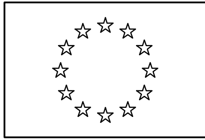

COMMISSION OF THE EUROPEAN COMMUNITIES

Brussels
C(2008) XXX final

COMMISSION DECISION

of

on the financing of humanitarian Actions from the general budget of the European Communities in Western Africa

(ECHO/-WF/BUD/2008/04000)

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COMMISSION DECISION

of

on the financing of humanitarian Actions from the general budget of the European Communities in Western Africa

(ECHO/-WF/BUD/2008/04000)

THE COMMISSION OF THE EUROPEAN COMMUNITIES,

Having regard to the Treaty establishing the European Community,

Having regard to Council Regulation (EC, Euratom) No.1257/96 of 20 June 1996 concerning humanitarian aid[1] , and in particular Article 2 and 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) Armed conflicts, the increased number of natural disasters, poverty aggravated by the high cost of living, the lack of basic sanitation facilities and low hygiene standards in the region increase the vulnerability to communicable diseases and enhance the transmission of infections.

(3) Epidemics occur on a seasonal basis, and it is recommended to undergo assessments and responses ahead of expected outbreaks.

(4) To reduce morbidity and mortality rates related to outbreaks, early and effective actions are required. Both preparedness and response are needed in order to respond effectively to epidemics.

(5) Readiness and timely response to epidemics can be guaranteed through stockpiling of vaccines, drugs, medical and water and sanitation supplies.

(6) To reach populations in need, aid may be channelled through Non-Governmental Organisations (NGOs), International Organisations including United Nations (UN) agencies Therefore the European Commission may implement the budget by direct centralized management or by joint management.

(7) For the purposes of this Decision the African countries concerned are: Benin, Burkina Faso, Cape Vert, Chad, Ivory Coast, Gambia, Ghana, Guinea, Guinea Bissau, Liberia, Sierra Leone, Mauritania, Niger, Nigeria, Sao Tomé and Principe, Senegal, Mali and Togo.

(8) Due to the rapidly evolving situation in the field and the nature of the Actions to be funded under this Decision, it is necessary to establish a contingency reserve inorder to meet unforeseen events.

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[1] OJ L 163, 2.7.1996, p. 1..

(9) An assessment of the humanitarian situation leads to the conclusion that humanitarian aid operations should be financed by the Community for a period of 12 months.

(10) It is estimated that an amount of EUR 2,000,000 from budget line 23.02.01 of the general budget of the European Communities is necessary to address the identified needs of epidemics-affected populations in West Africa. Therefore the activities covered by this Decision may be financed in full in accordance with Article 253 of the Implementing Rules of the Financial Regulation.

(11) The present Decision constitutes a financing Decision within the meaning of Article 75 of the Financial Regulation (EC, Euratom) No 1605/2002[2], Article 90 of the detailed rules for the implementation of the Financial Regulation determined by Regulation (EC, Euratom) No 2342/2002[3] , and Article 15 of the Internal Rules on the Implementation of the general budget of the European Communities[4]

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 2,000,000 for humanitarian aid Actions aimed at preparedness and response to epidemics in West African countries by using line 23 02 01 of the 2008 general budget of the European Communities.

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

Specific objective 1

- Develop preparedness operations including early containment activities aimed at allowing better reaction in case of epidemics

An amount of EUR 900,000 is allocated to this specific objective.

Specific objective 2

- Support the rapid implementation of operations aimed at controlling epidemic outbreaks, including case management of victims of epidemics

An amount of EUR 900,000 is allocated to this specific objective.

An amount of EUR 200,000 is allocated to a contingency reserve

Article 2

Without prejudice to the use of the contingency reserve, the Commission may, where this is justified by the humanitarian situation, re-allocate the funding levels established for one of the specific objectives set out in Article 1(2) to another objective mentioned therein, provided that the re-allocated amount represents less than 20% of the global amount covered by this Decision.

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2 OJ L 248, 16.9.2002, p. 1.
3 OJ L 357, 31.12.2002, , p.1
4 Commission Decision of 5/03/2008, C/2008/773

Article 3

1. The duration for the implementation of this Decision shall be for a maximum period of 12 months, starting on 1 October 2008.

