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COMMISSION OF THE EUROPEAN COMMUNITIES

Brussels,
C(2008) final

Draft

COMMISSION DECISION

of

**on the financing of emergency humanitarian actions from the general budget of the
European Communities in West Africa**

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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 aid¹, and in particular Article 2 (a) and Article 13 thereof,

Whereas:

- (1) Several West African countries², particularly Nigeria, Niger and Liberia, are affected by recurrent epidemics of communicable diseases, which result in great suffering and loss of life.
- (2) Poverty, lack of basic sanitation facilities and low hygienic standards increase vulnerability to communicable diseases and enhance the transmission of infections in this context (chronic malnutrition crisis, post crisis recovery period).
- (3) Currently epidemic outbreaks, in particular of measles, meningitis and yellow fever are reported and confirmed in Nigeria, Niger, and Liberia.
- (4) Considering that epidemic thresholds have been reached and the epidemics situation is out of authorities' control, outbreaks of communicable diseases shall be addressed, in order to reduce morbidity, expansion and mortality rates related to epidemics in West African countries.
- (5) Humanitarian aid operations financed by this Decision should be of a maximum duration of 6 months.
- (6) It is estimated that an amount of EUR 1,000,000 from budget line 23 02 01 of the 2008 general budget of the European Communities is necessary to prevent the transmission of infections and treat those already affected.
- (7) The present Decision constitutes a financing Decision within the meaning of Article 75 of the Financial Regulation (EC, Euratom) No 1605/2002³, Article 90 of the detailed rules for the implementation of the Financial Regulation determined by

¹ OJ L 163, 2.7.1996, p 1-6. Regulation as amended by Regulation (EC, Euratom) No. 1882/2003, OJ L 284, 31.10.2003, p. 1

² West African countries include: Mauritania, Senegal, Mali, Guinea Bissau, Guinea Conakry, Sierra Leone, Liberia, Ivory Coast, Burkina Faso, Niger, Ghana, Togo, Benin, Nigeria and Chad

³ OJ L 248, 16.9.2002, p. 1. Regulation as last amended by Regulation (EC, Euratom) No. 1995/2006, OJ L 390, 30.12.2006, p.1 and by Regulation (EC, Euratom) No. 1525/2007 of 17.12.2007, OJ L 343 of 27.12.2007, p 9

Regulation (EC, Euratom) No 2342/2002⁴, and Article 15 of the Internal Rules on the Implementation of the general budget of the European Communities⁵

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 1,000,000 for emergency humanitarian aid operations to reduce morbidity and mortality rates related to epidemics by using line 23 02 01 of the 2008 general budget of the European Communities.
2. In accordance with Article 2(a) of Council Regulation No.1257/96, the humanitarian operations shall be implemented in pursuance of the following specific objective:
To contribute to ensuring an adequate response to sudden major threats to public health, such as the on-going epidemics with a potential trans-national impact.

The total amount of this Decision is allocated to this objective.

Article 2

1. The implementation of humanitarian aid operations funded by this Decision shall have a maximum duration of 6 months from their starting date.
2. Expenditure under this Decision is eligible from 15 March 2008.
3. If the operations envisaged in this Decision are suspended due to *force majeure* or comparable circumstances, the period of suspension will not be taken into account for the calculation of the duration of the humanitarian aid operations.

Article 3

1. The Commission shall implement the budget by direct centralised management or by joint management with international organisations.
2. The actions supported by this Decision will be implemented by humanitarian aid organisations that are signatories to the Framework Partnership Agreements (FPA) or the EC/UN Financial Administrative Framework Agreement (FAFA).
3. Taking in account the specificities of humanitarian aid, the nature of the activities to be undertaken, the specific location constraints and the level of urgency, the activities covered by this Decision may be financed in full in accordance with Article 253 of the Implementing Rules of the Financial Regulation.

