Supporting Ebola Preparedness in 13 at risk countries in Western Africa – Concept Note to prepare for further EU support

This document is based on a situation analysis presented in the Annex and has been prepared by DEVCO B4 with inputs from DEVCO E2 - Version 27.11.14

Potential areas for further EU support

Following the results of the EUD consultations (see Annex) and an HQ exchange between concerned units and Commission services the following key elements for EU actions on Ebola preparedness in 13 West-African at-risk countries[1] are suggested:

1. Continue country level support through re-orientation of bilateral programmes.

The survey highlights that considerable efforts are still required to improve country preparedness and health systems resilience against a possible Ebola outbreak. It also demonstrated that already many EUD are in a dialogue process with the government, other donors and civil society in countries at-risk (Guinea-Bissau, Senegal, Gambia, Ivory Coast, Niger and Mali) on their preparedness plans. Although health is a focal sector for EU development cooperation only in Guinea-Bissau, the EUDs in these other countries have become involved as well. The dialogue relates to the technical quality and feasibility of the national preparedness plans, the review of its priorities and – where available - the justification for the amount of funding proposed to implement the preparedness plans (28.3 million EUR for Mali, 1.8 million EUR for Guinea Bissau, 21 million EUR in Ivory Coast, 12.5 for Ghana and 6.3 million EUR for Senegal). The quality and costing of these plans is still evolving, and while some of the differences may be explained by country size and pre-existing investments, there appear to be major differences in estimates of needed resources and of unit costs, and the financing gaps on these plans are variable and changing, as inputs and funding commitments from development partners are continuing to come in. DEVCO services keep updating country level input mapping, but usually the time of finalising the table it is already outdated.

In countries where health is a focal sector (Guinea-Bissau, Burkina Faso, Nigeria, Mauritania), the EUDs have started to set aside amounts out of the bilateral portfolio, to be able to support specific elements of the national preparedness plans (e.g. EDF 2.9 million EUR in Burkina Faso; e.g. EDF 0.5 million EUR in Guinea Bissau). In other countries possible re-attribution of on-going programme components is done as well (e.g. EDF 0.3 contribution to Ebola treatment centre in Ivory Coast) or are being explored (e.g. on the State Building Contract in Mali). EUDs will have to continue to explore needs and possibilities, and will need substantial flexibility as development of national preparedness plans and incoming donor contributions keep evolving. - The results of the WHO missions which

[1] Based on various criteria of risk (in particular proximity to currently most affected countries and intensity of economic exchange and migratory and travel movements) a list of countries has been established, that comprises Benin, Burkina Faso, Cape Verde, Gambia, Ghana, Ivory Coast, Guinea Bissau, Mali, Mauritania, Niger, Nigeria, Senegal, Togo)

include a "stress test" in most of the at-risk countries[2] listed here, examining preparedness plans, will help improve the quality of these and lay the basis for better identifying funding gaps. The calendar of these missions had been shared with concerned EUD Delegations and reports from these missions keep coming in throughout November and the first half of December. An assessment of first drafts (Mali and Cote d'Ivoire) suggests that the budgeting side is not covered in any detail and will require further assessment, review and dialogue at country level. EUDs may require some thematic support for the related work (health budgets, required Ebola-preparedness supplement, unit costs etc.).

The rapidly changing landscape in terms of Ebola preparedness support coming from multiple donors will require on-going work at country level to ensure complementarity and comprehensiveness of preparedness plans and related support, but also identify any critical funding gaps. The situation calls for full application of the already well-established aid effectiveness mechanisms and tools as provided by the International Health Partnership IHP+ .

1.1 EUDs already participating in the established **country-level Ebola preparedness coordination and policy dialogue** should be commended (Guinea-Bissau, Senegal, Gambia, Ivory Coast, Niger and Mali), and encouraged to continue.

1.2 Delegations where no such participation has yet been reported should be encouraged to participate in established coordination mechanisms (suggested through a note by DEVCO). The main purpose of such participation would be to a.) support strengthening of country level coordination mechanisms and sharing off information as required, b.) **monitor adjustments of plans and implementation** of recommendations following the WHO gap analysis and "stress-test" of national Ebola preparedness plans (with a stress on performance of processes), and c.) assess related **budgets and funding gaps** that would need to be covered by additional funding , in cooperation and burden sharing with EU Member states wherever possible.

