



EUROPEAN COMMISSION

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**COMMISSION DECISION**

**of**

**on the approval and financing of a Global Plan for humanitarian Actions in Zimbabwe  
from the general budget of the European Union**

**(ECHO/ZWE/BUD/2010/01000)**

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THE EUROPEAN COMMISSION,

Having regard to the Treaty on the Functioning of the European Union,

Having regard to Council Regulation (EC) No.1257/96 of 20 June 1996 concerning humanitarian aid<sup>1</sup>, and in particular Articles 2 and 4 and Article 15(3) thereof;

Whereas:

- (1) Progress has been noted since the Government of National Unity took office, yet the challenge of reversing economic and structural collapse still remains. The rehabilitation of the social and public health services and the restoration of the delivery of these services remains critical for building confidence in the transition ;
- (2) It is necessary to consolidate the tentative gains made in the provision of primary health care and in epidemic surveillance, response and control capacity ;
- (3) It is equally necessary to consolidate the reestablishment of safe water supply at district level, as a basis for the launching of comprehensive and sustainable long-term water and sanitation programmes, which are considered more appropriate to tackle the country's degraded water infrastructure ;
- (4) Though food availability has improved, economic access to food remains problematic for the most vulnerable, particularly in a hard-currency economy ;
- (5) To ensure the efficiency of aid in the present humanitarian context, coordination of humanitarian assistance, including an effective capacity to respond to population displacements, is essential;
- (6) As the scale and complexity of the humanitarian crisis is such that it is likely to continue, it is necessary to adopt a Global Plan to provide a coherent framework for the implementation of humanitarian Actions;
- (7) To reach populations in need, humanitarian 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;

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<sup>1</sup> OJ L 163, 2.7.1996, p. 1.

- (8) An assessment of the humanitarian situation leads to the conclusion that humanitarian aid Actions should be financed by the European Union for a period of **12** months;
- (9) It is estimated that a total amount of EUR 15,000,000, of which EUR 12,000,000 from budget article 23 02 01 and EUR 3,000,000 from budget article 23 02 02 of the general budget of the European Union is necessary to provide humanitarian assistance to over 2,000,000 million vulnerable Zimbabweans, taking into account the available budget, other donors' contributions and other factors. Although as a general rule Actions funded by this Global Plan should be co-financed, the Authorising Officer, in accordance with Article 253 of the Implementing Rules of the Financial Regulation, may agree to the full financing of Actions;
- (10) The present Decision constitutes a financing Decision within the meaning of Article 75 of the Financial Regulation (EC, Euratom) No 1605/2002<sup>2</sup>, Article 90 of the detailed rules for the implementation of the Financial Regulation determined by Regulation (EC, Euratom) No 2342/2002<sup>3</sup>, and Article 15 of the internal rules on the implementation of the general budget of the European Union<sup>4</sup>;
- (11) In accordance with Article 17(2) of Council Regulation (EC) No.1257/96 of 20 June 1996, the Humanitarian Aid Committee gave a favourable opinion on 9 June 2010.

HAS DECIDED AS FOLLOWS:

#### *Article 1*

1. In accordance with the objectives and general principles of humanitarian aid, the Commission hereby approves a 2010 Global Plan for the financing of humanitarian Actions in Zimbabwe for a total amount of EUR 15,000,000 of which EUR 12,000,000 from budget article 23 02 01 and EUR 3,000,000 from budget article 23 02 02 of the 2010 general budget of the European Union.
2. In accordance with Articles 2 and 4 of Council Regulation No.1257/96, the principal objective of this Decision is to provide humanitarian assistance and protection to vulnerable populations affected by the breakdown of essential services in Zimbabwe.  
The humanitarian Actions shall be implemented in the pursuance of the following specific objectives:
  - To contribute to improving the humanitarian situation of the most vulnerable population groups through support to the recovery of essential health and water supply services  
A total of EUR 11,000,000 from budget article 23 02 01 is allocated to this specific objective.
  - To contribute to improving the humanitarian situation of the most vulnerable population groups by providing food assistance, short term food security and livelihood support  
A total of EUR 3,000,000 from budget article 23 02 02 is allocated to this specific objective.

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<sup>2</sup> OJ L 248, 16.9.2002, p.1.

<sup>3</sup> OJ L 357, 31.12.2002, , p.1.

<sup>4</sup> Commission Decision of 5.3.2008, C/2008/773

- To improve the conditions for delivering humanitarian assistance through support to coordination and protection mechanisms

A total of EUR 1,000,000 from budget article 23 02 01 is allocated to this specific objective.

3. The Authorising Officer may decide on non-substantial changes in accordance with Article 90.4 of the Implementing Rules of the Financial Regulation. Accordingly, when required by the changing circumstances, resources may be reallocated between specific objectives 1 and 3, where specific objectives 1 and 3 are funded from the same budget article, up to a maximum of 20% of the total amount of the Financing Decision or up to a total of EUR 3,000,000, whichever is reached first.

#### *Article 2*

1. The period for the implementation of the Actions financed under this Global Plan shall start on 1 August 2010 and shall run for 12 months. Eligible expenditure shall be committed during the implementing period of the Decision.
2. If the implementation of individual Actions is suspended owing to force majeure or other exceptional circumstances, the period of suspension shall not be taken into account in the implementing period of the Global Plan in respect of the Action suspended.
3. In accordance with the contractual provisions ruling the Agreements financed under this Global Plan, the Commission may consider eligible those costs arising and incurred after the end of the implementing period of the Action which are necessary for its winding-up.
4. The Authorising Officer may, where this is justified by the humanitarian situation, extend the duration of the Global Plan for a maximum of 6 months provided that the total duration of the Global Plan does not exceed 18 months, in accordance with Article 90.4 of the Implementing Rules of the Financial Regulation.

#### *Article 3*

1. As a general rule, Actions funded by this Global Plan should be co-financed.  
The Authorising Officer, in accordance with Article 253 of the Implementing Rules, may agree to the full financing of Actions when this will be necessary to achieve the objectives of this Global Plan and with due consideration to the nature of the activities to be undertaken, the availability of other donors and other relevant operational circumstances.
2. Actions supported by this Global Plan 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. The Commission shall implement the budget:
  - \* either by direct centralised management, with non-governmental Organisations
  - \* or by joint management with international organisations that are signatories to the Framework Partnership Agreements (FPA) or the EU/UN Financial Administrative Framework Agreement (FAFA) and which were subject to the four pillar assessment in line with Article 53d of the Financial Regulation.

