World Health Organization
REGIONAL OFFICE FOR Africa

**AFR/RC66/15**
21 August 2016

**REGIONAL COMMITTEE FOR AFRICA**

**ORIGINAL: ENGLISH**

Sixty-sixth session
Addis Ababa, Federal Democratic Republic of Ethiopia, 19–23 August 2016

Agenda item 17

# THE AFRICAN PUBLIC HEALTH EMERGENCY FUND: THE WAY FORWARD

## Report of the Secretariat

## CONTENTS



## ANNEXES

## BACKGROUND

1. The African Public Health Emergency Fund (APHEF or the Fund) was established by the Regional Committee in 2012 with the aim of providing catalytic resources for initiating timely responses to public health emergencies. Ever since, commitments have been made at every subsequent Regional Committee session to improve the functionality of this solidarity fund.

2. Despite all the commitments made, actual contributions to APHEF have remained very low. Between 2012 and June 2016, only 13 countries had ever contributed to the Fund.[1] Total contributions stand at US$ 3 619 438. This constitutes about 1.5% of the expected amount. Of the 13 countries that have contributed so far, Eritrea has done so three times, Rwanda twice and the rest have contributed once (Annex 2).

3. APHEF has contributed to the management of public health emergencies in the Region (Annex 3). The Fund has so far disbursed a total of US$ 2.73 million to support life-saving interventions in 13 countries.[2] Only four of the countries that have received APHEF support have ever contributed to the Fund.[3] None of the requested amounts for each of the emergencies could be fully allocated, mainly owing to inadequate funds. US$ 473 897 was the average requested amount, while the average allocation was US$ 210 257 (Annex 3). For 12 of the 13 requests received from 2014 to 2016, funds were made available within two working days as stipulated in the APHEF operations manual.

4. In 2016, APHEF has supported responses to the yellow fever outbreak in Angola and the El Niño crisis in Ethiopia. In 2014 and 2015, the Fund supported the provision of emergency health care to internally-displaced populations in the Central African Republic and South Sudan; refugees in Cameroon and flood victims in Burundi, Malawi and Zimbabwe. In addition, APHEF supported the responses to the outbreaks of meningococcal meningitis in Niger and Ebola in the Democratic Republic of the Congo, Guinea, Liberia and Sierra Leone. The disbursements from APHEF complement resources from other funding initiatives such as the newly established Contingency Fund for Emergencies (CFE),[4] which supports WHO deployments.

5. Considering the crucial role of APHEF, the Sixty-fifth session of the Regional Committee reiterated the importance of strengthening its functionality. The ministers of health deliberated on possible demotivating factors that could explain the inadequate contributions. These included significant variations in the amounts of countries' contributions and the limited involvement of the ministries of finance. The Committee adopted a report, AFR/RC65/9, that called for the revision of the APHEF framework.

6. The above report requested the Secretariat to establish a multidisciplinary expert group to review the current APHEF framework and undertake an assessment to understand the reasons why

---

1 Angola, Benin, Chad, Democratic Republic of the Congo, Eritrea, Ethiopia, Gabon, Islamic Republic of The Gambia, Lesotho, Liberia, Mauritius, Rwanda and Seychelles.

2 Angola, Burundi, Cameroon, Central African Republic, Democratic Republic of the Congo, Ethiopia, Guinea, Liberia, Malawi, Niger, Sierra Leone, South Sudan and Zimbabwe.

3 Angola, Democratic Republic of the Congo, Ethiopia and Liberia.

4 WHO Contingency Fund for Emergencies: http://www.who.int/about/who_reform/emergency-capacities/contingency-fund/Contingency-Fund-Emergencies.pdf: last accessed on 21 July 2016.

countries are not making their contributions. Furthermore, it requested the Regional Director to facilitate consultations between ministers of health and finance, and other relevant sectors.