1.3 Additional technical and thematic **support for the assessment of Ebola preparedness plans and gap analysis** will be provided by the DEVCO health team supported by its Health Advisory Service, particularly for those EUDs not having health as a focal sector and not having health expertise in-country. Joint utilisation of in-country health experts of EU MS will be further promoted. The related cross-country exchange of experiences (e.g. on quantities, overall and unit costs of Ebola preparedness plans) will be facilitated. A specific functional mailbox has been opened for this purpose (DEVCO EBOLA PREPAREDNESS) and will be managed by DEVCO B4.

Any additional input should be based on the established in-country assessment and donor coordination through the EUD (where available in close coordination with the in-country Ebola coordinators of ECHO and / or EU MS' or other donors' health experts). – For Ebola preparedness to be effective, the 10 dimensions proposed by WHO (see listing in the Annex) need to be addressed simultaneously.

[2] Apparently only Niger and Cabo Verde are currently not foreseen to be covered by the WHO missions. However, the WHO missions will cover 4 more countries that are not included in the 13 countries listed here: Angola, Cameroon, Central African Republic and DRC

For these to be effective not only the related goods and materials need to be available, but also the related processes need to function, and monitoring needs to cover both. There is little room for complacency and compromise, and preparedness measures must be ratcheted up to also anticipate worst case scenarios (contrary to the usually prevailing tendency in development cooperation to rather see the positive side of things). This has implications for the monitoring and policy dialogue, as more rigour in target setting and follow-up will need to be applied.

2. Further explore options for actions at the regional level

Although the essence of Ebola preparedness lies at the national level, there is substantial scope for action at the regional level: Exchange of experiences, common use of laboratory or training capacities, pooling of reserve equipment through regional stockpiling would just be some of the elements, that would at the same time facilitate regional and cross border cooperation and promote regional integration.

The potential role of the regional level is still being debated, and there are conflicting messages from both donors and at risk countries. Because of the managerial and operational limitations of any regional organisation in West Africa (be it WHO hubs, ECOWAS, WAHO, etc.) these might not be by themselves effective and sufficient for issues that require rapid reaction. On the other hand side-lining these organisations in any regional response and preparedness plan would be a missed opportunity to allow strengthening of these institutions and qualifying them for future needs. Therefore a combination of a good implementer and a sufficiently mandated regional organisation should be envisaged.

2.1 EU to advance discussions with WHO and other key players on establishing strong regional technical collaborations to coordinate and take forward regional Ebola preparedness work.

One of the **options for regional support** would be to explore whether one of the established and mandated regional health organisations (e.g. WAHO) could be brought in partnership with a well-reputed implementer (e.g. UNICEF), to provide meaningful regional support to countries. – If this idea is to be pursued the related thematic support for programme design could be provided by the DEVCO health team. After a first exploration with EU MS mid-November further design details are being developed (scope in terms of main preparedness areas, mutual TA and exchange in setting up some of the elements that are particularly weak, like for example Rapid Response Teams RRT and epidemiological surveillance, regional stockpiling options for rapid deployment of Personal Protective Equipment PPE etc.).

2.2 EU to actively participate in the planned WHO meeting on health systems resilience and recovery planned to be held in **Geneva on December 10th and 11th** (DEVCO B4 thematic lead).

2.3 Complementary roles of **existing regional technical networks** should be further explored[3] particularly in the areas of epidemiological surveillance and overall preparedness plans (DEVCO B4 could take the thematic lead).

2.4 Regional support under the EDF could also be investigated: by adapting (via a rider) the soon to be launched 'AWARE', LRRD Ebola response project for affected countries, to include preparedness actions, and/or under the resilience window of the West Africa Regional Indicative Programme through a regional action addressing preparedness against epidemics. Both these actions would require funding from the 11th EDF to come on stream, given the limited resources under the 11th EDF Bridging Facility. If needs arise, other additional EDF funding needs would require to be explored (given that current DCI / GPGC are fully committed already)

3. Support from global level

This note focusses on the needs **of countries** that could possibly be addressed by global support mechanisms. The rapidly evolving situation at country level (both in terms of preparedness and in terms of incoming international support) will require maximum flexibility of inputs. Although some of the 10 preparedness areas appear to be particularly weak in many countries, none can be singled out for possible global support. It is therefore suggested to foresee a flexible financing facility from which EUDs could draw depending on the evolving country level situation based on the local coordination and dialogue around the implementation of the recommendations of the WHO stress test mission, and the identification of funding gaps that goes with it. While such gap-filling approach might be the most appropriate response in operational terms, it may be less appealing in visibility terms. This weakness could be addressed through appropriate accompanying branding and communications.