⁴ OJ L 357, 31.12.2002, p. 1. Regulation as last amended by Regulation (EC, Euratom) No 478/2007, OJ L 111 of 28.4.2007 p. 13

⁵ Commission Decision of 5/03/2008, C/2008/773

Article 4

The Decision shall take effect on the date of its adoption

Done at Brussels,

For the Commission

Member of the Commission



Emergency Humanitarian Aid Decision
23 02 01

Title: Responding to epidemics in West African countries

Location of operation: West Africa

Amount of Decision: EUR 1,000,000

Decision reference number: ECHO/-WF/BUD/2008/03000

Explanatory Memorandum

1. – Rationale, needs and target population.

1.1. – Rationale:

Communicable diseases are highly endemic in African countries and West Africa is no exception. On the continent, World Health Organization (WHO) declares more than two new epidemic outbreaks each week. This is due to a number of reasons, including the high burden of endemic and epidemic-prone diseases; the existence of concurrent and complex emergencies resulting from natural disasters and/or conflict, increasing the vulnerability to infectious diseases and reducing the ability of countries to respond to public health risks, especially if pre-existing health systems are poorly resourced. The vaccination coverage of the populations is generally low and the risk of transmission of infections is thus enhanced. Poverty, lack of basic sanitation facilities, low hygienic standards and malnutrition in post-emergency or structurally weak countries increase the vulnerability to communicable diseases.

Meningitis, measles, cholera, and various viral hemorrhagic fevers are responsible for major epidemics in African countries, and outbreaks of these diseases have accounted for over 50% of all outbreaks notified by the WHO in the last four years.

Epidemics pose great risks to the health, lives and livelihoods of people in the region with increasing risk of international spread.

Meningitis is an infection of the membranes encompassing the brain, and is caused by the bacteria *Neisseria meningitidis*, which are transferred by direct person-to-person contact. Susceptibility to meningitis decreases with age – children and adolescents hence constituting the most vulnerable groups.

Meningitis presents a sudden onset of intense fever, nausea and vomiting, plus various neurological signs. The disease is fatal within 24-48 hours in about 50% of those untreated, and even with prompt medical treatment the disease is fatal in 5 to 10% of all cases. Among individuals who survive, up to 20% have permanent brain damage.

Sub-groups A and C of *Neisseria meningitidis* are the main causes of epidemic outbreaks of meningitis. In Africa, 90% of outbreaks are caused by sub-group A, however there is increasing evidence that considerable sized outbreaks are caused by a different sub-group, the W135. Classical meningitis vaccines, which provide protection against infection with sub-groups A and B, do not protect against infection with sub-group W135. The protection provided by classical vaccines through standard mass vaccination campaigns lasts for a period of 2 to 3 years and cannot guarantee universal prevention. Every outbreak must hence be contained in order to mitigate morbidity and mortality.

Measles is one of the most contagious diseases known. Almost all non-immune children contract this respiratory disease if exposed to the virus. Measles is an acute illness caused by a virus in the paramyxovirus family. The first sign of infection is usually high fever, which begins approximately 10 to 12 days after exposure and lasts one to seven days. During the initial stage, the patient may develop a runny nose, cough, red and watery eyes and small white spots inside the cheeks. After several days, a rash develops, usually on the face and upper neck. Over a period of about three days, the rash spreads, eventually reaching the hands and feet. The rash lasts for five to six days, then fades. The rash occurs, on average, at day 14 after exposure to the virus, with a range of seven to 18 days.

Severe measles is particularly likely in poorly nourished young children, especially those who do not receive sufficient vitamin A, or whose immune systems have been weakened by HIV/AIDS or other diseases. Children usually do not die directly of measles, but from its complications. Vaccination has had a major impact on measles deaths.

Cholera is an acute intestinal infection caused by the bacterium *Vibrio cholerae*. It occurs through ingestion of food or water contaminated directly or indirectly by faeces or vomit of infected persons. The resulting disease varies in intensity – in mild cases, diarrhoea may occur without other symptoms. But acute watery diarrhoea is frequently accompanied by nausea and vomiting, rapid dehydration and circulatory collapse. Between 25 and 50% of cholera cases are fatal, if untreated. But appropriate treatment can reduce mortality rates to below 1-2%.

There is no geographical, gender or age limitation for cholera infection. Large population movements prompted by conflicts, combined with insufficient sanitation facilities facilitate the extension of the disease. The cholera case-fatality rate in African countries is typically 5% – which is the highest in the world.

