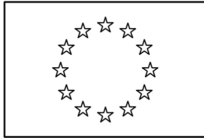


EUROPEAN COMMISSION
DIRECTORATE-GENERAL FOR HUMANITARIAN AID - ECHO

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 1,250,000

Decision reference number: ECHO/-WF/BUD/2006/01000

Explanatory Memorandum

1 - Rationale, needs and target population.

1.1. - Rationale :

Communicable diseases are highly endemic in West Africa. The vaccine coverage of the population 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. However, most West African Ministries of Health still focus on "regular" diseases and do not target systematic prevention or containment of declared epidemics. Epidemics are more frequent in West Africa than elsewhere, with 20% of the world epidemic alerts for 2% of the world population. On the basis of this regular and cumulative risk in West Africa, DG Humanitarian Aid can reasonably forecast a minimal volume of needs and responses.

To reduce morbidity and mortality rates related to outbreaks, early and effective actions are required. Indeed, small initial outbreaks are frequently manageable locally, whereas major epidemics arise when they are not addressed in time. Smaller epidemics shall be equally addressed on a case by case basis to prevent their escalation to large scale epidemics, which are undeniably more difficult to manage and therefore affecting to a greater extent the population. Financial contributions are usually hard to gather quickly in the early stages of an epidemic, with the result that outbreaks may develop into major disasters.

Throughout the world, DG Humanitarian Aid has been supporting emergency operations to address outbreaks of communicable diseases. Commonly, a start date of the crisis could hardly be determined, although it triggers an emergency procedure leading eventually to a

Primary Emergency Decision. DG Humanitarian Aid was spending more than EUR 1 million reacting to epidemics in West Africa each year. It was therefore decided in 2004 to adopt a first ad hoc decision dedicated to combating epidemics in the region.

In 2004, DG Humanitarian Aid implemented a first "epidemics" decision, (ECHO/-WF/BUD/2004/02000) for EUR 1 million. Meningitis responses were supported in Burkina Faso and Chad, while Cholera interventions were financed in several West African capital cities – N'Djamena, Conakry and Freetown. Other funding for epidemic mitigation included responses to Yellow Fever in Burkina Faso, to Hepatitis E in Chad and to a Measles epidemic in Niger. Additional funding was granted to WHO/GOARN for rapid assessment of epidemics in West Africa.

In 2005, a second EUR 1,5 million decision (ECHO/-WF/BUD/2005/02000) was taken and allowed 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. Cholera outbreaks in Mali, Senegal, the Gambia, Mauritania, Burkina Faso, Côte d'Ivoire, Togo, Benin and Niger were closely monitored. Yellow Fever and Cholera trends were followed in the whole sector but no intervention was specifically funded.

The decision to assist the fight against epidemics in West Africa permitted over the last two years a rapid and flexible response by partners to deal with epidemics and the risks of other communicable disease and emerging pathogens. To increase its flexibility, the 2006 decision pertaining to epidemics will cover 18 months. It will ensure that operations aimed at containing and controlling confirmed epidemics are implemented swiftly during one rainy season and two dry seasons, as it starts from the 15th of February 2006. It amounts to EUR 1,25 million.

1.2. - Identified needs :

From the 25th of November 2004 to the 25th of November 2005, WHO's system dedicated to the verification of public health emergencies identified 59 events in West Africa of potential signification for the international public health. Among 59 events, 49 (83%) were authenticated, as specified in the table below:

	Number of events	Percentage %
Cholera	20	41
Yellow Fever	8	16
Meningococcal Disease	5	10
Acute Jaundice Syndrome/Hepatitis	5	10
Acute Haemorrhagic Fever Syndrome	4	8
Others	7	15
Total	49	100

Country	Number of events	Percentage
Benin	1	2
Cape Verde	0	0
Burkina Faso	4	8
Chad	6	12
Cote D'Ivoire	5	11

Gambia	2	4
Ghana	2	4
Guinea	4	8
Guinea-Bissau	2	4
Liberia	4	8
Mali	3	6
Mauritania	1	2
Niger	1	2
Nigeria	10	21
Senegal	2	4
Sierra Leone	1	2
Togo	1	2
Total	49	100

Source: WHO.

An unusual long and heavy rainy season led to major Cholera outbreaks in 2005. An early small Cholera outbreak in the city of Touba (Senegal) where a 2 million person pilgrimage took place end March, may have extended the disease even before the rainy season. Guinea-Bissau and Senegal in particular registered more than 70'000 Cholera cases.