2. Expenditure under this Decision shall be eligible from 1 October 2008.

3. If the Actions 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

1. The Commission shall implement the budget by direct centralised management or by joint management with international organisations.

2. Actions supported by this Decision will be implemented either by:

Non-profit-making organisations which fulfill the eligibility and suitability criteria established in Article 7 of Council Regulation (EC) No. 1257/96;

or International organisations

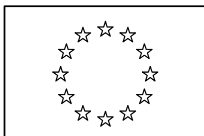
3. Taking account of the specificities of humanitarian aid, the nature of the activities to be undertaken, the specific location constraints and the level of urgency, the activities covered by this Decision may be financed in full in accordance with Article 253 of the Implementing Rules of the Financial Regulation.

Article 5

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

Done at Brussels

For the Commission
Member of the Commission



EUROPEAN COMMISSION
DIRECTORATE-GENERAL FOR HUMANITARIAN AID - ECHO

Humanitarian Aid Decision

Title: Preparedness and Response to epidemics in West African countries

Location of operation: Western Africa

Amount of Decision: EUR 2,000,000

Decision reference number: ECHO/-WF/BUD/2008/04000

Explanatory Memorandum

1. – Rationale needs and target population.

1.1. – Rationale:

The occurrence of epidemics in the West Africa Region is persistent. Over the last three decades, natural disasters have increased by 94% in the West Africa region and epidemics represented 40% of these disasters from 1975 to 2003. Epidemics are more frequent in West Africa than anywhere else, with 20% of the world epidemic alerts, for only 2% of the world population. West Africa's population is at serious risk from outbreaks of Cholera, Meningitis, Yellow fever and other diseases like Measles, and Lassa fever. In many cities of West Africa's coastal countries, Cholera has become endemic and is one of the major causes of epidemics in the region.

The increased circulation of the Yellow fever virus has been confirmed by the onset of cases in the last years in Ivory Coast, Ghana, Togo, Liberia and Guinea Conakry.

To reduce morbidity and mortality rates related to outbreaks, early and effective actions are required. Both preparedness and response are intimately linked so as to respond effectively to epidemics.

Cholera is an acute intestinal infection which greatly varies in intensity. Between 25 and 50% of Cholera cases are fatal, if untreated. But appropriate treatment can reduce mortality rates below 1-2%. Official figures highly underestimate the real burden of Cholera due to the problem of underreporting.

There is no geographical, gender or age limitation for Cholera infection. Cholera is a water related disease linked to the lack of access to safe water, sanitation and hygiene. The ever-increasing proportion of vulnerable populations who live in unsanitary conditions is certainly responsible for the spread of the disease. The disease is transmitted via the faecal – oral route: water, hands, food and contaminated dead bodies can be vectors for the transmission of the disease. Control activities are part of the Cholera responses and have the objective to limit the transmission of the epidemics. Treatment and control measures should be coordinated and quickly deployed. Preparedness is essential to provide timely quality response.

Meningitis is an infection transmitted by direct person-to-person contact. Susceptibility to Meningitis decreases with age; children and adolescents hence constituting the most vulnerable groups. The disease is fatal within 24-48 hours in about 20% 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. Meningitis is endemic in the whole West Africa region though the most affected countries are Burkina Faso, Mali, Chad, Niger and North of Nigeria. Every year during the dry season there are surges of Meningitis cases that reach epidemic proportions in some countries. In 2006 there were 31,559 reported cases of Meningitis only in West Africa. These figures increased to 36,016 cases in 2007 and about 25,000 cases in the first 6 months of 2008. In 2007, from January to May, 47,925 Meningitis epidemic cases were reported in the whole meningitis belt[1]. The number of Meningitis cases in West Africa represented 75% of the total reported cases in the Meningitis belt.

It is estimated that a mass immunization campaign, promptly implemented, can avoid 70% of cases. To be effective, reactive vaccination campaigns must achieve high coverage rates among those most at risk. The serious risk of Meningitis epidemics in the region is coupled with the international shortfall of Meningitis vaccines.

