EUROPEAN COMMISSION

DIRECTORATE-GENERAL FOR HUMANITARIAN AID - ECHO

Humanitarian Aid Decision

23 02 01

Title: Humanitarian aid to populations affected by epidemics in West Africa

Location of operation: WESTERN AFRICA

Amount of decision: EUR 1,500,000

Decision reference number: ECHO/-WF/BUD/2005/02000

Explanatory Memorandum

1 - **Rationale, needs and target population**:

1.1. - Rationale:

Between January and August 2004 the World Health Organization (WHO) reported for West Africa : 15,887 cases of meningitis, most of them in Burkina Faso; 119 cases of yellow fever (13 deaths), most of them (92 cases) in Côte d'Ivoire; and 16,865 cases of cholera in several countries. The threat posed by epidemics is that their transmission by definition increases the number of cases and the case-fatality rate (mortality specific to a given disease), hence the number of deaths. Early and effective action is required to reduce the morbidity and mortality related to outbreaks. Local reaction by national authorities in West Africa is inadequate as budgets prioritize "regular" diseases to the detriment of potential epidemics. Furthermore, it is known that in emergencies, in countries in conflict or structurally weak countries, communicable diseases, alone or in combination with malnutrition, account for most deaths.

In recent years, ECHO has been supporting emergency projects that respond to outbreaks of communicable diseases in West Africa. One lesson learned is that, on most occasions, it is very difficult to determine a specific date that would trigger emergency procedures, such as a Primary Emergency Decision. ECHO's experience in the region shows that every year ECHO spends at least EUR 1,500,000 reacting to the most important epidemics; thus a yearly level of expenditure can be anticipated justifying the preparation of a humanitarian aid decision to help those affected by epidemics in West Africa. Reaction to epidemics is particularly needed in West Africa due to the high incidence of epidemics there. Initial effective experience with the epidemic decision for West Africa may lead to it being applied to other areas of Africa.

ECHO implemented a decision (ECHO/-WF/BUD/2004/02000) for EUR 1 million for epidemic response in West Africa in 2004. Meningitis response was supported in Burkina Faso and Chad. The incidence of cholera has been unusually high over a wide area, being an indicator of generally poor sanitation in West Africa. ECHO supported cholera reaction in several African capitals: N'Djamena, Conakry, Freetown. Other funding for epidemic mitigation included reactions to yellow fever in Burkina Faso, to hepatitis E in Chad and to a measles epidemic of suspected higher case-fatality rate in Niger. Cholera outbreaks in Mali, Niger, and Senegal did not require external support. A cholera epidemic in Togo was supported by the EU as part of an ongoing health project, without ECHO's support. Cholera trends were followed but no action was specifically funded in Nigeria, Guinea-Bissau, Ghana, Liberia and Côte d'Ivoire. Additional funding was granted as planned to WHO/GOARN for rapid assessment of epidemics for the whole West Africa region. Lassa fever was managed with alternative funds (ECHO West Africa Global Plan 2004, DFID, WHO, UN, MoH, other donors) in Sierra Leone, Liberia and Nigeria.

Polio expanded explosively during 2004 from 2 countries in Africa to 12 (most of them in West Africa), prompting a massive international reaction in which ECHO participated with resources from the 2004 Coastal West Africa Global Plan. The experiences of those projects were reported in the West Africa Health Organization (WAHO/OOAS) meeting to plan for regional epidemic response.

During 2004 epidemics in West Africa were relatively small (the expected major meningitis outbreak did not occur). Thereforeso the epidemic decision was sufficient and did not require a continuation with the B envelope of the European Development Funds (EDF). At the same time ECHO is coordinating and assisting longer term initiatives to reinforce the local capacity of response, particularly to a West Africa plan for epidemic response with a 5 year EU funding from the EUR 15 million Regional West Africa Health Program, with 9th EDF funds. A strategic partnership on health and development between the EC and WHO was signed July 2004. It includes, amongst its priorities, the support to strengthen local capacities to respond to epidemics and refers particularly to meningitis epidemics.

