create networks and set their own priorities for regional health. For example, an official in the Directorate of Public Health and Research frequently cited how most development partners, including the United States Agency for International Development, WHO, and the UK Department for International Development, come to

WAHO offering a range of health-development projects and which often do not align with WAHO priorities and appropriated funding to focus on specific kinds of projects.[10] As self-described screeners of health-related projects in the region, WAHO officials are well aware that most external funding priorities will not match the needs of WAHO. However, they accept projects that might not be of need in order to create relationships with donors that will endure and eventually help them meet the needs of the organisation. One WAHO official notes that donors are more concentrated on epidemics and emergency preparedness; yet donor funding for maternal and child health is scarce. From the view of the official, maternal and child health is an actual priority of the organisation even though donors do not take the time to learn the situation and context within African communities: "As the international community, they cannot tell us that maternal health is not an issue, we know it is! So, we use our relationships with donors to address issues that cut across. Our relationships and interests are complementary."[11]

Networking as a practice is an important tool that officials use to promote their interests and assert agency. By framing the relationship as complementary and not subservient, WAHO practitioners are able to build relationships with regional health stakeholders that not only endure but end up representing the strategic and ideational interests of WAHO over time. Officials in the community of practice often argue that they approach meetings with donors from a position of strength and evidence. Through their research and data collected from member state liaisons and their fields of expertise, they are able to network with the external actors in the region to achieve policy priorities. Officials emphasise their evidence-based networking strategy as a way to assert agency and also aid in diversifying donor interests. The Chief Accountant of WAHO mentions specifically that donors are all working on essentially the same projects (in this case, epidemics and HIV/AIDS – through contraception initiatives); however, by strategically networking with external donors and building relationships through evidence, WAHO officials are better able to communicate the priorities of member states and secure the necessary material resources to align with their goals.

Some examples of the kinds of networking that WAHO engages in are workshop activities. For instance, WAHO and WHO supported an Emergency Medical Team Awareness Workshop through the Cote d'Ivoire National Institute of Public Hygiene in February 2020. This workshop provided training for regional awareness, which followed recommendations from a previous workshop and consultative meeting two years prior in Cote d'Ivoire. The incorporation of WHO in this programme was a direct result of practitioners aligning the resources and work of member states with shared priorities identified by WHO and WAHO. Relatedly, WAHO also organised a Training of Trainers workshop to help facilitate the creation of botanical gardens for the protection of medicinal plants in Lomé, Togo. WAHO also held comprehensive workshops on Innovating for Maternal and Child Health in Africa as a means to share experiences and capacity strengthening activities throughout West Africa.

Another significant networking tool is the use of Memorandums of Understanding (MoUs). WAHO officials use MoUs to get external donors to adapt to WAHO policy priorities. MoUs can be highly detailed or not complicated at all. WAHO officials note that MoUs are useful in helping to specify their relations with partners. One official

argued that WAHO's desire for specialised projects and partnerships are also shared by the partner organisations. Thus, the practice of networking gives WAHO officials agency in being able to forum shop to find issue alignment with partner organisations while specifying the priorities of WAHO.

Due to WAHO's intentional networking, officials are often invited on behalf of governments to attend advocacy networks and workshops abroad. For instance, a group of WAHO officials represented the organisation at the Global National Immunisation Technical Advisory Group Network meeting and at the United States' Advisory Committee on Immunisation Practices in the USA as a means to identify research and capacity priorities in West Africa and to facilitate mutual interactions with transnational counterparts. More notably, WAHO officials view these activities as ways to deepen the competencies of the community of practice. One official mentioned that they attend these meetings and hold wide-ranging workshops to elevate health issues in the sub-region to a wider audience and to demonstrate WAHO's contribution to the improvement of regional health systems.[12]

WAHO officials acquire agency by using networking to gain material resources, demonstrate their relevance as regional health policy stakeholders, and reframe the organisation's relations and dynamics with external actors. WAHO officials rely on their technical expertise, coupled with their lived experiences in trying to mobilise their inherently weak health systems, to assert their capacity as central actors in regional health. The practice of networking also complements ECOWAS' broader turn towards an inclusive, people-centred governance and the inclusion of civil society into regional health governance practices.