Viral hemorrhagic fevers (VHF) are infections with different groups of viruses, which are characterized by their potential of giving rise to often lethal bleedings in internal organs and from the mucosa (mouth, stomach, intestines, anus). They are transmitted either from person-to-person or via contact with contaminated human or animal bodily fluids (**Ebola fever, Marburg fever, Rift Valley fever and Lassa fever**), or through bites from infected insects (**Yellow fever, Dengue fever, Rift Valley fever**).

Although VHFs overall cause fewer cases and deaths than other communicable diseases, their high fatality rate and massive psychological effects upon the affected communities require immediate action.

Marburg fever is a severe and highly fatal VHF caused by a virus of the same family as the Ebola virus. These viruses are among the most potent viruses known to infect humans. Both diseases are rare, but have the capacity to cause dramatic outbreaks with high fatality. Marburg illness begins abruptly, with severe headache and malaise, and many patients develop internal bleedings between days 5 and 7 after onset of the disease. There is no vaccine available for the disease and there is no specific treatment. Case fatality rates have varied greatly, from 25% in the initial laboratory-associated outbreak in 1967, to more than 80% in the Democratic Republic of Congo from 1998-2000, and even higher in the outbreak that began in Angola in late 2004.

Ebola fever is a VHF caused by the Ebola virus, which is transmitted by direct contact with blood, secretions, or other bodily fluids of infected persons. The disease is characterized by a sudden onset of fever, intense weakness, muscle pain, headache and sore throat. This is often followed by vomiting, diarrhoea, skin rash, impaired kidney and liver function, and in some cases, both internal and external bleeding. No specific treatment or vaccine is available for Ebola Fever. Several vaccine candidates are being tested but it could be years before any are available.

Yellow fever is a VHF transmitted through the bite of infected *Aedes aegypti* mosquitoes. Infection leads to an acute illness characterized by fever, nausea and/or vomiting. Thereafter, about 15% of patients develop jaundice and internal bleedings. The high case-fatality rate of this disease – up to 50% – requires a prompt containment in order to avoid major public health threats.

Vaccination against Yellow fever is highly effective for the prevention and the control of epidemics. WHO recommends that Yellow fever immunization should be integrated into the Extended Program of Immunization (EPI) of many African countries, but this is hampered by the high cost of the vaccine. Even though the recommended coverage will probably not be reached during the next decade, an increased coverage will reduce the current upward morbidity trend of the disease.

Most African countries still need external support to respond in a timely manner and/or to prevent recurrent epidemics. Outbreak detection and control intervention have been improved in certain countries mainly due to better epidemic surveillance and Early Warning Systems but the availability of donor support has been reduced and governments' contingency plans are rare or not sufficiently funded. Health systems do not have either the capacity to absorb the increased number of patients, nor the resources to respond to the epidemics using public health measures, considering also that certain epidemics require a high level of expertise (e.g. VHF's), which is not available at the country level.

Throughout the world, DG ECHO¹ has been supporting emergency operations to address outbreaks of communicable diseases. In recent years DG ECHO has annually been spending more than EUR 1,000,000 reacting to epidemics in West Africa alone.

In 2007, DG ECHO launched an Ad Hoc decision using funds from the 9th EDF. The decision ECHO/-AF/EDF/2007/01000 covered all African countries signatories to the Cotonou convention and represented a turning point in responding to epidemics on the basis of a wider, continental approach. All the funds of this decision have already been allocated. Part of it was addressed to respond to the current measles and Meningitis epidemic in Niger.