Meningitis is endemic in West Africa. Every year there is a surge of cases during the first five months of the year. In some years, the surge reaches epidemic proportions, as reflected in the WHO statistics. During the period 1996-1997, 278,966 cases were reported with 21,830 deaths in West African countries. According to the Centre for Disease Control (CDC), epidemics of meningitis in Africa have an incidence of up to 2% of the population with an estimated 10%-15% of cases being fatal. Around 10%-15% of patients that recover suffer permanent hearing loss, mental retardation or other serious consequences. According to the same authoritative source the following trends can be expected: "devastating epidemics will continue to occur in countries throughout the African meningitis belt (going from Senegal to Ethiopia) and cause the emergence of epidemics due to a new sero-group in Africa".

The age group most affected by meningococcal meningitis includes children and adolescents, who in this region represent the majority of the population. The most affected area is the savannah region that lies between the Sahara desert and the coastal rainforest-lands. The most affected countries are Burkina-Faso, Mali, Chad, Niger and Nigeria, but outbreaks can occur in any other country of the region. The highest risk is from January to May, which corresponds to the dry season.

Universal prevention to avoid outbreaks of meningitis is not a realistic option as the immunization provided by the vaccine lasts for a short period (2 to 3 years). Therefore, there has to be a response to each epidemic in order to limit its spread and to mitigate morbidity

and mortality. Sero-group A and C of Neisseria meningitidis are the main causes of epidemic meningococcal meningitis in most countries, although serogroup W135 is becoming increasingly prevalent in sub-Saharan Africa. The classic vaccine A/C is unable to stop the spread of the W135 strain. A new A/C/W135 vaccine is now available but, according to WHO, in limited quantities.

Epidemics of **yellow fever** are increasing in West Africa. Only Africa and South America are affected by yellow fever. Outbreaks became rare in Africa between 1950 and 1990, possibly due to the large immunisation coverage reached in the fifties. Since the 90s, outbreaks of yellow fever are on the increase. The extreme case-fatality rate of this hemorrhagic fever justifies a prompt and firm reaction to outbreaks in order to avoid major health threats.

Areas most affected by yellow fever are the humid savannah regions of West and Central Africa during the rainy season. Cases occur between latitude 15° North and 10° South. There are no clear-cut gender or age group limitations. Outbreaks occur occasionally in urban areas in Africa and, to a lesser extent, in jungle regions. Historical data shows that during an epidemic up to 30% of an urban population can be affected whilst case mortality rates can reach 50%.

Vaccination is highly effective for the prevention and the control of yellow fever epidemics as the protection provided by the protein vaccine is high, fast and is believed to last for more than 35 years. Theoretically yellow fever immunization is slowly being integrated into many West African countries' Extended Programmes of Immunization, but this is hampered by the high cost of the vaccine. Increased coverage would reduce the current upward morbidity trend, although the required coverage will probably not be attained during the next decade.

Cholera manifests itself as acute watery diarrhoea frequently accompanied by vomiting, circulatory collapse and shock. Between 25 and 50% of cholera cases are fatal, if untreated. Appropriate treatment leads to mortalities below 1-2%. Cholera epidemics are a sign of poverty and lack of basic sanitation facilities.

Cholera appears worldwide and is very common in West Africa, where it was introduced in the 1970's. Recurrent outbreaks of cholera in the region are compounded by large population movements prompted by conflict and insufficient sanitation facilities e.g. the outbreak in Monrovia, Liberia, from June to August 2003 during fighting in the capital.

There is no geographical, gender or age limitation for cholera. Cholera case-fatality rate in Africa is the highest in the world (estimated at 5%).