*Article 4*

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

Done at Brussels, **[Date to be inserted by SG]**

*For the Commission  
Member of the Commission*



COMMISSION EUROPÉENNE

DIRECTION GENERALE DE L'AIDE HUMANITAIRE AND CIVIL PROTECTION - ECHO

**Supporting document to the Commission Decision  
on the approval and financing of a Global Plan for  
humanitarian Actions in Zimbabwe from the general budget  
of the European Union**

**ECHO/ZWE/BUD/2010/01000**

**Submitted to the Humanitarian Aid Committee in June 2010**

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## 1. EXECUTIVE SUMMARY

Following troubled elections in Zimbabwe earlier in the year, a Global Political Agreement (GPA) was signed on September 15, 2008, between ZANU-PF<sup>1</sup>, MDC-T<sup>2</sup> and MDC-M<sup>3</sup>. Five months later, a Government of National Unity (GNU) was formed with the swearing in of Mr. Morgan Tsvangirai as Prime Minister on February 11, 2009, and of a new Cabinet on February 13, 2009. As the Government of National Unity enters its second year, some progress has been noted, but the challenge of reversing economic and structural collapse remains. The rehabilitation of the social, public health and education services are seen as key priority areas, whilst the restoration of the delivery of basic services remains critical for building confidence in the transition.

Zimbabwe's national health system was once among the best in the region. The sharp economic decline over the last decade and its recent acceleration has resulted in a dramatic decrease of public funding in real terms and led to a severe deterioration of the health delivery system, particularly since the beginning of 2008. There is only a limited supply of safe water all over the country. The water situation has worsened over the last years against the background of economic instability and the degradation of water and sewage systems in most urban areas. The adverse implementation of the Fast Track Land Reform Programme (FTLRP) resulted in forced seizures of mostly white-owned land by ZANU war veterans, and wider inappropriate economic policies, crippled the country and led to an unrelieved shortage of basic commodities and services from 2000 onwards. The collective result of all of these events is that the difficult access to food – both physical and economic – has had serious deleterious effects on the food security status of vulnerable populations.

DG ECHO's<sup>4</sup> strategy for the health sector, as part of the European Commission's response, and in order to have an impact on the protection of the health system and on the protection of the lives of the most vulnerable, has been to address structural and life-saving interventions in parallel. During the past years, the EU has been one of the largest donors in funding emergency water and sanitation interventions, as part of the integrated public health approach to tackle potential epidemics (cholera, measles and typhus outbreaks are currently occurring in the country). The focus is on basic humanitarian actions that guarantee access to water and sanitation facilities, particularly at health centres. With the collapse of the water supply sector, however, additional interventions are considered necessary to support the reestablishment of safe water supply at district level, as a basis for the launching of comprehensive and sustainable long-term water and sanitation programmes, which are considered more appropriate to tackle the country's degraded water infrastructure.

As far as the food sector is concerned, the European Commission has made a concerted effort to link food aid with food security interventions. Whilst large-scale inputs procurement and distribution activities have been taken over and expanded by the EU Delegation in Harare, DG ECHO can add value to the inputs distribution

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<sup>1</sup> Zimbabwe African National Union – Popular Front

<sup>2</sup> Movement for Democratic Change – Morgan Tsvangirai

<sup>3</sup> Movement for Democratic Change – Arthur Mutambara

<sup>4</sup> Directorate General for Humanitarian Aid - ECHO

actions particularly, by promoting pilot livelihoods activities involving cash and vouchers, as well as small-scale peri-urban agriculture.

This Global Plan makes available a total of €15 million, of which €12 million from the general humanitarian budget line, and €3 million for the food aid budget line. Actions will be funded for a period of 12 months from 1<sup>st</sup> August 2010.

## **2. CONTEXT AND SITUATION**

### ***2.1. General Context***

Following troubled elections earlier in the year, a Global Political Agreement (GPA) was signed on September 15, 2008, between ZANU-PF, MDC-T and MDC-M. Five months later, a Government of National Unity (GNU) was formed with the swearing in of Mr. Morgan Tsvangirai as Prime Minister on February 11, 2009, and of a new Cabinet on February 13, 2009. The Zimbabwe dollar (ZIM\$) was withdrawn in October 2008, replaced by the US dollar and the South African rand (ZAR). This put an end to the rampant and historic hyperinflation experienced for the last four or five years. The new Government, however, faces many more difficult challenges.

As the Government of National Unity enters its second year, some progress has been noted, but the challenge of reversing economic and structural collapse remains. Since its installation, the GNU has been defining its strategy for the stabilization of Zimbabwe in the Short Term Economic Recovery Programme (STERP), which has become the blue print document to address in the short term key issues on democratization, stabilization and national healing. The STERP targets a series of core issues in the social (food security, health, water and sanitation, education), economic and governance sectors. The priorities of the STERP have been endorsed by the European Commission, and mirrored in the European Commission's Short-Term Strategy for Zimbabwe, adopted in September 2009. Humanitarian action is an important pillar of the Short-Term Strategy as Zimbabwe has entered what all stakeholders agree to be a transitional phase. The rehabilitation of the social, public health and education services are seen as key priority areas, whilst the restoration of the delivery of basic services remains critical for building confidence in the transition.

The drastic deterioration of social services over the past decade, culminating in a state of effective collapse at the end of 2008/early 2009, is reflected in an effective loss of almost 40 places in the Human Development Index (HDI)<sup>5</sup> compiled by the United Nations Development Programme : Zimbabwe's index fell – one of a tiny handful of such cases – from 0.654 in 1990 to 0.513 in 2005, when it came in 151<sup>st</sup>. No index could be calculated for the 2009 HDI report, but if the 2005 score of 0.513 were to have remained stable, this would put Zimbabwe between 157<sup>th</sup> (Lesotho and Uganda) and 158<sup>th</sup> (Nigeria) place in 2009.

