



COMMISSION OF THE EUROPEAN COMMUNITIES

Brussels
C(2009) XXX final

COMMISSION DECISION

of

**on the financing of emergency humanitarian Actions from the general budget of the
European Communities in Southern Africa**

(ECHO/-SF/BUD/2009/01000)

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on the financing of emergency humanitarian Actions from the general budget of the European Communities in Southern Africa (ECHO/-SF/BUD/2009/01000)

THE COMMISSION OF THE EUROPEAN COMMUNITIES,

Having regard to the Treaty establishing the European Community,

Having regard to Council Regulation (EC, Euratom) No.1257/96 of 20 June 1996 concerning humanitarian aid¹, and in particular Article 2(a) and Article 13 thereof,

Whereas:

- (1) Eight countries² of the southern African region have been reporting cholera cases since the last quarter of 2008, with the largest outbreaks in Mozambique, South Africa, Zambia and particularly Zimbabwe ;
- (2) On 31 December 2008, 32,519 cases with 1,622 deaths had been reported in Zimbabwe alone. By 29 January 2009 this figure had risen to 60,000 cases with 3,100 fatalities (Case Fatality Rate 5,2% as compared to the emergency threshold CFR 2%). 3,333 cases and 46 deaths were recorded in Mozambique, 2,270 cases and 28 deaths in Zambia, and 5,000 cases in South Africa, mostly affecting Zimbabwean migrants ;
- (3) The cholera epidemic in Zimbabwe is, however, only a symptom of the progressive deterioration and ultimate collapse of the public health system ;
- (4) The trends are clearly on the increase, and the cholera outbreak is still not under control as 10 out of 10 provinces (53 out of 62 districts) in Zimbabwe have consistently continued to report cholera cases and deaths. The situation is likely to be exacerbated all over the region by the ongoing rainy season ;
- (5) Humanitarian aid Actions financed by this Decision should be of a maximum duration of 6 months.
- (6) To reach populations in need, aid should be channelled through Non-Governmental Organisations (NGOs) and International Organisations, including United Nations (UN) agencies. Therefore, the European Commission should implement the budget by direct centralized management or by joint management.
- (7) It is estimated that an amount of EUR 5,500,000 from budget article 23 02 01 of the general budget of the European Communities is necessary to provide humanitarian assistance to over 100,000 people in cholera-affected areas, taking into account the available budget, other donors' contributions and other factors. Therefore, the activities

¹ OJ L 163, 2.7.1996, p. 1.

² Angola, Botswana, Malawi, Mozambique, Namibia, South Africa, Zambia, Zimbabwe

covered by the Decision may be financed in full, in accordance with Article 253 of the Implementing Rules of the Financial Regulation.

- (8) The present Decision constitutes a financing Decision within the meaning of Article 75 of the Financial Regulation (EC, Euratom) No 1605/2002³, Article 90 of the detailed rules for the implementation of the Financial Regulation determined by Regulation (EC, Euratom) No 2342/2002⁴, and Article 15 of the Internal Rules on the Implementation of the general budget of the European Communities⁵.

HAS DECIDED AS FOLLOWS:

Article 1

1. In accordance with the objectives and general principles of humanitarian aid, the Commission hereby approves a total amount of EUR 5,500,000 for emergency humanitarian aid Actions to provide the necessary assistance and relief to up to 100,000 people in areas of Southern Africa affected by cholera by using budget article 23 02 01 of the 2009 general budget of the European Communities.
2. In accordance with Article 2(a) of Council Regulation No.1257/96, the humanitarian Actions under this Decision shall be implemented in pursuance of the following specific objective:
 - To meet immediate humanitarian requirements, resulting from the outbreaks of cholera, and to create conditions to contain such outbreaks.

Article 2

1. The implementation of humanitarian aid Actions funded by this Decision shall have a maximum duration of 6 months from their starting date.
2. Expenditure under this Decision shall be eligible from 1 January 2009.
3. If the Actions envisaged in this Decision are suspended owing to force majeure or comparable circumstances, the period of suspension shall not be taken into account for the calculation of the duration of the humanitarian aid Actions.

Article 3

1. The Commission shall implement the budget by direct centralised management or by joint management with international organisations.
2. Actions supported by this Decision will be implemented either by:
 - Non-profit-making organisations which fulfil the eligibility and suitability criteria established in Article 7 of Council Regulation (EC) No. 1257/96;
 - or International organisations
3. Taking account of the specificities of humanitarian aid, the nature of the activities to be undertaken, the specific location constraints and the level of urgency, the activities covered by this Decision may be financed in full in accordance with Article 253 of the Implementing Rules of the Financial Regulation.