Measles is a common disease that produces higher case-fatality rate among displaced populations, in particular when the immunization coverage has decreased (usually the case in war-affected areas). Measles is common among young children but it is even more severe when it appears among adolescents or adults. In tropical areas outbreaks of measles usually take place during the dry season. The case-fatality rate is 3-5% in developing countries but can reach 30% under certain conditions (e.g. malnutrition, displacement, dense concentrations of people, etc).

Outbreaks of other communicable diseases such as **viral hemorrhagic fevers** (e.g. **Lassa Fever, Ebola**...) or **Shigellosis** may also appear in West Africa, requiring immediate action. Although viral hemorrhagic fevers cause fewer cases and deaths than other communicable diseases, their high fatality rate and massive psychological effects in the affected communities can be devastating. **Emerging and dangerous pathogens** are a global threat today and fear of SARS extension prompted new practices in air travel in West Africa.

Hepatitis E affected Sudanese refugee and Chadian local populations in Chad in 2004. Reversing a decade long tendency, **Polio** expanded explosively during 2004 from 2 countries in Africa (Nigeria and Niger) to 12. **Malaria**, one of the most common causes of death in Africa, is not an object of this particular decision when it is endemic. However, in some circumstances, particularly in mountainous countries, Malaria could become an epidemic well above the usual tendencies.
The epidemic season in West Africa varies according to the disease. Most Meningitis epidemics are reported between January and May; Yellow Fever outbreaks generally occur between June and November.

1.2. - Identified needs:

Between January 1st 2001 and December 8th 2004, WHO's Outbreak Verification team identified 424 epidemic events in 40 sub-saharan African countries, 164 (38.7%) of them in the 17 West Africa countries and verified 131 of the West Africa events. The 164 epidemic events reported in West Africa concerned the following diseases and countries:

	Number of events Africa	Number of events WA
Meningococcal Disease	49	29
Cholera	128	38
Yellow Fever	24	20
Acute Watery Diarrhoeal Syndrome	22	10
Unknown	33	10
Acute Hemorrhagic Fever Syndrome	42	14
Others	126	43
Total	424	164

Source WHO Global Alert and Response sector.

Country	Number of events	Percentage
Benin	8	4.9
Burkina Faso	12	7.3
Chad	10	6.1
Cote d'Ivoire	14	8.5
Gambia	5	3.1
Ghana	13	7.9
Guinea	8	4.9
Guinea-Bissau	2	1.2
Liberia	12	7.3
Mali	2	1.2
Mauritania	5	3.1
Niger	13	7.9
Nigeria	40	24.4
Senegal	7	4.3
Sierra Leone	9	5.5
Togo	4	2.4
Cape Verde	0	0
Total	164	100

Source WHO Global Alert and Response sector.

It is essential to respond not just to large-scale outbreaks already reporting high mortality rates, but also to smaller ones before they escalate, as an early, small, comparatively cheap and fast reaction can often effectively contain and control the epidemic.

The faster the response to an outbreak of communicable disease, the smaller the overall cost of bringing it under control. However history shows that, financial contributions in the early stages of an epidemic have usually been insufficient or arriving late, with the result that the outbreak develops into a major disaster.

1.3. - Target population and regions concerned:

The targeted population will be people affected by epidemics of communicable diseases in the West Africa region (Benin, Burkina Faso, Cape Verde, Chad, Côte d'Ivoire, The Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, and Togo). The potential target population is estimated at over 200 million. The entire population of West Africa is at risk from the above mentioned diseases, regardless of gender, age or location (see point 1.1. for disease-specific epidemic patterns). However, children are the most vulnerable group. The number of direct beneficiaries will vary but can easily reach 400, 000 people.

1.4. - Risk assessment and possible constraints:

In the event of large-scale outbreaks, with funding requests exceeding the amount foreseen provided for in this decision, additional resources might be required. The funds made available by this decision will be used exclusively to provide the necessary capacity for the early management of smaller-scale outbreaks.