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<sup>5</sup> UNDP Human Development Report 2007/2008

## 2.2 Current Situation

Zimbabwe's national health system was once among the best in the region. The sharp economic decline registered over the last decade and its recent acceleration resulted in a dramatic decrease of public funding in real terms and led to a severe deterioration of the health delivery system, particularly the since the beginning of 2008. As a consequence, the high HIV prevalence rates<sup>6</sup> have not decreased, the maternal mortality rate has substantially increased<sup>7</sup> and the proportion of pregnant women delivering in an institutional environment as part of a safe motherhood programme has dropped from 72% in 1999 to 53.6% in 2005<sup>8</sup>. Against a background of falling access to and availability of safe water, the country experienced one of the largest nationwide cholera outbreaks ever recorded in Africa. A huge effort was required by many actors to bring the epidemic under control by July 2009, with outbreaks being reported – but controlled – ever since. Vaccination coverage rates (previously a model for the continent) have fallen from 80% in 1994 to 53% in 2005<sup>9</sup>. In view of the serious deterioration in the health sector since these statistics were compiled, it is highly likely that vaccination and safe motherhood coverage has fallen even further. Indeed, at the time of writing, outbreaks of measles had been recorded in 90% of districts, with upwards of 2200 cases and 185 deaths nationwide, necessitating the organisation of an emergency vaccination campaign targeting all children from 6 months to 15 years old. Furthermore, 73.4% of the HIV and AIDS patients eligible for anti-retroviral treatment (ART) have not been treated<sup>10</sup>, whilst prevention of mother-to-child transmission (PMTCT) coverage is only 6%, despite its clear and significant added value. Though HIV and AIDS is a long-term problem whose response requires long-term interventions by the Global Fund and the Ministry of Health, the collapse in the health system is more immediately increasing the gap in the response to the pandemic while seriously threatening the basic implementation of universal precautions in health facilities. The main challenge remains how to intervene to mitigate this deterioration process in order to protect the capacity for ensuring the delivery of basic services and prevent a major humanitarian crisis which, in turn, would require major resources to save lives and massive support in the medium- to long-term for the rehabilitation and recovery of the social systems.

There is only a limited supply of safe water all over the country. The water situation has worsened over the last years against the background of economic instability and the degradation of water and sewage systems in most urban areas due to age, overloading, pump breakdowns and absence of spare parts, poor operation and lack of maintenance due to the departure of technicians and the breakdown of the cost recovery system. This is cause for great concern as epidemic outbreaks of diarrhoeal diseases, including cholera, have been appearing regularly in peri-urban areas since mid-2007. The explosion of cholera in the last quarter of 2008 into the largest ever epidemic recorded in Africa (almost 100,000 cases and over 4,400 deaths) is only a symptom of the combined collapse of the health and water supply services, as well as

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<sup>6</sup> HIV/AIDS prevalence rate 15.6% in 2007

<sup>7</sup> From 555/100.000 in 2005 to 725/100.000 in 2007

<sup>8</sup> Although the percentage of ante-natal care coverage is still high when compared to other countries, deliveries attended by trained personnel are much lower and the percentage has shifted towards less qualified health staff (traditional birth attendants) mainly due to problems in access (financial + transport + drug availability at health facility).

<sup>9</sup> Zimbabwe Directorate of Health Services survey 2006

<sup>10</sup> Though it needs to be clearly noted that, despite the fact that an additional 200,000 may be in need, the increase in the number of patients under ART has been really impressive from 43,000 in January 2007 to 94,000 in November 2007, especially considering the crisis and its severe impact on the health system

of the low public awareness of cholera and its transmission. After such an epidemic, cholera is very likely to become endemic, and with a high risk of recurrence on an annual basis. Moreover, the migration of qualified staff and the incidence of HIV and AIDS among health staff have also been major contributing factors to the deterioration of the health services and the water supply. In December 2008, the national water supply system effectively collapsed, with the dissolution by the Government of the Zimbabwe National Water Authority (ZINWA), the parastatal organization responsible for water supply, and the nominal delegation of responsibility for the sector to the district councils – in the absence, however, of any financial means to assume that responsibility.

The adverse implementation of the Fast Track Land Reform Programme (FTLRP) which involved forced seizures of mostly white-owned land by ZANU war veterans, and wider inappropriate economic policies, crippled the country and led to an unrelieved shortage of basic commodities and services from 2000 onwards. The crisis was aggravated by a severe drought in 2002, since when Zimbabwe has suffered from chronic food insecurity. The impact of adverse weather, combined with the severe economic constraints combined to reduce agricultural production over the last 7-8 years, and commercial maize production is now about one-tenth of 1990s levels. Apart from dry weather, the reduction in the harvest was due to shortages of tractor/draught power for tillage, fuel, and fertilizers, under-investment in infrastructure and lack of incentive because of price controls. The collective result of all of these events is that the difficult access to food – both physical and economic – has had serious deleterious effects on the food security status of vulnerable populations. A better harvest in 2009 was the result of the coincidence of huge and timely inputs programmes and good rains, whilst the liberalization of the economy in early 2009 ended import restrictions on cereals and other produce, hugely improving food availability across the country.

### **3. IDENTIFICATION AND ASSESSMENT OF HUMANITARIAN NEEDS**

As far as public health is concerned, the challenge in the short-term, as highlighted in the STERP II<sup>11</sup>, is to mitigate the collapse of the system, and improve the delivery of basic health, water and sanitation services for the people of Zimbabwe, with particular attention to the most vulnerable.

In the health sector proper, the recommended areas of intervention – where there is a clear need for support – are two-fold :

a) At the structural level, through the provision of essential drugs and supplies, detailed assessments and surveys, advocacy for policy changes and programmatic interventions (for example through the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) in close collaboration with the EU Delegation and other donors.) Failing to address this level will have implications in terms of opportunity cost, as it is very likely that it will have to be addressed at a later stage with much higher cost, both financial and in terms of recovery time. The provision of drugs at the peripheral

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<sup>11</sup> The Government within its STERP II identifies the core issues affecting the sector, which include: 1) the loss of medical and managerial health professionals, 2) the inadequate supply of essential drugs and medical supplies, 3) the inadequate provision and maintenance of equipment and infrastructure, and 4) disrupted transportation and telecommunications systems.

level will reduce disease complications and the emergence of resistance. Moreover, efficient public health management advocates that patients who are treated at peripheral level incur fewer costs than when their health conditions are allowed to deteriorate and they are forced to seek expensive hospital treatment at secondary level.

b) Through supporting life saving operational interventions, essential health care, and coordination. Such support will focus on collaboration with implementing partners for the field-based provision of basic services, as well as response to epidemic outbreaks.

During the past years, the EU has been one of the largest donors in funding emergency water and sanitation interventions. This support is part of the integrated public health approach to tackle potential epidemics (cholera, measles and typhus outbreaks are currently occurring in the country), and is focusing on basic humanitarian actions that guarantee access to water and sanitation facilities, particularly at health centres. With the collapse of the water supply sector, however, additional interventions are considered necessary to support the reestablishment of safe water supply at district level, as a basis for the launching of comprehensive and sustainable long-term water and sanitation programmes, which are considered more appropriate to tackle the country's degraded water infrastructure.

In terms of food security, over 80% of rural households and 60% of urban households get a significant proportion of their annual food requirements from their own crop production. Improved harvests are, therefore, likely to lead to improved post-harvest access to food for the majority of these households compared to previous years. The dollarization of the economy and the abolition of restrictions on commercial imports of cereals have had clear benefits in terms of the availability of food. Lack of access to foreign currency, however, is problematic for the most vulnerable.

