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THE EU RESPONSE TO THE EBOLA CRISIS

Diploma Thesis

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Brno, 2015

DECLARATION

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ABSTRACT

ŠAŠINKOVÁ, I., Mgr., Bc. The EU Response to the Ebola Outbreak. Diploma thesis. Brno, 2015.

The aim of this thesis is to analyse EU response towards the Ebola outbreak that developed in spring and summer 2014 in Western Africa. The emphasis is put on the EU external action towards the Ebola crisis in the frame-work of the EU development policy and humanitarian aid provided by the EU while identifying the financial framework, institutional structure, key players and the role of the EU Members. It was a common endeavour of whole range of global actors, national governments and many regional or local stakeholders that led to elimination of the threat represented by the Ebola Virus Disease. The European Union traditionally emphasized multilateral approach that is in compliance with the EU *middle power* capacities. The development policy financial mechanisms within the EU have two resources, the EC and the Member States which cumulatively contributed twice as much as the European Commission to resolving the crisis.

KEYWORDS: Ebola, European Union, development policy, humanitarian aid, Guinea, Sierra Leone, Liberia

ABSTRAKT

ŠAŠINKOVÁ, I., Mgr., Bc. Reakce EU na epidemii eboly. Diplomová práce. Brno, 2015.

Cílem této práce je analyzovat reakci Evropské unie na vypuknutí epidemie Eboly na jaře a v létě 2014 v západní Africe. Důraz byl kladen na vnější činnosti EU směřující k řešení krize, a to konkrétně v rámci rozvojové politiky EU a humanitární pomoci na základě identifikace finančního rámce, institucionální struktury, klíčových hráčů a role členských zemí EU. Společné úsilí řady globálních aktérů vedlo k eliminaci hrozby Eboly. Evropská unie jako tradičně kladla důraz na multilaterální přístup, který je v souladu s kapacitami *middle power.* Mechanismy rozvojové politiky v rámci EU jsou financovány ze dvou zdrojů, Evropskou komisí a členskými státy, které k řešení krize kumulativně přispěly dvakrát vice než Evropská komise.

KLÍČOVÁ SLOVA: ebola, Evropská unie, rozvojová politika, humanitární pomoc, Guinea, Sierra Leone, Libérie

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List of Abbreviations

ACP	Africa, Caribbean, Pacific
AU	African Union
CFSP	Common Foreign and Security Policy
DAC	Development Assistance Committee (of the OECD)
DCI	Development Cooperation Instrument
DEVCO	Directorate General for International Cooperation and Development
DG ECHO	Directorate General for Humanitarian AID and Civil Protection
DG SANTE	Directorate-General for Health and Food Safety
EC	European Commission
ECDC	European Centre for Disease Prevention and Control
ECOWAS	Economic Community of West African States
EDF	European Development Fund
EERC	Emergency Response Coordination Centre
EFSA	European Food Safety Authority
EHPA	European Public Health Alliance
EPA	Economic Partnership Agreement (with ACP countries)
EU	European Union
EVD	Ebola Virus Disease
HDI	Human Development Index
MSF	Médecins Sans Frontières = Doctors Without Borders
ODA	Official Development Assistance
SADC	Southern African Development Community
TB	Tuberculosis
TEU	Treaty of the European Union
UN	United Nations
UNDP	United Nations Development Programme
WHO	World Health Organization

1 Introduction

1.1 Situation Summary

The presented diploma thesis will focus on the dimensions of the EU response to the Ebola crisis that developed in spring and summer 2014 in West Africa. The 2014 –2015 Ebola epidemic is the largest one in the history, affecting multiple countries mainly in West Africa.

After a positive development in early 2015[1], the number of reported Ebola cases has increased again in February 2015 in three West African countries (Guinea, Liberia, Sierra Leone), where the transmission was still active (U.S. Army Public Health Command 2015). Since the very beginning of the Ebola outbreak, there have been 25 872 reported cases in the three most affected countries, and 10 721 deaths announced by the WHO on 24 April 2015[2] (WHO 2015a).

Some cases of Ebola were also diagnosed in the USA and in Europe. The European Union together with the WHO and other international organizations both profit and non-profit is very active in reporting, analyzing the situation and attempting to find the best pre-emptive action applicable within the EU and a solution applicable in the affected region. The aim of this thesis is to analyze and describe the crisis from a political and international point of view. To explore factors affecting the EU's policy making in the area of development policy and humanitarian aid and the consequent internal and external actions and so identify the EU response to the Ebola outbreak on the crossroad of more EU policies (namely the Common Foreign and Security Policy, Development Policy, Public Health Policy etc.) and finally to classify all possible levels of the EU action towards the Ebola outbreak.

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1 The WHO published first slightly positive report on 23 January 2015 that Ebola was declining but still represented a serious threat. (U.S. Army Public Health Command 2015, Voice of America 2015)

2 However even the updated Data and Statistics provided by the World Health Organization do not include complex and exact figures due to the fact that some countries (Liberia) do not report to WHO. (WHO 2015e)

The EU is not obliged to react to the Ebola crisis only due to the historical ties and relations with the African continent and due to the proclaimed EU engagement in responding to global challenges and resolving international threats. The EU also has the responsibility *"to promote peace, its values and the well-being of its peoples"* (Article 3 TEU) that arises from the EU primary law and currently is embedded within the Public Health Policy (EC 2015a). This implies that the EU measures taken in relation to the Ebola outbreak have two dimensions, internal and external. The internal dimension is the internal activity of the EU in order to protect the health and safety of the EU citizens in accordance with the primary goals of the European integration although the real power of EU law in the field of health care is limited. The external dimension emerges from the fact that the Ebola crisis broke up far away behind the European borderline and therefore is primarily a foreign policy issue yet with unpredictable impact and consequences.

1.2 Structure and Methodology

As regards the structure of the thesis, after the general introduction and defining the research area, its limits and methodology, specifying the primary and secondary objectives will follow. The literature review will precede the completion of partial sections. The theoretical part will bring an overview of the Ebola Virus Disease that will be further explained including the background, transmission and development of the current Ebola wave and Ebola in media. In the subsequent analytical part, demographic impact of the EVD on the populations of the affected countries will be analysed considering the Human Development Index values for the respective countries.

In the following chapter, the European Union as a global player will be presented including the EU Development Policy and the Humanitarian Aid provided by the Union. The EU relations towards Africa will be specifically described, outlining the institutional structure, key players, starting points and the EU capacity to react to global challenges and its *modus operandi* in this particular issue. The EU response towards the Ebola crisis will subject of the subse-

quent chapter divided into two sections according to the nature of the measures taken into the external dimension and internal dimension. The external dimension covers humanitarian aid, development aid and diplomatic outreach, an area with a great impact on international security. The internal dimension covers the activities within the EU health policy, medical framework and public safety and research. Obviously, both dimensions are interconnected since the affaires taking place far behind the EU borderline may have a serious impact on the quality of life of the EU citizens. This determines, that the EU internal and external policies are connected to ensure the final equilibrium of revenues and expenses not only in the financial matters but figuratively as well. The financial dimension of the EU measures is connected to all spheres[3]. The EU Multi-annual Financial Framework Perspective for the current period is embedded within the chapter dealing with the specific EU action towards the EVD.

A combination of descriptive and analytical approaches and both qualitative and quantitative methods will be used in the presented thesis. Discourse analysis is the prevailing method. Evaluating the achievement of primary and secondary goals and assessment of the EU external action towards the Ebola outbreak will create the concluding section of the presented thesis.

1.3 Defining the Research Area and the Research Limits

The presented topic is of a great importance from all points of view since it touches upon obviously very sensitive areas as health of individuals, international security, humanitarian actions and development aid. Furthemore it raises questions in much wider perspective related to global safety and security, bioterrorism, role of media, medical and military research and many others. Therefore the EU action towards the Ebola crisis can be described as interdisciplinary and multilevel covering wide scope of areas: financial aid, humanitarian aid, de-

3 The European Union, together with its Member states, has made available more than €1.4 billion in financial aid to help contain the outbreak of Ebola virus disease in West Africa. (EC 2015b). Detailed information regarding the financial perspective of the EU development policy is covered by the following chapters.

velopment aid, medical research, both public safety and international security dimension and diplomatic outreach.

In autumn 2014 the Ebola issue was a hot topic discussed at all levels in majority of the EU institutions. The need of preparing an action plan with concrete measures was emphasized by Commissioner for Humanitarian Aid and Crisis Management and EU Coordinator on Ebola, Christos Stylianidessaid, as well as by the MEP's involved in Development and Cooperation. (EP 2014a) However Development Committee rapporteur on Ebola, Charles Goerens (ALDE, LU), criticized the Council for very late action emphasizing the immediate campaign. (EP 2014a)

The resource base is extensive and rich, there is a wide range of primary and secondary resources available. The data sources come from the EU institutions, from various international organizations and NGOs with a health and development focus, from health experts and scientific centres, from the governments of affected countries as well as from the governments of not affected countries. However, there is no comprehensive work dealing with this topic available at the moment. The Ebola issue generally corresponds with the media trends in grave matters. The enormous interest of the world press present at the very beginning rapidly declined in 2015. In summer 2014 lots of information related to the Ebola outbreak was being published daily by both the major global press and less known regional media. In 2015 the latest development is monitored only by the major organizations involved in health policy (WHO, MSF), development aid (UN, EU) or by stakeholders with direct interest in theregion. Not any longer by daily media coverage.

There were lots of measures taken by the EU, however to assess whether these steps were effective, well targeted and successful, an intense and continuous observation in the field would be inevitable. This fact creates the first research limit. Another research limit is the interdisciplinary and multilevel character of this issue resulting into unclear competencies and fragmented accountability, parallel actions, challenging logistics and delayed operations. Last yet very serious research obstacle is the inaccessibility of the primary data. Not all af-

fected countries are responsibly reporting the casualties and latest developments in the regions as was requested by the international community. The Western African countries were not affected equally on the national level. The remote provinces / regions performed more intensive appearance of the disease. However due to the data unavailability, the comparison of the regional units was not possible and therefore the results of the data analysis bring evaluation of the national levels.