Measles is one of the most contagious diseases known. Almost all non-immune children contract this respiratory disease if exposed to the virus. Severe Measles is particularly likely to occur for poorly nourished young children. Children usually do not die directly of Measles, but from its complications. Immunisation has a major impact on the reduction of deaths caused by Measles. The number of Measles cases in West Africa has increased dramatically in the last 6 months. Some regions of Niger and Northern Nigeria have been affected by simultaneous epidemics of Measles and Meningitis. In Niger, from the beginning of 2008 and until July 2008, 7,509 cases were reported through the national surveillance system. These figures are only indicative as the number of cases and deaths of Measles are always under-reported. At the same time, in northern Nigeria, there was also a significant increase of Measles hospitalised cases in 6 LGA[2].

In West Africa, the most common Hemorrhagic fevers are **Yellow fever** and **Lassa fever**. The high case-fatality rate of Yellow fever – up to 50% – requires a prompt containment in

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[1] 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.

[2] LGA: Local Government Area

order to avoid major public health threats. Yellow fever does not have a favourable period for its transmission and it can occur at any time. Yellow Fever epidemics erupted earlier this year in Abidjan (Ivory Coast) Liberia and Guinea Conakry. Immunisation against Yellow fever is highly effective for the prevention and the control of epidemics. Current efforts are underway to reduce the risk of Yellow fever epidemics through the implementation of preventative vaccination campaigns in some of the regions/countries most at risk. However it will take years before the risk is significantly reduced.

Lassa fever is known to be endemic in Guinea (Conakry), Liberia, Sierra Leone and parts of Nigeria, but probably exists in other West African countries as well. The overall case-fatality rate is 1%, up to 15% among hospitalized patients. Lassa fever occurs in all age groups and in both men and women. No vaccine exists and the main prevention measure is "community hygiene" to discourage rodents from entering homes. In 2007, Liberia, Sierra Leone and Nigeria reported suspected Lassa fever cases. These figures are only indicative because diagnosis requires testing that is available only in highly specialized laboratories. This often leads to an underestimation of the number of cases.

Polio is a highly infectious disease for which there is no cure. It can only be prevented. The Polio vaccine, given multiple times, can protect a child for life. Northern Nigeria is currently affected by a new outbreak of wild poliovirus type (WPV1) 1[3] that threatens to spread to the whole of the West Africa region and the rest of the world. Benin, Niger and Chad have reported Poliomyelitis cases in April 2008. This year, Nigeria accounts for 86% of WPV1 cases in the world. Large-scale emergency polio immunization campaigns were conducted in June in high-risk in border areas of Benin, Burkina Faso, Mali and Niger, followed by additional campaigns in July. Nigeria, too, has planned two large-scale rounds of emergency Polio immunization in the northern states in July and August 2008.

Most West African countries still need external support to respond in a timely manner and/or to prevent recurrent epidemics. Preparedness activities are not a priority and/or National contingency plans are not sufficiently funded. As such, these recurrent health emergencies need considerable and sustainable efforts in terms of coordination, including information management, technical support and resource mobilization.

The Directorate-General for Humanitarian Aid (DG ECHO) has supported emergency operations to address outbreaks of communicable diseases throughout the world. In recent years DG-ECHO has spent more than EUR 1,000,000 every year to react to epidemics, in West Africa alone.

In 2004, DG-ECHO implemented a first epidemics Decision (ECHO/-WF/BUD/2004/01000) of EUR 1,000,000 to respond to Meningitis outbreaks in Burkina Faso and Chad, and Cholera interventions in several West African capital cities – N'Djamena, Conakry and Freetown. It also allowed the funding of epidemic mitigation, including responses to Yellow fever in

[3] Source WHO

Burkina Faso, Hepatitis E in Chad and Measles epidemic in Niger. Additional funding was granted to WHO/GOARN[4] for rapid assessment of epidemics in West Africa.

In 2005, a second EUR 1,500,000 Decision (ECHO/-WF/BUD/2005/02000) was taken, allowing a rapid response to Cholera outbreaks in Monrovia, Conakry, Bissau and Sao Tome. Support was also provided to WHO's mass vaccination campaign against Yellow fever in Côte d'Ivoire.