Global support via the IcSP is already under preparation by the FPI that will address some of the 10 preparedness areas but apparently not all (currently foreseen are EUR 13 million, of which 8 are planned to be implemented via the WHO (10 countries planned) and EUR 5 million via the IFRC (8 countries planned). Any additional complementary support would need to take these inputs into consideration and be complementary.

An examination of the first drafts of the WHO country level preparedness assessments (Cote d'Ivoire and Mali) suggests that they focus on technical aspects of preparedness scrutiny and largely leave out related budgets and assessment of existing funding and funding gaps. Budgeting and funding gap analysis may therefore become an area that needs additional support.

3.1 Consider intended IcSP / FPI support in terms of geographic coverage and coverage of the 10 essential preparedness areas. Support the assessment of countries' underlying budgets of country level plans, and support the identification of funding gaps, possibly using standard tools (Options for support via HAS and IHP+ will be explored by the DEVCO health team). Develop, as needed, a concept for **additional flexible global support** that could be deployed in a demand driven manner,

[3] In particular CBRN Network ("Centres of Excellence") financed under IcSP, potential of "Le FEWSNET du choléra" (ECHO/UNICEF 2012-14), and MediPiet-like networks in collaboration with ECDC, as well as regional CSOs (e.g. ALIMA)

according to gaps identified in the on-going assessments and monitoring. Develop **branding** for such operation (e.g. "EBO-FLEX") and the accompanying communication strategy.

3.2 Make use of the experiences of IcSP / DEVCO support to Centres of Excellence on CBRN threats, to enhance preparedness, in particular in the area of laboratory capacity and the deployment of mobile laboratories and the use of rapid diagnostic tests.

The proposed support to Ebola preparedness involves almost the full spectrum of health systems functions, and as such can benefit the strengthening of health systems, provided it will be deployed in an aligned and aid-effective manner, that leaves sufficient room for countries' own leadership and development of management capacities. Once the current Ebola outbreak has been controlled, the emergency response will need to be complemented by a longer term vision of better funding and strengthening neglected health systems.

Annex

To the Document: Supporting Ebola Preparedness in 13 at risk countries in Western Africa – Concept Note to prepare for further EU support

Situation analysis and background

The on-going outbreak of Ebola Virus Disease (EVD) in the most affected countries Liberia, Sierra Leone and Guinea has been posing a continuing threat to neighbouring countries. What most distinguishes the current situation from previous outbreaks is the high proportion of transmission occurring in the community. The transmission and rapid spread of Ebola infections in the 3 countries is mainly through mucosal contact with human body fluids from persons with clear symptomatic disease or from persons that died of EVD. The essential measures to contain and control the outbreak are early detection, isolation and treatment of EVD cases under appropriate infection control measures, contact tracing and monitoring of contacts, and safe burial of victims of EVD.

On the side of the health care providers, implementation of these measures requires that they have the appropriate procedural instructions and guidelines, have received the related training and acquired the required skills, are provided with the appropriate Personal Protective Equipment (PPE) and correctly use the PPE. It is further of crucial importance that health staff are motivated and committed to deliver health care services which will bring them into contact with EVD patients (diagnostic, therapeutic and caring procedures) and develop an empathic and patient- centred approach with the welfare of the patient, the community and the wider population in mind.

On the side of the people involved in burials similar interventions are required to enable them to effectively and safely perform their job which is crucial for infection containment while minimising the risk to themselves.

On the side of the general population, implementing of these measures requires that trust in the public service providers is (re-)established which will require awareness raising using culture-sensitive messages that inform about the need of early case detection, isolation and treatment to improve survival and minimise transmission, and reduce the risk for other family and community members, as well as appropriate handling and transport of suspected EVD cases and the dead.

Problem analysis

The outbreak is happening in countries that have come out of conflict and civil wars (except Guinea, which also went through destabilising regime changes), that have not yet fully recovered, and that have severely under-funded public health systems (less than 20 USD per capita per year, which is far below the WHO recommended threshold of around 86 USD per capita), and that were neither prepared nor equipped to address an outbreak of this magnitude. Sites of treatment for EVD affected patients (in the formal health system, but also with traditional healers) rapidly became places of increased spread, as were unsafe burial practices involving unprotected physical contact with the EVD patients. One of the lessons learned from this outbreak is that while control is technically relatively easy and feasible, it poses serious problems if health systems are fragile, if trust between

users and the health system is disrupted, and if the population's knowledge about the disease is low and required behavioural changes are at odds with long-standing traditions and habits.