The primary objective of the presented thesis is to analyse the external dimension of the EU response to the Ebola Virus Disease. To achieve the main objective, the following set of partial objectives was defined:

1. To present a theoretical background of the Ebola Virus Disease and its demographic impact on the population of the most affected Western African countries.
2. To analyse the development policy and humanitarian aid settings within the EU while identifying the financial framework, institutional structure and key players and the role of the EU Members.
3. To specify and analyse the EU external action specifically in case of the Ebola Virus Disease while using the variables set in the previous step.
4. To evaluate the EU response to the Ebola outbreak on the basis of the strengths and weaknesses assessment.

2 The Ebola Disease

"The Ebola disease tends to come and go over time. The viruses are constantly circulating in animals, most likely bats. Every once in a while, the disease spills over into humans, likely when someone handles or eats undercooked or raw meat from a diseased ape, monkey, or bat. An outbreak can then happen for several months. And then, usually, it becomes quiet again." (Locke 2015)

2.1.1 Background

The Ebola virus causes an acute, serious illness often fatal if untreated. Ebola virus disease first appeared in 1976 in two simultaneous outbreaks, one in Nzara, Sudan, and the other in Yambuku, Democratic Republic of Congo. The latter occurred in a village near the Ebola River, from which the disease takes its name[4]. (WHO 2014a)

The current outbreak in West Africa, (first cases notified in March 2014), is the largest and most complex Ebola outbreak since the Ebola virus was first discovered in the seventies. There have been more cases and deaths in this outbreak than all others combined. It has spread between countries starting in Guinea then spreading across land borders to Sierra Leone and Liberia, by air to Nigeria, and by land to Senegal[5]. (EC 2015b)

The most severely affected countries Guinea, Sierra Leone and Liberia have very weak health systems, are lacking human and infrastructural resources, having only recently emerged from long periods of conflict and instability. On August 8, the WHO Director-General declared this outbreak a *"Public Health*

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4 The virus family Filoviridae includes 3 generations: Cuevavirus, Marburgvirus, and Ebolavirus. There are 5 species that have been identified: Zaire, Bundibugyo, Sudan, Reston and Taï Forest. The first 3, Bundibugyo ebolavirus, Zaire ebolavirus, and Sudan ebolavirus have been associated with large outbreaks in Africa. The virus causing the 2014 West African outbreak belongs to the Zaire species. (WHO 2015a)

5 A separate, unrelated Ebola outbreak began in Boende, Equateur, an isolated part of the Democratic Republic of Congo (WHO 2015a).

Emergency of International Concern". (WHO 2014a, WHO 2015a, CIA 2014a, CIA 2014b, CIA 2014c)

2.1.2 Transmission and Symptoms of Ebola Virus Disease

"It is thought that fruit bats of the Pteropodidae family are natural Ebola virus hosts. Ebola is introduced into the human population through close contact with the blood, secretions, organs or other bodily fluids of infected animals such as chimpanzees, gorillas, fruit bats, monkeys, forest antelope and porcupines found ill or dead or in the rainforest." (WHO 2015a) Ebola then spreads through human-to-human transmission via direct contact (through broken skin or mucous membranes) with the blood, secretions, organs or other bodily fluids of infected people, and with surfaces and materials (e.g. bedding, clothing) contaminated with these fluids. Health-care workers have frequently been infected while treating patients with suspected or confirmed EVD. This has occurred through close contact with patients when infection control precautions are not strictly practiced. (WHO 2015a)

Burial ceremonies in which mourners have direct contact with the body of the deceased person can also play a role in the transmission of Ebola. People remain infectious as long as their blood and body fluids, including semen and breast milk, contain the virus. Men who have recovered from the disease can still transmit the virus through their semen for up to 7 weeks after recovery from illness. (WHO 2015a, Williams 2014)

"The incubation period, that is, the time interval from infection with the virus to onset of symptoms is 2 to 21 days. Humans are not infectious until they develop symptoms. First symptoms are the sudden onset of fever fatigue, muscle pain, headache and sore throat. This is followed by vomiting, diarrhoea, rash, symptoms of impaired kidney and liver function, and in some cases, both internal and external bleeding (e.g. oozing from the gums, blood in the stools). Laboratory findings include low white blood cell and platelet counts and elevated liver enzymes." (WHO 2015a)

2.1.3 Diagnosis

It can be difficult to distinguish EVD from other infectious diseases such as malaria, typhoid fever and meningitis. Samples from patients represent an extreme biohazard risk; laboratory testing on non-inactivated samples should be conducted under maximum biological containment conditions. (WHO 2015a, Williams 2014)

Supportive care-rehydration with oral or intravenous fluids- and treatment of specific symptoms, improves survival. There is as yet no proven treatment available for EVD. However, a range of potential treatments including blood products, immune therapies and drug therapies are currently being evaluated. No licensed vaccines are available yet, but 2 potential vaccines are undergoing human safety testing. (WHO 2015a, Jones 2014)

2.1.4 Prevention and Control

Good outbreak control relies on applying a package of interventions, namely case management, surveillance and contact tracing, a good laboratory service, safe burials and social mobilization. Community engagement is key to successfully controlling outbreaks. Raising awareness of risk factors for Ebola infection and protective measures that individuals can take is an effective way to reduce human transmission. (WHO 2015a, Jones 2014) The following factors are of an enormous importance and significantly contribute to the risk reduction:

1. Reducing the risk of wildlife-to-human transmission from contact with infected fruit bats or monkeys/apes and the consumption of their raw meat. Animals should be handled with gloves and other appropriate protective clothing. Animal products (blood and meat) should be thoroughly cooked before consumption.
2. Reducing the risk of human-to-human transmission from direct or close contact with people with Ebola symptoms, particularly with their bodily fluids. Gloves and appropriate personal protective equipment should be

worn when taking care of ill patients at home. Regular hand washing is required after visiting patients in hospital, as well as after taking care of patients at home.

3. Outbreak containment measures including prompt and safe burial of the dead, identifying people who may have been in contact with someone infected with Ebola, monitoring the health of contacts for 21 days, the importance of separating the healthy from the sick to prevent further spread, the importance of good hygiene and maintaining a clean environment. (WHO 2015a)

2.1.5 Controlling Infection in Health-Care Settings:

Health-care workers should always take standard precautions when caring for patients, regardless of their presumed diagnosis. These include basic hand hygiene, respiratory hygiene, use of personal protective equipment, safe injection practices and safe burial practices. Health-care workers caring for patients with suspected or confirmed Ebola virus should apply extra infection control measures to prevent contact with the patient's blood and body fluids and contaminated surfaces or materials such as clothing and bedding. When in close contact (within 1 metre) of patients with EBV, health-care workers should wear face protection (a face shield or a medical mask and goggles), a clean, non-sterile long-sleeved gown, and gloves (sterile gloves for some procedures). Laboratory workers are also at risk. Samples taken from humans and animals for investigation of Ebola infection should be handled by trained staff and processed in suitably equipped laboratories. (WHO 2015a, Williams 2014)

2.1.6 Ebola in Media

The Ebola issue generally corresponds with the media trends in any extremely serious matters. The enormous interest of the world press present at the very beginning significantly declined in 2015. In summer 2014 many news related

to the Ebola outbreak were being published daily by both the major press and local media. Since the beginning of 2015 the latest development is only monitored by the major organizations involved in health policy (WHO, Médecins Sans Fronti`eres), development aid (UN, EU) or by stakeholders with direct interest in the region. Not any longer by daily press.

Considering reporting on the EVD both in the US and the EU, the media began to pay attention after the death of the first EU[6] and US[7] citizens. The EVD had predominantly been perceived as a developing world disease until the first casualties from the Western World had been recorded. The Ebola virus outbreak was declared by the UN Security council to be the *"threat to international peace and security"* on September 18 2014. (UN 2014)

Since that time the EVD made it to be the most often reported issue by all kinds of media. The awakening of Europe and America is being evaluated positively since it enhanced the interest of the entire international community. It can be stated retrospectively that the media attention was not balanced at all. It was exaggerated till the end of 2014 and neglected in 2015. It is hardly possible to track the latest development in regular media coverage when searching for another resources later provided by the WHO, MSF and the EU only.

Considering the gravity of some other diseases that are not in the spotlight of the media coverage, the media concern for the EVD generally was exaggerated. This can be demonstrated on the tuberculosis awareness. *"One-third of the world's population is currently infected with the tuberculosis (TB) bacillus. Every year, nine million people develop active TB and 1.5 million die from it."* (MSF 2015) Another grave risk is represented by *"the gastrointestinal infections which kill around 2.2 million people globally each year, mostly children in developing countries. Diarrhoea occurs world-wide and causes 4% of all deaths and 5% of health loss to disability."* (WHO 2015b)

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6 The first European victim of the West African Ebola outbreak, Miguel Pajares, died shortly after being transported to Madrid hospital August 7, 2014. (The Telegraph 2014)

7 Thomas Duncan died of EVD October 8, 2014. He arrived in Liberia from Texas to visit his family and his case showed Ebola could easily spread to and in this country. (The Conversation 2014)

3 Analysis of the EVD Demographic Impact[8]

The first objective of this chapter is to identify the demographic impact of the Ebola Virus Disease on the population of the three most affected countries, Guinea, Liberia and Sierra Leone based on infection rate calculation and death rate calculation.