However, the EUR 1,5 million 2005 decision proved sufficient and the use of the B envelopes of the European Development Funds (EDF) was not required. Through geographical or regional decisions, DG Humanitarian Aid coordinated and assisted other epidemics related initiatives or capacity building projects to benefit health actors. Besides, the European Commission dedicated part of its EUR 15 million Regional West Africa Health Program under the 9th EDF fund to epidemic responses. This five years lasting project was launched on the 15th of December 2003 to increase the coordination and harmonization of national health policies in the region. It was also foreseen to strengthen rapid response capacities and improve epidemiologic alert systems at national and sub-regional levels. To provide political guidance and recommendations on strategies and to select project applications in partnership with the EC, a steering committee was set up encompassing representatives of the ECOWAS countries.

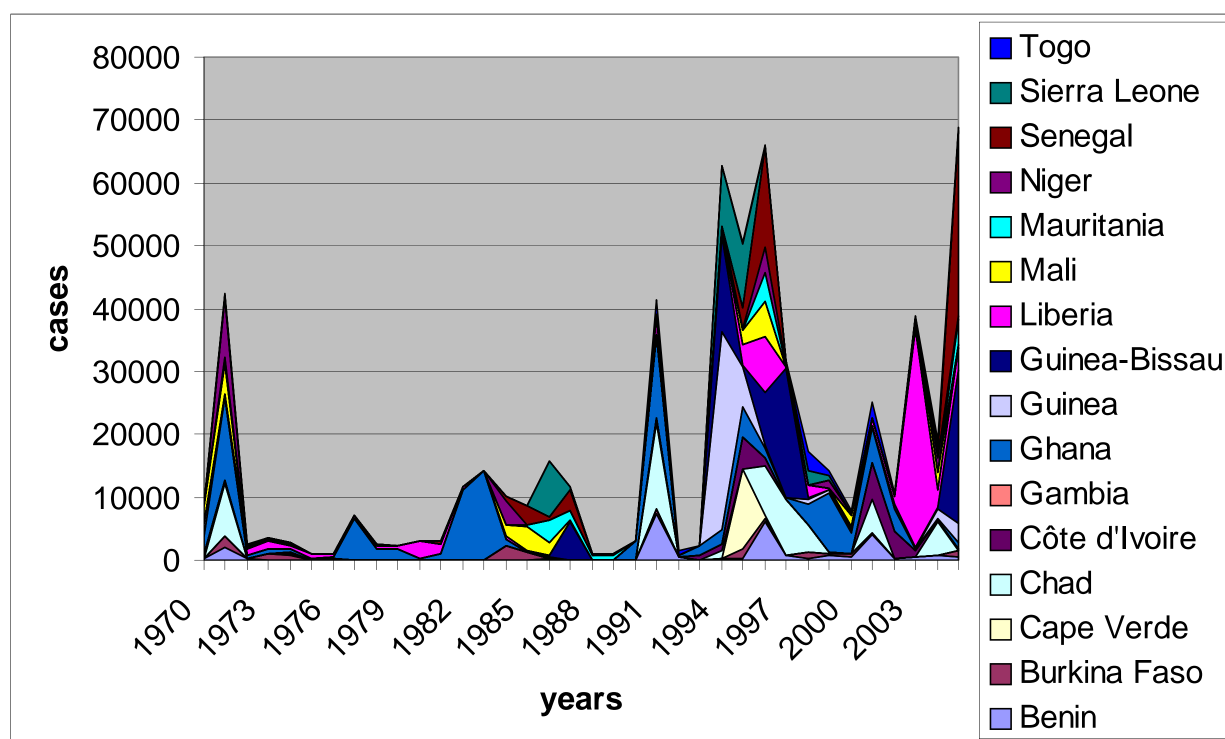
In addition, a strategic partnership on health and development was signed in July 2004 between the EC and WHO, focusing on the following: a reduced maternal mortality, an accelerated action on communicable diseases and monitoring progress in achieving better health outcomes. EUR 25 million were then provided from the 9th European Development Fund to improve the accessibility of essential medicines in the African, Caribbean and Pacific (ACP) countries. To strengthen local capacities, the partnership pertained in particular to a better use of medicines needed in the treatment and prevention of HIV/AIDS, tuberculosis and malaria. The content of the Partnership is to be reviewed after three years and additional allocation of EUR 25 million is being discussed.