7. WHO convened a meeting of the multidisciplinary group of experts from the ministries of health and finance in June 2016. The key questions the experts deliberated upon included whether APHEF was needed, why it was not functioning optimally and how its functionality could be improved. The experts unanimously acknowledged the usefulness of APHEF and highlighted the critical challenges to be addressed. They reviewed the APHEF formula for contributions and made recommendations for consideration by the Regional Committee (Annex 1a). In addition, WHO conducted an assessment using a structured questionnaire filled by the countries, to understand the difficulties they face in honouring their contributions.

8. This paper highlights the key issues and challenges affecting the optimal functioning of APHEF. It takes into account recommendations from the multidisciplinary expert group and proposes actions for improved performance.

## ISSUES AND CHALLENGES

9. **Persistently low level of contributions by Member States:** On average, only four countries pay their contributions yearly. The major factors affecting countries' contributions as highlighted by both the WHO survey and the expert group include:

(a) Absence of established mechanisms such as funded budget-lines to ensure that countries meet their yearly obligations.

(b) No focal persons assigned within Member States to facilitate implementation and close monitoring of APHEF activities.

(c) Limited involvement of national treasuries and the ministries of finance.

(d) Lack of a dedicated APHEF Secretariat, resource mobilisation strategy and plan.

(e) Weak engagement between the APHEF Secretariat and the Monitoring Committee to follow up on progress and challenges. Meetings were rarely convened for regular monitoring.

10. **Lack of sustained advocacy in the countries on APHEF**: The country assessment report and experts' meeting highlighted inadequate awareness of APHEF among influential potential advocates at country level, especially legislators and parliamentary committees on health and finance. In addition, regional economic communities and other regional partners who can advocate for APHEF contributions are not currently actively involved.

11. **Variations in the amounts of Member States' contributions:** The formula for Member States' contributions which was approved by the Sixtieth session of the Regional Committee through Resolution AFR/RC60/R5 is based on an adjusted United Nations methodology of assessing countries[5] (Annex 1b). It is the same formula used for determining WHO assessed contributions. The formula takes into account the countries' income, ability to pay, poverty levels, equity and other social determinants. According to this formula, three countries, namely, Algeria, Nigeria and South

[5] United Nations: Sixty-ninth session of the General Assembly. Report of the Committee on Contributions, Document A/64/11 New York: UN; 2009.

Africa, are responsible for 63.7% of the total annual APHEF contributions. Algeria's annual contribution is US$ 9 870 000, while South Africa and Nigeria are expected to contribute US$ 11 million each. In contrast, 11 countries[6] that contribute US$ 5000 each, are responsible for 0.11% of the total annual contributions. These variations probably demotivate some overburdened countries and impede payment of contributions.

12. **Delay in engaging the private sector and other donors for APHEF contributions:** Resolution AFR/RC61/R3 and Framework document AFR/RC61/4 adopted by the Sixty-first session of the Regional Committee state that APHEF shall be financed from agreed appropriations and voluntary contributions from Member States. The Framework document also proposes mechanisms to be put in place to attract contributions from external donors. However, to date, no mechanisms have been established to mobilize contributions from stakeholders. The responsibility for putting in place this resource mobilization mechanism has not been specified. To date, no innovative funding mechanisms have been established for financing and replenishment of the Fund from the private sector.

13. **Insufficient funds to respond to country requests:** As of June 2016, a total of US$ 2 733 338, which is 75.5% of all received contributions, has already been disbursed to 13 Member States and utilized to respond to emergencies. In most cases, the country requests could not be fully honoured due to inadequate funds. For the 13 requesting countries, the disbursements were able to meet 40% of the amounts requested. Currently, the APHEF account has a balance of US$ 508 838. This amount is less than the US$ 2 million maximum amount that a country can request, according to the APHEF operations manual.

14. **Inadequate reporting and accountability**: The APHEF operations manual streamlines the reporting and accountability processes. However, lack of adherence to the APHEF guidelines is linked to inadequate awareness of the Fund and its operations manual. Delays have been noted in the submission of technical and financial reports, which affects timely accountability.

