EU EBOLA LESSONS LEARNED EXERCISE

SESSION WITH PARTNERS.

8 July 14.00 – 17.00

This outlines in annotated format the main points made by the four presenting partners (Alima, IFRC, MSF, WHO) and during the ensuing discussion.

ALIMA

EU Medevac was sine qua non with regard to Alima's deployment

The fact that the EU funded both preparedness and response and was took a regional approach was considered positive;

More consistent approach was needed for EU preparedness funding: it was unclear which service was funding preparedness measures with what budget-line (ECHO , EUDel or FPI);

As a major donor of both UN agencies and INGOS , EU should insist on better coordination amongst the two in the field;

EU/ECHO should consider more investment in Hospital and Intensive care in crises (many lives were lost because of this lack);

Deployment of ECDC epidemiologists was extremely positive;

Importance of reinforcing existing local capacity is more effective and sustainable.

Europe did not get the visibility in comparison with the many different elements of its actions;

WHO

EU coordination was done well through the Task Force;

Medevac was well received but slow to develop;

EU was quick at recognizing the crisis and providing early funding,

EU the reaction time and deployment of medical staff should be improved.

EU was slow to engage with UNMEER although confusion between role of UNMEER and WHO was understandable.

Lack of French-speaking international expertise.

Too much funding was earmarked.

Need for earlier incentives strategy.

Lead country concept was useful for setting up National and District Coordination centres and supporting Government authorities (especially in SL and Lib) - ? Guinea Bissau.

OCHA and cluster system not initially adapted to an epidemic response.

Noted that there are several disincentives for affected countries to declare a problem. Need for assessments to have clearer trigger criteria.

MSF

Highlighted the fact that Epidemic was on-going and there were still significant weaknesses in the response notably with community sensitisation– in sense too early for lessons learned but also appropriate to improve on-going response.

EU role on mobilization through the conferences and EP and Ebola Coordinator was well received;

EU role on information sharing and advocacy through the Task force was well received;

EU Task Force should have been more operational;

EU field response was too slow – including full-time ECHO expert deployment

EU response capacity in terms of FMTs should be reviewed;

EU should promote Research on vaccines and treatments for neglected tropical diseases.

Agrees with Alima need to improve clinical care

IFRC

ERCC meeting positive for information exchange and advocacy;

EU Helped to advocate for scale up response early on;

EU Medevac positive.

Potential for EU to be more involved in promoting new technologies for the more rapid dissemination of data;

HR was a major problem.

Highlighted importance of supporting Local organizations and mechanisms;

Importance of building preparedness

Importance of pushing national authorities to legislate for improved crisis response

Points from the Floor.

IOM - The crisis was not just medical and should have involved non-medical agencies in an earlier stage.

UK - Accepted slow response but also noted the lead time to prepare and deploy a safe and effective response from scratch

Would not expect Lead role to be streamlined – exceptional situation plus specific request were unique – traditional response mechanism should prevail.

ES – highlighted the difficulty of recruiting Human resources and the danger of competing amongst agencies (including new EU voluntary system)

OCHA - Observed the need to review the coordination of health crises at global and regional level to make best use of comparative advantages and avoid duplication.

UNICEF - Appreciated early EU support – notably funding and transport support (NL ship).

WFP - Logistic cluster worked well. Nonetheless Health crises produced unique logistic challenges which WFP was not prepared for.

EU/ERCC role in coordinating the EU in-kind donations was very positive. Need to build more formal relationship between ERCC and logistics cluster in order to establish stand-by systems.

US - Agreed that Lead role status was useful in leveraging support but would not necessarily recommend it becoming a systematic approach.

Military response was as a result of specific request from USAID and not systematic response.

Antwerp Tropical Medicine -Notes that 57 countries do not have the capacity to enforce IHR. Need for Coherence in incentives for national health workers. Need to create fiscal space for affected countries