A EUR 20 million project under the 9th EDF is currently under discussion to increase the vaccination coverage in 43 ACP countries through Global Alliance for Vaccines and Immunization – GAVI's country financing mechanism. All the 16 ECOWAS countries as well as Chad are targeted. Through the strengthening of national immunization programs of the poorest countries in a sustainable manner, the project shall contribute to the reduction by two-thirds, between 1990 and 2015, of the under-five mortality rate as pointed out in the health-related Millennium Development Goals. Support for the procurement and delivery of

new and under-used vaccines may then be provided to ACP countries eligible to GAVI funding.

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 some mild cases, diarrhea may occur without other symptoms. But the acute watery diarrhea is frequently accompanied by nausea and vomiting, rapid dehydration and circulatory collapse. Between 25 and 50% of cholera cases are fatal, if untreated. But an appropriate treatment can reduce mortality rate below 1-2%.
There is no geographical, gender or age limitation for Cholera. Large population movements prompted by conflicts and insufficient sanitation facilities facilitate the extension of the disease. The Cholera case-fatality rate in Africa amounts to 5% and is the highest in the world. The figure below shows the tremendous increase of the attack rate in West Africa over the last 30 years and in particular in the 1990s.

Figure 1. Cases of cholera in West Africa since the detection of the *vibrio* in 1970[1].



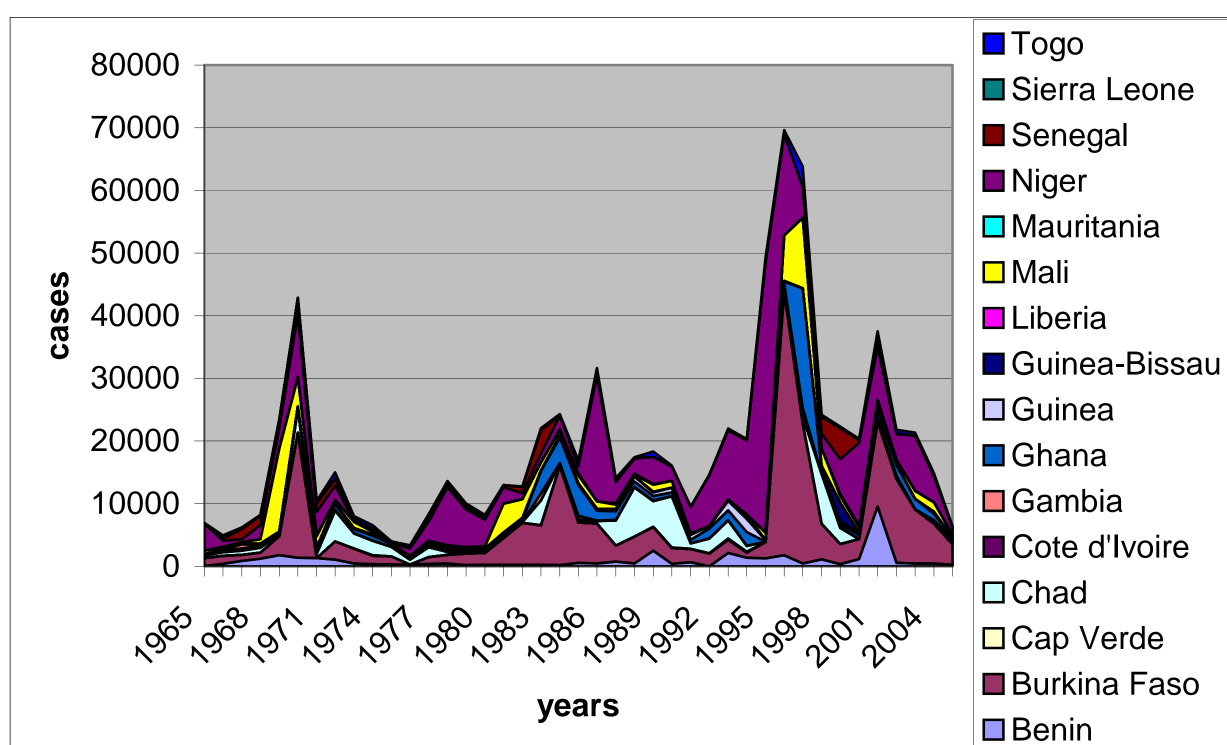
Source: WHO.