The second objective is to prove the presumed hypothesis: *"The higher HDI of a selected country, the lower overall infection rate and the lower overall death rate of a selected country".*

The Human Development Index measures the development of a country in terms of accessability of education, healthcare and level of income: *"The HDI was created to emphasize that people and their capabilities should be the ultimate criteria for assessing the development of a country, not economic growth alone. The HDI can also be used to question national policy choices, asking how two countries with the same level of GNI per capita can end up with different human development outcomes. These contrasts can stimulate debate about government policy priorities. The Human Development Index (HDI) is a summary measure of average achievement in key dimensions of human development: a long and healthy life, being knowledgeable and have a decent standard of living. The HDI is the geometric mean of normalized indices for each of the three dimensions."* (UNDP 2015a, UNDP 2014b)

The selected countries representing the area in Western Africa most affected by the Ebola disease are: Guinea, Sierra Leone, Liberia. The key variables are: *number of confirmed, probable and suspected cases* and *total number of all cases* in respective country in the time frame from the beginning of the disease

[8] The findings described in this chapter were subject of a Seminar paper for the Course SODA - Socioeconomic Demography in English (FRDIS - SS 2014/2015)

to April 19th 2015. April 19th 2015 is the latest update of the WHO statistical entries in Guinea and Sierra Leone, Liberia is not reporting any cases to WHO since the mid of 2014[9].

The variables indicating the impact of the disease on the population are *infection rate and the death rate*. Infection rate indicates how many per cent of the population were affected. Death rate indicates how many per cent of the population died due to the Ebola Virus Disease.

3.1 Situation Summary

Table 1 - Latest Available Situation Summary Indicating the Ebola Virus Disease

Situation summary Latest available situation summary: 24 April 2015			Number of Cases Cumulative	Number of Deaths Cumulative	Population (July 2014 est.)	Overall Infection Rate (April 24 2015)	Overall Death Rate (April 24 2015)
Guinea	19 April 2015	Confirmed	3136,00	1943,00			
		Probable	415,00	415,00			
		Suspected	14,00	NA			
		Total	3565,00	2358,00	11474383,00	0,03%	0,02%
Liberia	11 April 2015	Confirmed	3151,00	NA			
		Probable	1879,00	NA			
		Suspected	5012,00	NA			
		Total	10042,00	4486,00	4092310,00	0,25%	0,11%
Sierra Leone	19 April 2015	Confirmed	8573,00	3511,00			
		Probable	287,00	208,00			
		Suspected	3405,00	158,00			
		Total	12265,00	3877,00	5743725,00	0,21%	0,07%
All coun-tries	19 April 2015	Confirmed	14860,00	NA			
		Probable	2581,00	NA			
		Suspected	8431,00	NA			
		Total	**25872,00**	**10721,00**	**21310418,00**	**0,12%**	**0,05%**

Source: Author, based on the WHO Data and Statistics (WHO 2015c)

3.1.1 Guinea

The infection rate of Ebola was 0,03% in Guinea. Ebola produced an overall death rate of 0,02% in this country. Both variables are below the average level of all countries.

[9] These data are valid for April 24th 2015.

3.1.2 Liberia

Ebola infection rate was 0,25% in Liberia. Ebola produced an overall death rate of 0,11% in this country. The infection rate was almost twice as high as the average infection rate of all countries. Both variables are the highest for Liberia.

3.1.3 Sierra Leone

Ebola infection rate was 0,21% in Sierra Leone. Ebola produced an overall death rate of 0,07% in this country. Both variables are higher for Sierra Leone than the average level of all countries.

3.1.4 Overall Evaluation

Ebola infection rate was 0,12% in the respective area of monitored countries Guinea, Sierra Leone and Liberia. Ebola produced an overall death rate of 0,05% in this area. The selected variables, the infection rate and the death rate indicate that Guinea performed the best and Liberia performed the worst.

3.2 Human Development Index Value for the Respective Countries

The Human Development Index (HDI) is a measure of achievement in the basic dimensions of human development across countries. The methodology is a simple unweighted average of a nation's longevity, education and income and is widely accepted in development discourse. (UNDP 2015a)

The higher HDI, the better living conditions in all areas of human development. Better living conditions cover healthcare via nation´s longevity, education and income and combination of these three variables should lead to a quality life. All three variables are linked to the transmission of disease generally. Good healthcare system prevents the transmission as well as population

that is educated, informed and well aware of the specific disease. Higher income ensures affordability of healthcare and education.

Table 2 - Comparison of the Human Development Index of Liberia, Guinea and Sierra Leone

Rank	Country	Human Development Index (HDI) Value, 2013
175	Liberia	0,412
179	Guinea	0,392
183	Sierra Leone	0,374

Source: Author, based on the UNDP HDI Statistics (UNDP 2015b)

Table 3 - Assignment of the Overall Infection Rate and Overall Rate of Liberia, Guinea and Sierra Leone to the Humand Development Index of the Respective Countries

Rank	Country	Human Development Index (HDI) Value, 2013	Overall Infection Rate (April 24 2015)	Overall Death Rate (April 24 2015)
175	Liberia	0.412	0,25%	0,11%
179	Guinea	0.392	0,03%	0,02%
183	Sierra Leone	0.374	0,21%	0,07%

Source: Author

3.2.1 Partial Evaluation

The Assignment of the overall infection rate and overall death rate of Liberia, Guinea and Sierra Leone to the Human Development Index of the respective countries indicates that the hypothesis is not valid. Liberia is a country with the highest HDI and with the highest overall infection rate and with the highest overall death rate.

The data unavailability represents a serious constraint for the research. Therefore the calculation is comparing the levels of HDI from 2013 with population estimated in 2014 and with number of infected / deaths from second quarter of 2015. This imposes an uncertainty on the research results. The analyzed variables must always relate to the same area and to a specific time period. The second condition of same time period was not fulfilled this time due to the data unavailability.

3.3 Partial Conclusion

The selected variables, the infection rate and the death rate indicate that Guinea performed the best and Liberia performed the worst. Liberia is a country with the highest HDI and with the highest infection rate and with the highest death rate at the same time. This fact disconfirms the presumed hypothesis: *"The higher HDI, the lower overall infection rate and the lower overall death rate".*

HDI is index measured from the variables for the whole country at the national level. However it was never the entire country affected in the same proportion. Some of the remote provinces / regions performed more intensive appearance of the disease than the others. However, due to the data unavailability the comparison of the particular regions was not possible and therefore the results are related to the entire country.

The factual reasons for this situation are not analyzed within this paper. It is assumed that the conditions for reducing the disease transmission were violated in larger scope in Liberia than in the other two selected countries. The aggression and violent attacks on the medical workers were reported repeatedly from Monrovia, Liberia. The approach of the population towards necessary measures ensuring improvement in the development was not accepted for long time in Liberia. However, these reasons would have to be justified yet by a surveillance and continuous field research in the country also after declaring Liberia to be Ebola free. (Technet 2015, New York Times 2015)

The governments of the affected countries were providing the WHO with misleading information, hiding the disease or announcing not relevant data. It took three months form the very first case of Ebola disease detected in the Guinean Prefecture of Guéckédou in late December 2013 until the identification of the disease by the MSF and acceptation by the Ministry of Healthcare of Guinea. In the meantime, no special action was taken and the EVD was incorrectly identified as Cholera. This malpractice was caused by the fact that EVD had never occurred in the area before and so it had not been anticipated. The transmission from the first area of occurrence had been very easy and fast

since the borderline between Guinea, Liberia and Sierra Leone is open and under no supervision. The engagement of international organization (with the exception of MSF) was very reluctant at the beginning. Even according to the president of Guinea Alpha Condé, the reactions and predictions done by the international community were excessive and the disease was under control from the very beginning. (Technet 2015, New York Times 2015) There is set of reasons for this attitude however none of the reasons can justify conduct that may lead (and might have actually contributed) to an epidemic and a serious global threat. Since Guinea is export oriented, the engagement in international trade with bauxite is crucial for the industry and the government downplayed the situation in order not to threaten the image of Guinea in international environment. (Technet 2015, CIA 2014a)

The costs of EVD are evaluated mainly in terms of human lives. However it is important to assess all impacts exceeding the casualties like general debilitation of all economy sectors, specifically health care. Methods for EVD treatment were improved but the capacities prepared particularly for this disease can hardly be used for general medical operations and the EVD treatment centers built by joined forces of the US Army[10] and the international joint forces. (New York Times 2015)

Even after the EVD had been recognized as a global threat, it took some time until enough attention by the international community was paid to the illness. The turning point was when the disease exceeded the African continent. USA was the leading country in the fight against the disease generally.

10 The USA was a leading country in the Ebola campaign, focusing on Liberia. “On Sept. 16, President Obama announced an expanded plan to assist Liberia, after some criticized the United States for being slow to act against Ebola. The United States military built 11 Ebola treatment centers, but nine have seen no patients.” (New York Times 2015)

4 EU as a Global Player

Obviously, the EU has a very wide scope of interest in the international arena. The ability of a global actor to respond to global challenges arises from the capacity and potential of a particular player defined as a *small, middle* or a *great power* category. The division between small and great powers was formalized with the signing of the Treaty of Chaumont in 1817. Before that all states were formally equal, regardless of differences in material capacity. (Toje 2011: 45).

Today, a vast majority of UN members would be categorized as small powers. There are many concepts[11] yet no agreed standard method properly defining the categories of states according to measurable indicators had been established or accepted. Asle Toje evaluates the EU foreign policy potential and capabilities and ranks the EU to be a small power as for example Sweden or Argentina. However, according to another classification (Cooper 1997) both EU and Argentina do correspond with the middle power[12] characteristics. Or, in most cases, the common denominators overlap: the multilateral approach is once considered to be the best example of a middle power diplomacy, once to be typical for small power diplomacy.

Furthermore, some of the features of small power diplomacy, as for example the interdependence (Vital 1967: 134) rather describe the current international settings than a typical behaviour of a small power. Thanks to the interdependence of today's world, even a trivial decision made by a small power may have much greater consequences than it might have had ever before.