³ OJ L 248, 16.9.2002, p.1.

⁴ OJ L 357, 31.12.2002, p.1.

⁵ Commission Decision of 5.3.2008, C/2008/773

Article 4

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

Done at Brussels

*For the Commission
Member of the Commission*



Emergency Humanitarian Aid Decision
23 02 01

Title: Continuing emergency response to cholera epidemics in southern Africa

Location of Action: SOUTHERN AFRICA

Amount of Decision: EUR 5,500,000

Decision reference number: ECHO/-SF/BUD/2009/01000

Supporting Document

1 - Rationale, needs and target population.

1.1. - Rationale :

Eight countries¹ of the southern African region have been reporting cholera cases since the last quarter of 2008, with the largest outbreaks in Mozambique, South Africa, Zambia and Zimbabwe.

Water-borne diarrhoea cases, including cholera, have been reported at a low level in Zimbabwe since August 2008, a symptom of the combined collapse of the health and water supply structures. From its low-level incidence, outbreaks of cholera have erupted all over the country since mid-November 2008. As of 29th January 2009, there have been 60,000 cases and 3,100 fatalities (Case Fatality Rate 5,2%) in Zimbabwe. In December 2008 alone, 19,921 cases and 1,102 deaths (CFR 5.5% - emergency alert threshold is CFR 2%, under control is < 1%) were recorded, or **643 cases/day – 36 deaths/day** compared to November 2008 with a total number of cases recorded of 9,463, with 389 deaths (CFR 4.1%), **315 cases/day – 13 deaths/day**. The trends are clearly on the increase, and the cholera outbreak is still not under control as 10 out of 10 provinces (53 out of 62 districts) have consistently continued to report cholera cases and deaths. 150 cholera treatment centres (CTCs) have been established. The Government of Zimbabwe declared a national emergency on 3rd December 2008.

¹ Angola, Botswana, Malawi, Mozambique, Namibia, South Africa, Zambia, Zimbabwe

The cholera epidemic in Zimbabwe is, however, only a symptom of the progressive deterioration and ultimate collapse of the basic services in terms of health, safe water and sanitation (lack of human resources, medicines and medical supplies, poor provision of water and electricity, lack of consumables and of maintenance of the infrastructures). It is characterised by widespread occurrence of cases with periodic explosive outbreaks in high density urban, peri-urban and rural areas. Cholera is likely to spread to new areas with the movement of people and has led to large outbreaks in some areas due to the poor water and sanitation infrastructure, unsafe funeral practices and family gatherings. Indeed, more than two-thirds of the deaths have thus far occurred in the community, a sign of the difficulty of access to, and of a general lack of, health services. After such a serious epidemic, cholera becomes endemic, and there is an extremely high likelihood of annual recurrence.

Against the background of this alarming and extremely rapid spread, and the weak capacity of the Government to cope with so many outbreaks at the same time, non-governmental organizations and UN agencies have continued to scale up their existing interventions and established new intervention sites all over the country. This substantial emergency scaling up includes the deployment of medical teams from Europe, and the dispatch of large quantities of ringer lactate, oral rehydration salts (ORS) and other essential items from Europe, as such stocks are insufficient or completely absent in many areas. Indeed, the Government of Zimbabwe authorized the import of ORS – the most effective treatment for patients affected by severe acute watery diarrhoea - only on 12th December 2008.

In Mozambique, 3,333 cases and 46 deaths were recorded from 1st October 2008 to 20th January 2009. Though the case fatality rate of 1.4% has not yet reached emergency levels, the epidemic is not under control. The situation is likely to deteriorate before the end of the rainy season in April.

In Zambia, during the same period, 2,270 cases and 28 deaths have been recorded, a case fatality rate of 1.25%. The main foyer is in and around Lusaka, where the outbreak is said to be serious outbreak. Zambia, too, will normally have rains until April.

South Africa has recorded almost 5,000 cases since mid November 2008, with 34 deaths. The vast majority of patients have been Zimbabwean migrants crossing the border at Beitbridge/Musina. The case fatality rate of 0.78% shows that, though cases are on the increase, the outbreak has been controlled by the swift intervention of the South African health services. The South African government in mid-December declared a state of emergency in Vhembe district of Limpopo Province.

Angola, Botswana, Malawi and Namibia have recorded a much smaller number of cases, though the situation particularly in Malawi could deteriorate with the first floods of the season in the south of the country.

In Swaziland, over 2,500 cases of acute watery diarrhoea were recorded in the three weeks to 11th January, though fortunately without fatalities.