Two distinct trends appear to be emerging, however, in terms of accessibility to food linked to the dollarization, with a common denominator which is access to the dollar (or rand) itself:

- Vulnerable urban and peri-urban populations who have little or no land, so cannot produce (enough) food to ensure household food security, have typically coped by evolving in the informal economy. Now, many are quickly being squeezed out by the formal economy which is rapidly taking over, as shops and markets can now offer a wide range of produce at normal market prices. In the meantime, Zimbabwe's depressed economy continues to limit employment opportunities, and even for those that are employed, low wages limit their purchasing power for food and other basic commodities and services. In addition, most of these households have limited access to other sources of income such as casual labour, livestock sales, etc. to access food on the market. Though prices are reasonable, it is necessary to pay in foreign currency, which the most vulnerable groups do not have. For these groups, the potential for non-in-kind based livelihoods interventions is enormous: swipe card technology, for example, offers very promising avenues to explore as a type of urban voucher system now that the era of hyper-inflation is over.

- Many rural households are likely to find their food security situation improved this year as compared to pre-2008 levels. Indeed, many will have a harvest which will ensure relative food security for their families, and for some of them will even have crops and vegetables, such as sweet potatoes, to sell. A big issue here, however, is that the dollarization of the economy and limited stocks of hard currency has increased barter trade. Most rural households have only their crops to pay for goods and services. Deterioration of the terms of trade between grains and other priority goods and services (such as soap, school fees, etc.) imposed upon them result in early depletion of household food stocks and could end up making them food insecure after a good harvest<sup>12</sup>.

On the other hand, in spite of ample evidence that food aid has served many relevant purposes, including disaster mitigation and short-term safety net for vulnerable households, it should be made clear that food aid in Zimbabwe is a preventive action and not a life-saving operation, with one notable exception being that of food aid to prisons. With the collapse of state provision for detainees, food aid in prisons has prevented starvation and saved lives. In general, though, it is particularly important to properly and accurately target the beneficiaries in order to avoid falling into a “relief-trap” and create structural food aid dependency.

The last nutritional survey, conducted in November 2008 by UNICEF<sup>13</sup>, showed that the nutritional situation had remained stable, or even improved, since 2006. Therefore it is interesting to note that, despite the socio-economic collapse, nutrition indicators remained almost unchanged in 2008 as compared to previous years.

As the Government structures have collapsed, the need to ensure coordination of humanitarian interventions has become much more pressing, whether it be general or sectoral coordination. Under the GNU, an Aid Coordination Unit at technical level will be set up in the Ministry of Finance under the direct leadership of the Minister. A Cabinet Committee chaired by Prime Minister Tsvangirai will be set up at political level. Until these units are functioning, though, the responsibility for coordination activities is likely to continue to rest with non-governmental actors, and specifically the United Nations organisations.

Though large waves of displacement are not currently being reported, the displacement of some specific groups, for example as land changes hands, cannot be excluded. Moreover, the end of the construction boom in South Africa associated with the FIFA World Cup in June 2010, coupled with recurrent xenophobic incidents against foreigners, may mean that a substantial reverse migration of some of the estimated 3 million Zimbabweans in South Africa may take place. Should such a situation occur, it is likely to place considerable strain on an already fragile economic and social system, and give rise to protection needs.

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<sup>12</sup>As an example, the two priority items mentioned without exception by beneficiaries are soap (essential for hygiene with 100,000 cholera cases in the country) and school fees. The barter price for a bar of soap (70 cents on the market) is 24 kg of maize (worth USD 8). The barter price for school fees is equivalent to more than double the USD/ZAR price. The barter price to mill 20 kg of maize is between 5-10 kg of maize, etc. etc. In addition, between 10-15% of the harvest is typically lost in storage due to insects. So, bucket of maize by bucket of maize, the food security of the farmer is jeopardized, and he/she still has not succeeded in accessing any cash.

<sup>13</sup> Combined Micronutrient and Nutrition Surveillance Survey, report prepared by the Food and Nutrition Council and UNICEF, November 2008.

#### 4. PROPOSED DG ECHO STRATEGY

DG ECHO<sup>14</sup>'s strategy for the health sector, as part of the European Commission's response, and in order to have an impact on the protection of the health system and on the protection of the lives of the most vulnerable, has been to address the levels mentioned in 3 a) and b) above in a properly coordinated manner. This funding decision will complement previous actions to address the more structural level under a) above, and will in turn complement emergency actions being implemented under b) above. Actions implemented by DG ECHO will also be coordinated and coherent with the EU Delegation's "Delivery of Vital Health Services Programme" (DVHSP). The EU support will continue to mitigate the "drastic decline in the quality of public health services<sup>15</sup>" caused by loss of health professionals, drug shortages and deterioration of health infrastructure. It will also facilitate access to health care especially by pregnant women and children.

In terms of water and sanitation, and in view of its impact, attention will be paid to the consolidation and sustainability of the system established during 2009 and early 2010 to identify, respond to, control and contain cholera and other disease outbreaks. The water and sanitation activities will in general support as a priority an integrated public health response, through health posts and clinics. The activities will also target rural and peri-urban communities where the cholera epidemic has had a much bigger impact because of the way people live close together with poor access to clean water or because of the lack of access to health system.

As far as the food sector is concerned, food aid and food security programmes in Zimbabwe have to a large extent been dissociated rather than complementing each other in a perspective of linking seasonal relief to development (LRRD). The European Commission has made a concerted effort over the past several years to effect this link, which has resulted in actions targeting large-scale inputs procurement and distribution and food security coordination being taken over and expanded by the EU Delegation in Harare. Such actions in turn fit into the overall strategy of boosting small- and large-scale agricultural production and diversification, and re-establishing market networks, which is also a key pillar of the Government's STERP as well as of the European Commission's Short-Term Strategy. DG ECHO can add value to the inputs distribution actions particularly, by promoting pilot livelihoods activities involving cash and vouchers, as well as small-scale peri-urban agriculture. It is also planned to move away even from the vital food aid support to detainees by supporting the rehabilitation of prison farms.

This Decision will support interventions targeted at the most vulnerable population groups all over the country, and specifically at district level in urban, peri-urban and rural areas. This targeting is a reflection of the vulnerability on a national level, and the widespread breakdown of primary health and water supply services. DG ECHO-implemented interventions will specifically aim at preventing a further deterioration of the health and sanitation situation of the population as a whole.

In view of the fact that children are high on the vulnerability scale, and are the most affected by diarrhoeal diseases – a high percentage of children under 5 are estimated

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<sup>14</sup> Directorate General for Humanitarian Aid - ECHO

<sup>15</sup> STERP, par. 58

to be at a higher risk of water-borne diseases since they will experience dehydration and possible death much quicker – as well as the effects of a lack of basic treatment for common pathologies, it is fair to say that children will be the major beneficiaries of this Decision.