The medicines and vaccines necessary to control most epidemics exist but are not always available when needed; there is a great risk of running short of vaccines as production, and research for new alternatives, is limited to diseases that most commonly affect people and provide a commercial benefit to the producer. In case of an acute shortage, the focus will shift from morbidity and mortality control to mortality mitigation, while at the same time encouraging additional production.

External support to epidemic response does save lives but may decrease the pressure to develop autonomous responses. External support needs an enlightened approach to the local capacities and it should be strengthening in order not to weaken the local capacity of response.

Coordination among countries and among agencies has been a problem for generating an appropriate reaction in the past. Close and regular coordination with WHO and other specialised agencies is however required since early and qualified assessments are essential.

2- Objectives and components of the humanitarian intervention proposed:

2.1. – Objectives:

Principal objective :
Morbidity, expansion and mortality rates related to epidemics in West Africa are reduced.

The expected outcome is lower mortality related to epidemics. The main indicator of success is case-fatality rate (i.e. specific case mortality rates) which should be within internationally recognized thresholds.

Given the well-known effect of appropriate response to reducing mortality and preventing the spread of epidemics, appropriate and timely action may be used as a proxy indicator. The trend that an outbreak would have followed if there had been no action cannot indeed be known with certainty and therefore cannot be used as an indicator.

Specific objectives :

- Reported outbreaks are rapidly assessed by qualified personnel
- Confirmed epidemics are contained and controlled

2.2. - Components:

Assessment: Early, qualified and rapid assessment in order to assist adoption of timely decisions for health intervention and priority funding.

Response : Provision of effective medicines to most affected people, prevention of additional cases and control of potential expansion through immunisation, awareness campaigns and water and sanitation activities.

3 - Duration of actions within the framework of the proposed decision:

The duration for the implementation of this decision will be 15 months**.** The starting date of the decision is 15 April 2005**.** Humanitarian operations funded by this decision must be implemented within this period.

Expenditure under this Decision shall be eligible from 15 April 2005. The previous decision to respond to epidemics in West Africa (ECHO/-WF/BUD/2004/02000) will end on 31 March 2005 and all funds have already been allocated. The adoption of this new decision will permit an immediate response to new epidemics covering the most immediate needs.

If the implementation of the actions envisaged in this decision is suspended due to *force majeure* or any comparable circumstance, the period of suspension will not be taken into account for the calculation of the duration of the decision.

Depending on the evolution of the situation in the field, the Commission reserves the right to terminate the agreements signed with the implementing humanitarian organisations where the suspension of activities is for a period of more than one third of the total planned duration of the action. In this respect, the procedures established in the general conditions of the specific agreement will be applied.

4 –Previous interventions/decisions of the Commission (ECHO) within the context of the crisis concerned

	2002		2003		2004	
Country	**Subject**	**Amount**	**Subject**	**Amount**	**Subject**	**Amount**
BURKINA FASO	meningitis	175 000	Meningitis	75 000	Meningitis/ yellow fever	139 846
			Meningitis	600 000		
CÔTE D'IVOIRE						
GUINEE	Yellow fever	320 000	Yellow fever	70 000	Cholera	61 992
LIBERIA	cholera	150 000				
MALI			Cholera	500 000		
NIGER			Meningitis/ measles	245 000	Measles	100 000
SENEGAL	Yellow fever	750 000				
SIERRA LEONE					Cholera	100 000
CHAD	Cholera	230 000			Cholera	168 991
					Hepatitis E	228 295
West Africa					Assessment	80 000
MANO REGION					Polio	400 000
Sub-Total		**1 625 000**		**1 490 000**		**1 297 124**

Source: ECHO/1.