⁶ Directorate-General for Humanitarian Aid - ECHO
ECHO/-WF/BUD/2008/03000

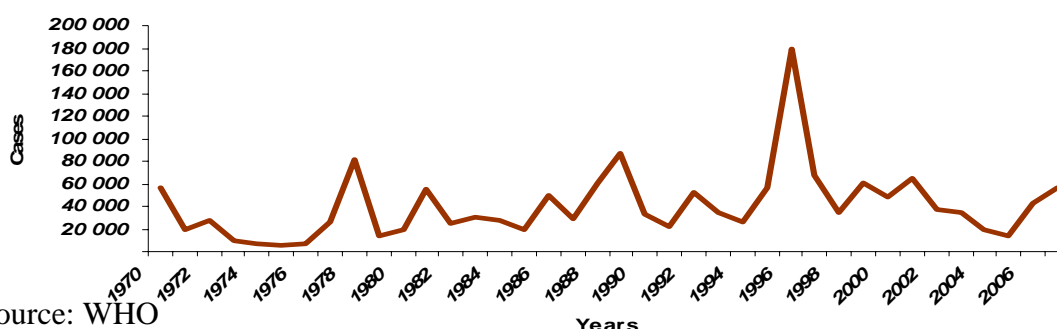
1.2. – Identified needs

Meningitis and Measles. Meningitis is endemic in **Sub-Saharan Africa**, an area known as the “**Meningitis Belt**” running from Senegal to Ethiopia with an estimated population of 310 million people. During the dry season there is a significant increase in the number of cases, in some countries reaching epidemic proportions. In 2007, **Burkina Faso** was ravaged by a large meningitis epidemic reporting more than 26,000 cases while Sudan reported around 12,000 cases.

As for 2008, Nigeria has notified 1.859 meningitis cases and 210 deaths (case fatality rate of 11.3%). Epidemic has spread to 16 out of 22 states in the meningitis belt states and it risk to spread further. Out of these, Sokoto (623), Katsina (608), Kebbi (159), Jigawa (120) and Kano (103) are the most hit states. These northern states are bordering Niger. Nm Serotype A seems to be the main germ responsible for the outbreak. About one million doses of Cerebrospinal Meningitis (CSM) vaccines have been sent to the 22 high risk states in the 'meningitis belt' and more will be required. Oily Chloramphenicol for Treatment, a drug recommended by WHO as a basic treatment against meningitis, has also been mobilised to Sokoto State which is hardest hit. In addition, a measles epidemic is ongoing in the same regions.

More generally, considering the regularity of the meningitis cycle, and the analysis of global trends in the Meningitis Belts since 1970, it is apparent that periodicity and magnitude of these waves are in fact the result of epidemic cycles occurring at a country level, the largest waves being those in which several countries' cycles occur simultaneously. The biggest epidemic of the last 40 years was in 1995-1996 where 200,000 cases were recorded, causing almost 20,000 deaths. Following the epidemiological cycle and the increasing number of cases during 2006, it is feared that a new epidemic wave may have begun in Sub-Saharan Africa². Should such an epidemic wave occur, up to 80 million individuals within the outbreak area could require vaccination over the course of the next two to three epidemic seasons.

**Trends of epidemic meningitis disease in the African belt,
1970-2007**



Source: WHO

Measles and meningitis epidemics are reported to be ongoing in Niger in the regions of Zinder and Maradi, in the south, near the border with Nigeria. Both regions are also suffering from high levels of acute malnutrition, which is an aggravating factor in case of measles infection, leading to high mortality rate for children.

⁷ WHO risk analysis (unpublished)
ECHO/-WF/BUD/2008/03000

Having spread to Nigeria as well, the country is now touched by two epidemics occurring at the same time and affecting the same states. There have been 17,292 notified measles cases with 1,235 deaths reported (Case fatality of 7.14%). 225 Local Government Areas (LGAs) in 24 states are currently affected. The intervention to fight both epidemics will need considerable efforts in terms of coordination (including information management), technical support and resource mobilization. The health system does not have the capacity to deal with the increased number of patients, nor the resources to respond to the epidemics using the public health system.