15. **Interim arrangement for administration of the Fund**: The Sixty-first session of the Regional Committee approved the designation of the African Development Bank (AfDB) as the Trustee for the management of APHEF contributions and maintaining a Revolving Fund with a limit of US$ 30 million within the WHO Regional Office for Africa. However, the Revolving Fund's account for receiving Member States' contributions has not yet been created. As an interim measure, the Regional Office continues to receive contributions to APHEF through a WHO bank account as approved by the Regional Committee.[7] A permanent arrangement to manage APHEF would be useful.

---

[6] Burundi, Democratic Republic of the Congo, Eritrea, Ethiopia, Guinea-Bissau, Liberia, Malawi, Niger, Rwanda, Sao Tome and Principe, and Sierra Leone.

[7] WHO Regional Committee for Africa, Sixty-fourth session Cotonou, Republic of Benin, AFR/RC64/R6 http://www.afro.who.int/en/sixty-fourth-session/documents.html last accessed on 29 June 2016.

## ACTIONS PROPOSED

16. The Regional Committee should:

(a) Maintain APHEF as a solidarity and trust fund, sustained by Member States with additional contributions from donors with the following amendments:
   (i) keep the total annual contribution at US$ 50 million of which US$ 30 million (60%) will be contributed by Member States and US$ 20 million (40%) mobilized from other sources;
   (ii) continue using the previously agreed adjusted United Nations formula to determine Member States' contributions, with adjustments made to increase lower income countries' contributions to a minimum of US$ 37 700 and those of higher income countries to a maximum of US$ 6 million;
   (iii) consider approving a flexible method for Member States' contributions, such as contributing in instalments;
   (iv) consider a replenishment approach to maintain the total amount at US$ 50 million;
   (v) recommend that Member States' contributions be reviewed every three years by internal and external experts in order to reflect changes in the countries' socioeconomic status;

(b) consider recommending that WHO should take up full responsibility for managing the funds contributed to APHEF; and

(c) propose any other actions pertaining to the effective operation of APHEF.

17. Member States are urged to:

(a) advocate to their Heads of State and Government to honour their contributions for 2016 based on the agreed appropriations;

(b) put in place institutionalized mechanisms to ensure their obligations for the yearly contributions are met and monitoring of the Fund is strengthened;

(c) designate a focal point at senior level to facilitate APHEF implementation;

(d) hold country-level advocacy to be led by the ministry of health with support from the WHO country office to bring on board the ministry of finance, Members of Parliament, cabinet members and other stakeholders; and

(e) honour the proposed revised contribution, maintaining the minimum contribution at US$ 37 700.

18. The Regional Director is requested to:

(a) continue advocacy with Heads of State and Government, the African Union and regional economic communities to ensure sustained contributions to APHEF;

(b) develop an innovative and coordinated resource mobilization strategy and plan for APHEF, taking into account similar emergency funds, to ensure complementarity; and in accordance with the Framework of engagement with non-State actors;[8]

[8] WHA68.9 Framework of engagement with non-State actors: http://apps.who.int/gb/ebwha/pdf_files/WHA68-REC1/A68_R1_REC1-en.pdf#page=27 last accessed on 29 June 2016.

(c) organize joint resource mobilization with the WHO Contingency Fund for Emergencies in the context of the unified Health Emergencies Programme;

(d) convene resource mobilization forums such as round table discussions with donors and pre-identified African leaders as champions for APHEF;

(e) integrate APHEF functions into WHO business with dedicated staff to mobilize resources, follow up on country requests including reporting, monitoring and evaluation;

(f) establish a task force to revise the formula for Member States' contributions and make recommendations to the Sixty-seventh session of the Regional Committee for Africa; and

(g) report to the Sixty-seventh session of the Regional Committee for Africa on the operations of APHEF based on the revised modalities.