Early detection and a rapid response are of utmost importance to contain and control the disease. Preparedness therefore involves specific measures to ensure adequate surveillance and early detection, isolation and treatment of EVD cases and contacts. While special Rapid Response Teams (RRT) can play a pivotal role in early stages of the epidemic and in limited outbreaks, they can no longer cope once case numbers have gone over a certain threshold and controlling the outbreak becomes increasingly difficult.

Preventing the introduction and spread in neighbouring countries can to some extent build on control of entry points (border crossing points, harbours, airports) but this is difficult to reinforce in a region with porous borders and limited capacity of enforcement. Moreover, because of the potentially long incubation period (up to 21 days), and the danger of causing substantial economic damage through overly draconian and relatively ineffective sealing off measures of entire districts, regions or countries, this has overall limited potential for success. While underlying factors outside the health sector (such as excessively low public budgets, traditional beliefs and behaviours, etc.) have contributed to the outbreak, and while its effects are being felt outside the health sector (security, trade etc.), the key for the control of the outbreak, and for preventing its spread to neighbouring countries, clearly lies within the health sector and its ability to early identify, isolate , treat and care for patients and its success in changing behaviour of the population.

Current state of preparedness

Neighbouring countries that successfully have controlled and contained initial cases have been able to use – as part of their response - pre-existing platforms for public awareness raising (e.g. in Senegal SMS messaging via an m-health platform initially created for diabetes) or pre-existing highly specialised surveillance and outbreak control mechanisms (like the polio-eradication programme in Nigeria). Successful preparedness requires a broad systemic approach that takes sufficient account of each country's specificities and there is no one-size fits all approach. . – Essential key elements of national preparedness plans are well established and described in the related WHO guidelines. The concern the following 10 elements: 1) coordination, 2) RRT, 3)Public Awareness Raising, 4) Infection prevention and control in the basic health care system, 5) Capacity for case management in Ebola Treatment Centres (ETC), 6) Safe burials, 7) Epidemiological surveillance, 8) Contact tracing, 9) Laboratory capacity and 10) Entry points screening capacity

Governments in at risk countries have started to assess their preparedness and have identified gaps and drawn up preparedness plans, but many of these are not yet completed , are not appropriately prioritised, nor costed, and let alone operationalized. WHO has scheduled a series of 5-day missions to the 15 identified at-risk countries to assess Ebola preparedness based on the standardised 10 point checklist. These missions are taking place in October /November and assessment reports are expected in due course.

DEVCO however has completed a quick interim assessment using the same WHO assessment grid to assess the degree to which at risk countries are already complying with the WHO preparedness

guidelines, to which extent they have started to improve their preparedness and whether they have been supported by or are receiving support from the international community

The **EU Delegations** in the 13 at risk countries have responded to a questionnaire sent out by the DEVCO geographic unit on October 21st; these reported observations have been completed via telephone contacts with EUD carried out by the DEVCO health team. Also the intentions of major **EU MS donors** for future support to preparedness in the 13 countries have been assessed through phone contact with MS by the DEVCO health team.

An EVD preparedness assessment **WHO expert missions** is currently being carried out by WHO (1-week missions) and will go through to December. Although two such assessments have been obtained informally, no official documents have been shared by WHO yet. The WHO missions cover practically the same 13 countries as the EU assessment (except Niger and Cabo Verde, but includes some additional countries: Angola, Cameroon, CAR, and DRC).

Findings preliminary preparedness assessment

The findings of DEVCO assessments provide a preliminary picture of preparedness in the 13 countries. Details are provided in the Annex 1 while a summary is provided below. The technical capacity of EUD staff to assess the EVD situation in country is variable; from excellent in countries where health is a focal sector for development cooperation, and where the EUD is equipped with a public health expert, to limited in countries where health is not a focal sector. Therefore this preliminary assessment will require to be updated with information obtained from the technical and detailed assessment currently carried out by the WHO.

To facilitate future adaptations the preparedness measures are listed blow using the same categories and in the same order as the assessment grid used by the WHO:

1. Coordination: 2 countries are reported to have reasonable to good coordination mechanisms being set up, 6 countries are reported to have some coordination that needs improvement and 5 countries are reported to have no or extremely weak coordination mechanisms; countries' preparedness plans are being presented and reviewed in dialogues with development partners, and most EUDs are participating in these dialogue fora.