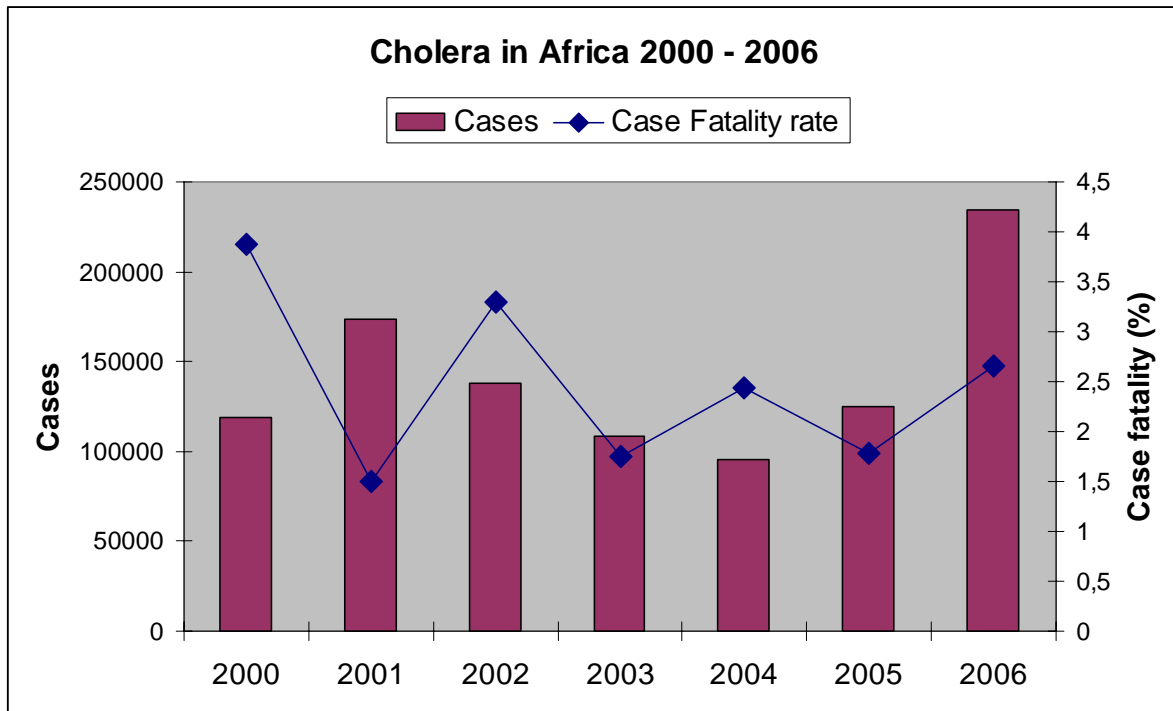
Local health authorities have requested support to **MSF – Netherland** and **MSF - France** to respond to the current epidemics. MSF- NL is working in Zamfara, Kebbi, Niger and Sokoto while MSF F is targeting Yobe and Katsina states. Further assistance may be required for LGAs in other affected states. The Epidemiology Unit of the Ministry of Health lacks adequate resources for effective surveillance activities. Response capacity of the Federal government (800.000 meningitis vaccines doses had been stockpiled earlier this year and had been already used in some states) is now limited.

MSF – Spain too has been planning an intervention aimed at vaccinating and treating meningitis in the area of the border between Niger and Nigeria.

A start date of a given crisis cannot be determined as both epidemics are ongoing and they are showing a significant escalation in the last days. In both cases, timely response is important to contain their progression and reduce the risk of them becoming major humanitarian emergencies.