List of previous ECHO operations in BENIN/BURKINA FASO/COTE D'IVOIRE/CAPE VERDE/GHANA/GUINEA/GAMBIA/GUINEA-BISSAU/LIBERIA/MALI/MAURITANIA/NIGER/NIGERIA/SENEGAL/SIERRA LEONE/CHAD/TOGO

		2003	2004	2005
Decision number	Decision type	EUR	EUR	EUR
ECHO/LBR/EDF/2004/01000	Non Emergency		4,300,000	
ECHO/MLI/210/2003/01000	Emergency	500,000		
ECHO/TCD/210/2003/01000	Emergency	2,000,000		
ECHO/TCD/BUD/2004/01000	Non Emergency		4,000,000	
ECHO/TCD/EDF/2004/02000	Non Emergency		8,000,000	
ECHO/-WF/BUD/2004/02000	Non-Emergency		1,000,000	
ECHO/-WF/BUD/2004/01000	Global Plan		18,000,000	
ECHO/-WF/BUD/2005/01000	Global Plan			25,000,000
ECHO/TPS/210/2003/01000	Global Plan	16,000,000		
	Subtotal	18,500,000	35,300,000	25,000,000
	TOTAL			78.800.000

Dated : 16/02/2005
Source : HOPE

The European Commission also provides structural, preventive and long -term support to tackle epidemiological problems in the region considered. Co-ordination and synergies with epidemic response preparedness under these programmes (regional programme "d'appui au renforcement de l'indépendance vaccinale en Afrique", West Africa Regional Strategy) have been sought and will continue, in order to complement, to avoid duplication and to gradually ensure country and regional ownership. The West Africa EUR 15 million Regional Health Program from the 9th EDF will support the strengthening of regional capacity of reaction to epidemics but even if the program is approved it is yet to start. ECHO epidemic decision, whilst directed towards emergency, will precede, complement and act as safeguard to the 9th EDF program.

5 - Other donors and donor co-ordination mechanisms

Donors in BENIN/BURKINA FASO/COTE D'IVOIRE/CAPE VERDE/GHANA/GUINEA/GAMBIA/GUINEA-BISSAU/LIBERIA/MALI/MAURITANIA/NIGER/NIGERIA/SENEGAL/SIERRA LEONE/CHAD/TOGO the last 12 months

1. EU Members States (*)	EUR	2. European Commission	EUR	3. Others	EUR
Austria	0	ECHO	44,942,857		
Belgium	1,000,000	Other services			
Denmark	5,179,880				
Finland	2,680,000				
France	8,284,457				
Germany	18,562,781				
Greece	0				
Ireland	3,421,933				
Italy	0				
Luxembourg	583,728				
Netherlands	7,692,712				
Portugal	255,000				
Spain	0				
Sweden	5,623,620				
United Kingdom	15,838,617				
Subtotal	69,122,728	Subtotal	44,942,857	Subtotal	0
		Grand total	114,065,585		

Dated : 16/02/2005
(*) Source : ECHO 14 Points reporting for Members States. https://hac.cec.eu.int
Empty cells means either no information is available or no contribution.

The US government is also providing preventive and long-term assistance in the field of epidemics. The GAVI (Global Alliance for Vaccines and Immunization) is actively involved in the introduction of new vaccines and private foundations, e.g. The Bill & Melissa Gates Foundation, are also supporting prevention, treatment and control of epidemics in West Africa and in other regions.

The main coordination group for meningitis and yellow fever epidemic response is the ICG (International Coordination Group), which includes WHO, Unicef, MSF and the Red Cross. The WHO Global Alert and Response sector is a key partner.

The West African Health Organization is working to build a three-year epidemic response strengthening plan that permitted the creation of an informal network that put together, physically and by e-mail, the epidemiological surveillance sectors of West Africa Ministries of Health and other actors including ECHO. The 9th EDF will provide funds (EUR 15 million) for a Regional West Africa Health Program during 5 years starting in 2005. A major component of this program is the strengthening of a regional capacity of response.