Meningitis is endemic in the whole West African region though the most affected area lies between the Sahara desert and the coastal rainforest-lands. Most affected countries are Burkina-Faso, Mali, Chad, Niger and Nigeria, but outbreaks can occur in any other country of the meningitis belt running from Senegal to Ethiopia. The surge which is usually recorded during the dry season can reach epidemic proportions. Transmission occurs by direct person-to-person contact, including aerosol transmission and respiratory droplets from the nose and pharynx of infected persons, patients or asymptomatic carriers. Indeed, most infections do not

[1] Nigeria is not taken into account an account of its large population. An outbreak in Nigeria would double the region's trend and hide the variability on the other countries. In 1991, a big Cholera outbreak was reported in Nigeria with 59,478 cases.

cause clinical disease. Susceptibility to meningococcal disease decreases with age; children and adolescents constitute, then, the most vulnerable group.
Meningitis presents a sudden onset of intense fever, nausea and vomiting, plus various neurological signs. The disease is fatal in 5 to 10% of cases even with prompt antimicrobial treatment; among individuals who survive, up to 20% have permanent neurological *sequelae*.
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. The immunization provided by the vaccine lasts for a short period (2 to 3 years) and excludes universal prevention. Therefore, every outbreak shall be contained in order to mitigate morbidity and mortality.
Considering the regularity of Meningitis cycle, as per the figure below, a major peak is overdue and it could occur in 2006.

Figure 2. Cases of meningococcal meningitis in West Africa 1965-2005[2].



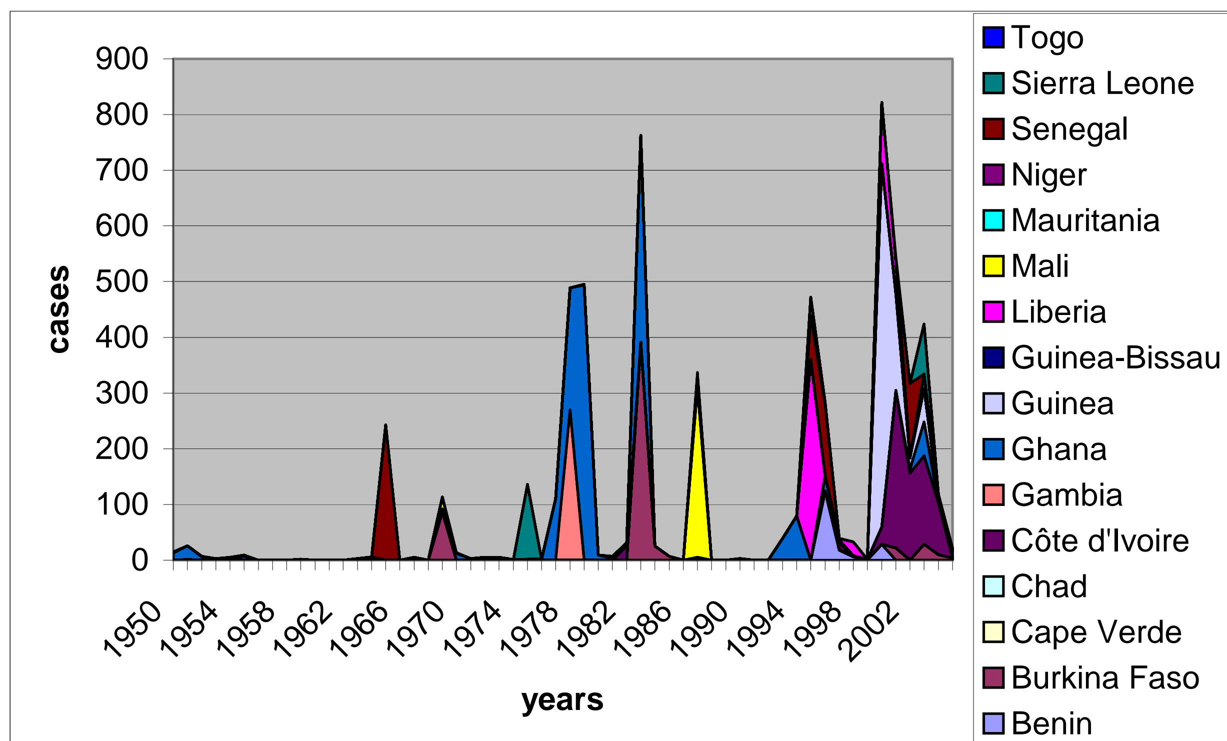
Source: WHO.