1.2. - Identified needs :

Cholera is an acute intestinal infection caused by the bacterium *vibrio cholerae*. It occurs through ingestion of food or water contaminated directly or indirectly by faeces or vomit of infected persons. The resulting disease varies in intensity: in some mild cases, diarrhoea may occur without other symptoms. However, the severe cases of acute watery diarrhoea are

frequently accompanied by nausea and vomiting, rapid dehydration and circulatory collapse. Between 25 and 50% of cholera cases are fatal, if untreated, though an appropriate treatment can reduce mortality rate below 1-2%.

There is no geographical, gender or age limitation for cholera. Large population movements prompted by conflicts and insufficient access to safe water and to sanitation facilities, the latter being the case in much of southern Africa, facilitate the extension of the disease.

In Zimbabwe, the very serious prognosis of UN agencies and NGO partners with regard to the evolution of this epidemic is confirmed by forecasts established by DG ECHO's² medical staff, who note that 50,000 cumulative cases means that there are probably more than 500,000 asymptomatic carriers spreading the disease all around, and probably outside, the country. As of mid-January, the epidemic in Zimbabwe had not peaked, which makes it difficult to forecast how many additional cases will be reported. However, with the end of the rainy season more than three months away, the outlook is not optimistic.

The most vulnerable areas are the small rural remote locations where several people may die in each village if unattended, while the close promiscuity of the population living in high density areas with poor or no access to clean water creates conditions for explosive outbreaks of water related diseases.

Without appropriate actions, both case fatality rate (number of deaths due to cholera) and attack rate (number of people affected by cholera) will be very high.

To reduce the spread and the attack rate of cholera cases (or the morbidity), social mobilization and public awareness efforts, hygiene education together with the chlorination of water sources are critically important and should complement adequate access to safe water and to sanitation in cholera treatment centres. Emergency supplies of clean water are also required, for both household and hospital use, in order to break the cycle of transmission of the infection.

To reduce the mortality rate of patients affected by cholera, pre-emptive positioning of oral rehydration salts, ringer lactate, and other essential treatments, and the creation of ORS corners are the most effective interventions, together with appropriate case management of severe cholera cases and quick referral of patients. It is clearly too late for vaccine strategies.

The high mortality rate during the early phase of the outbreak strongly points to the need for a strengthening of the early warning and response system, and calls for the immediate establishment of systems to access the remote areas. The mortality rates at the CTC level are still a serious concern, especially where case management is not supported by international organisations.

A joint health/watsan mission from DG ECHO's Regional Support Office in Nairobi took place in Zimbabwe from 15-19 December 2008, in support of the DG ECHO Harare office. This mission confirmed the needs on the ground, and made recommendations for additional emergency interventions to contribute to tackling the cholera/public health crisis. This decision aims to provide additional funding to such interventions.

² Directorate-General for Humanitarian Aid - ECHO

1.3. - Target population and regions concerned :

At the time of writing, the outbreaks are affecting the entire territory of Zimbabwe, and have spread to the neighbouring countries, which in turn are experiencing their own endemic outbreaks. Due to the unpredictable nature of epidemics, and the exponential spread of this particular one, interventions funded from this decision will mainly focus on Zimbabwe, but may, and will more than likely, extend to other countries of the southern African region. In view of the debilitating nature of the disease, it is likely to have more consequences on the most vulnerable groups such as children (and especially on under-5's), elderly people, pregnant and breastfeeding women.

1.4. - Risk assessment and possible constraints :

The rainy season is typically very heavy and long in much of southern Africa. The effects of this on the already extremely poor infrastructure, exacerbated by lack of availability of fuel in Zimbabwe, may constrain the logistics aspects of this intervention, especially as far as transport to rural areas is concerned.

External support to emergency containment of epidemics is efficient, but it may also decrease the motivation of the Government to develop autonomous responses. External actors also need to develop a comprehensive approach and integrate local capacities, in order not to jeopardize development oriented processes, or in the case of Zimbabwe, to mitigate a further structural deterioration. In order to enhance co-ordination among health authorities and among agencies themselves, close and regular co-ordination with WHO and specialized agencies is required more than ever.

2 - Objectives and components of the humanitarian intervention proposed:

2.1. - Objectives :

Principal objective: To support the continuing response to cholera outbreaks in southern Africa

Specific objective:

- To meet immediate humanitarian requirements resulting from the outbreaks of cholera, and to create conditions to contain such outbreaks

The expected outcome is, in particular, to decrease the mortality rate and maintain the case-fatality rate within internationally recognized thresholds (less than 2% of reported cases).