6 –Amount of decision and distribution by specific objectives:

6.1. - Total amount of the decision: EUR 1,500,000

6.2. - Budget breakdown by specific objectives

Principal objective: *Morbidity, expansion and mortality rates related to epidemics in West Africa are reduced*				
Specific objectives	**Allocated amount by specific objective (EUR)**	**Possible geographical area of operation**	**Activities**	**Potential partners**[1]
Specific objective 1: Reported outbreaks are rapidly assessed by qualified personnel	120,000	Benin, Burkina Faso, Cape Verde, Chad, Côte d'Ivoire, The Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone and Togo		- ACF - FRA - ACH- ESP - CROIX-ROUGE - FICR-IFCR-CH - IRC - UK - MDM - FRA - MERLIN - MSF - BEL - MSF - CHE - MSF - ESP - MSF - FRA - MSF - NLD - PSF - FRA/CLERMONT-FERRAND - UN - UNICEF - BEL - WHO - OMS
Specific objective 2: Confirmed epidemics are contained and controlled	1,380,000	Benin, Burkina Faso, Cape Verde, Chad, Côte d'Ivoire, The Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone and Togo		- ACF - FRA - ACH- ESP - CROIX-ROUGE - FICR-IFCR-CH - IRC - UK - MDM - FRA - MERLIN - MSF - BEL - MSF - CHE - MSF - ESP - MSF - FRA - MSF - NLD - PSF - FRA/CLERMONT-FERRAND - UN - UNICEF - BEL - WHO - OMS
TOTAL	1,500,000			

[1] ACCION CONTRA EL HAMBRE, (ESP), ACTION CONTRE LA FAIM, (FR), ARTSEN ZONDER GRENZEN (NLD), FEDERATION INTERNATIONALE DES SOCIETES DE LA CROIX-ROUGE ET DU CROISSANT ROUGE, International Rescue Committee UK, MEDECINS DU MONDE, MEDECINS SANS FRONTIERES (CHE), MEDECINS SANS FRONTIERES (F), MEDECINS SANS FRONTIERES BELGIQUE/ARTSEN ZONDER GRENZEN BELGIE(BEL), MEDICAL EMERGENCY RELIEF INTERNATIONAL (GBR), MEDICOS SIN FRONTERAS, (E), PHARMACIENS SANS FRONTIERES COMITE INTERNATIONAL, UNICEF, WORLD HEALTH ORGANISATION - ORGANISATION MONDIALE DE LA SANTE

7 –Evaluation

Under Article 18 of Council Regulation (EC) No 1257/96 of 20 June 1996 concerning humanitarian aid the Commission is required to "regularly assess humanitarian aid operations financed by the Community in order to establish whether they have achieved their objectives and to produce guidelines for improving the effectiveness of subsequent operations." These evaluations are structured and organised in overarching and cross-cutting issues forming part of ECHO's Annual Strategy such as child-related issues, the security of relief workers, respect for human rights, gender. Each year, an indicative Evaluation Programme is established after a consultative process. This programme is flexible and can be adapted to include evaluations not planned as part of the initial programme, in response to particular events or changing circumstances. More information can be obtained at:

http://europa.eu.int/comm/echo/evaluation/index_en.htm.

8 –Budget impact article 23 02 01

	CE (in EUR)
Initial Available Appropriations for 2005	476.500.000
Supplementary Budgets	
Transfers	
Reinforcement from Emergency aid reserve	100.000.000
Total Available Appropriations	**576.500.000**
Total executed to date (as at 10/03/2005)	344.291.734
Available remaining	232.208.266
Total amount of the Decision	**1,500,000**

COMMISSION DECISION

of

on the financing of humanitarian operations from the general budget of the European Union in
WESTERN AFRICA

THE COMMISSION OF THE EUROPEAN COMMUNITIES,

Having regard to the Treaty establishing the European Community,
Having regard to Council Regulation (EC) No 1257/96 of 20 June 1996 concerning humanitarian aid,[2] and in particular Article 15(2) thereof,

Whereas:

(1) West Africa is affected by recurrent epidemics of communicable diseases, which result in great suffering and loss of life.