Yellow Fever is a viral infection usually transmitted during the rainy season by the bite of infective *Aedes aegypti* mosquitoes. Outbreaks of Yellow Fever became rare in Africa between 1950 and 1985, possibly due to the large immunisation coverage reached in the fifties. Since then, outbreaks of Yellow Fever have been increasing especially in the humid savannah regions between latitude 15° North and 10° South. Introduction of infection into densely populated urban areas may also lead to larger epidemics of Yellow Fever.
There are no clear-cut gender or age group limitations. Infection leads to an acute illness characterized by fever, nausea and/or vomiting. Thereafter, about 15% of patients develop jaundice and haemorrhagic manifestations. The extremely high case-fatality rate of this hemorrhagic fever – up to 50% – requires a prompt containment in order to avoid major health threats.

[2] Nigeria is not taken into account (see previous note). A big outbreak of meningitis was reported in Nigeria in 1996 with 108.068 cases.

Vaccination is highly effective for the prevention and the control of Yellow Fever epidemics. Yellow Fever immunization should slowly be integrated into many West African countries' Extended Programs of Immunization, but this is hampered by the high cost of the vaccine. Even though the required coverage will probably not be reached during the next decade, an increased coverage will reduce the current upward morbidity trend.
The figure below indicates that the risk has increase since 1978 after a rather long period of control.

Figure 3. Cases of Yellow fever in West Africa since 1950[3].



Source: WHO.

Measles is recognized as one of the most contagious diseases and it can reach an epidemic level once the immunization coverage has decreased. The case-fatality rate amounts to 3 to 5% in developing countries but it can reach 30% under certain conditions, notably among displaced populations.
The signs of infection are usually high fever, cough, red and watery eyes, rash on the face and upper neck. Almost all non-immune poorly nourished young children contract measles if exposed to the virus. But Measles is even more severe when it appears among adolescents or adults. Children usually do not die directly of measles, but from its complications which are more common in children under the age of five or adults. In tropical areas, outbreaks of measles usually take place during the dry season.

Outbreaks of other communicable diseases such as **shigellosis** or **viral hemorrhagic fevers** – **Lassa Fever** in particular – also occur in West Africa. 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 require immediate action.

[3] Nigeria is not taken into account (see previous note). A big yellow fever outbreak was reported in Nigeria in 1987, with 5,067 cases.

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 and 2005. Reversing a decade long tendency, **Polio** expanded explosively from 2004 on, 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 Malaria can reach, under specific circumstances, an epidemic level.

1.3. - Target population and regions concerned :

The beneficiaries of this financial decision are the resident populations potentially 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, Sao Tome and Principe, Senegal, Sierra Leone, and Togo.

These potential beneficiaries regardless of gender, age or location are an estimated 200 millions. However, outbreaks of communicable diseases may have more consequences on vulnerable groups like children, elderly people, pregnant and lactating women, refugees. The number of direct beneficiaries of an intervention may vary but it can easily reach 400, 000 people in the case of a mass vaccination campaign.

1.4. - Risk assessment and possible constraints :

In the event of large-scale outbreaks, additional resources might be required. The funds made available under this decision will be used exclusively to provide the necessary capacity for the early containment of outbreaks. For very large outbreaks, additional resources may be required.

The medicines and vaccines necessary to control most epidemics exist but are not always available when needed. Production and research for new alternatives are limited to diseases that most commonly affect people. In case of an acute shortage, the focus will shift from morbidity and mortality control to mortality mitigation.

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. Close and regular coordination with WHO and specialized agencies is required more than ever since DG Humanitarian Aid has been supporting the development of their assessment capacity over the last two years.

2 - Objectives and components of the humanitarian intervention proposed:[4]

4 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 article 110 thereof, and its Implementing Rules in particular article 168 thereof (Council Regulation (EC, Euratom) No 1605/2002 of 25 June 2002, OJ L248 of 16 September 2002 and No 2342/2002 of 23 December 2002, OJ L 357 of 31 December 2002).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 DG 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 may be found at http://europa.eu.int/comm/echo/partners/index_en.htm

2.1. - Objectives :

The principal objective of this decision is to reduce morbidity and mortality rates related to epidemics in West Africa.

The expected outcome is in particular to decrease the mortality rate and maintain the case-fatality rate within internationally recognized thresholds.