In 2006, a EUR 1,250,000 Decision (ECHO/-WF/BUD/2006/01000) was taken in order to address a severe Meningitis outbreak in Burkina Faso, an immunisation campaign against Yellow fever in Togo and one against Measles in Liberia. DG-ECHO funded WHO for the third consecutive year to conduct rapid field risk assessments during the initial phases of the epidemics, facilitating the operational response and resources mobilization in West Africa.

In 2007, DG ECHO launched a EUR 2,000,000 Decision (ECHO/-AF/EDF/2007/01000) using funds from the 9th EDF. It covered all African countries signatory to the Cotonou convention. The funds of this Decision were allocated to the constitution of an emergency international Meningitis stockpile managed by WHO/ICG[5] and a reactive Meningitis vaccination campaign in Niger. Additional funding was provided to some countries of Eastern Africa to fight Cholera, Meningitis and Hemorrhagic fevers.

In March 2008, following a series of associated Measles and Meningitis epidemics in Niger and Nigeria along with a Yellow fever outbreak in Liberia, DG ECHO launched a EUR 1,000,000 Emergency Humanitarian Aid Decision to respond to the various epidemics. Almost 100 % of the funds of this decision (EUR 995,500) have already been committed.

Currently, the European Commission is supporting national efforts in the health sector in West Africa already through various development assistance programmes, i.e. through regional programmes (six programmes, e.g. a EUR 20 million programme "Increasing Vaccination Coverage in ACP countries through GAVI's support mechanisms; a EUR 62 million programme "Suppport to Polio eradication in 14 ACP countries") , through health sector support at country level in some countries (vaccination usually being one core element of primary care services) and through general budget support (variable tranche disbursement linked to vaccination coverage).

2. – Identified needs

Preparedness:

Every year, **Cholera** hits one or more African countries. In 2007, the Western Africa sub-region reported a similar number of cases in 2007 than in 2006; WHO recorded about 19,000

[4] GOARN: Global Outbreak Alert and Response. Technical collaboration of existing institutions and networks that pool human and technical resources for the rapid identification, confirmation and response to outbreaks of international importance.

[5] Following large outbreaks in Africa in 1995-96, WHO was instrumental in establishing the International Coordinating Group (ICG) on Vaccine Provision for Epidemic Meningitis Control to ensure rapid and equal access to vaccines, injection material and treatment, as well as for their adequate use when the stocks are limited. The ICG is composed of partners from the UN, including WHO, nongovernmental organizations, technical partners and the private sector

Cholera cases in 2007 from 13 countries with a case fatality rate 2.5%. The majority of the cases occurred in Guinea Conakry (8,546), Liberia 3.063), Senegal (3,984) and Sierra Leone (2,219). The true number of cases is much higher.

The whole West Africa region is highly vulnerable to Cholera. Some countries, already suffering from a deteriorating humanitarian situation are more vulnerable than others and have a much weaker capacity than others to respond to epidemics. Liberia and Sierra Leone are examples of countries facing a difficult transition period with a worrisome degradation of the humanitarian indicators and heavy dependency on humanitarian aid to provide access to health services for the most vulnerable populations.

In Guinea Bissau and Guinea Conakry, Cholera has become endemic with recurrent outbreaks during the rainy seasons. The serious impact of the current major epidemic in Guinea Bissau is aggravated by the collapsing health system. The situation is also deteriorating in Guinea Conakry where political instability has lead the country to the verge of social and economic collapse and where access to the most essential needs is a major challenge for the most part of the population. The situation is especially difficult in the capital and main cities where the majority of the population lives.

The preparedness component of this Decision will mainly focus on providing a more coherent approach to Cholera control, addressing both preparedness and early response. This approach requires integrated strategies including medical, sanitary and environmental aspects, taking into account that critical steps to reduce the transmission of the disease through water, sanitation and hygiene interventions must be strengthened. Long term actions undertaken are not yet sufficient to improve the existing low sanitary conditions and they do not have a specific focus on Cholera. Furthermore, current mechanisms to set up Cholera emergency responses are weak and external assistance is required every year to respond to the major outbreaks. Current responses to Cholera outbreaks are also reactive and often not adequately prepared.