According to Vital, the small powers are not able to project power globally (Vital 1967: 134). There are clear evidences that the EU is capable to project power globally. Sure, the usually long time needed for decision-making and fur-

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11 Robert Keohane introduced a fourfold taxonomy: system-determining powers, system-influencing powers, system-affecting states, system ineffectual states; Rudolf Kjellén identified the geopolitical global great powers, regional great powers, small powers and small states. (Toje 2011: 45)

12 *"Middle powers have growing potential to pursue specific foreign policy goals but their ability to achieve these goals is constrained by Great Powers' interests and consent and also, by the nature or "commonalities" of middle power diplomatic practice."* (Baba, Kaya 2014: 240)

ther action must be taken into a consideration but generally there is a capability. Another argument that ranks the EU into the category of a middle power is that the EU does consume more international cooperation than it produces. In favour of a small power speaks the fact of emphasizing multilateral approach (Cooper, Higgott, Nossal 1993: 19 - 20) and risk aversion (Laïdi 2010: 1).

The engagement of the European Union in resolving global challenges was set very ambitiously and obviously the EU limited capacities do not allow the EU to achieve the aims and targets set by the platform of Development Policy and Humanitarian Aid[13] nor by the Common Foreign and Security Policy. However the EU capacities do exceed the framework of a small power. Nevertheless the real distinction of power is more ambiguous than the theoretical distinction. Some of the categories overlap and even change in time due to the alternating world and global area. Today world is very much complex and so such a basic distinction of all international actors into small and great powers is obviously not satisfactory.

4.1 The EU Development Policy and Humanitarian Aid

The development cooperation globally had risen steadily between the 1970s and the 1980s but had declined dramatically since the early 1990s. There are various explanations that could be given, including the costly and demanding end of the Cold War and related budget deficits. After 2000, the MDGs were set but yet the particular goals could have not been met due to financial deficiencies. (Carbone 2011: 62 – 80)

One of the outcomes of the summit in Monterrey 2002 was boosting the EU's volume of development aid led by the European Commission playing a key role in the complicated preparatory phase. Despite the initial resistance of various Member States (e.g. France, Italy, Spain), the proposal was eventually adopted in March 2002 at the European Council in Barcelona. The MS agreed

11 The sustainability itself of the Development Policy and Humanitarian Aid is questionable even if more resources would be available.

to set a collective target of 0.39 per cent of their GNI and country targets of at least 0.33 per cent. (Carbone 2011: 62 – 80)

According to Maurizio Carbone (2011: 80), *"The decision may seem modest in terms of commitment, but its significance and consequences are remarkable. For the first time in the history of the EU development policy, the European Commission was able to have a say on the amount of money that each Member State allocates for development assistance. More significantly, it managed to affect the pace of international development – in reaction to the EU pledge, the US committed to boost its volume of aid."*

Aid policy may lead to improving the living conditions of people in developing countries in short – term period. However it is development policy that should result in long lasting transformation. (Barder 2010)

4.1.1 The Financial Framework

Financing the external action of the European Union is very wide, complex area being constantly reformulated which makes it very uneasy to carry out a simple and clear analysis. All instruments with external action aspect are embedded within the *Heading 4: EU as a Global Player of the EU budget.* Some of the instruments involved in this particular chapter create the multiannual financial framework while some are only short term, annual programmes for ad hoc solutions or crisis situations. (Gaub, France, Fiott 2014: 261) Specifically, the *Heading 4: EU as a Global Player* covers the CFSP[14] budget, crisis management operations (CSDP missions), European Union Special Representatives (EUSRs), non-proliferation and disarmament missions, and other preparatory actions.

[14] The CFSP will not be assessed nor analysed within the presented thesis although it may also touch upon the area of humanitarian aid and development policy.

On the contrary the European Development Fund (EDF)[15] is a main tool for development cooperation with the ACP countries. (Gaub, France, Fiott 2014: 263)

4.1.2 Definition

The EU Development Policy is in accordance with the Millennium Development Goals and seeks to eradicate poverty in context of sustainable development. It is one of the fundamental pillars shaping the EU external relations *“alongside foreign, security and trade policy (and international aspects of other policies like environment, agriculture and fisheries)”.* The Development Policy is based on European values such as human rights, fundamental freedoms, good governance etc. being promoted and exported outside the EU in its relations with partner countries. (EC 2014a)

The humanitarian aid provided by the EU is based on the international humanitarian aid principles of humanity, neutrality, impartiality and independence[16] and consists of needs-targeted humanitarian assistance *“with particular attention to the most vulnerable victims. Aid is channelled impartially to the affected populations, regardless of their race, ethnic group, religion, gender, age, nationality or political affiliation.* […] *The EU also plays a crucial role in assisting and raising awareness of "forgotten crises" – often protracted crises which escaped the media and international community's attention.”* […] *“EU humanitarian aid covers areas such as: food and nutrition, shelter, healthcare, water*

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15 The EDF budget for the financial period 2008 – 2013 was EUR 22,682 million, financed outside the EU budget framework. (Gaub, France, Fiott 2014: 261)

16 *“The principles of humanity (human suffering must be addressed wherever it is found, with particular attention to the most vulnerable), neutrality (humanitarian aid must not favour any side in an armed conflict or other dispute), impartiality (humanitarian aid must be provided solely on the basis of need, without discrimination) and independence (autonomy of humanitarian objectives from political, economic, military or other objectives) are grounded in International Humanitarian Law. All Member States have committed to them by ratifying the Geneva Conventions of 1949. At EU level, the principles are enshrined in the European Consensus on Humanitarian Aid, signed in December 2007 by the Council of the EU, the European Parliament and the European Commission. The Consensus is the core framework which guides EU humanitarian aid policy providing common vision, principles and a practical approach. It ensures that the actions carried out by the European Commission's Humanitarian Aid and Civil Protection department (ECHO) comply with humanitarian principles and provide humanitarian assistance to those who need it most.”* (EC 2014a)

and sanitation, and others. Aid, funded by the EU, is carried out in partnerships with international organizations and humanitarian NGOs." (EC 2014a)

4.1.3 Historical Overview and Legal Basis

"EU Development Policy is a shared competence between each Member State and the Commission. Therefore, bilateral development policies co-exist with community policies managed by the EC, each with its own administration and institutions. The European Consensus on Development agreed in 2005 sets out the EU Development Policy. Under the Consensus, Member States and the Commission are committed to poverty reduction and the pursuit of the Millennium Development Goals as the primary objective of EU development cooperation." (Gavas 2011)

The individual Member States of the EC/EU have been major players of the EC/EU international engagement since the times of the Cold War and decolonization. The Development Policy towards selected African countries was firstly formalized in 1963 within the Treaty of Yaoundé but still predominantly in the context of the Trade Policy. Roots of EU development policy, however, go back to the creation of the European Economic Community (EEC) in 1956. The founding EEC Members who had colonies overseas, enforced association of twenty overseas countries and territories, based on two main elements - trade benefits and development help. (Euroskop 2015)

The Maastricht revision coordinates the policy both internally and externally and creates its legal basis and introduces three important principles of the EU Development Policy: coordination, coherence and complementarity. These principles became also an important part of the Paris Declaration Development Committee (DAC) of the OECD on Aid Effectiveness in 2005, which was signed by more than one hundred countries and international organizations. (Euroskop 2015)

After 2000, the development aid becomes part of foreign policy and covers also security issues. The principle of conditionality is introduced. The EU's

common vision to development cooperation was formalized by the European Consensus on Development (EDC) in 2005 by an agreement of the EU Heads of States and governments, the European Parliament and the Commission. For the first time in 50 years of development cooperation a common framework of objectives, values and principles shared by the Union and the Member States was created. (Euroskop 2015) Under the EDC, Member States and the Commission are committed to poverty reduction in accordance with the MDGs as the primary objective of the EU development cooperation under the principle of complementarity. *"The consensus also clarified the Commission's role in ensuring policy coherence, promoting development best practices, facilitating coordination and harmonization, promoting democracy, human rights, and good governance".* (Kitt 2013: 6) Bilateral development policies co-exist with community policies managed by the EC, each with its own agencies, administration and institutions. (Kitt 2013:4)

In terms of quantity, the EU itself is globally the second largest donor of the humanitarian aid after the US on a long-term basis. The humanitarian aid is in the responsibility of European Commission's Humanitarian Aid and Civil Protection department. The EU Commission proudly comments that: *"the EU is to be the world's largest donor of development aid" (Euractiv 2015) and the amount of the EU's ODA is continuously increasing since 2012*[17]*. However, the collective commitment of the Development Aid and Humanitarian Policy financing is not being accomplished*[18]*.* (Euractiv 2015)

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17 The EU's ODA increased from €55.3 billion in 2012 to €56.5 billion in 2013 (Euractiv 2015).