The specific objectives of the decision are to:
- Improve capacity so that reported outbreaks are rapidly assessed by qualified personnel
- Ensure that operations aimed at containing and controlling confirmed epidemics are implemented swiftly

2.2. - Components :

The funds made available under this decision will be used exclusively to reduce morbidity and mortality rates related to outbreaks at their early stage, so that escalation to large scale epidemics is prevented. 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 to assist the fight against epidemics in West Africa is aimed at supporting responses to Cholera, Yellow fever, Meningitis epidemics as the most frequent outbreaks in West Africa but it can be used to rapid responses to other communicable diseases and emerging pathogens. Mass vaccination campaigns in emergency situations can also be considered by DG ECHO.

To mitigate epidemics and provide technical support to countries during the initial phase of epidemics, DG ECHO will further support capacity building projects so that reported outbreaks are rapidly assessed by qualified personnel. In the context of previous Contribution Agreements, evaluation of the humanitarian situation, data analysis and technical assessments supported by DG ECHO significantly facilitated decision-making and mobilization of international resources for outbreak responses. Support will then be further provided to all kind of actor able to carry out early, qualified and rapid field analysis leading to the adoption of timely decisions for health intervention.

3 - Duration expected for actions in the proposed Decision:

The duration for the implementation of this Decision is 18 months

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

Expenditure under this Decision shall be eligible from the 15th of February 2006.

Start Date: 15th of February 2006

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 (DG ECHO) within the context of the crisis concerned

	2003		2004		2005	
	Subject	**Amount**	**Subject**	**Amount**	**Subject**	**Amount**
BURKINA FASO	Meningitis	75 000	Meningitis/ Yellow Fever	139 846		
	Meningitis	600 000				
CÔTE 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
MALI	Cholera	500 000				
NIGER	Meningitis/ measles	245 000	Measles	100 000		
SIERRA LEONE			Cholera	100 000		
CHAD			Cholera	168 991		
			Hepatitis E	228 295		
SAO TOME AND PRINCIPE					Cholera	133 655
West Africa			Assessment	80 000	Assessment	120 000
MANO REGION			Polio	400 000		
Sub-Total		**1 490 000**		**1 297 124**		**1 313 894**

Source: HOPE

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

		2004	2005	2006
Decision Number	Decision Type	EUR	EUR	EUR
ECHO/BEN/EDF/2005/01000	Emergency		1,050,000	
ECHO/LBR/EDF/2004/01000	Non Emergency	4,300,000		
ECHO/LBR/EDF/2005/01000	Non Emergency		2,700,000	
ECHO/MLI/EDF/2005/01000	Emergency		2,000,000	
ECHO/NER/EDF/2005/01000	Emergency		4,600,000	
ECHO/NER/EDF/2005/02000	Emergency		1,700,000	
ECHO/TCD/BUD/2004/01000	Non Emergency	4,000,000		
ECHO/TCD/EDF/2004/02000	Non Emergency	8,000,000		
ECHO/TCD/BUD/2005/01000	Non Emergency		12,000,000	
ECHO/TCD/BUD/2005/02000	Non Emergency		2,000,000	
ECHO/TCD/BUD/2006/01000	Non Emergency			13,500,000
ECHO/CIV/BUD/2006/01000	Non Emergency			5,200,000
ECHO/GIN/BUD/2006/01000	Non Emergency			1,500,000
ECHO/LBR/BUD/2006/01000	Non Emergency			16,400,000
ECHO/NER/BUD/2006/01000	Non Emergency			2,000,000
ECHO/-WF/BUD/2006/02000	Non Emergency			900,000
	Subtotal	16,300,000	26,050,000	0
	Grand Total	42,350,000		

Dated : 07/02/2006

Source : HOPE

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/SAO TOME AND PRINCIPE/SENEGAL/SIERRA LEONE/CHAD/TOGO the last 12 months

1. EU Members States (*)	EUR	2. European Commission	EUR	3. Others	EUR
Austria		ECHO	54,500,000		
Belgium	2,961,000	Other services			
Cyprus	26,316				
Czech republic	167,000				
Denmark	5,654,937				
Estonia					
Finland	2,050,000				
France	9,628,497				
Germany	20,215,386				
Greece					
Hungary					
Ireland	7,794,841				
Italy	4,784,300				
Latvia					
Lithuania					
Luxemburg	3,901,874				
Malta					
Netherlands	13,901,471				
Poland	41,000				
Portugal	261,059				
Slovakia					
Slovenie					
Spain					
Sweden	15,582,884				
United kingdom	15,579,545				
Subtotal	102,550,111	Subtotal	54,500,000	Subtotal	0
		Grand total	157,050,111		

Dated : 07/02/2006
(*) 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 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 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.