Inclusion of Civil Society

At the broader, organisational level, ECOWAS promotes a policy of "people-centrism" designed to make the organisation more inclusive of civil society actors, allowing civil society to shape the complexion of regional governance (Glas and Balogun, 2020). WAHO has also embraced this call as a tool to make regional health governance more self-sustaining. A goal for WAHO has been to make its presence intelligible to citizens across the region. The expansion of WAHO to include more than the Assembly of Health Ministers was partly intended to provide WAHO more of an on-the-ground presence across the region. As such, the role of the WAHO member state liaisons is to seek to harmonise strategies for WAHO and to link WAHO objectives to those of the specialised agendas in health-oriented civil society organisations.

An example of the inclusion of civil society as a practice can be found in the domain of drug policy harmonisation. In an European-Union-funded action plan, ECOWAS tasked WAHO to spearhead the gathering of drug policy data in each member state, with the goal of improving the technical expertise of WAHO and mutually benefitting health-focused civil society actors. The West African Civil Society Institute (WACSI) identified the lack of co-ordinated and reliable data on drug policy as a constraint to mitigating drug abuse in West Africa. To address this constraint, WAHO member state liaisons began mobilising to assist the efforts of civil society.

Despite efforts like these, there still remains a gulf in the inclusion of civil society in WAHO policies. Yet WAHO officials cite the importance of including civil society to make WAHO relevant to citizens. A WAHO official in Health Information Systems, in describing their main objective as an official, made a point to highlight WAHO's inability to collect regional health data, and believes that one possible solution for WAHO to improve regional data collection would be to move beyond donor partners and instead mobilise civil society as information gatherers.[13] This reflects WAHO officials' belief that they can acquire agency by including civil society. It demonstrates a recognition of the conditions that constrain their social domain and a willingness to include civil society in governance to compensate for weak national health systems.

Another example where WAHO practitioners have acquired and demonstrated agency is in the dissemination of health information during the COVID-19 global pandemic, particularly in the areas of risk communication and medical staff training in ECOWAS member states. WAHO began prioritising and scaling up the use of risk communication during the EVD outbreak in 2014–2016 and has bolstered these efforts during the COVID-19 pandemic. WAHO defines risk communication as the real-time exchange of information, advice, and opinions between experts and people facing threats to their health, economic, and social well-being. WAHO practitioners use a strategy of incorpor ating community engagement and encouraging behavioural change among civilians to strengthen health systems across the region. Specifically, in the context of the COVID-19, WAHO practitioners used risk communication to engage civil society in three ways.

First, WAHO established a "Diaspora Health Specialist" network to create a database of medical specialists across the member states that would be tasked to train medical staff across the sub-region. Second, WAHO tasked practitioners to develop strategies for inclusive dialogue that included at-risk communities in the development of acceptable mitigation responses based on community buy-in and trust from civilians. In this vein, WAHO practitioners have collaborated with regional civil society organisations, such as WACSI, to use risk communication to combat misinformation campaigns by disseminating information in local languages and by promoting community education opportunities around best public health practices. One practitioner noted that it become harder for collaboration to occur in person with the pandemic; however, the pandemic enabled practitioners to think more creatively about how they could work with their civil society partners to engage local populations on how to remain safe. Risk communication offers one such creative solution.[14] Finally, WAHO, through partnerships with the United States Centre for Disease Control (CDC) and the German Agency for International Cooperation (GIZ), engaged civil society in a series of National One Health platform trainings and courses to develop a systematic way to engage and incorporate the One Health initiative into responses to COVID-19. WAHO also identifies regional One Health stakeholders in civil society that would improve health surveillance infrastructure and infectious disease monitoring in member states.

WAHO officials believe that the inclusion of civil society in regional health governance serves as another way to assert WAHO's autonomy while also avoiding the constraining factors of member-state-focused harmonisation. WAHO officials view the integration of civil society as crucial to bolstering national health systems as well,

evidenced by a joint workshop held by WAHO, WHO, USAID, and the United Nations Population Fund (UNFPA) to integrate community health workers into national health systems. The goal of this workshop was to formalise and embed the integration of community-level health practitioners into national health systems, as a means to improve progress towards universal health coverage in West Africa (Ministère de la santé et de l'Hygiène Publique, 2019). Dr. Kofi Busia, director of the Directorate of Healthcare Services, stressed the importance of civil society inclusion as a harmonisation practice. Specifically, he notes that traditional healers hold legitimacy and respect among civilians and civil society, so it is incumbent upon WAHO officials to not only include them in the regional health infrastructure but to also use them to mediate with and communicate information to civilians. The incorporation of traditional and religious leaders has also been part of WAHO's COVID-19 strategy, which tasks these leaders with assisting with disease surveillance and management particularly during lockdowns.[15]