#### ***4.1. Coherence with DG ECHO's overall strategic priorities***

The strategy as described in this Global Plan is coherent with DG ECHO's overall priorities in terms of the focus on children and women, on the provision of safe water and free medical treatment, the attention given to HIV and AIDS as a cross-cutting issue, and the diversification of food assistance interventions. The strategy firmly adheres to the approach of linking relief to rehabilitation and development (LRRD), and is coherent with the overall European Commission's strategy for Zimbabwe.

#### ***4.2. Impact of previous humanitarian response***

During 2009, the humanitarian response has had a major impact, particularly in the wake of the cholera epidemic, in contributing to the setting up of effective WASH (Water, Sanitation and Hygiene) and health coordination structures, in establishing Water Emergency Response (WERU) and Health Emergency Response (HERU) units, and in re-establishing safe water supply, with a focus on health centres. This has resulted in epidemic outbreaks being rapidly identified, controlled and contained, in ensuring supplies of essential medicines being procured and delivered to clinics, and water treatment chemicals being provided at district level. The food security response has had an impact in terms of the launching of pilot voucher/cash interventions targeted at preserving food security and improving accessibility to food.

Through DG ECHO's implementing partners, EU funding has benefitted a large part of the population. Though some beneficiaries have received support in more than one sector, water and sanitation interventions have reached 500,000 people, health interventions 700,000, whilst approximately 100,000 have benefited from food assistance support. The essential drugs procurement and distribution actions have, moreover, reached up to 7.8 million people.

#### ***4.3. Coordination with activities of other donors and institutions***

The European Commission has gained a leading role in the coordination and funding of the Food Security Working Group<sup>16</sup> and of the WASH<sup>17</sup> cluster (DG ECHO field officer is donors' representative). Health sector coordination<sup>18</sup>, from a low base at the beginning of 2009, has become stronger. General coordination under the UN<sup>19</sup> is also improving, and requires support to consolidate this improvement. DG ECHO's activities are fully coordinated with those of the EU Delegation, and through regular multilateral contacts, with those of the other main donors. Moreover, donors have

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<sup>16</sup> The UN's Food and Agriculture Organisation - FAO is in the lead

<sup>17</sup> UNICEF in the lead

<sup>18</sup> World Health Organisation – WHO now taking the lead

<sup>19</sup> Office for the Coordination of Humanitarian Assistance – OCHA in the lead

established an informal group, the "Friends of Zimbabwe", which meets on a regular basis outside the country to take stock of the most recent developments.

#### ***4.4. Risk assessment and constraints***

A possible constraint to the implementation of this Decision may arise due to the ongoing uncertainty surrounding the stability of the new Unity Government, and the potential new policies and structures which will emerge over the next months, and which may have an impact at district level. The possibility of the collapse of the power-sharing arrangement and a return to civil unrest cannot, unfortunately, be ignored.

An important constraint is that the specific context of Zimbabwe makes it difficult to apply the usual phases of a post-conflict transition. The main issues to take into consideration with regard to the LRRD process are:

a) The lack of longer-term funding to ensure the support of the critical structural interventions in the health and water sectors which are required to mitigate the collapse and signal the recovery of the delivery of basic services to the population. Against a background of substantial continuing need, humanitarian funding will be called upon to continue to fill the gap. There is, however, currently very little prospect of assured longer-term funding for such activities from the European Commission side (a potential Second Water Facility with a global Call for Proposals may, but will not necessarily, assist the LRRD process). It should be noted that the draft 10<sup>th</sup> EDF Country Strategy Paper as it currently stands does not address the water issue at all.

b) The situation in the agriculture/food security sector appears to be more balanced. Zimbabwe has in 2009 benefited from the best harvest in five years, which came fortuitously at a time of currency stability, of economic liberalisation, and of transitional strategies. Furthermore, the EU Delegation currently has access to a series of food security instruments which are supporting the 2009/2010 and 2010/2011 agricultural campaigns. In such a context, the phasing out of humanitarian food assistance funds could be envisaged in the near future (after a second successive successful harvest, for example). The LRRD strategy of advocating for a scaling down of the massive food distributions in favour of food security actions, and reinforcing the complementarities with the EU Delegation and other donors' food security projects, is now bearing fruit.

The trigger for moving forward in the transition process will be the holding of free, fair and peaceful elections in Zimbabwe (now planned for 2011), which in turn would undoubtedly encourage donors to release substantial long-term funding.

#### ***4.5. DG ECHO Strategy***

Principal objective : To provide humanitarian assistance and protection to vulnerable populations affected by the breakdown of essential services in Zimbabwe

Specific objectives :

- To contribute to improving the humanitarian situation of the most vulnerable population groups through support to the recovery of essential health and water supply services
- To contribute to improving the humanitarian situation of the most vulnerable population groups by providing food assistance, short term food security and livelihood support
- To improve the conditions for delivering humanitarian assistance through support to coordination and protection mechanisms

Component activities for specific objective 1 might include :

- Provision of vital and essential medicines and medical supplies, including in kit form, on the basis of a limited emergency list ;
- Distribution of these medicines and medical supplies ;
- Training of and support to health staff in the area of quality essential service delivery, including incentives ;
- Developing/updating outbreak prevention and response strategies and plans ;
- Supporting early warning and outbreak assessment and response activities ;
- Provision of basic reproductive health package ;
- Provision of essential water treatment and supply materials;
- Distribution of essential water treatment and supply materials;
- Provision of spare parts for the rehabilitation of water treatment plants, boreholes and water points, particularly at health centres and in high population density areas ;
- Emergency water and sanitation needs assessments ;
- Dissemination of water and sanitation needs assessments ;
- Water and sanitation rapid response interventions, particularly at health centres ;
- Rehabilitation of wastewater conveyance, particularly at health centres ;
- Minor infrastructure rehabilitation, including of waste management and hygiene facilities, at health centres

Components activities for specific objective 2 might include :

- Distribution of food rations on a targeted basis to individuals or households affected by severe food insecurity. Attention will be paid to the appropriateness, quality and acceptability of the food, as well as its micro-nutrient composition ;
- Use of non-food transfers (through the use of cash transfers or voucher systems, such as swipe cards linked to local supermarkets) that improve beneficiaries' access to food as an alternative or complement to food aid, where appropriate;

- Restoration of basic livelihoods and strengthening of resistance to future shocks by ensuring access to agriculture and livestock inputs and services (such as milling vouchers, pest control chemicals, appropriate storage containers, sweet potatoes seedlings and non-maize cereals), and other factors of production and livelihoods ;
- Support to short-term employment generation and labour schemes, such as food for work, vouchers for work or cash for work programmes;
- Strengthening of food assistance partners' capacities for designing optimally appropriate responses, through technical review, development of assessment tools, training, dissemination and follow-up.