18 *"A recent study of the Centre for EU Studies (Ghent University) reveals that EU Membership is not a relevant factor in explaining ODA spending, whereas other country groupings such as the 'Nordics' are. EU member states have broadly followed global trends since the early 2000s. This also clearly reflects from the following figures. While a number of Member States such as the UK (+27,8%), Italy (+13,4%) or Poland (+ 8,6%) increased their aid budgets significantly, they fell sharply in other EU countries such as Portugal (-20,4%), France (-9,8%) or Greece (-7,7%). Other country groupings, most notably the Nordic group which includes both EU and non-EU countries, show a more cohesive pattern. Also at the EU's collective level, there is no evidence that the Union's combined efforts are greater than those of non-EU donors, as is suggested by the European Commission. On the contrary, while on average development aid rose with 6,1% in 2013 (compared to 2012), the EU as a whole performed less, with a rise of 'only' 5,2%. Moreover, the EU is lagging far behind its collective 0,7% target, once again illustrating that there is no such thing as an orchestrated European up-scaling of aid."* (Euractiv 2015)

4.1.4 Institutional Structure and Key Actors

Until the eighties, the development policy was centralized around one Directorate General of the European Commission and its five years planning. Since 1999, more actors are involved in the decision-making and implementation of development policies: several Directorates-General of the Commission, the European Parliament and the EU Council[19]. Recently, the key actors in EU Development Policy are the European Commission and the Council. The European Commission is responsible for legislative initiative and implementation of development policies. Within the Commission, a central role is played by the DG Development, which undertakes initiatives to promote coordination with the Member States, initiates general development policy, and is responsible for relations with the ACP group. The main distinction between the DG Development and other DGs involved in the EU Development Policy is the prevailing poverty orientation of the DG Development. (Carbone 2011: 48, Euroskop 2015)

The Directorate General for International Cooperation and Development is responsible for relations with more than half of the countries including the sub-Saharan Africa, Caribbean and Pacific (ACP) countries, the African Union, regional economic communities and the Overseas Countries and Territories (OCT). Directorate General for International Cooperation and Development is preparing draft strategies of cooperation with these countries and coordinates and monitors the funding provided through the European Development Fund and the Development Cooperation Instrument. (Euroskop 2015, Euractiv 2015)

Relations of the EC with international organizations such as the United Nations, OSCE, Council of Europe as well as the development strategies towards Central Asia, the Mediterranean countries, the Middle East, Latin America, Asia Pacific are the responsibility of Directorate-General for External Relations. Directorate General for Trade is involved in development policy by helping poor

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19 The European Investment Bank (EIB) is also participating in the EU Development Aid by providing concessional loans to developing countries. (Carbone 2011: 64)

countries to expand their foreign trade, primarily by improving access to the EU market. (Euroskop 2015, Euractiv 2015, Carbone 2011: 49)

Table 4 – DGs Involved in EC/EU Development Policy

DG	Key Tasks
Development	ACP, general development policy
RELEX	Mediterranean, Latin America, Asia, horizontal budget lines
Trade	Trade issues with developing countries
Enlargement	Eastern Europe, Balkans, former Soviet Union, pre-accession
ECOFIN	Economic monitoring
ECHO	Humanitarian affairs
EuropeAid	Implementation, evaluation

Source: Carbone 2011: 49, edited by the author

Note: "DG Agriculture, DG Fisheries, DG Education and Culture manage very small amounts of money; Europe aid is not a DG." (Carbone 2011: 49)

In 1992 the Office for Humanitarian Aid was established in order to provide direct emergency assistance to victims of disasters and wars outside the EU[20]. In 2010, the humanitarian aid was merged with the civil protection under the European Commission's Humanitarian aid and Civil Protection department (ECHO). *"The ECHO aims to save and preserve life, prevent and alleviate human suffering and safeguard the integrity and dignity of populations affected by natural disasters and man-made crises. EU assistance, amounting to one of the world's largest, is enshrined in the Treaty of Lisbon and supported by EU citizens an as expression of European solidarity with any person or people in need."* Bringing these two areas together should have helped creating an effective mechanism for disaster response and management both outside and inside the EU. The incumbent EU Commissioner for Humanitarian Aid and Crisis Management is Mr. Christos Stylianides, since November 2014. (EC 2015c)

20 In 2011 the total amount was EUR 700 million. (Euractiv 2015)

EuropeAid was founded in 2001 during the reorganization of the external services of the Commission. The Office became responsible for implementing projects and programs in all regions of the world except the candidates for accession to the EU. EuropeAid is responsible for the project management from the very beginning to the completion of the project. (EC 2015d)

The legislative procedure is same for the Development Policy as for other EU policies. The EU Council adopts, together with the European Parliament legislative proposals by the Commission. The EP does not influence the use of funds coming from the European Development Fund since the EDF is a specific and important source of EU Development Aid standing outside the EU budget and representing 30% of all funds of EU development aid. (Euroskop 2015, Euractiv 2015)

4.1.5 Development Cooperation in the Member States

The purpose of this section is to present an overview of the basic principles of development cooperation provided by the members states. The individual countries create clusters with more or less similar foreign aid settings and characteristics according to their historical development, political settings, prevailing ideology and other factors. Close relations from the past colonial era for instance, usually determine that the specific country lies within a scope of interest of the world power also today. Political settings have a straight influence on the decision making in the area of foreign The Minister for Development has full responsibility for development issues in only few EU members (Belgium, Denmark, Finland, Germany, Ireland, Luxembourg, the Netherlands, Sweden and the UK). In countries where the instrument of an independent Development Policy is not implemented, the development issues fall within the competence of the Ministry for Foreign Affairs. It is obvious that in these cases the development policy may not receive adequate attention at the highest political level. (Carbone 2011: 43 - 62)

The theories of international relations project also into the perception of development policy. *"According to realists, foreign aid is driven by governments promoting their national interests, both political and economic."* (Carbone 2011: 40) Especially after September 2001, the hard-power dimension of foreign aid is emphasized by more and more countries, not only by the traditional realists[21]. The UK and Germany have boosted the security component of the development policy since that time.

According to Maurizio Carbone (2011: 41), the idealists emphasize the non-material motivations in shaping foreign policy objectives, such as moral obligation and altruism. *"Unlike realists, idealists are optimistic about the beneficial contribution of aid to reducing world poverty."* The altruistic perspective is often associated with the northern EU members including the Netherlands[22]. (2011: 41)

Institutionalists (Germany) perceive multilateral approach and the international organizations as very important components in setting the development agenda and development aid transfers. On the other hand, liberal approach represented by Denmark, considers the pressure from domestic arena, e.g. political parties, interest groups, public bodies etc. as the most important structural element in shaping the development aid. (Carbone 2011: 41 - 42)

All these factors in combination with all stakeholders like national governments, influence by the supranational institutions and other non-state actors contribute to the final shape of the development policy in terms of its quantity and quality. Some of the EU member countries perform similar characteristics and can be therefore divided into similar groups. Based on the typology by Maurizio Carbone and author's own analysis and judgment the following clusters of the EU Members were created:

1. Northern Idealists and Liberals (the Netherlands, Sweden, Denmark, Finland plus Ireland and Belgium) predominantly without colonial ties but traditionally performing strong foreign aid.

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[21] Besides the USA, Japan is considered to belong to this group (Carbone 2011: 40)
22 Canada and New Zealend represent idealists as well. (Carbone 2011: 41)

2. Big Realists (the UK, Germany[23], France) mainly driven by the colonial heritage and geopolitical perspective (security / economic issues).
3. Southerners (Greece, Italy, Spain, Portugal, Croatia) without consolidated development cooperation and traditionally low volume of aid.
4. Eastern Newcomers (according to Maurizio Carbone, the aid level of countries joining the EU in 2004 is very small and ad-hoc oriented, with the exception of the Czech Republic and Hungary).

4.1.6 Partial Conclusion

The EU does not proceed as a unitary actor in the area of development policy. There is wide range of actors involved, wide range of financial resources and wide range of channels for delivering the aid. It is obvious that it is quite lot of obstacles associated with the EU Development Policy settings, mainly dual character of the development aid provided by the EU and by member countries and related fragmented competence. It is possible to track traditional patterns in providing the development aid among the EU Members.

4.2 EU – Africa Relations

The official documents promoting intense cooperation of the two continents declare that Europe and Africa are two continents bound together by a common history, culture, geography and by the very close exchanges which they entertain at a human, economic[24] and political level. Cooperation between the EU and Africa has reflected early on the rich and diverse nature of the relations between both continents while also keeping up to speed with wider economic and politi-

23 Germany does not have a legacy of rooted colonialism. It benefited from the Marshall Plan after WWII but became a significant donor soon and today belong to very active players. (Carbone 2011: 42)

24 The funding for Africa is provided by the following channels: €25.3 billion of Official Development Aid (ODA) came from the EU in 2011 and represented more than half of the total amount of ODA being directed to Africa. Top 10 donors to Africa (by share of aid) are only made by European countries, topped by Ireland (with 81% of its total aid to Africa), followed by Belgium (77%) and Portugal. (Africa – EU Partnership 2015)

cal developments. (Consilium 2015) Clearly not all kids of relations and mutual interconnections are as ideal or functional as officially declared. However, remnants of the colonial era when these two continents were connected firmly, have developed into strategic partnership of crucial importance for all stakeholders.
Relations between the European Union (EU) and Africa have been traditionally developed in two dimensions depending on the regional belonging: African countries that are part of the ACP countries and Mediterranean African countries. However, at the beginning of the new millennium, the EU launched new measures strengthening existing dialogue with Africa in order to establish a strategic partnership with the entire continent. The first EU-Africa summit was held in Cairo in April 2000. (Europa 2007) The key milestones for the EU – Africa relations that will be subsequently elaborated are:

- 1975 - Lomé Convention for African, Caribbean and Pacific countries
- 2000 - first Africa-EU Summit in Cairo
- 2000 - Cotonou Agreement
- 2007 - adoption of the Joint Africa-EU Strategy at the 2nd EU-Africa Summit in Lisbon
- 2010 – 3rd EU-Africa Summit in Tripoli
- 2014 – 4th EU-Africa Summit in Brussels

Currently, two grand frameworks govern the EU relations with African countries. The most long-standing one is the one established with African, Caribbean and Pacific (ACP) countries, enshrined in 1975 by the Lomé Convention and updated in 2000 by the Cotonou Agreement. (Consilium 2015)

4.2.1 Institutional Framework: The Cotonou Agreement

One of the main frameworks for EU relations with Africa is the Cotonou Agreement, adopted in 2000 to replace the 1975 Lomé Convention for African, Carib-

bean and Pacific (ACP) countries[25]. It is the most comprehensive partnership agreement between developing countries and the EU, covering the EU's relations with 79 countries and based on three pillars: development cooperation, economic and trade cooperation, political dimension. (EEAS 2015)

Its central objective is to reduce and eventually eradicate poverty, consistent with the objectives of sustainable development and the gradual integration of the ACP countries into the world economy. The EU supports programmes and initiatives benefiting multiple countries across the ACP group of countries. Specific regions within the ACP also benefit from programmes and initiatives to bring about further regional economic growth and development. Funding for both purposes is from the European Development Fund. (EEAS 2015c)