Preparedness is essential to guarantee a more efficient response and should include an efficient surveillance, diagnosis and treatment capacity. Spread of the disease within an area can be prevented; early detection, case confirmation and mapping can help to specifically identify the environmental health actions to be taken. These actions include provision of safe water and sanitation, hygiene, food safety and health education.

Effectiveness of the response also depends on the coordination of the different actors involved at different levels; an important aspect of the preparation is to strengthen this multi-sector coordination. Early response should also be considered in areas where there is a high risk of a Cholera outbreak. Quick impact actions should be implemented for the most vulnerable communities in the most risk-prone areas during the most risky period accompanied by an active advocacy to the concerned actors in order to establish the implementation of longer term preventive measures.

Cholera cases & deaths in West Africa Region, source WHO.

Countries	2005		2006		2007		2005 - 2007		2005	2006	2007
	Cases	deaths	Cases	deaths	Cases	deaths	Cases	deaths	letality rate	letality rate	letality rate
Benin	749	11	91	0	0	0	840	11	1,47	0,00	0,00
Burkina	1 050	16	0	0	0	0	1 050	16	1,52	0,00	0,00
Cap Vert	0	0	5	0	0	0	5	0	0,00	0,00	0,00
Ivory Coast	39	6	414	15	8	1	461	22	15,38	3,62	12,50
Gambia	357	13	0	0	12	1	369	14	3,64	0,00	8,33
Ghana	3 958	63	3 357	107	179	18	7 494	188	1,59	3,19	10,06
Guinea Bissau	25 146	399	37	0	153	8	25 336	407	1,59	0,00	5,23
Guinea Conakry	3 839	107	3 230	218	8 546	311	15 615	636	2,79	6,75	3,64
Liberia	3 777	18	4 989	19	3 063	7	11 829	44	0,48	0,38	0,23
Mali	903	66	7	0	0	0	910	66	7,31	0,00	0,00
Mauritania	3 953	62	25	0	3	0	3 981	62	1,57	0,00	0,00
Niger	515	52	1 204	81	24	2	1 743	135	10,10	6,73	8,33
Nigeria	4 249	151	1 906	110	1 661	48	7 816	309	3,55	5,77	2,89
Senegal	29 813	431	365	10	3 984	24	34 162	465	1,45	2,74	0,60
Sierra Leone	0	0	2 560	99	2 219	84	4 779	183	0,00	3,87	3,79
Tchad	0	0	1 437	72	0	0	1 437	72	0,00	5,01	0,00
Togo	1 320	15	1 159	25	65	1	2 544	41	1,14	2,16	1,54
TOTAL	79 668	1 410	20 786	756	19 917	505	120 371	2 671	1,77	3,64	2,54

The case of Guinea Bissau which is currently affected by a cholera epidemic which started in July 2008 adequately illustrates the problem. To date, the country has reported more than 9,800 cases including 178 deaths. Guinea Bissau and Guinea Conakry have low capacities to respond to outbreaks. Both countries are among those most at risk from Cholera in West Africa region and in need to develop a comprehensive preparedness approach. Lessons learnt and available tools and methodologies could be used to develop a regional approach, with a special focus on the promotion of these actions in other neighbouring countries such as Liberia and Sierra Leone.

This Decision will also cover other early response actions to fight against epidemics in case of imminent risk of large scale epidemics, such as contingency plan activation, stockpiling of medical and non medical supplies, in order to contribute to the early containment of the outbreak.

Response:

Given the weak existing local capacities to cope with the burden of epidemics, health systems have neither the capacity to absorb the increased number of patients, nor the resources to respond to the epidemics using public health measures. DG ECHO could be requested to support response operations to fight against Cholera, Meningitis, Yellow fever, Measles and other emerging pathogens represent a serious risk for all the affected population.

1.3. – Target population and regions concerned

For the preparedness component, beneficiaries are local populations in areas at high risk of epidemics. Special attention will be paid to urban settings in Guinea Bissau and Guinea Conakry. The estimated number of beneficiaries is 800,000 individuals.