Components activities for specific objective 3 might include :

- Support to general and sectoral coordination activities ;
- Support to protection activities, particularly for displaced groups;
- Support to the communications network at district level.

#### ***4.6. Duration***

The duration for the implementation of this Decision will be 12 months. Humanitarian Actions funded by this Decision must be implemented within this period.

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.

#### ***4.7. Amount of Decision and strategic programming matrix***

##### **4.7.1 Total amount of the Decision:**

EUR 15,000,000

### 4.7.2. Strategic Programming Matrix

Principal objective	<i>To provide humanitarian assistance and protection to vulnerable populations affected by the breakdown of essential services in Zimbabwe</i>				
Specific objectives	Allocated amount (EUR)	Geographic area of operation	Activities proposed	Expected outputs / indicators	Potential partners
<p><b>Specific objective 1:</b> - To contribute to improving the humanitarian situation of the most vulnerable population groups through support to the recovery of essential health and water supply services</p>	<p><b>11,000,000</b></p>	<p>National</p>	<ul style="list-style-type: none"> <li>• Provision of vital and essential medicines and medical supplies, including in kit form, on the basis of a limited emergency list;</li> <li>• Distribution of these medicines and medical supplies;</li> <li>• Training of and support to health staff in the area of quality essential service delivery, including incentives ;</li> <li>• Developing/updating outbreak prevention and response strategies and plans ;</li> <li>• Supporting early warning and outbreak assessment and response activities ;</li> <li>• Provision of basic reproductive health package ;</li> <li>• Provision of essential water treatment and supply materials;</li> <li>• Distribution of essential water treatment and supply materials;</li> <li>• Provision of spare parts for the rehabilitation of water treatment plants, boreholes and water points, particularly at health centres and in high population density areas ;</li> <li>• Emergency water and sanitation needs assessments ;</li> <li>• Dissemination of water and sanitation needs assessments ;</li> <li>• Water and sanitation rapid response interventions, particularly at health centres ;</li> <li>• Rehabilitation of wastewater conveyance, particularly at health centres ;</li> <li>• Minor infrastructure rehabilitation, including of waste management and hygiene facilities, at health centres</li> </ul>	<ul style="list-style-type: none"> <li>• Functioning of the primary health care system and key referral services ;</li> <li>• Improvement of access to clean water, sanitation facilities and hygiene (decreasing of waterborne diseases);</li> <li>• Emergency preparedness and response mechanisms consolidated ;</li> <li>• Vital medicines and medical materials available free of charge at district level ;</li> <li>• Epidemic outbreaks rapidly identified, controlled and contained ;</li> <li>• Morbidity and mortality reduced ;</li> <li>• Vital water treatment chemicals available and properly used at local council level.</li> </ul>	<p><u>Direct centralised management</u></p> <ul style="list-style-type: none"> <li>- ACF - FRA</li> <li>- CARE - DEU</li> <li>- CONCERN WORLDWIDE</li> <li>- CROIX-ROUGE - FRA</li> <li>- GERMAN AGRO ACTION</li> <li>- HELP</li> <li>- HELPAGE</li> <li>INTERNATIONAL - UK</li> <li>- IMC UK</li> <li>- IRC - UK</li> <li>- MDM - FRA</li> <li>- MEDAIR CH</li> <li>- MEDAIR UK</li> <li>- MERCY CORPS</li> <li>SCOTLAND</li> <li>- MERLIN</li> <li>- MSF - BEL</li> <li>- MSF - ESP</li> <li>- MSF - NLD</li> <li>- NORWEGIAN REFUGEE COUNCIL</li> <li>- OXFAM - UK</li> <li>- PLAN GERMANY</li> <li>- PLAN INTERNATIONAL UK</li> <li>- SAVE THE CHILDREN - UK</li> <li>- WORLD VISION - UK</li> <li>- WORLD VISION DEU</li> </ul> <p><u>Joint management</u></p> <ul style="list-style-type: none"> <li>- ICRC-CICR</li> <li>- IFRC-FICR</li> <li>- UNHCR</li> <li>- UNICEF</li> <li>- WHO</li> </ul>

<p><b>Specific objective 2:</b> - To contribute to improving the humanitarian situation of the most vulnerable population groups by providing food assistance, short term food security and livelihood support</p>	<p><b>3,000,000</b></p>	<p>National</p>	<ul style="list-style-type: none"> <li>• Distribution of food rations on a targeted basis to individuals or households affected by severe food insecurity. Attention will be paid to the appropriateness, quality and acceptability of the food, as well as its micro-nutrient composition ;</li> <li>• Use of non-food transfers (through the use of cash transfers or voucher systems, such as swipe cards linked to local supermarkets) that improve beneficiaries' access to food as an alternative or complement to food aid, where appropriate;</li> <li>• Restoration of basic livelihoods and strengthening of resistance to future shocks by ensuring access to agriculture and livestock inputs and services (such as milling vouchers, pest control chemicals, appropriate storage containers, sweet potatoes seedlings and non-maize cereals), and other factors of production and livelihoods ;</li> <li>• Support to short-term employment generation and labour schemes, such as food for work, vouchers for work or cash for work programmes;</li> <li>• Strengthening of food assistance partners' capacities for designing optimally appropriate responses, through technical review, development of assessment tools, training, dissemination and follow-up.</li> </ul>	<ul style="list-style-type: none"> <li>• Reduction of vulnerability to food insecurity and restart of agricultural system ;</li> <li>• Knowledge of innovative food assistance approaches disseminated and lessons learned ;</li> <li>• Economic access to food improved ;</li> <li>• Dependence on food distribution reduced and transition to food security reinforced ;</li> <li>• Diversification of production and diet.</li> </ul>	<p><u>Direct centralised management</u></p> <ul style="list-style-type: none"> <li>- ACF - FRA</li> <li>- ADRA - DK</li> <li>- CARE - DEU</li> <li>- CONCERN WORLDWIDE</li> <li>- CORDAID</li> <li>- CROIX-ROUGE - DNK</li> <li>- CROIX-ROUGE - FIN</li> <li>- CROIX-ROUGE - SWE</li> <li>- GERMAN AGRO ACTION</li> <li>- HELP</li> <li>- HILFSWERK AUSTRIA</li> <li>- OXFAM - UK</li> <li>- PLAN GERMANY</li> <li>- PLAN INTERNATIONAL UK</li> <li>- SAVE THE CHILDREN - UK</li> <li>- SOLIDARITES</li> <li>- WORLD VISION - UK</li> <li>- WORLD VISION DEU</li> </ul> <p><u>Joint management</u></p> <ul style="list-style-type: none"> <li>- FAO</li> <li>- ICRC-CICR</li> <li>- IFRC-FICR</li> <li>- IOM</li> <li>- UNHCR</li> <li>- WFP-PAM</li> </ul>
<p><b>Specific objective 3:</b> - To improve the conditions for delivering humanitarian assistance through support to coordination and protection mechanisms</p>	<p><b>1,000,000</b></p>	<p>National</p>	<ul style="list-style-type: none"> <li>• Support to general and sectoral coordination activities ;</li> <li>• Support to protection activities, particularly for displaced groups.</li> <li>• Support to the communications network at district level</li> </ul>	<ul style="list-style-type: none"> <li>• Humanitarian objectives are mainstreamed into long-term development planning</li> <li>• Progressive integration of clusters into government coordination structures</li> <li>• No. of situation reports and maps produced</li> <li>• No. of meetings, workshops held with Government and donors;</li> <li>• Population displacements rapidly identified and tackled.</li> </ul>	<p><u>Joint management</u></p> <ul style="list-style-type: none"> <li>- IOM</li> <li>- OCHA</li> <li>- UNHCR</li> <li>- UNICEF</li> </ul>
<p><b>Risk assessment</b></p>	<p>Collapse of power-sharing agreement, possible waves of reverse migration</p>				
<p><b>Assumptions</b></p>	<p>Continued stability of power-sharing agreement</p>				
<p><b>Total cost</b></p>	<p>15,000,000</p>				