The Cotonou Agreement broadens the scope of EU-ACP partnership while seeking to adapt it to the changing international environment and the deriving challenges. Its three pillars are: 1. development cooperation (funded by the EDF), 2. economic and trade cooperation through the EPA's, seeking to make EU-ACP trade regimes WTO-compatible, 3. a stronger political dimension with an emphasis on Article 8 on political dialogue. The main financial instrument for development cooperation in ACP countries is the European Development Fund. The EDF is now at its 11th round (2014-2020) and includes three financial envelopes: a national envelope covering bilateral cooperation with individual ACP countries (National Indicative Strategies and Programmes), a regional one covering relations with ACP regions (Regional Indicative Strategies and Programmes), namely Central Africa, West Africa, Eastern and Southern Africa and Indian Ocean, the Southern African Development Community (SADC), the Caribbean and the Pacific; and a third one to address the common challenges facing ACP States that transcend geographical criteria. Moreover, the intra-ACP envelope funds the Africa Peace Facility which, within the Joint

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25 The Cotonou Agreement was adopted in 2000, revised in 2010 is covering EU-ACP relations until 2020. Currently, the ACP Group includes 79 countries: 48 from sub-Saharan Africa, 16 from the Caribbean and 15 from the Pacific region. (EEAS 2015)

Africa-EU Strategy, contributes among other initiatives to the African Union Peace Support Mission in Somalia. (EEAS 2015a, EEAS 2015c)

4.2.2 Institutional Framework: Political and Strategic Partnership

An additional framework, the Joint Africa-EU Strategy (JAES), was adopted in 2007 as the formal channel for EU relations with African countries. The JAES is implemented through action plans. The latest roadmap framing EU-Africa relations was agreed at the 4th EU-Africa Summit in Brussels in 2014. It covers 5 key priorities and areas for joint action for the period 2014-2017. (Africa – EU Partnership 2015)

A partnership driven through formal dialogue at various levels: EU-Africa summits (held regularly - so far there have been summits in Cairo 2000, Lisbon 2007, Tripoli 2010 and Brussels 2014; ministerial-level or *troika* meetings (held regularly, representatives from African Union foreign ministries, the AU Commission, EU foreign ministries, the European Commission, the Council of the EU, and the European External Action Service (EEAS 2015a, Africa – EU Partnership 2015). More recently, a continental approach is now emphasized after the adoption of the Joint Africa-EU Strategy (JAES) by 80 African and European Heads of States in 2007. The Africa-EU Partnership, enshrined in the JAES, embodies a new forward-looking vision for relations between Europe and Africa as one single continent, and sets out the overarching political framework defining relations between both sides. Going beyond development, it seeks to establish a partnership among equals, determined to tackle issues of common concern together. (Consilium 2015) The Continental Approach is focused on: Bringing Africa-EU relations to a new level: the Joint Africa-EU Strategy. The Strategic Partnership established in 2007 in Lisbon has moved the Africa-EU relationship to a new level. Both sides agreed to pursue common interests and strategic objectives together, beyond the focus of traditional development policy. The two continents started cooperating as equal partners. Since 2007, the Part-

nership has considerably extended the Africa-EU political dialogue and cooperation. Innovative working arrangements (illustrated by the establishment of the EU Delegation to the African Union in Addis Abeba, the participation of actors such as the European and Pan-African parliaments, civil society or the private sector and the broadening of the scope of the African Peace Facility) have led to tangible results. The Joint Africa-EU Strategy defines the long-term policy orientations between the two continents, based on a shared vision and common principles. It is the overall political framework defining the relations between Africa and the EU. Its four main objectives are:

1. Improving the Africa-EU political partnership.
2. Promoting: peace, security, democratic governance and human rights, basic freedoms, gender equality, sustainable economic development, including industrialisation , regional and continental integration, ensuring that all the Millennium Development Goals are met in all African countries by 2015.
3. Effective multilateralism.
4. A people-centred partnership. (EEAS 2015b)

The Joint Africa-EU Strategy (JAES) strategic orientations are being implemented on a day to day basis through Action Plans which have reinforced the intercontinental dialogue and led to concrete action in key areas of common concern. The two successive action plans are structured around eight thematic areas: Peace and Security, Democratic Governance and Human Rights, Regional Economic Integration, Trade and Infrastructure, Millennium Development Goals, Climate Change, Energy, Migration, Mobility and Employment Science, Information Society and Space (EEAS 2015b)

5 The EU Response to the EVD

There was a wide range of various measures taken by the European Union varying from the monitoring and analyzing the situation, reporting, preparing action plans, designing specific steps and their implementation, coordination and management, continuous evaluation. The EU aims to ensure that its all measures taken in response to the EVD are consistent with each other and complementary with the effort of other stakeholders.

In order to classify all possible levels of the EU action towards the Ebola outbreak, the activities implemented with regards to the EVD either by the Member States or by the EU were investigated and grouped into two main groups: external and internal action depending on whether the particular action was aiming on actors inside or outside the EU. Each of the two main groups is subsequently divided into thematic sectors. The result is that the general EU response to the Ebola outbreak can be stratified as follows.

1. **EU external action in response to the EVD**

A. EU development policy and humanitarian aid provided by the EU incorporates all activities by the EU heading primarily to support the affected countries and are implemented primarily in the affected countries.

B. Diplomatic Outreach covers the activities carried out on higher (national) level, primarily between the EU and affected countries, between the E and international organizations involved in resolving crisis, but also between the EU and other country when related to the EVD

C. Security issues: surprisingly, there was no direct EU external action that could be defined as primarily security operation eliminating the threat of bioterrorism. Clearly, every effort on fighting the EVD indirectly supports the security.

2. **EU internal action in response to the EVD**

A. Medical framework and internal security is aiming towards ensuring the immediate wellbeing of the EU citizens. This area that was kept in the gesture of member states.

B. Research framework covers the funding available for open calls on Ebola research provided mainly within the Horizon 2020 programme. This is a tool oriented towards the affected regions, however the grant could be awarded only to a EU beneficiary or his partner. Therefore it creates an opportunity primarily within the EU for the EU stakeholders and the patients from the third countries are final recipient.

C. Official fundraising campaigns, public donations under the umbrella of the EU were not investigated. This is positively evaluated, since such campaigns or donations were already coordinated by MSF and by the International Committee of the Red Cross and the duality of resources represents management fail.

5.1 The EU Response to the EVD: the Financial Perspective

The European Commission explains the budgeting system and its implementation in the particular EU policies *"through a wide range of programmes and funds which provide financial support to hundreds of thousands of beneficiaries such as farmers, students, scientists, NGOs, businesses, towns, regions and many others".* (EC 2014b)

The MFF[26] for the period 2014-2020 is divided into six categories of expense ('headings') corresponding to different areas of EU activities. (EC 2014b) From all programmes of the 2014-2020 Multiannual Financial Framework, the following headings relevant for the presented thesis are taken into consideration[27]:

The Heading Global Europe is related to the external dimension of EU action, *"such as development assistance or humanitarian aid with the exception of the European Development Fund (EDF) which provides aid for development cooperation with African, Caribbean and Pacific countries, as well as overseas countries and territories. As it is not funded from the EU budget but from direct contributions from EU Member States, the EDF does not fall under the MFF".* (EC: 2014b)

Security and Citizenship covers the internal dimension of security and *"includes justice and home affairs, border protection, immigration and asylum policy, public health, consumer protection, culture, youth, information and dialogue with citizens".* (EC: 2014b)

Also the **Heading, Competitiveness for Growth and Jobs** including research and innovation[28] should be incorporated, since it covers the funding within Horizon 2020, the main tool for Ebola research.

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26 "The MFF 2014 - 2020 sets a maximum amount of EUR 960 billion for commitment appropriations and EUR 908 billion for payment appropriations." (EC 2014b)

27 The MFF consists of these headings: Competitiveness for Growth and Jobs, Economic, Social and Territorial Cohesion, Security and Citizenship, Global Europe, Administration, Compensations. (EC 2014b)

28 The Heading specifically covers research and innovation; education and training; trans-European networks in energy, transport and telecommunications; social policy; development of enterprises. (EC 2014b)

5.1.1 2014 – 2020 Multiannual Financial Framework Analysis

The Table 5 below illustrates the financial involvement of the European Union in resolving the Ebola crisis. The total financial contribution of the EU to fight the epidemic amounts close to €1.4 billion, including funding from the Member States. The European Commission has allocated over €417 million for emergency measures and longer-term support. (EC: 2014b)

The Table 5 is divided into sections corresponding with the particular Heading of the Multiannual Financial Framework for the period 2014 – 2020. The proportion of financial contribution provided by the EC to fight Ebola on the EU MFF was analyzed for the following areas:

1. EU development aid and humanitarian policy represented by the Heading Global Europe of the MFF
2. EU public health represented by the Heading Security and Citizenship of the MFF
3. EU research represented by the Heading Competitiveness for Growth and Jobs of the MFF

The findings are as follows:

1. The proportion of financial amount provided by the EC to development aid on Ebola was 0,64% of the funds allocated for the Global Europe Heading of the MFF.
2. The proportion of financial amount provided by the EC to maintaining public health within the EU was 0,41% of the funds allocated for the Security and Citizenship Heading of the MFF.
3. The proportion of financial amount provided by the EC to Ebola research within Horizon 2020 was 0,17% of the funds allocated for the Competitiveness for Growth and Jobs Heading of the MFF.
4. The overall proportion of financial contribution provided by the EC to support the fight against Ebola was 0,33% of the EU Multiannual Financial Framework for the current period

Table 5 - The Proportion of Financial Amount Provided by the EC on EVD on Financial Amount Allocated wihin the MFF 2014 - 2020