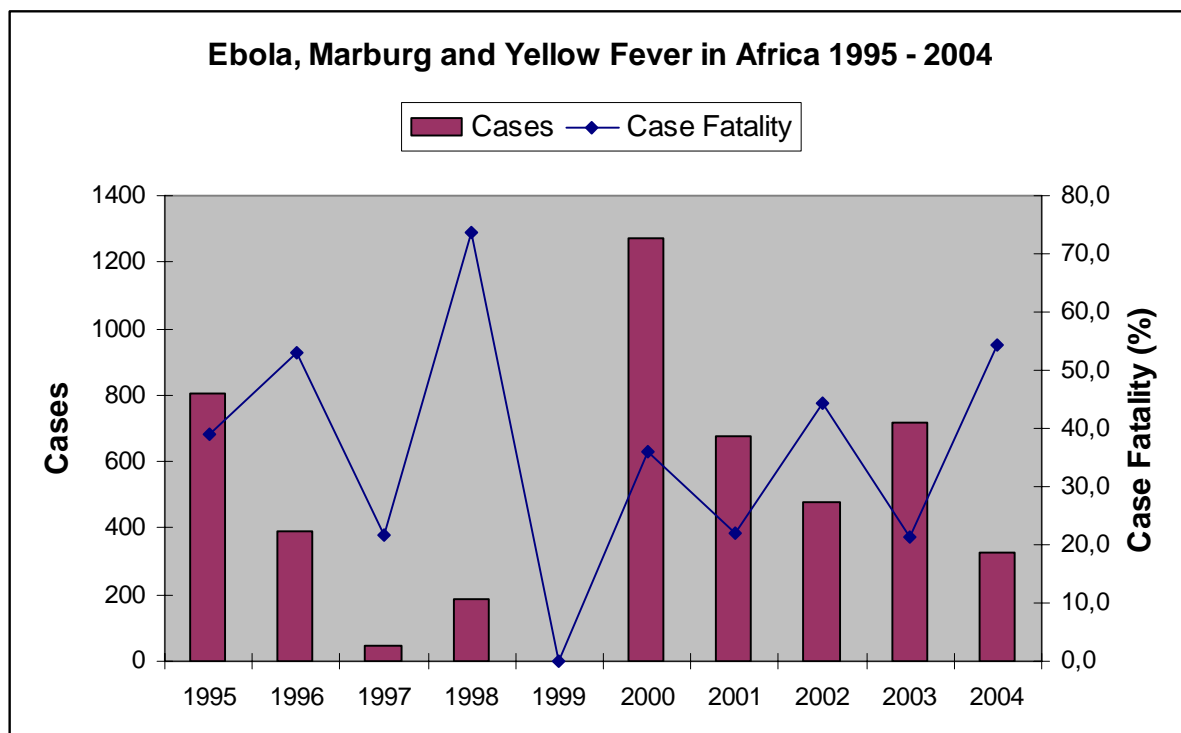
Cholera. In 2005 there was a significant series of cholera outbreaks in Africa, affecting 29 countries, and in 2006 the number of cholera cases reported worldwide rose dramatically with an overall increase of 87% compared with the number of cases in 2005³. This resulted from several major outbreaks, with 67,257 cases in Angola, 45,070 in Ethiopia, 30,662 in Sudan and 20,642 in the Democratic Republic of Congo (DRC). In 2006 there was a three fold increase in the number of deaths, the overall case fatality rate (CFR) rose from 1.72% in 2005 to 2.66% in 2006. Almost all global deaths were reported from the African continent. In total in 2006, 99% of worldwide cases of cholera were reported in Africa. Concerns about potential further spreading of the disease are still concrete.

⁸ In 2006 the number of cholera cases notified in Africa was 234.349



Note to above figure: Registered cases of cholera are generally subject to both over- and underestimation. Cases of simple acute watery diarrhoea are often included (i.e. AWD caused by other agents than the Cholera Vibrio), increasing the total number of reported cases, and in some countries, e.g. Ethiopia and Somalia, there is a reluctance to declare cholera outbreaks, and cholera cases in these countries are registered as Acute Watery Diarrhoea, hence reducing the total number of reported cholera cases. Source: WHO.

Viral hemorrhagic fevers. In recent years, Africa has been seeing a significant number of outbreaks of VHF's, among these **Yellow fever** and **Lassa fever** in West Africa, and **Ebola fever**, **Marburg fever** and **Rift Valley fever** in the Horn of Africa and in Eastern and Central Africa.



Note to above figure: The data represent verified and registered cases. It is estimated by WHO that annually there are more than 100,000 undetected cases of Yellow Fever alone, causing 10-20,000 deaths. Source: WHO.

At the beginning of April 2008, WHO officially announced the **Yellow Fever outbreak in Liberia**. They are planning a vaccination campaign in seven districts located in 4 different counties (Tappita and Saclepea - Nimba county, Tchien and Putu - Gran Gedeh county, Compound # 3 - Gran Bassa county and Jowien and Doedain in River Cees county). The intervention shall target a total catchment population of 382,000 persons with an overall number of beneficiaries estimated at 294,000 persons. WHO together with UNICEF should be leading the outbreak investigations and the implementation of isolation and treatment procedures for suspected cases.