2. Rapid Response Teams (RRT): No country is reported to have an adequate number of tested RRT mechanisms, 3 countries are reported to have some fledgling RRT mechanism that needs improvement and 1 countries is reported to have no RRT mechanisms (currently insufficient or no information for 9 countries) – this is apparently one of the weakest areas in the current preparedness state of play, and because of its crucial role of the detection of "the first case" is where possibly most urgent support is needed.

3. Public Awareness Raising: 6 countries are reported to have reasonable to good comprehensive public awareness campaigns with correct essential messages and good coverage being set up, 7 countries are reported to have some initial awareness raising that needs improvement and no country is reported to have no systematic awareness raising with adequate messaging and coverage at all (currently insufficient information for 1 countries).

4. Infection prevention and control in the basic health care system: This is one of the weakest areas of the entire system. Small studies with very incomplete coverage and anecdotal evidence suggest that hygiene practices, particularly in the highly under-funded basic health systems, are extremely weak for lack of basic equipment and for lack of rigor in the training, supervision and application of essential hygiene and diagnostic practices. This situation leads to a high risk that health care facilities can become places of increased spread of infectious diseases, including Ebola. – It is expected that there will be only limited additional evidence coming out of the WHO Ebola preparedness< mission, and identification of specific support needs could start immediately; activities should start in border areas of most affected countries.

5. Capacity for case management in Ebola Treatment Centres (ETC): 1 country is reported to have reasonable preparation for ETCs being set up, 5 countries are reported to have started identifying ETCs and related procedures for transfer and 1 country is reported to have not yet embarked on preparing for a ETC set up. For 6 countries currently no information is available and will again have to wait for the results of the WHO assessment.

6. Safe burials: In most populations of the region traditional burial practices involve close physical contact with the deceased and thus poses a high risk of Ebola transmission. Public authorities, supported by Red Cross / Red Crescent societies have started to sensitise the population and to offer instructions and specific assistance for safe burials. Little is known about the coverage and effectiveness of these measures, and again it is unlikely that the WHO mission will come up with more quantitative information – depending on need and demand, opportunities for support could already be identified at country level (according to EUD information 3 countries report starting to develop safe burial procedures, whereas no information is given for 9 countries)

7. Epidemiological surveillance: A good and comprehensive mechanisms is reported for only 1 country, 6 countries are said to have at least some surveillance mechanism and 2 countries are reported to have no proper mechanism at all (no information for 4 countries).

8. Contact tracing: Comprehensive for 1 country, some preparation for contact tracing by 6 countries, no information for 6 countries.

9. Laboratory: Sufficient capacity reported for no country Some lab capacity in 10 countries, no information for 3 countries.

10. Entry points capacity: Sufficient capacity for no country, some capacity in 9 countries, no info in 4 countries.

UNMEER has not been contacted on preparedness for neighbouring countries, but is said to be fully occupied with the 3 most affected countries and currently no capacity left for going much further (though it appears that UNMEER has now started with this, i.a. by opening a contact office in Mali).

Information on other donors' funding intentions is sketchy while it is unclear how much domestic resources will be/can be mobilised to cover anticipated costs to improve preparedness in country. However, in most countries coordination networks are available which can be used for policy

dialogue and to coordinate, mobilise and align any support available. UK DFID fund health programmes in Nigeria and Ghana with health expertise in country and will be able to play an active role in these countries. EU MS are keen to work with the EU and see the Commission take a central role to advance coordination required with respect to regional preparedness work as also highlighted in the recent EU MS Meeting in Brussels (12-13 Nov'14).

Following the country assessment WHO will be providing immediate technical support to address urgent gaps in preparedness and the assessment is expected to also identify additional TA needs to take forward any needs/gaps in preparedness identified which subsequently is expected to be mobilised through the WHO.

There is currently no central focus on health system strengthening in the Ebola response framework and most if not all inputs / resources are aimed to control the current outbreak and prevent further spread. A high level meeting is being organised by WHO in Geneva December 10-11, 2014 in which results of the assessment will be presented and next steps discussed and prioritised with involvement key stakeholders and partners. The focus of the meeting will be on health system resilience and recovery; the character of the meeting (high level vs. senior technical level) is still under discussion (apparently Ministerial representation from Ministry of Health and Ministry of Finance of the 3 most affected countries is intended).

In summary, the findings of the preliminary assessment highlight that none of the at risk countries is adequately prepared with shortcomings in many of the 10 essential preparedness areas but with insufficient resources to do so. No effective coordination mechanism is currently in place to ensure critical gaps in regional preparedness are urgently addressed for which additional resources will need to be mobilised.