Programme	Heading	Financial amount allocated within the MFF 2014 - 2020 (Current Prices), according to the specific Programmes [EUR million]	Financial amount allocated within the MFF 2014 - 2020 (Current Prices), according to the specific Headings: Heading Global Europe, Security and Citizenship, Compet-itiveness for Growth and Jobs [EUR mil-lion]	Financial amount provided by the EC allocated to fight the EVD since the 2014 outbreak [EUR million]	The proportion of financial amount provided by the EC on EVD fight in the particular area on the par-ticular MFF Heading [%]	Financial amount provided by the MS allocated to fight the EVD since the 2014 outbreak [EUR mil-lion]
Development Cooperation Instru-ment	4. Global Europe	19661,64	41206,16	263,00	0,64	983,00
EU Civil Protection and European Emergency Response Coordina-tion Centre	4. Global Europe	144,65				
European Instrument for Democ-racy and Human Rights	4. Global Europe	1332,75				
European Neighbourhood Instru-ment	4. Global Europe	15432,63				
Guarantee Fund for External Ac-tions	4. Global Europe	1193,07				
Humanitarian Aid	4. Global Europe	147,94				
Instrument Contributing to Stabil-ity and Peace	4. Global Europe	2338,72				
Partnership Instrument	4. Global Europe	954,76				
Asylum, Migration and Integration Fund	3. Security and Citizenship	3137,42	3810,59	NA	0,41	
Civil Protection Mechanism	3. Security and Citizenship	223,78		15,50		
Health	3. Security and Citizenship	449,39		NA		
Horizon 2020	1a. Competitiveness for Growth and Jobs	79401,83	79401,83	138,00	0,17	
TOTAL		**124418,58**	**124418,58**	**416,5**	**0,33**	**983,00**

Source: Author, based on the EC MFF 2014 – 2020 (EC 2014b)

5.2 The EU External Action in Response to the EVD: the EU Development Policy and Humanitarian Aid

In this section the theoretical background defined in the Chapter `EU as a Global Player`, specifically the EU Development Policy and Humanitarian Aid settings will be applied on the case of EU contribution to resolving the Ebola crisis.

The variables identified in the previous chapter will be analysed:

1. Institutional Structure and Key Players
2. Financial Perspective
3. The Role and Action of the EU Member States
4. The Diplomatic Outreach

5.2.1 Institutional Structure and Key Players

It is sometimes not easy to distinguish the development policy from the humanitarian aid and vice versa. Especially when these two areas should be evaluated in aftermath of a humanitarian catastrophe or crisis. The theoretical distinction is very clear as was stated in the previous chapter. However some of the actions taken in emergency response to the EVD originally with short-term impact finally developed into a long – term impact and therefore might have developed from one-time operation to longer lasting strategy or mission. The EU development policy and humanitarian aid provided by the EU to fight the EVD will therefore be assessed indivisibly.

The institutional structure confirms the settings delineated in the theoretical part. The European Commission plays the dominant role in coordinating the activities related to the Ebola crisis relief, in monitoring and reporting. Implementation of the policies is in the gesture of Member States. The Members are independent in providing their own development aid although it should be in accordance with the EU development policy and humanitarian aid framework and grand strategies.

The humanitarian aid provided by the EU as such is channelled through humanitarian partner organizations, such as MSF, the International Federation of the Red Cross and Red Crescent societies, IMC, Save the Children, IRC, Alima, WFP's Humanitarian Air Service, UNICEF and WHO. According to the US AID it is around thirty-six non-governmental organizations operating in West Africa apart from the EU agencies an initiatives (US AID 2015). EU aid specifically contributed to *"epidemic surveillance, diagnostics, treatment and medical supplies; deployment of doctors and nurses and training of health workers; raising awareness among the population and promotion of safe burials."* (EC 2015c).

5.2.2 Financial Perspective

The financial contribution of the EU to fight the epidemic amounts close to €1.4 billion, including funding from the Member States. The European Commission has allocated over €417 million for emergency measures and longer-term support

Table 6 - Financial support by MS committed to fight the EVD

EU Member	**Financial amount committed to fight the EVD in October 2014 [EUR million]**
France	70
Germany	102
Ireland	3
Netherlands	35
UK	571
Other MS	NA
EU MS TOTAL in October 2014	**781**
EU MS TOTAL in May 2015	**983**
USA	674

Source: Author, based on the EC Factsheets and Statistics (EC 2015a, EC 2014a)

5.2.3 The Role and Action of the EU Member States

The EU Members were generally active in responding to the Ebola Crisis. The action differed, of course, depending on the capacities of the particular country, on the current and historical relations with the countries from the affected region, on position within the EU and in the international community and many others.

The first and most common type of development aid provided directly by the Member States was material relief covering the material aid shipments (medical supplies, generators, lorries and specially adapted motorbikes, testing laboratories, beds, etc.) to the affected regions and ensuring new capacity for medical evacuations of international aid workers, in providing isolation facilities, staff training, biocontainment exercises. A group of Member States created by Austria, Belgium, Czech Republic, Finland, Hungary, the Netherlands, Romania, Slovakia and the UK in cooperation with UNICEF supported by France and Germany was specifically active in sending the material support. The Members States were also sending medical volunteers to the affected area. However, this contribution is primarily channelled via MSF and therefore will not be further analyzed in this section. *"Luxembourg has become the first EU member state to commit aeroplanes for European medical evacuations of international humanitarian workers diagnosed with Ebola. The two planes have been retrofitted, with co-funding by the Commission, which will also finance the bulk of the transport costs for evacuations under the EU Civil Protection Mechanism."* (Euractiv 2014)

Second type of providing the development cooperation was a direct financial commitment. From this point of view the biggest contributor among the EU Members was the United Kingdom (as indicated in Table 6). Germany and France made a significant commitment as well. In the previous evaluation based on the typology by Maurizio Carbone, it was exactly these three countries that were grouped into the cluster Big Realists performing the same features their development cooperation. Both France and the UK have important

relations with the West African region thanks to the colonial era. Guinea (CIA 2014a) was the former French colony, Liberia (CIA 2014b) was influenced by the British and in the beginning of the 20th became a U.S. protectorate and finally, Sierra Leone being an integral part of the Commonwealth of Nations (CIA 2014c). Strong historical ties determine tight relations in the current era as well. Germany alone does not have a legacy of rooted colonialism nor performs significant bindings with the countries of Western Africa but is a significant donor of foreign aid and generally belongs to the leaders in terms of responding to the global challenges. The main drivers of the development cooperation identified within the realist group are of material character, e.g. own security and commercial reasons.

5.2.4 Diplomatic Outreach

There is also a significant diplomatic outreach accompanying the development assistance. According to the reports by the European Commission, "t*he EU has been in constant contact with the United Nations, relief agencies on the ground, the governments in the region as well as with regional organizations such as the African Union and the Economic Community of West African States (ECOWAS)".* (EC 2015c)

The coordination amongst the EU institutions, Member States and international organizations was strengthened by the appointment of the EU Commissioner Christos Stylianides as the EU Ebola Coordinator and by the creation of EU Ebola Task Force. The Ebola Task Force was bringing together the Member States, Commission services, the European External Action Service and representatives of the UN, the Red Cross and NGOs was another attempt that should have led towards effectiveness and action readiness. The Task Force meetings took place three times a week. (EC 2015c)

The Ebola top-level diplomacy was conducted by the EU and key partners by organizing a high-level International Conference on Ebola on 3rd March 2015: *Ebola: From Emergency to Recovery* The aim was to coordinate further

action for the total eradication of the disease and to discuss the recovery process in the most affected countries. The participants were the EU, the UN, Guinea, Liberia, Sierra Leone, the African Union and ECOWAS. (EC 2015c)

5.3 EU Internal Action in Response to the EVD

The Ebola epidemic is considered to be a *"serious cross border health threat"* (Decision 1082/2013/EU) and therefore the EU Member States consult each other within the Health Security Committee and in liaison with the Commission with a view to exchanging information as regards serious cross border health threats and coordinating their response. (Decision 1082/2013/EU) The European Commission is working closely with the EU Member States within the HSC to coordinate approaches on prevention and preparation for Ebola, in accordance with the specific Decision. The Commission's Health & Consumers Directorate-General has been closely monitoring the event in cooperation with the ECDC and the WHO since news of the outbreak broke in March 2014. (ECDC 2015a, ECDC 2015e)

Simultaneously with all coherent internal and external actions towards the affected countries, the Commission and the Member states have been working on risk assessments, epidemiological updates, preparedness and coordination of risk management in close cooperation with the European Centre for Disease Prevention and Control (ECDC) and the WHO. The EU's Early Warning and Response System for medical emergencies has been activated. There is also a campaign providing information for travellers in all EU languages and establishing procedures for airports and health authorities on handling possible Ebola cases. (ECDC 2015a, ECDC 2015e)

In addition, the Commission has launched the *"Ebola Communication Platform for Clinicians"* - an online platform enabling the rapid exchange of information on the treatment and prevention of the Ebola disease. The platform brings together EU hospitals and physicians recognized as reference centres for the treatment of Ebola. (ECDC 2015a, ECDC 2015e)

5.3.1 Medical Framework and Internal Security[29]

The European Union, with some very limited exceptions, does not have a legal competence to adopt EU law in the field of health care since this is a matter of national competence according to the EU's primary law. (Mossialos; Permanand, Baten; Hervey 2010: 85) *"Unsurprisingly, both Member States and EU institutions are heavily bound in their ability and willingness (on account of national interests, political sensitivities and the huge diversity of health care systems in the EU) to issue legislation in this area."* (Mossialos; Permanand, Baten; Hervey 2010: 85) However, since the beginning of the European integration, other areas of EU law or policies have had unintended effects in health care contexts. *"These effects on health care in the Member States form a kind of patchwork, unconnected by legal or policy coherence."* (Mossialos; Permanand, Baten; Hervey 2010: 85) The EU action towards EVD in the medical field was kept in the gesture of member states. There was no regulatory provision setting the minimum amount of specialized EVD health care centres for each member country.