Dr. Busia and another WAHO official point to intellectual property training provided by WAHO to members of the traditional medicine community in Burkina Faso, Togo, and Ghana. In addition to this training, WAHO in its networking with the French Development Agency (AFD) and the Bill and Melinda Gates Foundation provided funding to civil society organisations to be included in WAHO research on sexual and reproductive health programmes. Dr. Busia described the objectives of the funding to cover the emergence of civil society-led projects and service delivery, to promote technical collaboration between WAHO and CSOs, and to build the structure for national civil society organisations to improve indicators on sexual and reproductive rights.[16]

The practice of including civil society in regional health governance processes exemplifies how WAHO practitioners acquire and use agency to transform WAHO. By incorporating civil society in a technical sector, WAHO officials aim to transform the organisation its earlier insular and elite structure towards a more open, people-focused organisation.

Intra-Organisational Linkages

Finally, WAHO officials acquire agency by building intra-organisational linkages across ECOWAS as a means of elevating health issues. In describing WAHO's mandate and capacity to act, Dr. Carlos Brito, director of Public Health Research, notes that WAHO officials have to account for sovereignty of member states: WAHO is an implementing body, not a decision-making body.[16] Health was not originally a strategic priority for ECOWAS. However, as epidemics such as malaria, tuberculosis, and HIV became prominent throughout the region, public health became a primary issue for member states. Dr. Brito and other WAHO officials pointed to 2009, where WAHO officials in their strategic plans began to consciously link health initiatives to the broader ECOWAS agenda of facilitating the free movement of people. As Dr. Brito notes, it was the goal of WAHO to conceive of West Africa as a "common space" as a way to frame health issues indirectly as political issues.

The framing of health as a cross-cutting issue area in ECOWAS helps us understand the relationship between practices and institutional change. WAHO officials were keenly aware of the practical sense and background knowledge of officials in the broader

organisation, and responded by trying to make health issues more relevant to the security and economic integration priorities of other parts of ECOWAS. A relevant example is the creation of the ECOWAS Regional Centre for Surveillance and Disease Control (ECOWAS CDC) in 2016.[17] The EVD outbreak in 2014 provided the policy and political opening for officials to call for the prioritisation of health in ECOWAS. From March 2014 to December 2015, there were over 11,000 Ebola-related deaths and in this time period, country borders were closed and flights were forbidden across the region. As such, the political and economic impact of the outbreak loomed large. Officials in WAHO called for the Assembly of Health Ministers to facilitate the creation of the ECOWAS CDC to support the national health systems of Sierra Leone, Guinea, and Liberia. Dr. Brito noted that the ECOWAS CDC had been in the works since 2009; however, it took the EVD outbreak to fast-track its implementation in 2016.[18]

The creation of the ECOWAS CDC follows an institutional trend in ECOWAS of creating new institutional spaces to facilitate linkages across a sometimes insular and disparate organisation. The novel ECOWAS CDC, an agency within WAHO, creates another opportunity for WAHO practitioners to expand their institutional space in ECOWAS and shape the rules of engagement, allowing them to acquire more agency. The creation and transformation of institutions provides an opportunity structure for practitioners to acquire and use agency despite the constraints of the overarching institutional structure. In this vein, intra-organisational linkages become crucial tools for practitioners in new institutional spaces. For instance, surveillance and early warning practitioners in the ECOWAS CDC will need to align and liaise with their counterparts in peace and security in order to incorporate institutional contexts to their technical roles.

Since the EVD response, WAHO has been more proactive about asserting the relevance of health across ECOWAS. WAHO has more of a direct presence with the Social and Humanitarian Affairs Directorate in the ECOWAS Commission and the previous Director-General of WAHO, Xavier Crespin, has worked in conjunction with the ECOWAS External Affairs Directorate to build more synergies with the ECOWAS member state liaisons and WAHO member state liaisons. Further, since the onset of COVID-19, WAHO officials and the Assembly of Health Ministers have been spearheading high-level regional co-ordination meetings to develop harmonised responses and preparedness approaches for ECOWAS member states.