To strengthen the regional response capacity, the West African Health Organization launched a three-year capacity building plan aimed at prepared enhancing epidemiological surveillance through the network of West African Ministries of Health. The 9th EDF also provides financial support (EUR 15 million) to a 5 years Regional West African Health Program.

6 - Amount of decision and distribution by specific objectives:

6.1. - Total amount of the decision: EUR 1,250,000

6.2. - Budget breakdown by specific objectives

Principal objective: *Morbidity and mortality rates related to epidemics in West Africa are reduced*				
Specific objectives	**Allocated amount by specific objective (EUR)**	**Geographical area of operation**	**Activities**	**Potential partners**[5]
Specific objective 1: Improve capacity so that reported outbreaks are rapidly assessed by qualified personnel	100,000	Benin, Burkina Faso, Cape Verde, Chad, Côte d'Ivoire, the Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Niger, Nigeria, Sao Tome and Principe, Senegal, Sierra Leone, Togo	1/ Rapid field assessment during initial phases of outbreaks 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	- ACF - FRA - ACH- ESP - CROIX-ROUGE - FICR-IFCR-CH - IRC - UK - MDM - FRA - MDM-P - MERLIN - MSF - BEL - MSF - CHE - MSF - ESP - MSF - FRA - MSF - LUX - MSF - NLD - UN - UNICEF - BEL - WHO - OMS

[5] 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 (LUX), MEDECINS SANS FRONTIERES BELGIQUE/ARTSEN ZONDER GRENZEN BELGIE(BEL), MEDICAL EMERGENCY RELIEF INTERNATIONAL (GBR), MEDICOS SIN FRONTERAS, (E), Médicos do Mundo Portugal, UNICEF, WORLD HEALTH ORGANISATION - ORGANISATION MONDIALE DE LA SANTE

Specific objective 2: Ensure that operations aimed at containing and controlling confirmed epidemics are implemented swiftly	1,150,000	Benin, Burkina Faso, Cape Verde, Chad, Côte d'Ivoire, the Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Niger, Nigeria, Sao Tome and Principe, Senegal, Sierra Leone, Togo	1/ Provision of curative primary health free care 2/ Punctual support to existing health centres and facilities through provision of drugs, vaccines and medical equipment 3/ Organization and supervision of mass vaccination campaigns	- ACF - FRA - ACH- ESP - CROIX-ROUGE - FICR-IFCR-CH - IRC - UK - MDM - FRA - MDM-P - MERLIN - MSF - BEL - MSF - CHE - MSF - ESP - MSF - FRA - MSF - LUX - MSF - NLD - UN - UNICEF - BEL - WHO - OMS
TOTAL:	1,250,000			

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 - Budget Impact article 23 02 01

-	CE (EUR)
Initial Available Appropriations for 2006	470.429.000
Supplementary Budgets	-
Transfers Commission	-
Total Available Appropriations	470.429.000
Total executed to date (14/2/2006)	245.157.235
Available remaining	225.271.765
Total amount of the Decision	1,250,000

9 – Annexes

Table I : Meningitis

Country	Meningitis Cases in West Africa						
	1999	2000	2001	2002	2003	2004	2005*
Burkina Faso	380	1150	9545	559	451	436	246
Burkina Faso	3 215	3178	13565	13368	8 661	6 329	3291
Cap-Vert	0	0	7			98	134
Côte d’Ivoire	94	22	220	462		458	492
Gambie			130	63		42	16
Ghana	527	676	1348	1649	1 681	1 007	332
Guinée	507	325	579	123		195	
Guinée Bissau	2 836		3			0	
Liberia	114		24			152	88
Mali	1040	862	1107	703	1 257	1 500	414
Mauritanie	264	254		51		12	1
Niger	5 576	13233	8556	4092	8 843	4 136	1110
Nigeria	1906	711	4215		16 753	1 729	635
Sénégal	6870	454	1106	132		76	62
Sierra Leone	8					0	
Togo	171	213	1339	623	422	436	261
TOTAL	23 508	21 078	41 744	21 825	**40 071**	**18 610**	**7082**

Source WHO. * Partial information.