A common procedure accepted by the member states, however, was in coordinated effort towards Ebola screening. Ministers of Health agreed on common protocol for passenger information and advice for travellers at the international airports since 16th of October 2014. The member states, after a meeting *"with Tonio Borg, the European Commissioner for Health, agreed upon a common EU protocol that covers questionnaires for passengers, information at points of entry to the EU, and advice for travellers. The implementation of the Entry checks remained up to each member country. Passengers travelling from countries in the affected region – principally Guinea, Liberia and Sierra Leone – are checked upon leaving those countries. These screen-*

[29] The findings described in this chapter were subject of a Seminar paper submitted within the Course RREUGAA - European Union as a global actor in English (FRDIS - WS 2014/2015).

ings are monitored by the Commission and by the World Health Organization". (Politico 2014)

5.3.2 Scientific and Research Framework

In response to the UN Declaration on Ebola outbreak representing *"an extraordinary event and a public health risk"* in early August 2014, the European Commission through its research and innovation programme, Horizon 2020, mobilised financial resources for opening calls on research projects to be open in October 2014. (UN 2014, EC 2015f)

Currently, the European Commission, together with the European pharmaceutical industry, is funding eight research projects aiming to develop vaccines and rapid diagnostics tests, range from large-scale clinical trials to tests of existing cases. These projects are run under the new Ebola+ programme that combines funding provided by the EC research programme Horizon 2020 and the Innovative Medicines Initiative (IMI)[30]. (EC 2015c, EC 2015f).

The Ebola Crisis has required a global response also in the field of medical research. The European and Developing Countries Clinical Trials Partnership (EDCTP) recognized Ebola as a poverty-related disease[31] and could be encompassed in effort towards developing testing and new medical interventions. Within this partnership, a call for diagnostics for poverty-related diseases, including Ebola, was open till 2 March 2015. In February 2015, EU-funded project REACTION reported that their treatment reduces mortality by half (from 30% to 15%) in patients with early stage of Ebola. However, the clinical trials have not been launched yet. (EC 2015f).

The multi-stakeholder approach and cooperation in the research projects was especially appreciated by Carlos Moedas, the European Commissioner for Research, Science and Innovation: *"I would also like to stress*

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30 The US research on Ebola was activated already in April 2014 when a $140 million contract among the U.S. Department of Defense and a private medical company Temira was concluded. The human trials were already in progress at that time. (International Business Times 2014)
31 Such as malaria, HIV/AIDS, and tuberculosis. (EC 2015f)

that without the excellent Guinean-French cooperation, the pioneering role of the Médecins Sans Frontières (MSF) in this research, the fruitful partnerships with all NGOs involved, and the European Commission's responsiveness, this progress could not have been accomplished." (EC 2015g)

„Currently, five projects are being funded, including a trial of the most advanced vaccine against Ebola being developed by GSK (EbolaVac, with a European Commission financial contribution). This vaccine is already being tested in humans, with very promising results being seen so far. Other projects are studying the potential therapeutic effect on Ebola patients of an existing treatment against influenza (REACTION, using favipiravir), plasma from survivors (Ebola_Tx), and serum from antibody-producing horses (IF-Ebola). A further project is working on the transmission of the virus and the clinical importance of its mutations (EVIDENT)." (EC 2015f, EC 2015h).

The unprecedented EVD wave leads to many questions related to ethics in research. Under an enormous time pressure, it is very complicated to define the right conditions for unsafe clinical trials, experimental treatment and for transmission a drug of a very limited supply without violating human rights.

6 Evaluation: Strengths and Weaknesses

It was a common endeavour of whole range of global actors, national governments and many regional or local stakeholders that led to elimination of the threat called Ebola Virus Disease. The European Union traditionally emphasizes multilateral approach that is in compliance with the EU *middle power* capacity. The European Union is very ambitious in terms of engaging in global challenges. Its resources, however, are often exaggerated by the Union itself and underestimated by the scholars and experts on the EU external action.

The case of the EU response to the Ebola outbreak confirms the preconceived formula of foreign policy problem solving and the EU external action. According to the European Commission idealistic statements, the EU response towards the Ebola crisis was enormous, perfectly planned and implemented, effective and successful and well-timed. The world media and some non-profit organizations, and some of the Members of the European Parliament, on the other hand, claim, that the EU response towards the Ebola crisis was negligible, not coordinated, lacking results, chaotic and late. According to Charles Goerens, MEP, Ebola rapporteur for the European Parliament: *"The EU's response still fails to reflect the severity of the crisis we face in West Africa. There is so much more we could still be doing to help.*" (ALDE 2014) It is matter of fact, that the EU funded Ebola research has been launched in October (EC 2015f), however the US research on Ebola has been activated already in April 2014. (International Business Times 2014)

A set of various and sometimes contradictory examples was presented in this paper. Therefore, a clear and unprejudiced evaluation can hardly be provided, also due to many research obstacles that were discovered. The most serious one for conducting any research, the lack of reliable data or lack of any data, was revealed also in this case when some of the data were manipulated.

Based on the conducted analysis, it is presumed that the scope and financial framework of the EU development policy and humanitarian action were

adequate. The development policy financial mechanisms within the EU have two resources, the EC and the Member States which cumulatively contributed twice as much as the European Commission to resolving the crisis. The EU financial contribution towards resolving the crisis provided solely by the EC was even smaller than the financial contribution provided by some of the Member Countries independently (namely the UK), yet still appropriate.

The duality in development policy financial mechanisms within the EU may determine imbalance in decision-making, responsibility fragmentation, long transaction costs and many other negative effects. On the other hand it still gives the Members States some level of autonomy.

The focus of the presented thesis is not to underestimate the severity of the Ebola Virus Disease nor to neglect its serious impacts. However, the demographic impact of the EVD in the Western African region was very small. Ebola´s infection rate was 0,12% in the respective area of monitored countries Guinea, Sierra Leone and Liberia. Ebola produced an overall death rate of 0,05% in this area. The selected variables, the infection rate and the death rate, indicate that Guinea performed the best and Liberia performed the worst. The demographic impact of some other common disease, such as tuberculosis or diarrhoea on the population of Sub-Saharan Africa is much more serious. Considering these facts and figures, the EC cumulated financial support representing 0,33% of the EU Multiannual Financial Framework allocated to all dimensions of EU response towards the Ebola crisis was adequate.

On the other hand, one of the most serious weaknesses and threats of the EU external EU action was the late action timing. Nevertheless, declaring the EVD to be a serious global threat and accepting this fact globally, was delayed as well. Nowadays this is evaluated as one of the most serious misconducts in the entire Ebola crisis resolution.

Regarding planning and coordination of the EU approach towards the EVD, it is assumed that this was carried out in compliance with the EU

standard decision making procedures. The EU involvement in resolving the Ebola crisis did not cover all possible actions yet. For instance, the fund-raising campaigns, donations stayed under the umbrella of other actors experienced in this field, such as Médecins Sans Frontières or the Red Cross. This is evaluated positively since duplication of resources and activities is a fail of management.

The EU does not proceed as a unitary actor in the area of development policy. There is wide range of actors involved, wide range of financial resources and wide range of channels for delivering the aid. It is obvious that it is quite lot of problems associated with the EU Development Policy settings, mainly dual character of the development aid provided by the EU and by member countries and related fragmented competence. It is possible to track routine patterns in providing the development aid among the EU Members when the traditionally committed Members keep on being very active in the development policy and vice versa.

7 Conclusion

The presented thesis was dealing with the external dimension of the EU response towards the Ebola outbreak that developed in spring and summer 2014 in Western Africa and that has been the gravest Ebola wave in the history. After the spread of the disease into Europe and the USA, the EU, along side the major international players, became actively involved in resolving this crisis. Some of the efforts were more successful, some less successful. The levels of the EU response were classified according to their internal or external dimension and divided into more specific thematic sectors. The internal dimension covers medical framework and ensuring internal security and Ebola research. EU development policy and humanitarian aid including the diplomatic outreach of the EU foreign intervention create the external dimension. The primary objective, analysing the EU external action towards the Ebola outbreak, was accomplished based on meeting the secondary objectives. Firstly the development of the latest Ebola wave was tracked and the demographic impact on the population of the affected countries in Western Africa was identified. Secondly, the institutional structure and the key actors, financial framework of the EU development policy and humanitarian aid were analyzed. The role of EU Members has proven to be very important for shaping and implementing the development policy. Therefore, the influential factors were analyzed and groups of countries performing similar characteristics were created. Subsequently, the EU external action was specifically inspected and evaluated in case of the Ebola Virus Disease while using the previously identified variables: financial framework, institutional settings and key actors, the role of member states and diplomatic outreach. Finally, the strengths and weaknesses of the EU response towards the Ebola outbreak were assessed.

A combination of descriptive and analytical methods with qualitative and quantitative assessment was applied in the presented thesis. The major research limit was represented by data unavailability / uncertainty while completing one of the partial sections dealing with demographic impact of the Ebola Virus Disease on the population of the Western African countries. The unbalanced reflection of the Ebola outbreak in media, however, represented a research obstacle as well. The enormous interest of the world press present at the very beginning significantly declined in 2015. Evaluating the media attention retrospectively, it was exaggerated till the end of 2014 and neglected in 2015.

It was a common endeavour of whole range of global actors, national governments and many regional or local stakeholders that led to elimination of the thread represented by the Ebola Virus Disease[32]. The European Union traditionally emphasized multilateral approach that is in compliance with the EU *middle power* capacity. The development policy financial mechanisms within the EU have two resources, the EC and the Member States cumulatively contributing twice as much as the European Commission to resolving the crisis. However, in such a grave matter, every support counts. It is entirely positive to witness that the multilateral approach and gained forces eventually led to resolving another global threat.

[32] Liberia was declared Ebola free on May 7th 2015. There were 35 new cases reported from Guinea and Sierra Leone. (WHO 2015d)

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