19. The Regional Committee examined the report and endorsed the actions proposed.

## ANNEX 1a: Proposed and previous yearly contributions by Member States to APHEF in US$

| Member State | Previous annual contribution | Proposed new contribution |
|---|---|---|
| Algeria | 9 870 000 | 5 877 900 |
| Angola | 1 750 000 | 1 110 000 |
| Benin | 405 000 | 257 500 |
| Botswana | 900 000 | 570 800 |
| Burkina Faso | 385 000 | 244 000 |
| Burundi | 5000 | 37 700 |
| Cameroon | 1 615 000 | 1 024 800 |
| Cabo Verde | 100 000 | 64 000 |
| Central African Republic | 80 000 | 52 300 |
| Chad | 185 000 | 116 400 |
| Comoros | 35 000 | 37 700 |
| Congo | 405 000 | 255 900 |
| Côte d'Ivoire | 1 545 000 | 978 300 |
| Democratic Republic of the Congo | 5000 | 37 700 |
| Equatorial Guinea | 385 000 | 245 300 |
| Eritrea | 5000 | 37 700 |
| Ethiopia | 5000 | 37 700 |
| Gabon | 725 000 | 460 000 |
| Islamic Republic of The Gambia | 35 000 | 37 700 |
| Ghana | 890 000 | 564 400 |
| Guinea | 210 000 | 134 000 |
| Guinea-Bissau | 5000 | 37 700 |
| Kenya | 1 845 000 | 1 171 000 |
| Lesotho | 170 000 | 106 300 |
| Liberia | 5000 | 37 700 |
| Madagascar | 315 000 | 201 200 |
| Malawi | 5000 | 37 700 |
| Mali | 400 000 | 252 300 |
| Mauritania | 195 000 | 122 700 |
| Mauritius | 635 000 | 402 500 |
| Mozambique | 320 000 | 202 600 |
| Namibia | 720 000 | 457 300 |
| Niger | 5000 | 37 700 |
| Nigeria | 11 000 000 | 6 000 000 |
| Rwanda | 5000 | 37 700 |
| Sao Tome and Principe | 5000 | 37 700 |
| Senegal | 860 000 | 545 700 |
| Seychelles | 85 000 | 52 600 |
| Sierra Leone | 5000 | 37 700 |
| South Africa | 11 000 000 | 6 000 000 |
| South Sudan | – | 215 400 |
| Swaziland | 260 000 | 165 400 |
| Tanzania | 120 000 | 595 000 |
| Togo | 650 000 | 77 000 |
| Uganda | 940 000 | 410 900 |
| Zambia | 630 000 | 404 600 |
| Zimbabwe | 280 000 | 171 800 |
| **Grand Total** | **50 000 000** | **30 000 000** |

**ANNEX 1b: Explanation of Member States' contributions**

1. The scenario applies the United Nations methodology used for assessed contributions from Member States as recommended by the experts' meeting.

2. The methodology takes into account the population, debt burden, equity, level of poverty, and puts a limit on the minimum and maximum amount that a country can pay to the Fund.

3. The arithmetic average of Gross National Income (GNI) data for base periods of 2012-2014 and 2009-2014 was calculated for each country. The six-year (2009-2014) Gross National Income (GNI) data (in US$) for individual Member States in the WHO African Region were obtained from the World Bank database (http://data.worldbank.org/indicator/NY.GNP.ATLS.CD).

4. The debt-burden adjustment (DBA) and the low per capita income adjustment was applied to every Member State whose average debt-adjusted per capita GNI is lower than the average per capita GNI (threshold).

5. The minimum amount of US$ 37 700 recommended for a group of Member States was applied to the countries concerned (Burundi, Comoros, Democratic Republic of the Congo, Eritrea, Ethiopia, The Gambia, Guinea-Bissau, Malawi, Liberia, Niger, Rwanda, Sao Tome and Principe and Sierra Leone).

6. The maximum of US$ 6 million recommended for a group of Member States was applied to the countries concerned (Nigeria and South Africa).

7. The corresponding "gap" after reducing the total amount for countries with a previous amount of more than US$ 6 million was then distributed on a prorated basis among other Member States, except for those affected by the ceiling of US$ 6 million.