1.3. – Target population and regions concerned

The beneficiaries of this financial decision are the resident populations affected by epidemics of communicable diseases in the West African countries, namely Mauritania, Senegal, Mali, Guinea Bissau, Guinea Conakry, Sierra Leone, Liberia, Ivory Coast, Burkina Faso, Niger, Ghana, Togo, Benin, Nigeria and Chad.

These beneficiaries, regardless of gender, age or location are an estimated 830,000 individuals. Outbreaks of communicable diseases may have more consequences on vulnerable groups like children, elderly people, pregnant and lactating women and refugees.

As an overall figure, about 280,000 individuals are expected to be vaccinated against meningitis and to receive treatment against both meningitis and measles in Niger and Nigeria. In the case of meningitis in Nigeria the age group would be from 2 years until 30 years.

As for yellow fever, 550,000 people living in the two infected counties in Liberia are expected to be vaccinated.

1.4. – Risk assessment and possible constraints

The medicines and vaccines necessary to control most epidemics exist but are not always available when needed. Nonetheless, preventive measures have been undertaken by partners through International Coordinating Group (ICG) to secure the vaccine provisions.

External support to emergency containment of epidemics is efficient but it may also decrease the motivation to develop autonomous responses. External actors shall develop a comprehensive approach and integrate local capacities, so as not to jeopardize development oriented processes. Lack of coordination among health authorities and among agencies themselves has been hampering tailor-made containment operations. Close and regular coordination with WHO and specialized agencies is required more than ever since DG ECHO has been supporting the development of their assessment capacity over the last years. Close coordination and cooperation with respective national authorities will also be needed in order to maximise the impact of epidemiological surveillance, cases notification and vaccination campaigns.

2 – Objectives and components of the humanitarian intervention proposed

2.1. – Objectives

The **principal objective** of this Decision is to reduce morbidity and mortality rates related to epidemics in targeted countries.

Specific objective:

- To contribute to ensuring an adequate response to sudden major threats to public health, such as the on-going epidemics with a potential trans-national impact.

The expected outcome is in particular a reduction of outbreak mortality rates and maintenance of case-fatality rates below internationally recognized thresholds.

2.2. – Components

The funds made available under this Decision will be used for management of vaccines or pharmaceutical stock piles and vaccination and treatment activities.

The containment and control of confirmed epidemics requires provision of effective medicines to most affected people, prevention of additional cases and control of potential expansion through immunization and awareness campaigns. The decision assists the fight against epidemics in targeted countries, aimed at supporting responses primarily to outbreaks of **meningitis, measles, cholera and viral haemorrhagic fevers**, through mass emergency vaccination campaigns and case management. Hygiene-related activities might also be supported whenever deemed appropriate.

DG-ECHO will ensure that relevant national authorities are involved both in the design of specific projects, and in the implementing activities, hence ensuring developmental and capacity building contributions of this decision.

3. – Duration expected for actions in the proposed Decision

The duration of humanitarian aid operations shall be 6 months.

Since the beginning of March 2008, there was strong evidence of epidemics and partners started to respond to the emergencies accordingly. Therefore, expenditure under this Decision shall be eligible from 15 March 2008.

Start Date: 15 March 2008

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 humanitarian aid operations.

Depending on the evolution of the situation in the field, the Commission reserves the right to terminate the agreements signed with the implementing humanitarian organizations 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 procedure established in the general conditions of the specific agreement will be applied.

4 – Previous interventions/Decisions of DG ECHO within the context of the crisis concerned

	2003		2004		2005		2006		2007	
	Subject	EUR	Subject	EUR	Subject	EUR	Subject	EUR	Subject	EUR
Burkina Faso	Meningitis	75 000	Meningitis/ Yellow Fever	139 846			Meningitis	364 760		
Cote d'Ivoire					Yellow Fever	349 163				
Guinee Conakry	Yellow fever	70 000	Cholera	61 992	Cholera	100 000				
Guinee Bissau					Cholera	250 000				
					Cholera	258 684				
Liberia					Cholera	102 392	Measles	157 000		
Mali	Cholera	500 000								
Niger	Meningitis/ measles	245 000	Measles	100 000						
Senegal									Meningitis	1 086 050
Sierra Leone			Cholera	100 000						
			Cholera	168 991						
Chad			Hepatitis E	228 295						
Sao Tome and Principe					Cholera	133 655				
Togo							Yellow Fever	480 000		
West Africa			Assessment	80 000	Assessment	120 000	Assessment	248 000		
Angola					Marburg	500	Cholera	1.500.000		
Angola					Marburg	1.500.000	Cholera	1.500.000		
Sudan					Yellow Fever	2.000.000				
Total		1,490,000		879,124		5,313,894		4,249,760		1,086,050

