

# Contingency Fund for Emergencies



Report of the WHO Health Emergencies  
Programme | April 2017

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# 1. Overview

In accordance with the request of the World Health Assembly in resolution WHA68(10) *2014 Ebola virus disease outbreak and follow-up to the Special Session of the Executive Board on the Ebola Emergency*, and in accordance with the request of the Independent Oversight and Advisory Committee (IOAC), this report provides a review of the scope and criteria of the WHO Contingency Fund for Emergencies (CFE) after two years of its implementation, including proposals to improve the fund's performance and sustainability. To support the review, an overview of the CFE's performance is also presented.

## *Establishment of the CFE*

The CFE was established by the World Health Assembly in May 2015 following a review of WHO's response to the 2014 Ebola outbreak in West Africa and as one element of the reform of WHO's work in emergencies with health and humanitarian consequences. The CFE is designed to provide funding during a critical gap - from the moment the need for an emergency response is identified, to the point at which resources from other financing mechanisms begin to flow. Before the CFE, WHO had no central fund capable of rapidly disbursing funds to pay for early emergency response activities – a particular problem when dealing with a fast-moving disease outbreak. During the early stages of the response to the Ebola outbreak in West Africa, funding from donors took many months to disburse. That lack of funding hampered WHO's ability to take action that would have helped to save lives.

## *How the CFE works*

The creation of the Fund was deemed to be an essential step as part of the wide-ranging reform of the way WHO responds to disease outbreaks and health emergencies. The mechanics of the CFE were designed to be as streamlined and as flexible as possible. Financing is achieved through flexible, voluntary contributions. In the context of the WHO Health Emergencies Programme (WHE), the Contingency Fund for Emergencies forms a discrete financing envelope outside of the Health Emergencies Programme core budget.

Crucially, initial awards for small amounts (under US\$ 500 000) can be released within 24 hours of approval. This ability to mobilize funds rapidly and with minimal bureaucracy is essential in fast-moving emergency situations, when deploying responders to the theatre of operations is an urgent priority. Requests for more substantial amounts (>US\$ 500 000) must be underpinned by a WHO-led Health Cluster joint agency action plan.

## *Financing the CFE*

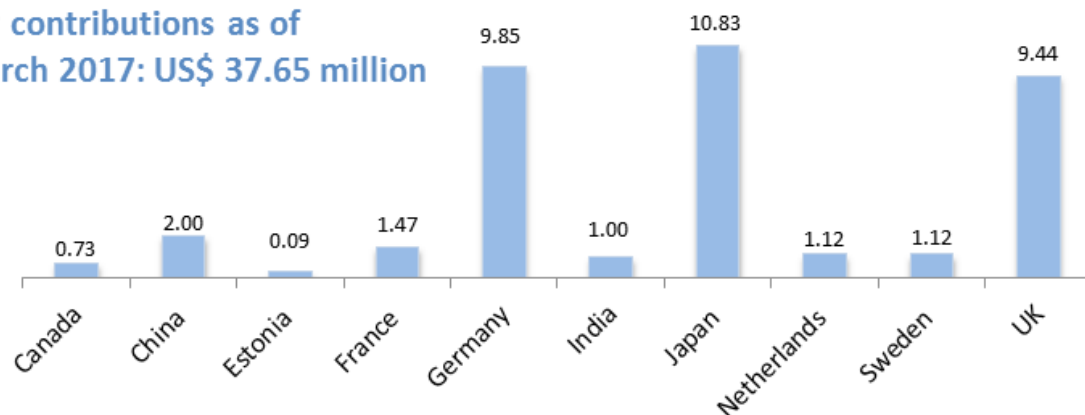
The WHO Health Emergencies Programme has three main funding categories: the core budget that covers the essential functions of the Programme; the appeals budget that covers the additional work that is done in response to protracted health emergencies; and the WHO Contingency Fund for Emergencies. The CFE is to be financed through flexible voluntary contributions and is replenished through reimbursement from benefitting WHO Country Offices or through new direct contributions. As of 31 March 2017 the CFE has raised US\$ 37.65 million of its US\$ 100 million target capitalization. Allocations to date total US\$ 19.1 million in support of WHO activities in response to 21 health emergencies ranging from public health emergencies of international concern (Zika virus disease) to localized humanitarian crises such as the health emergency in northern Nigeria.

Out of 17 requests received for amounts under US\$ 500 000, a total of 14 (83%) were approved and funding was made available within 24 hours. This rapid disbursement of funds from the CFE has been pivotal in getting people and supplies where they are needed without delay. In Haiti, for example, CFE funds enabled WHO to deliver life-saving medical supplies to affected areas within only 5 days of the initial request. In northern Nigeria, CFE funds were the only available source of funding for response activities between August and the end of 2016. And in the response to Zika virus, CFE enabled a full Incident Management Structure (IMS) to be implemented in WHO headquarters in Geneva and all WHO regional offices. Without this bridge funding the response would have been significantly delayed until the first donor contributions were received, 6 weeks after the declaration of the PHEIC.