8. The table in Annex 1a shows the proposed Member States' contributions after applying the above criteria.

## ANNEX 2: Status of Member States' contributions and disbursements as of 30 June 2016

| | Member State | Scale of assessment (%) | Expected (yearly assessment – US$) | Contributions Received | | | | | | Disbursements | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | 2012 | 2013 | 2014 | 2015 | 2016 | Total | 2012 | 2013 | 2014 | 2015 | 2016 | Total |
| 1 | Algeria | 19.74 | 9 870 000 | | | | | | **0** | | | | | | **0** |
| 2 | Angola | 3.5 | 1 750 000 | 1 750 590 | | | | | **1 750 590** | | | | | 289 386 | **289 386** |
| 3 | Benin | 0.81 | 405 000 | | | 1 014 203 | | | **1 014 203** | | | | | | **0** |
| 4 | Botswana | 1.8 | 900 000 | | | | | | **0** | | | | | | **0** |
| 5 | Burkina Faso | 0.77 | 385 000 | | | | | | **0** | | | | | | **0** |
| 6 | Burundi | 0.01 | 5000 | | | | | | **0** | | | 148 360 | | | **148 360** |
| 7 | Cameroon | 3.23 | 1 615 000 | | | | | | **0** | | | 68 700 | | | **68 700** |
| 8 | Cabo Verde | 0.2 | 100 000 | | | | | | **0** | | | | | | **0** |
| 9 | Central African Republic | 0.16 | 80 000 | | | | | | **0** | | | 279 723 | | | **279 723** |
| 10 | Chad | 0.37 | 185 000 | | | 183 555 | | | **183 555** | | | | | | **0** |
| 11 | Comoros | 0.07 | 35 000 | | | | | | **0** | | | | | | **0** |
| 12 | Congo | 0.81 | 405 000 | | | | | | **0** | | | | | | **0** |
| 13 | Côte d'Ivoire | 3.09 | 1 545 000 | | | | | | **0** | | | | | | **0** |
| 14 | Democratic Republic of the Congo | 0.01 | 5000 | 5 000 | | | | | **5 000** | | | 346 100 | | | **346 100** |
| 15 | Equatorial Guinea | 0.77 | 385 000 | | | | | | **0** | | | | | | **0** |
| 16 | Eritrea | 0.01 | 5000 | 5 000 | | 9 974 | 5 000 | | **19 974** | | | | | | **0** |
| 17 | Ethiopia | 0.01 | 5000 | 4 975 | | | | | **4 975** | | | | | 143 276 | **143 276** |
| 18 | Gabon | 1.45 | 725 000 | | | | 382 577 | | **382 577** | | | | | | **0** |
| 19 | Islamic republic of The Gambia | 0.07 | 35 000 | | | 36 403 | | | **36 403** | | | | | | **0** |
| 20 | Ghana | 1.78 | 890 000 | | | | | | **0** | | | | | | **0** |
| 21 | Guinea | 0.42 | 210 000 | | | | | | **0** | | | 140 440 | | | **140 440** |
| 22 | Guinea-Bissau | 0.01 | 5000 | | | | | | **0** | | | | | | **0** |
| 23 | Kenya | 3.69 | 1 845 000 | | | | | | **0** | | | | | | **0** |
| 24 | Lesotho | 0.34 | 170 000 | | | | 167 625 | | **167 625** | | | | | | **0** |
| 25 | Liberia | 0.01 | 5000 | | | 14 950 | | | **14 950** | | | 100 150 | | | **100 150** |
| 26 | Madagascar | 0.63 | 315 000 | | | | | | **0** | | | | | | **0** |