Relatedly, social policy more broadly has been a crucial feature of ECOWAS' institutional agenda since the institutional transformation of the ECOWAS Secretariat to the ECOWAS Commission in 2007, particularly with the creation of the ECOWAS Political Affairs Peace and Security Commission or PAPS. Part of the strategic and practical activity of officials in PAPS during the response to the EVD was to assist in the co-ordination of monitoring and evaluation in member states to gather information about the spread of the virus, the behaviour of civilians, and the intersections of disease mitigation and peace and stability. The co-ordination between WAHO and PAPS was facilitated by ECOWAS' Early Warning Directorate (ECOWARN), which was previously housed in PAPS but now resides in External Affairs.

Intra-organisational linkages have been significant in the attempt by practitioners to make the health dynamics in the region intelligible and integral to regional governance. As such, the back-to-back health crises of Ebola and COVID-19 have thrust health into the front of the organisation's agenda, causing practitioners and other key decision-makers in the organisation to consider more directly how health implicates the peace and security of the sub-region.

Conclusion

This article considers three practical pathways through which officials in the WAHO community of practice acquire and use agency despite the recognised constraints of WAHO and ECOWAS: networking, inclusion of civil society, and creation of intra-organisational linkages. In practical pathways, we see the relationship among practices, the social contexts that inform them, and institutional change. Through their practices, WAHO officials become strategic agents within ECOWAS rather than passive actors completely constrained by others' political will and competing interests. WAHO's strategy of harmonising regional health governance deviates from conventional, highly centralised modes of decision-making in public health that rely on the capacities and agendas of state-led and/or hierarchal international organisations that prescribe interventions and reproduce power gaps between the global and the local (Riggirozzi and Yates, 2015). Such top-down public health frameworks often push particular norms and practical responses to public health crises that lack the proper regional contexts. For example, the global response to Ebola in West Africa highlighted the limits of a state-driven and global institution-driven health policy, which – if lacking an understanding of local contexts – can exacerbate the crises.

A focus on how practitioners acquire and use agency underscores the importance of the practical sense and autonomous nature of officials in regional communities. Further, a focus on the acquisition of agency helps explain how practices become embedded in the local levels of governance, through the networking and partnerships of social and political actors. It is through these practices that WAHO practitioners are able to transform the complexion of their institution and create an arena for regional health stakeholders to not only collaborate but also enhance their ability to work within and beyond the bounds of their own institution.

In focusing on WAHO, this article has focused on health, which is often perceived as a specialised, technical area. As such, it may be difficult to generalise about the practices. While the article highlights the ways in which WAHO officials frame public health as a cross-cutting issue area, in practice, these frames have not been widely embraced. Nonetheless, WAHO officials continue to stress the importance of making public health an area of broad organisational appeal in ECOWAS. Their strategy may be producing results. This appeal is evident in WAHO's handling of COVID-19. WAHO practitioners have been successful in securing resources for the region, particularly by seeking partnerships with the WHO, the African Union Centres for Disease Control, and other international research consortia to develop clinical trials and therapeutics for use on a compassionate basis (West African Health Organization, 2020). Similarly, the current

WAHO Director General, Dr. Stanley Okolo, has made it an institutional priority to embed and enhance the capacity of the ECOWAS CDC to supplement the work at the Africa CDC and strengthen collaborations from the sub-region and beyond. The willingness of the head of WAHO to insert the organisation and the work of the organisation more prominently in the public health landscape in Africa shows how practitioners use their autonomy from broader organisational structures to acquire agency and provide the space for other practitioners to use their agency to engage in regional health policy.

As ECOWAS' regional health infrastructure grows, one can point to the networks and strategies created and pursued by WAHO to highlight the drivers of regional health governance and trace the development of regional health practices over time. Identifying the WAHO community of practice as the driver of regional health governance takes the focus away from the state and/or global structures in measuring the effects of health governance and emphasises the processes of health network formation and the framing of regional health governance to measure the emergence of social and political practices related to health. In a broader context, WAHO officials and their process-driven network formation and capacity-building strategies offer important insights on the importance of the region in the context of African agency. The perspective offered here demonstrates the modes of agency and autonomy that global south regional organisations can have independently from their constitutive member state governments and stratifies the importance of regional stakeholders and their impact on regional health governance.