Source: HOPE and RSO's Dakar and Nairobi

5. – Other donors and donor co-ordination mechanisms

The US government provides preventive and long-term assistance in the field of epidemics. The Global Alliance for Vaccines and Immunization (GAVI) is actively involved in the introduction of new vaccines and facilitating the availability of Yellow fever vaccine whereas private foundations (e.g. The Bill & Melissa Gates Foundation) support prevention, treatment and control of epidemics in West Africa and other regions.

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

WHO is also involved through the project DCI SANTE/2008/154-090 worth EUR 2,000,000. This project, which will be submitted to the next DCI Committee on the 2nd June 2008, is complementary to ECHO decision and aims to enhance country capacity to detect and control epidemics of meningitis, yellow fever, Ebola, Marburg and Plague in Africa. More specifically, the objectives are (i) to enhance epidemiology and laboratory surveillance of Epidemics Meningitis and Yellow Fever in West Africa; (ii) to strengthen the management

and control of Ebola, Marburg and Plague outbreaks; and (iii) to improve timeliness, quality and effectiveness of the mass interventions for these diseases.

6. – Amount of Decision

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

6.2. - Specific objective and activities

Principal objective: To reduce morbidity and mortality rates related to epidemics.				
Specific objective	Allocated amount by specific objective (EUR)	Geographical area of operation	Activities	Potential partners
<ul style="list-style-type: none"> To contribute to ensuring an adequate response to sudden major threats to public health, such as the on-going epidemics with a potential trans-national impact in West Africa. 	1,000,000	Mauritania, Senegal, Mali, Guinea Bissau, Guinea Conakry, Sierra Leone, Liberia, Ivory Coast, Burkina Faso, Niger, Ghana, Togo, Benin, Nigeria and Chad.	<ol style="list-style-type: none"> 1) Data collection for epidemiological follow up and surveillance 2) Mass vaccination campaign 3) Provision of free curative primary and secondary health care including nutritional care when needed 4) Specific emergency support to existing health centres and facilities through provision of drugs, vaccines and medical equipment 5) Organization and supervision of mass vaccination campaigns 	<ul style="list-style-type: none"> - MSF-B - MSF-CH - MSF-ESP - MSF-F - MSF-NL - UNICEF - WHO

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 foreseen in the initial programme, in response to particular events or changing circumstances. More information can be obtained at:

http://ec.europa.eu/echo/evaluation/index_en.htm.

8. Budget Impact – Article 23.02.01

Budget impact article 23 02 01	
	CE (EUR)
Initial available appropriations for 2008	486.095.000,00
Transfers Commission	-
Total available appropriations	486.095.000,00
Total executed to date (17 April 2008)	408.650.000,00
Available remaining	77.445.000,00
Total amount of the Decision	1.000.000,00

9. MANAGEMENT ISSUES

Humanitarian aid actions funded by the Commission are implemented by NGOs, Specialised Agencies of the Member States, and the Red Cross organisations on the basis of Framework Partnership Agreements (FPA) and by United Nations agencies based on the EC/UN Financial and Administrative Framework Agreement (FAFA) in conformity with Article 163 of the Implementing Rules of the Financial Regulation. These Framework agreements define the criteria for attributing grant agreements and financing agreements in accordance with Article 90 of the Implementing Rules and may be found at http://ec.europa.eu/echo/partners/index_en.htm.

Individual grants are awarded on the basis of the criteria enumerated in Article 7.2 of the Humanitarian Aid Regulation, such as the technical and financial capacity, readiness and experience, and results of previous interventions.