| | Member State | Scale of assessment (%) | Expected (yearly assessment – US$) | Contributions Received | | | | | | Disbursements | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | 2012 | 2013 | 2014 | 2015 | 2016 | Total | 2012 | 2013 | 2014 | 2015 | 2016 | Total |
| 27 | Malawi | 0.01 | 5000 | | | | | | **0** | | | | 359 564 | | **359 564** |
| 28 | Mali | 0.8 | 400 000 | | | | | | **0** | | | | | | **0** |
| 29 | Mauritania | 0.39 | 195 000 | | | | | | **0** | | | | | | **0** |
| 30 | Mauritius | 1.27 | 635 000 | | | | 25 000 | | **25 000** | | | | | | **0** |
| 31 | Mozambique | 0.64 | 320 000 | | | | | | **0** | | | | | | **0** |
| 32 | Namibia | 1.44 | 720 000 | | | | | | **0** | | | | | | **0** |
| 33 | Niger | 0.01 | 5000 | | | | | | **0** | | | | 99 500 | | **99 500** |
| 34 | Nigeria | 22 | 11 000 000 | | | | | | **0** | | | | | | **0** |
| 35 | Rwanda | 0.01 | 5000 | 4 975 | 4 961 | | | | **9 936** | | | | | | **0** |
| 36 | Sao Tome and Principe | 0.01 | 5000 | | | | | | **0** | | | | | | **0** |
| 37 | Senegal | 1.72 | 860 000 | | | | | | **0** | | | | | | **0** |
| 38 | Seychelles | 0.17 | 85 000 | | | 4 650 | | | **4 650** | | | | | | **0** |
| 39 | Sierra Leone | 0.01 | 5000 | | | | | | **0** | | | 169 439 | | | **169 439** |
| 40 | South Africa | 22 | 11 000 000 | | | | | | **0** | | | | | | **0** |
| 41 | South Sudan* | – | – | | | | | | **0** | | | 523 200 | | | **523 200** |
| 42 | Swaziland | 0.52 | 260 000 | | | | | | **0** | | | | | | **0** |
| 43 | Togo | 0.24 | 120 000 | | | | | | **0** | | | | | | **0** |
| 44 | Uganda | 1.3 | 650 000 | | | | | | **0** | | | | | | **0** |
| 45 | United Republic of Tanzania | 1.88 | 940 000 | | | | | | **0** | | | | | | **0** |
| 46 | Zambia | 1.26 | 630 000 | | | | | | **0** | | | | | | **0** |
| 47 | Zimbabwe | 0.56 | 280 000 | | | | | | **0** | | | 65 500 | | | **65 500** |
| | **Grand Total** | **100** | **50 000 000** | **1 770 540** | **4 961** | **1 263 735** | **580 202** | **0** | **3 619 438** | **0** | **0** | **1 841 612** | **459 064** | **432 662** | **2 733 338** |

## ANNEX 3: Details of APHEF utilization and disbursement as of 30 June 2016

| | Date of request | Country | Reason for request | Amount requested (US$) | Amount approved/ disbursed (US$) | Summary of APHEF support to affected countries |
|---|---|---|---|---|---|---|
| 1 | 28 February 2014 | Burundi | Response to flooding which caused massive destruction and population displacement in Bujumbura | 279 760 | 148 360 | On 9 and 10 February 2014, Bujumbura experienced torrential rainfall with severe flooding that resulted in massive destruction of property and population displacement. At least 20 000 people, or 3784 households, were affected, with 77 dead and 182 injured.<br>The risk of epidemics, especially cholera and other diarrhoeal diseases, malaria and acute respiratory infections was very high.<br>APHEF funds contributed to the provision of emergency medical supplies and prevention of disease epidemics. |
| 2 | 7 March 2014 | Zimbabwe | Response to flooding which caused population displacement | 250 000 | 65 500 | Following unrelenting torrential rains in February 2014, the Tokwe Mukosi Dam rapidly flooded, threatening to cause a displacement of the communities within its basin. A phased relocation plan was implemented, targeting 6393 families (32 000 people) and their 18 764 cattle to make way for the dam. The area of relocation did not have basic social services or facilities and the nearest district hospital was 52 km away.<br>The risk of disease outbreak in both the flooded and the relocation areas was high, especially for cholera and other diarrhoeal diseases, malaria and acute respiratory tract infections. Given the magnitude of the threat of extensive flooding, the President of Zimbabwe declared a state of disaster.<br>APHEF resources supported the establishment of temporary health facilities, facilitation of referrals and provision of emergency and essential medicines for the relocated population. |
| 3 | 13 Mar 2014 | Central African Republic | Provision and restoration of free health care services for the most vulnerable populations following intensified armed conflict that led to total collapse of health systems | 421 678 | 279 723 | The crisis in the Central African Republic, fuelled by armed conflict, resulted in the total destruction of basic infrastructure and loss of essential social services, including health services. The Ministry of Public Health requested APHEF support to restore health services for the most vulnerable communities in Bangui at the Paediatric Hospital Complex and in the district hospitals of Mbaiki and Boda.<br>APHEF's contribution supported the implementation of the free health care policy for 3 months, anticipating a return to the normal health services system after that period. |
| 4 | 27 Mar 2014 | South Sudan | Re-establishment of free surgical care in three state hospitals following armed conflict that caused the collapse of health care services in the affected areas | 641 200 | 523 200 | The humanitarian crisis experienced by South Sudan since December 2013 has led to the disruption of essential health services. Health facilities were looted and destroyed. The State hospitals in Jonglei, Upper Nile and Unity states, the epicentre of the crisis, were among those providing only minimal services despite the increased demand. Between the onset of the crisis and March 2014, over 10 000 wounded patients were treated and more than 400 referred patients transported to Juba Teaching Hospital by air, which is a very costly means of transport. There are obvious gaps in life-saving surgical interventions since operating theatres are no longer functioning.<br>APHEF funds helped address the critical emergency surgery needs by reviving the operating theatres in Bor, Malakal and Bentiu hospitals and strengthening emergency surgical operations at Juba University Teaching Hospital. |
| 5 | 3 April 2014 | Guinea | Control of Ebola virus disease outbreak that caused widespread and high mortality | 386 090 | 140 440 | The outbreak of Ebola in Guinea was declared by the government in February 2014. Detailed investigation revealed that the disease had started in the country in December 2013 and had spread to neighbouring Liberia. By the end of March 2013, over 150 cases (including 102 deaths) had been reported from five districts including the capital city, Conakry. Health workers were among those reported to have the |