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Notes

1. Final Communique-Emergency Meeting of Ministers of Health of the Economic Community of West African States on the Preparedness and Response to the COVID-19 Virus Epidemic in China, 14 February 2020.
2. The WAHO Community of Practice is comprised of individuals who work exclusively for the West African Health Organisation, a specialised institution of ECOWAS. Members of WAHO are not political appointees; rather, they are procured from a professional class within

the sub-region. WAHO is headed by a director-general and comprises of six administrative units (strategic partnership/resource mobilisation, monitoring and evaluation, the ECOWAS Regional Centre for Disease Control, Communication, Legal, and Executive Assistant) and four directorates (Administration and Finance, Planning and Health Information, Public Health and Research, and Health Care Services).

3. All interviews were conducted in English, with the exception of five interviews with WAHO practitioners, which were conducted in English and French. All interviews were conducted in August 2018 and August 2019. Twenty interviews were conducted at the WAHO secretariat with WAHO Liaison Officers, officials in the ECOWAS Regional Surveillance Centre for Disease Control, ECOWAS Emergencies Workforce Database, directors in each of the Directorates, and finance officers. Ten interviews were conducted with officials from the United States Agency for International Development, Department for International Development in the United Kingdom, the West African Civil Society Institute, and the WHO Regional Office for Africa. One interview was conducted via Zoom, during the COVID-19 pandemic.
4. Interview, WAHO official, Bobo-Dioulasso, August 2018.
5. Interview, Social and Humanitarian Affairs Directorate Official, ECOWAS Commission, Abuja, August 2019.
6. Interview, Anonymous WAHO official, Bobo-Dioulasso, August 2019.
7. Interview, Chief Accountant, WAHO, Bobo-Dioulasso, August 2018.
8. Interview, WAHO official, Bobo-Dioulasso, August 2018.
9. Interview, WAHO member state liaison, Accra, August 2019.
10. Interview, WAHO official, Directorate of Public Health and Research, Bobo-Dioulasso, August 2018. For more on the misalignment of donor priorities in Africa, see Dionne (2017).
11. Interview, WAHO official, Accra, August 2019.
12. Interview, WAHO contracted health practitioner, Bobo-Dioulasso, August 2018.
13. Interview, WAHO Health Information System official, Bobo-Dioulasso, August 2018.
14. Interview, ECOWAS RCSDC official, Zoom Video Conference. July 2020.
15. West African Health Organisation Press Conference on ECOWAS COVID-19 Ministerial Coordination Committee on Health Virtual Meeting, 3 June 2020.
16. Interview, Dr. Kofi Busia, WAHO secretariat, Bobo-Dioulasso, August 2018. Interview, Dr. Carlos Brito, WAHO secretariat, Bobo-Dioulasso, August 2018.
17. While the agency was fast-tracked in 2016, the physical location was erected in Abuja in February 2018.

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Afrikanische Akteursqualität in der Praxis: Verwaltung und Institutioneller Wandel in der Westafrikanischen Gesundheitsorganisation

Zusammenfassung
In diesem Artikel wird die politisch autonome Akteursqualität der Westafrikanische Gesundheitsorganisation (WAHO) im Hinblick auf die Entwicklung einer regionalen Gesundheitspolitik untersucht. Viele prozessorientierte Darstellungen afrikanischer Agency konzentrieren sich auf die Freiheit und Fähigkeit afrikanischer Regierungen und regionaler Organisationen aktiv zu handeln. Dieser Artikel hingegen argumentiert, dass es notwendig ist, zu untersuchen, wie sich diese konstituieren und wie sie die Fähigkeit erwerben, eigenständige Akteure in ihren externen Beziehungen zu sein. Er zeigt, dass Funktionsträgerinnen und Funktionsträger innerhalb der WAHO drei institutionelle Strategien nutzen, die ihre Akteursqualität begründen: die Vernetzung mit außerregionalen Partnern, die Einbeziehung der Zivilgesellschaft in die regionale Sozialpolitik und die Entwicklung innerorganisatorischer Verflechtungen, um politische Kontrolle von außen einzudämmen. Durch diese strategischen Interaktionen konstituieren sich die Offiziellen innerhalb der

WAHO als autonome Akteure sowohl innerhalb der Organisation als auch im breiteren globalen Gesundheitsbereich.

Schlagwörter
Afrika, Akteursqualität, globale Gesundheitspolitik, ECOWAS, Praktiken