For the response component, the beneficiaries, regardless of gender, age or location are estimated at 400,000 individuals. They are the local populations affected by epidemics of communicable diseases in the West Africa.

1.4. – Risk assessment and possible constraints

Funds made available under this Decision will be used for preparedness operations and to provide the necessary capacity for early containment and response to outbreaks. In case of need, funds will be mobilised to respond to epidemics of diseases such as Cholera, Meningitis, Yellow fever, Measles and other emerging pathogens. For very large outbreaks, additional resources may be required.

External support to emergency containment of epidemics is efficient, but it may also decrease the motivation to develop autonomous responses. External actors shall develop comprehensive approach and integrate local capacities, not to jeopardize development-oriented processes. Lack of coordination among health authorities and among agencies themselves has been hampering tailor-made containment operations. More than ever, close and regular coordination with WHO and specialized agencies is required since DG ECHO has been supporting the development of their assessment capacity over the last years.

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 the West African countries

Specific objectives:

- Develop preparedness operations including early containment activities aimed at allowing better reaction in case of epidemics
- Support the rapid implementation of operations aimed at controlling epidemic outbreaks, including case management of victims of epidemics.

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

2.2. – Components

<u>Preparedness:</u>
The funds made available under this Decision will be used in preparedness operations to allow a better reaction in case of epidemics. The preparedness component includes 1) Reinforcement of the capacities for rapid field assessment during initial phases of the outbreak and analysis of epidemiological patterns 2) Improvement of the emergency response capacity through the development of disease specific criteria and technical guidelines 3) Mobilization of technical expertise for multidisciplinary assessments 4) Contribution to the constitution of emergency stocks of vaccines, drugs, medical and/or water and sanitation supplies 5) Development of contingency plans and set up of coordination mechanisms 6) Development of an early response capacity in high risk areas 7) Set up of surveillance systems – identification of areas to focus environmental actions 8) Reinforcement of the treatment capacity 9) Pre-positioning of critical medical and hygiene items.
The preparedness component requires pre-positioning and/or provision of effective emergency items material as medical supplies, water and sanitation products to respond in a timely fashion.

<u>Response</u>:
In case an epidemic occurs and the local capacities to fight the spread are overwhelmed, the decision will support operations against outbreaks such as Meningitis, Cholera, Yellow fever, Measles but it could also be used to ensure a response to other communicable diseases like Polio and other emerging pathogens. The rapid response component could include 1) Rapid field assessment during initial phases of outbreaks 2) Provision of free curative primary and secondary health care 3) Temporary support to existing health centres and facilities through provision of drugs, vaccines, medical equipment and water and sanitation products 4) Organization and supervision of mass vaccination campaigns and 5) Environmental health actions designated to control epidemics. All interventions will be closely coordinated with the respective Ministries of Health of recipient countries.

3. – Duration expected for actions in the proposed Decision

The duration for the implementation of this Decision is 12 months.

Humanitarian operations funded by this Decision must be implemented within this period.

Expenditure under this decision shall be eligible from the 1 October 2008.

Start Date: 1 October 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 the Commission within the context of the current crisis

List of previous DG ECHO epidemic operations in West Africa

		2006	2007	2008
Decision Number	Decision Type	EUR	EUR	EUR
ECHO/-WF/BUD/2006/01000 (*)	Ad hoc	1,250,000		
ECHO/-AF/EDF/2007/01000 (*)	Ad hoc		2,000,000	
ECHO/-WF/BUD/2008/03000 (*)	Emergency			1,000,000
	Subtotal	**1,250,000**	**2,000,000**	**1,000,000**
	Grand Total	**4,250,000**		

Dated : 29 July 2008

5. – Other donors and donor co-ordination mechanisms

The US government also 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.