| | Date of request | Country | Reason for request | Amount requested (US$) | Amount approved/ disbursed (US$) | Summary of APHEF support to affected countries |
|---|---|---|---|---|---|---|
| | | | | | | disease, suggesting gaps in infection prevention and control.<br><br>APHEF's contribution helped build the investigation and response to control the Ebola outbreak. |
| 6 | 14 April 2014 | Cameroon | Contribution to the provision of essential health care services to refugees from the Central African Republic | 192 634 | 68 700 | The deterioration of the security situation in the Central African Republic from December 2013 generated a daily influx of refugees into Cameroon. Between December 2013 and 14 March 2014, a total of 48 000 new refugees were received in Cameroon. The districts receiving the refugees are facing the challenge of providing essential health care to the increased population in their catchment areas. In addition, the risk of disease epidemics is very high.<br><br>APHEF's contribution was used to provide supportive resources, specifically in mobilizing emergency medical kits, strengthening surveillance and early warning mechanisms for early detection and response to epidemics, and supporting polio and measles vaccination. |
| **7** | 17 April 2014 | Liberia | Control of the Ebola virus disease outbreak | 317 770 | 100 150 | The Ministry of Health and Social Welfare in Liberia declared an Ebola outbreak in April 2014. The outbreak was epidemiologically linked to the ongoing outbreak in Guinea. As of 21 April 2014, a cumulative total of 26 clinical cases, six of which had laboratory confirmation, and 20 probable or suspected cases, including 13 deaths, were reported. All the six patients with laboratory-confirmed Ebola, including three health care workers, died.<br><br>The Government of Liberia, in collaboration with partners, initiated response activities including enhanced surveillance for early case identification and contact tracing, case management, social mobilization and detailed investigation. However, significant gaps existed in these areas as well as in laboratory coordination and confirmation of cases.<br><br>APHEF helped in raising additional resources to strengthen all aspects of the outbreak response. |
| 8 | 20 June 2014 | Sierra Leone | Support the emergency response to the Ebola viral haemorrhagic fever epidemic in Sierra Leone | 245 578 | 169 439 | On Monday, 26 May 2014, the Government of Sierra Leone, through its Ministry of Health and Sanitation, declared an outbreak of the Ebola virus disease in the country following the laboratory confirmation of a suspected case from Kailahun District, located along the border with Guinea and Liberia. A total of 60 cases had been confirmed for Ebola virus disease by 20 June. Responding adequately to contain the outbreak of the disease in Kailahun and other high risk districts was critical.<br><br>APHEF's contribution helped to stop the transmission of the Ebola virus disease and reduce its morbidity and mortality. |
| 9 | 2 Sept 2014 | Democratic Republic of the Congo | Control of Ebola virus disease in the country | 391 200 | 346 100 | The Ebola virus disease is highly contagious and starts with a fever accompanied by diarrhoea, vomiting, severe fatigue and sometimes bleeding. It is transmitted by direct contact with sick or infected animals. From 24 August 2014, the Democratic Republic of the Congo was faced with the likelihood of an Ebola epidemic. By 30 August 2014 the country had recorded 53 cases, of which 13 had laboratory confirmation, and 31 deaths.<br><br>APHEF's contribution was used in containing the outbreak and reducing morbidity and mortality from the disease. |
| 10 | 16 February 2015 | Malawi | Strengthening basic health care provision to flood-affected communities | 369 564 | 359 564 | Flooding in Malawi started on 8 January 2015. On 13 January the President declared a state of disaster after persistent rains resulted in flooding which affected 15 districts. Four of these districts – Chikhwana, Nsanje, Phalombe and Mulanje – were heavily affected by the floods. Their routine critical health services were disrupted. Also their personnel capacity and medical supplies were not adequate to cope with the |