## **5. 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](http://ec.europa.eu/echo/policies/evaluation/introduction_en.htm) .

## **6. MANAGEMENT ISSUES**

Humanitarian aid Actions funded by the Commission are implemented by NGOs and the Red Cross National Societies on the basis of Framework Partnership Agreements (FPA), by Specialised Agencies of the Member States and by United Nations agencies based on the EU/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](http://ec.europa.eu/echo/about/actors/partners_en.htm).

For NGOs, Specialised Agencies of the Member States, Red Cross National Societies and International Organisations not complying with the requirements set up in the Financial Regulation applicable to the general budget of the European Union for joint management, actions will be managed by direct centralised management.

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.

## **7. ANNEXES**

**Annex 1: Statistics on the humanitarian situation**

**Annex 2: Map of country and location of DG ECHO Actions**

**Annex 3: List of previous DG ECHO Actions**

**Annex 4: Overall European Commission funding**

**Annex 5: Other donors' contributions**

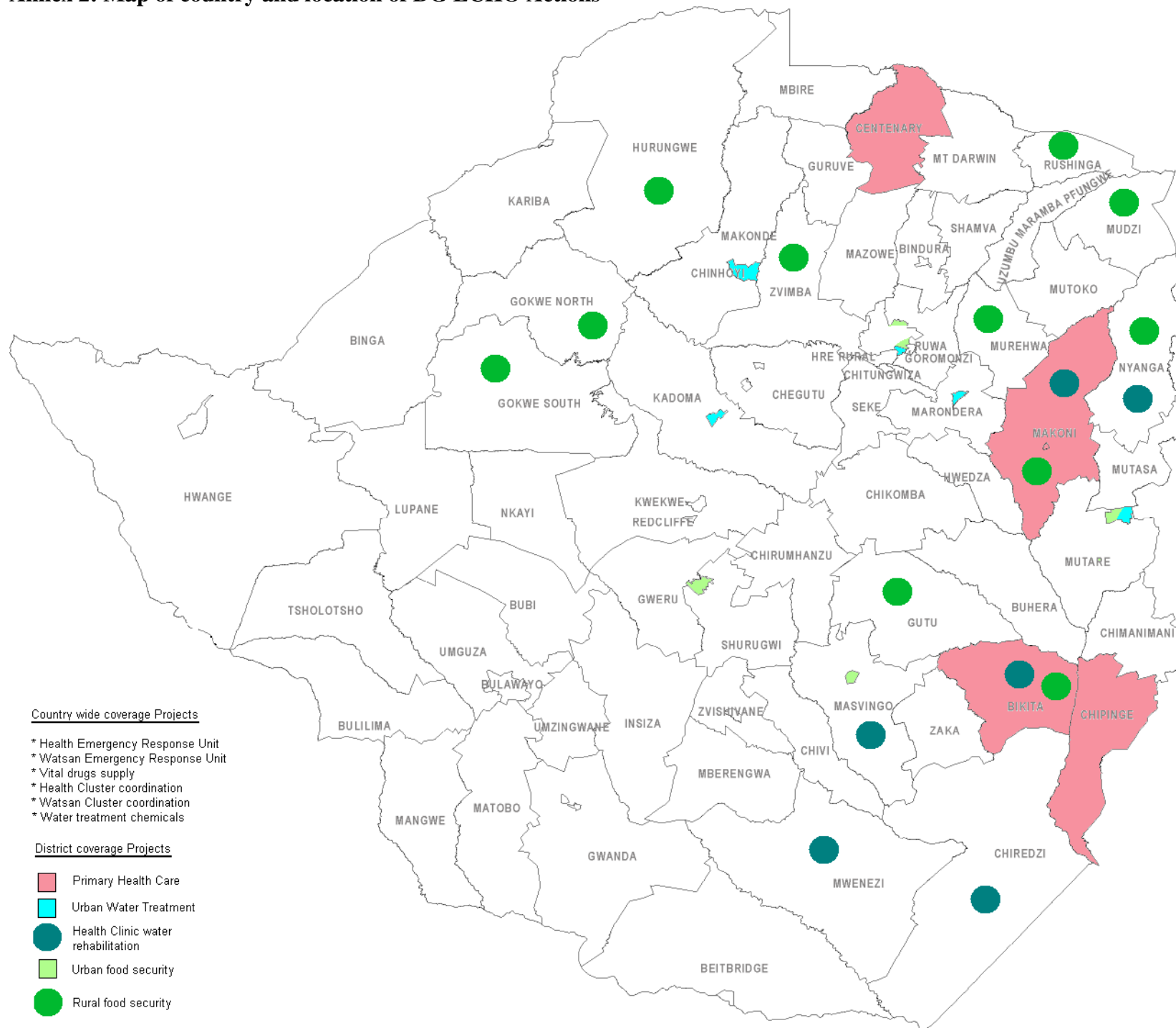
**Annex 1: Statistics on the humanitarian situation - Based on data from the Zimbabwe Demographic and Health Survey 2005/6 (ZDHS), Multiple Indicator Monitoring Survey 2009 (MIMS), Maternal and Perinatal Mortality Study, Zimbabwe STEPS Survey (2005), and other studies**