6. – Amount of decision

6.1. - Total amount of the Decision: EUR 2,000,000

6.2. - Specific objective and activities

Principal objective: To reduce morbidity and mortality rates related to epidemics in the West African countries.				
Specific objectives	**Allocated amount by specific objective (EUR)**	**Geographical area of operation**	**Activities**	**Potential partners**[6]
Specific objective 1 Develop preparedness operations including early containment activities aimed at allowing better reaction in case of epidemics	**900,000**	West Africa Region: - Benin, Burkina Faso, Cape Vert, Chad, Ivory Coast, The Gambia, Ghana, **Guinea Bissau, Liberia, Sierra Leone**, **Guinea Conakry,** Mauritania, Niger, Nigeria, Sao Tomé and Principe, Senegal, Mali and Togo	For preparedness 1) Reinforcement of the capacities for rapid field assessment during initial phases of the outbreak and analysis of epidemiological patterns 2) Improvement of the emergency response capacity through the development of disease specific criteria and technical guidelines 3) Mobilization of technical expertise for multidisciplinary assessments 4) Contribution to the constitution of emergency stocks of vaccines, drugs, medical and/or water and sanitation supplies 5) Development of contingency plans and set up of coordination mechanisms 6) Development of an early response capacity in high risk areas 7) Set up of surveillance system – identification of areas to focus environmental actions. 8) Reinforcement of the treatment capacity 9) Pre-positioning of critical medical and hygiene items	- UNICEF, - INTERMON-OXFAM- E - OXFAM-GB - ACH-ESP - ACF- F - CARITAS-DEU - CONCERN WORLWIDE - CONCERN UNIVERSAL - LVIA. - ICRC - IFRC-FICR - MSF-BEL - MSF-CH - MSF E- - WHO - MDM F - MDM E - MDM P

[6] ACCION CONTRA EL HAMBRE –ESP, ACTION CONTRE LA FAIM, (FR), ARTSEN ZONDER GRENZEN (NLD), ASSOCIAZIONE INTERNAZIONALE VOLONTARI LAICI- SERVIZIO DI PACE (ITA), CARITAS ALLEMAGNE, COMITE INTERNATIONAL DE LA CROIX-ROUGE (CICR), CONCERN WORLDWIDE, (IRL), CONCERN UNIVERSAL , FEDERATION INTERNATIONALE DES SOCIETES DE LA CROIX-ROUGE ET DU CROISSANT ROUGE, INTERMON OXFAM, (E), MEDECINS DU MONDE, MEDECINS DU MONDE - DOKTERS VAN DE WERELD, MEDECINS SANS FRONTIERES (F), MEDECINS SANS FRONTIERES (LUX), MEDECINS SANS FRONTIERES - SUISSE (CH), MEDECINS SANS FRONTIERES BELGIQUE/ARTSEN ZONDER GRENZEN BELGIE(BEL), MEDICOS DEL MUNDO ESPAÑA, MEDICOS SIN FRONTERAS, (E), Médicos do Mundo Portugal, OXFAM (GB), SOLIDARITES, (FR), TEARFUND (GBR), UNICEF, WORLD HEALTH ORGANISATION - ORGANISATION MONDIALE DE LA SANTE

Specific objective 2 Support the rapid implementation of operations aimed at controlling epidemic outbreaks, including case management of victims of epidemics	**900,000**	West Africa Region: - Benin, Burkina Faso, Cape Vert, Chad, Ivory Coast, The Gambia, Ghana, Guinea Bissau, Liberia, Sierra Leone, Guinea Conakry, Mauritania, Niger, Nigeria, Sao Tomé and Principe, Senegal, Mali and Togo.	For response: 1) Rapid field assessment during initial phases of outbreaks 2) Provision of free curative primary and secondary health care 3) Temporary support to existing health centres and facilities through provision of drugs, vaccines, medical equipment and WASH products 4) Organization and supervision of mass vaccination campaigns 5) Environmental health actions designated to control epidemics	- OXFAM-GB - INTERMON-OXFAM - E - ACF F - ACF E - SOLIDARITES -TEARFUND - CARITAS-DEU - CONCERN WORLWIDE - CONCERN UNIVERSAL - LVIA. - ICRC - IFRC-FICR - MSF-BEL - MSF-CH - MSF-F - MSF-LUX - MSF-NLD - MSF E - UNICEF - WHO - MDM F - MDM E - MDM P
Reserve	**200,000**			

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

8. 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.

For International Organisations identified as potential partners for implementing the Decision, actions will be managed under joint management.

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.