2.2. - Components :

The funds made available under this decision will be used to provide curative and preventive care, including access to clean water, to populations in cholera outbreak areas, in order to prevent the spread of the disease, and therefore unnecessary deaths. The following list of components are considered to be appropriate to the context :

Water, sanitation and hygiene

- Provision of chlorinated water in sufficient quantities to match the need for domestic use by the target population by trucking³ or other means ;
- Purification/chlorination of water sources ;
- Provision of hygiene and disinfectant items⁴ ; provision of essential relief items, such as soap and water containers ;
- Cleaning campaigns ;
- Provision of emergency access to sanitation, including limited short term works on drainage and sewerage systems ;
- Hygiene education with community emergency education, information, dissemination (EID) and social mobilisation. A particular emphasis will be put on promoting hand washing, safe food handling, promoting the control of disposal of faeces and the use of safe water, as well as on the promotion of safe burial practices ;
- Coordination of activities

Health

- Provision of essential medicines and items of equipment, such as, but not exclusively, zinger lactate, oral rehydration salts, antibiotics and beds, cholera kits and others ;
- Improvement of sanitary conditions of health facilities; creation of dedicated cholera treatment centres ;
- Epidemiological surveillance, establishment of contingency plans in areas vulnerable to cholera ;
- Provision of laboratory kits and consumables for confirmation of cholera cases ;
- Support to proper cholera case management and support to referral activities ;
- Provision of training to health staff ;
- Coordination of activities

3 - Duration expected for Actions in the proposed Decision:

The duration of humanitarian aid Actions shall be 6 months.

Expenditure under this Decision shall be eligible from 1st January 2009, in order to accommodate funding requests already received from partners.

If the implementation of the Actions envisaged in this Decision is suspended due to *force majeure* or any comparable circumstance, the period of suspension will not be taken into account for the calculation of the duration of the humanitarian aid Actions.

Depending on the evolution of the situation in the field, the Commission reserves the right to terminate the agreements signed with the implementing humanitarian organisations where the suspension of activities is for a period of more than one third of the total planned duration of the Action. In this respect, the procedure established in the general conditions of the specific agreement will be applied.

³ Support to water trucking should be linked with clear exit strategy defined and implemented before launching the water trucking activity

⁴ Household water treatment activities should not be limited to the distribution of purification tablets, but should include appropriate water storage capacity and awareness, training on the use of the consumables distributed.

4 - Previous interventions/Decisions of the Commission within the context of the current crisis

DG ECHO has been funding substantial health/public health interventions in Zimbabwe throughout 2008, with the focus being on water and sanitation, essential drugs, and cholera treatment and prevention. The EC Delegation in Harare has, amongst various interventions to the direct benefit of the population, been funding one-third of the drug list of Zimbabwe, and is supporting a staff retention scheme. The current decision aims to continue and complement that response.

DG ECHO has also intervened in cholera and other epidemic response in the region (Angola, Malawi, Mozambique, Zimbabwe) on a number of occasions in recent years.

List of previous DG ECHO operations in MOZAMBIQUE/ZAMBIA/ZIMBABWE

Decision Number	Decision Type	2007 EUR	2008 EUR	2009 EUR
ECHO/-AF/EDF/2007/01000 (*)	Non Emergency	0		
ECHO/-FA/BUD/2007/01000 (*)	Non Emergency	9,989,439		
ECHO/-FA/BUD/2007/02000 (*)	Non Emergency	5,000,000		
ECHO/MOZ/BUD/2007/01000	Emergency	2,000,000		
ECHO/MOZ/BUD/2007/02000	Prim. Emergency	2,000,000		
ECHO/MOZ/EDF/2007/01000	Non Emergency	3,000,000		
ECHO/ZMB/EDF/2007/01000	Non Emergency	2,000,000		
ECHO/ZWE/BUD/2007/01000	Global Plan	8,000,000		
ECHO/ZWE/EDF/2007/01000	Non Emergency	7,200,000		
ECHO/-FA/BUD/2008/01000 (*)	Non Emergency		12,565,840	
ECHO/-FA/BUD/2008/02000 (*)	Non Emergency		2,434,160	
ECHO/DIP/BUD/2008/04000 (*)	Non Emergency		1,788,634	
ECHO/ZWE/BUD/2008/01000	Global Plan		10,000,000	
Subtotal		39,189,439	26,788,634	0
Grand Total		65,978,073		