	<b>Population</b>	12.2 million people (CSO Population Projection 2008)	
<b>ECONOMIC STATUS</b>	<b>Gross domestic product per capita</b>	\$268 (International Monetary Fund (IMF) 2009)	
	<b>Percentage of population living on less than \$1 per day</b>	56.1% (UNDP HDR 2007/2008)	
<b>HEALTH</b>	<b>Cumulative mortality rate</b>	20/1,000 (Demographic Health Survey - DHS 2006)	
	<b>Maternal mortality</b>	725/100,000 live births (Zimbabwe Maternal Mortality study 2007)	
	<b>Life expectancy at birth</b>	44/43 years (WHO 2008). In 2005/6 life expectancy was still 63 years	
	<b>Infant Mortality Rate (IMR), per 1 000 live births</b>	67 (up from 53 per 1000 in 1994)	
	<b>Under-five Mortality Rate, per 1 000 live births</b>	94 (up from 77 per 1000 in 1994)	
	<b>Underweight (weight-for-age) prevalence, percentage, children aged 6-59</b>	12%	
	<b>Stunting (height-for-age) prevalence, percentage, children aged 6-59 months</b>	35% (The nutritional status of children indicators are high with stunting increasing from 29.4 in 1999 to 35% among children under 5 years old)	
	<b>Wasting (weight-for-height) prevalence, percentage, children aged 6-59 months</b>	2%	
	<b>Primary school Net Attendance Ratio (NAR)</b>	91%	
	<b>Fully immunized children, percentage, children aged 12-23 months</b>	49%	
	<b>Measles vaccination rate</b>	92% (National Immunization Days campaign 2009)	
	<b>Diarrhoea prevalence, percentage, children under five years</b>	11%	
	<b>Fever prevalence, percentage, children under 5 years</b>	8%	
	<b>Tuberculosis notification rate</b>	434 out of 100,000 (leading cause of morbidity)	
	<b>Number of cholera cases during 2008/2009 epidemic</b>	4,269 lives out of a total of 97,469 cases by end of April 2009	
	<b>Number of persons at risk of contracting malaria annually</b>	5,000,000	
	<b>Percentage of households with at least one Insecticide Treated Net (ITN)</b>	27%	
<b>Outbreaks of rabies and anthrax</b>	continue being reported in some parts of the country		
<b>Chronic non-communicable conditions such as diabetes and hypertension</b>	There is continued and increasing public health significance		
<b>WATER AND SANITATION</b>	<b>Use of improved drinking water sources</b>	73%	
	<b>Use of improved sanitation facilities</b>	60%	
	<b>Percentage of total population using an unimproved drinking water source</b>	27%	
	<b>Percentage of the total population using drinking water appropriately treated at household level</b>	35%	
<b>POPULATION MOVEMENTS</b>	<b>IDPs (number and percentage of population)</b>	No official statistics	
	<b>Refugees</b>	<b>In-country</b>	5,054 (UNHCR Zimbabwe 2008)
		<b>Abroad</b>	12,782 (UNHCR Statistical Online Population Database)
<b>OTHER VULNERABILITY INDICES</b>	<b>ECHO Vulnerability and Crisis Index score</b>	3/3 (Most severe rank) GNA 2008-09	
	<b>UNDP Human Development Index (HFI) score</b>	0.513: 151 out of 177 / medium human development (HDR 2007/2008)	

**HIV prevalence among adults (15-49 years)**

13.7% (National Aids Council 2009) of 15 – 49 year age group with only 180,000 of an estimated 400,000 persons requiring treatment actually receiving antiretroviral therapy (ART) by mid year 2009

## Annex 2: Map of country and location of DG ECHO Actions





#### Annex 4: Overall European Commission funding

<b>What the European Commission funds in Zimbabwe (in million Euros)</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009 *</b>
Human and Social Development	18.5	5.7	24.0	18.5	21.6	19.7	6.2	26.3
Micro projects, Decentralised Cooperation , Community Dev.	4.4	2.1	13.5	6.0	8.5	7.7	6.6	5.0
Governance, Human Rights, Gender, Support to Civil Society		3.5	1.0	2.0	2.0	7.8	8.9	11.3
Food Aid with WFP	52.5	52.0		22.0	25.0	12.5		
Food Security with NGOs and IO	10.9	8.1	6.0	6.0	10.0	14.6		40.9
Water facility / Energy Facility				0.0	5.1	5.0	0.7	
Accompanying Measures for Sugar Protocol							2.3	5.1
STABEX	1.7	0.4	0.8	0.5	0.8	1.1	19.3	0.3
Humanitarian Assistance through ECHO	15.3	22.7	13.6	15.0	12.0	21.6	24.2	31.5
Various Studies					1.1	0.9	0.6	0.1
<b>TOTAL</b>	<b>103.3</b>	<b>94.5</b>	<b>58.9</b>	<b>70.0</b>	<b>86.1</b>	<b>90.9</b>	<b>68.7</b>	<b>120.5</b>

<b>European Development Fund % of the total</b>	<b>24%</b>	<b>9%</b>	<b>51%</b>	<b>30%</b>	<b>28%</b>	<b>39%</b>	<b>60%</b>	<b>30%</b>
<b>General Budget % of the total</b>	<b>76%</b>	<b>91%</b>	<b>49%</b>	<b>70%</b>	<b>72%</b>	<b>61%</b>	<b>40%</b>	<b>70%</b>

<b>ACCUMULATED TOTAL 2002 - 2009</b>	<b>693.0</b>
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equivalent to 970 million USD

\* including 44.1 million Euros to be contracted early 2010

120.5 million Euros = 168.7 million USD

## Annex 5: Other donors' contributions

Donors in ZIMBABWE the last 12 months					
1. EU Members States (*)		2. European Commission		3. Others	
	EUR		EUR		EUR
Austria		DG ECHO	27,000,000		
Belgium	2,000,000	Other services			
Bulgaria					
Cyprus					
Czech republic					
Denmark	9,723,204				
Estonia					
Finland	3,100,000				
France	532,000				
Germany	5,668,595				
Greece					
Hungary					
Ireland	355,481				
Italy	40,000				
Latvia					
Lithuania					
Luxemburg					
Malta					
Netherlands	7,216,000				
Poland					
Portugal					
Romania					
Slovakia					
Slovenia					
Spain					
Sweden					
United kingdom	13,002,298				
Subtotal	41,637,578	Subtotal	27,000,000	Subtotal	0
		Grand total	68,637,578		

Dated : 24 March 2010

(\*) 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.