Table II : Yellow Fever

Country	Yellow Fever cases in West Africa						
	1999	2000	2001	2002	2003	2004	2005*
Bénin	0	28	0	0	0	0	0
Burkina Faso	1	1	22	0	29	10	4
Cap-Vert	0	0	0	0	0	0	0
Côte d'Ivoire	1	31	280	156	158	92	4
Gambie	0	0	2	0	0	0	0
Ghana	0	0	1	7	61	1	2
Guinée	0	651	172	20	60	6	8
Guinée Bissau	0	1	0	0	0	0	0
Liberia	0	110	59	0	25	5	0
Mali	0	0	0	0	0	2	25
Mauritanie	0	0	0	0	0	0	0
Niger	0	0	0	0	0	0	0
Nigeria	0	22	0	20	0	0	0
Sénégal	0	0	1	134	1	2	0
Sierra Leone	0	0	0	0	90	0	2
Togo	0	0	8	0	0	0	0
	2	844	545	337	424	118	45

Source WHO. * Partial information.

Table III : Cholera

Country	Cholera cases in West Africa						
	1999	2000	2001	2002	2003	2004	2005*
Algérie	ND	0	ND	ND			
Bénin	803	278	3941	165	434	642	630
Burkina Faso	93	0	421	0	1	0	1050
Cap-Vert	3	0	ND	ND			0
Côte d'Ivoire	ND	0	5912	1323	1 172	105	38
Gambie	ND	ND	ND	ND		0	174
Ghana	9 432	1263	2012	139		212	979
Guinée	506	517	155	0		1482	3066
Guinée Bissau	ND	0	ND	ND			24242
Liberia	215	318	1003	300	30 271	449	3534
Mali	6	0	67	18	1 455	2839	557
Mauritanie	0	0	ND	0	31	2178	4076
Niger	1 186	98	194	104	292	0	512
Nigeria	26 358	1232	2170	ND	274	999	4249
Sénégal	ND	0	ND	0		1236	29574
Sierra Leone	834	ND	ND	ND		835	0
Togo	667	180	2696	68	385	1163	437
TOTAL	**40 103**	**3 886**	**18 571**	**2 117**	**34 315**	**12 140**	**73118**

Source WHO. * Partial information.

Table IV : Measles

Countries	Measles Cases in West Africa						
	1999	2000	2001	2002	2003	2004	2005*
Bénin	514	ND	5846	ND	178	225	229
Burkina Faso	8636	5298	ND	ND		1981	1053
Cap-Vert	ND	ND	ND	ND			0
Côte d'Ivoire	3200	2270	ND	5264		3206	3625
Gambie	0	300	ND	ND		120	15
Ghana	6141	17092	ND	ND		665	245
Guinée	8165	5803	ND	ND		183	
Guinée Bissau	0	0	ND	ND			
Liberia	456	4755	ND	ND		207	24
Mali	2 349	183	ND	ND	215	602	86
Mauritanie	4307	2898	ND	ND			28
Niger	34 948	15833	56636	ND	14 411	64430	2176
Nigeria	ND	ND	ND	ND		11841	39405
Sénégal	1959	1400	ND	ND		70	49
Sierra Leone	95	ND	ND	ND			16
Togo	2285	2545	310	ND		583	148
TOTAL	**73055**	**58377**	**62792**	**5264**	**14804**	**84113**	**47099**

Source WHO. * Partial information.

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[1], and in particular Article 14 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, poverty, lack of basic sanitation facilities, low hygienic standards increase the vulnerability to communicable diseases and enhance the transmission of infections.

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

(4) Outbreaks of communicable diseases shall be addressed irrespective of their magnitude, in order to reduce morbidity, expansion and mortality rates related to epidemics in West Africa.

(5) An assessment of the humanitarian situation leads to the conclusion that humanitarian aid operations should be financed by the Community for a period of 18 months.

(6) It is estimated that an amount of EUR 1,250,000 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 and other donors' contributions.

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 1,250,000 for Humanitarian Aid to populations affected by epidemics in West Africa by using line 23 02 01 of the 2006 general budget of the European Union.

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

[1] OJ L 163, 2.7.1996, P.1-6

- Improve capacity so that reported outbreaks are rapidly assessed by qualified personnel
- Ensure that operations aimed at containing and controlling confirmed epidemics are implemented swiftly

The amounts allocated to each of these specific 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 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.

Article 3

1. The duration for the implementation of this decision shall be for a maximum period of 18 months, starting on the 15th of February 2006.

2. Expenditure under this Decision shall be eligible from the 15th of February 2006.

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 and mortality rates related to epidemics in West Africa are reduced	
Specific objectives	**Amount per specific objective (EUR)**
Improve capacity so that reported outbreaks are rapidly assessed by qualified personnel	100,000
Ensure that operations aimed at containing and controlling confirmed epidemics are implemented swiftly	1,150,000
TOTAL	1,250,000