Dated : 28 January 2009

Source : HOPE

(*) decisions with more than one country

5 - Overview of donors' contributions

Donors in MOZAMBIQUE/ZAMBIA/ZIMBABWE the last 12 months

1. EU Members States (*)		2. European Commission		3. Others	
	EUR		EUR		EUR
Austria	100,000	DG ECHO	26,788,634		
Belgium	1,399,500	Other services			
Bulgaria					
Cyprus					
Czech republic	200,000				
Denmark	4,557,906				
Estonia	57,508				
Finland	500,000				
France	2,339,520				
Germany	9,992,146				
Greece	690,000				
Hungary					
Ireland	4,653,704				
Italy	5,039,027				
Latvia					
Lithuania					
Luxemburg	350,000				
Malta					
Netherlands	19,499,140				
Poland					
Portugal	283,810				
Romania					
Slovakia					
Slovenie					
Spain					
Sweden	9,237,138				
United kingdom	24,418,888				
Subtotal	83,318,287	Subtotal	26,788,634	Subtotal	0
		Grand total	110,106,921		

Dated : 28 January 2009

(*) Source : DG ECHO 14 Points reporting for Members States. <https://webgate.ec.europa.eu/hac>
Empty cells means either no information is available or no contribution.

6 - Amount of Decision and distribution by specific objectives:

6.1. - Total amount of the Decision: EUR 5,500,000

6.2. - Budget breakdown by specific objectives

Principal objective: <i>To support the continuing response to cholera outbreaks in southern Africa</i>			
Specific objectives	Allocated amount by specific objective (EUR)	Geographical area of operation	Potential partners⁵
Specific objective 1: To meet immediate humanitarian requirements resulting from the outbreaks of cholera, and to create conditions to contain such outbreaks	5,500,000	National Zimbabwe. Localized areas of southern African countries suffering cholera outbreaks	- ACF – FRA - CARE DE - CROIX-ROUGE - ESP - GERMAN AGRO ACTION - GOAL - IFRC-FICR - INTERMON - IOM - IRC - MERLIN - MSF - BEL - MSF – ESP - MSF-CH - MSF - NLD - NORWEGIAN REFUGEE COUNCIL - OXFAM GB - UNICEF - WHO - WV DE - WV UK
TOTAL:5,500,000			

⁵ ACTION CONTRE LA FAIM, (FR), ARTSEN ZONDER GRENZEN (NLD), CARE DEUTSCHLAND, CRUZ ROJA ESPAÑOLA, (E), DEUTSCHE WELTHUNGERHILFE e.V., GOAL IRELAND, INTERNATIONAL RESCUE COMMITTEE, FEDERATION INTERNATIONALE DES SOCIETES DE LA CROIX-ROUGE ET DU CROISSANT ROUGE, INTERMON OXFAM, (E), INTERNATIONAL ORGANIZATION FOR MIGRATION (INT), MEDECINS SANS FRONTIERES BELGIQUE/ARTSEN ZONDER GRENZEN BELGIE(BEL), MEDICOS SIN FRONTERAS, (E), ARTSEN ZONDER GRENZEN NEDERLAND, MEDECINS SANS FRONTIERES SUISSE, OXFAM GB, NORWEGIAN REFUGEE COUNCIL (NOR), UNICEF, WORLD HEALTH ORGANISATION - ORGANISATION MONDIALE DE LA SANTE, WORLD VISION INTERNATONAL, WORLD VISION UK

7 - Evaluation

Under article 18 of Council Regulation (EC) No.1257/96 of 20 June 1996 concerning humanitarian aid the Commission is required to "regularly assess humanitarian aid Actions financed by the Community in order to establish whether they have achieved their objectives and to produce guidelines for improving the effectiveness of subsequent Actions." These evaluations are structured and organised in overarching and cross cutting issues forming part of DG ECHO's Annual Strategy such as child-related issues, the security of relief workers, respect for human rights, gender. Each year, an indicative Evaluation Programme is established after a consultative process. This programme is flexible and can be adapted to include evaluations not foreseen in the initial programme, in response to particular events or changing circumstances. More information can be obtained at:

http://ec.europa.eu/echo/policies/evaluation/introduction_en.htm.

8. MANAGEMENT ISSUES

Humanitarian aid Actions funded by the Commission are implemented by NGOs, Specialised Agencies of the Member States, and the Red Cross organisations on the basis of Framework Partnership Agreements (FPA) and by United Nations agencies based on the EC/UN Financial and Administrative Framework Agreement (FAFA) in conformity with Article 163 of the Implementing Rules of the Financial Regulation. These Framework agreements define the criteria for attributing grant agreements and financing agreements in accordance with Article 90 of the Implementing Rules and may be found at http://ec.europa.eu/echo/about/actors/partners_en.htm.

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

Individual grants are awarded on the basis of the criteria enumerated in Article 7.2 of the Humanitarian Aid Regulation, such as the technical and financial capacity, readiness and experience, and results of previous interventions.