(2) Chronic armed conflict in the region and the generally precarious economic and environmental context exacerbate the threat posed by these epidemics.

(3) The World Health Organisations (WHO) has reported the presence of a new, more virulent strain of meningitis, an increase in the scale of epidemics and, consequently, an increase in the number of cases and deaths.

(4) Due to the recurrence of outbreaks on a seasonal basis, it is possible to plan assessments and responses ahead of expected outbreaks.

(5) It is essential to respond to outbreaks of communicable disease, irrespective of their magnitude, in order to reduce morbidity, expansion and mortality rates related to epidemics in West Africa.

(6) An assessment of the humanitarian situation leads to the conclusion that humanitarian aid operations should be financed by the Community for a period of 15 months.

(7) It is estimated that an amount of EUR 1,500,000 from budget line 23 02 01 of the general budget of the European Union is necessary to provide humanitarian assistance to over 400 000 people affected by epidemics, taking into account the available budget, other donors' interventions and other factors.

HAS DECIDED AS FOLLOWS :

Article 1

1. In accordance with the objectives and general principles of humanitarian aid, the Commission hereby approves a total amount of EUR 1,500,000 for humanitarian aid operations to populations affected by epidemics in West Africa by using heading 23 02 01 of the 2005 general budget of the European Union.

[2] OJ L 163, 2.7.1996, p. 1-6

2. In accordance with Article 2 of Regulation (EC) No.1257/96, the humanitarian operations shall be implemented in the pursuance of the following specific objectives:

   - Reported outbreaks are rapidly assessed by qualified personnel
   - Confirmed epidemics are contained and controlled

The amounts allocated to each of these objectives are listed in the Annex to this decision.

Article 2

The Commission may, where this is justified by the humanitarian situation, re-allocate the funding levels established for one of the objectives set out in Article 1(2) to another objective mentioned therein, provided that the re-allocated amount represents less than 20% of the overall amount covered by this Decision.

Article 3

1. The duration for the implementation of this decision shall be for a maximum period of 15 months, starting on 15 April 2005.

2. Expenditure under this Decision shall be eligible from 15 April 2005.

3. If the operations envisaged in this Decision are suspended owing to *force majeure* or comparable circumstances, the period of suspension shall not be taken into account for the calculation of the duration of the implementation of this Decision

Article 4

This Decision shall take effect on the date of its adoption.

Done at Brussels,

For the Commission

Member of the Commission

Annex: Breakdown of allocations by specific objectives

Principal objective : Morbidity, expansion and mortality rates related to epidemics in West Africa are reduced	
Specific objectives	**Amount per specific objective (EUR)**
Reported outbreaks are rapidly assessed by qualified personnel	120,000
Confirmed epidemics are contained and controlled	1,380,000
TOTAL	1,500,000

Grants for the implementation of humanitarian aid within the meaning of Council Regulation (EC) No 1257/96 of 20 June 1996 concerning humanitarian aid are awarded in accordance with the Financial Regulation, in particular Article110 thereof, and its Implementing Rules in particular Article168 thereof. [3]

Rate of financing: In accordance with Article 169 of the Financial Regulation, grants for the implementation of this Decision may finance 100% of the costs of an action.

Humanitarian aid operations funded by the Commission are implemented by NGOs and the Red Cross organisations on the basis of Framework Partnership Agreements (FPA) (in conformity with Article 163 of the Implementing Rules of the Financial Regulation) and by United Nations agencies based on the Financial and Administrative Framework Agreement (FAFA). The standards and criteria established in Echo's standard Framework Partnership Agreement to which NGO's and International organisations have to adhere and the procedures and criteria needed to become a partner can be found at

http://europa.eu.int/comm/echo/partners/index_en.htm

[3] Council Regulation (EC, Euratom) No 1605/2002 of 25 June 2002, , OJ L248 of 16/09/2002 and No 2342/2002 of 23 December 2002, OJ L 357 of 31/12/2002.