| | Date of request | Country | Reason for request | Amount requested (US$) | Amount approved/ disbursed (US$) | Summary of APHEF support to affected countries |
|---|---|---|---|---|---|---|
| | | | | | | needs of the 638 000 affected people.<br><br>APHEF's contribution was used to fill the gaps in the critical medical supplies needed to strengthen the delivery of basic health services and epidemic preparedness and response in the four most affected districts. |
| 11 | 26 April 2015 | Niger | To strengthen meningococcal meningitis outbreaks response | 371 401 | 99 500 | Between 29 December 2014 and 26 April 2015, the Ministry of Public Health of Niger notified WHO of 2005 suspected cases of meningococcal meningitis, including 162 deaths. Suspected cases have been reported in seven of Niger's eight regions with meningococcal meningitis outbreaks confirmed in several areas of Dosso and Niamey regions. Three of Niamey's five districts had exceeded the epidemic threshold. Laboratory tests have confirmed the predominance of Neisseria meningitidis serogroup C in the affected areas, with Neisseria meningitides serogroup W also being identified in several samples.<br><br>APHEF contributed in supplementing the efforts of the Government to provide an efficient and effective response to the epidemic through proper case management and reactive immunization, and to strengthen all aspects of outbreak response. |
| 12 | 12 February 2016 | Angola | Support the response to the yellow fever outbreak in Luanda | 289 386 | 289 386 | In late December 2015, a cluster of cases with unspecified illness was reported in the Viana district of Luanda in Angola. Three (3) specimens taken from suspected cases were confirmed as positive for yellow fever by both NICD (South Africa) and Institute Pasteur (Dakar) laboratories. The Ministry of Health in Angola officially declared a yellow fever outbreak on 22 January 2016 and mounted a multisectoral response to conduct detailed investigation and reactive mass vaccination campaigns in all the affected areas.<br><br>APHEF's contribution complemented resources mobilized to control the yellow fever outbreak and reduce the potential for further transmission locally and internationally. |
| 13 | 18 February 2016 | Ethiopia | Support the El Niño driven public health emergency response | 2 004 405 | 143 276 | The El Niño experienced in Ethiopia resulted in severe drought, leading to the displacement of over 200 000 people followed by disease outbreaks such as measles, meningitis, acute watery diarrhoea, malnutrition and scabies in the drought affected areas and among the displaced populations. This resulted in the declaration of a public health emergency by the country.<br><br>The APHEF contribution was an additional resource to supplement the country's commendable efforts to strengthen the El Niño response. |
| **Total** | | | | **6 160 666** | **2 733 338** | |