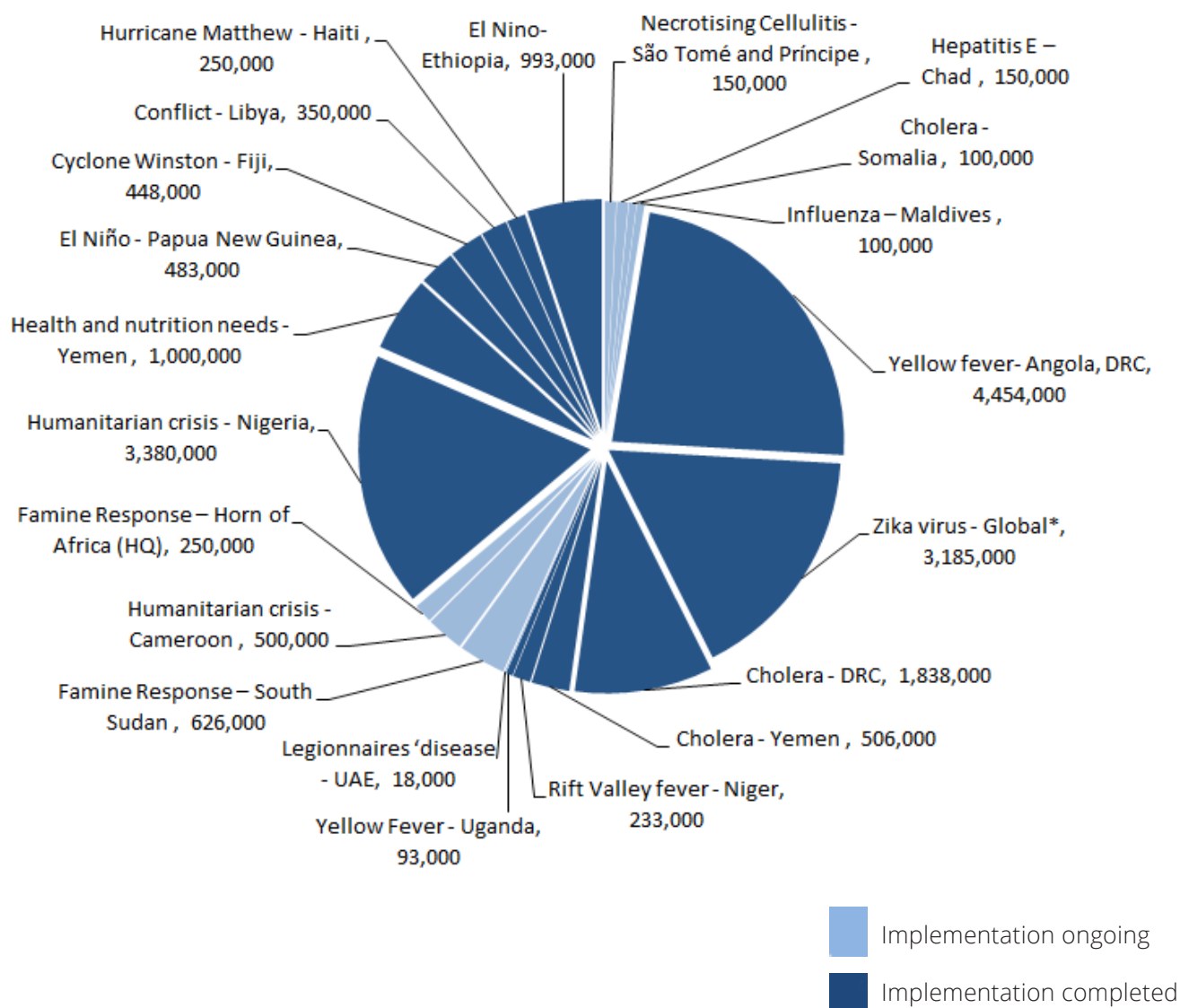


## At a glance | Funding and allocations: 26 May 2015 to 31 Mar 2017

Donor contributions as of  
31 March 2017: US\$ 37.65 million



Award allocations as of  
31 March 2017: US\$ 19.1 million



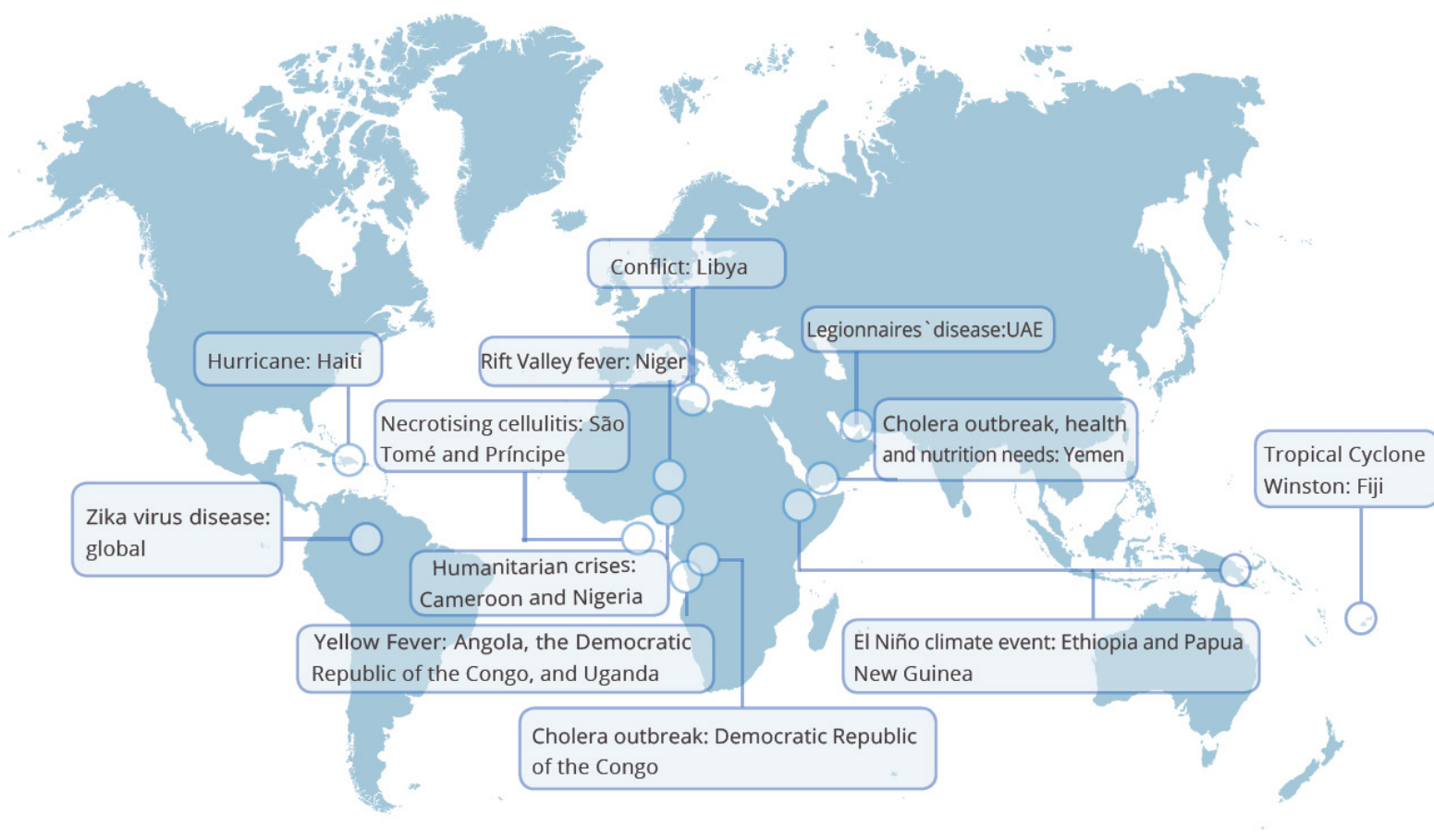
## 2. Impact

The CFE has been a critical tool to enable WHO to quickly respond to emergencies, rather than wait for funds through appeals and applications to external donors. The CFE has saved lives and helped avert disease outbreaks and their associated social and economic consequences through targeted interventions. In November 2015 the CFE made its first disbursement, mobilizing US\$ 400 000 for the response to the health consequences of drought in Ethiopia.

Disbursements have been made to support WHO's operations in **10 humanitarian crises**: the health and nutrition impact on populations affected by the conflict in Yemen, Hurricane Matthew in Haiti, the crisis in north-eastern Nigeria, the public health impact of El Niño in Ethiopia and Papua-New-Guinea, the conflict in Libya, and Tropical Cyclone Winston in Fiji.

To investigate, respond to and recover from **11 disease outbreaks**, the CFE released funds to the cholera outbreak in Yemen, the outbreak of Rift Valley Fever in Niger, the cholera outbreak in Democratic Republic of the Congo, the yellow fever outbreak in Angola, DRC and Uganda, and the clusters of microcephaly associated with Zika.

The following overview provides a summary of where, when and why funds have been used from the CFE, how WHO has delivered **results** on the ground, and what **achievements** have been made for populations affected by health and humanitarian emergencies.



# El Niño | Ethiopia

**Country:** Ethiopia  
**Amount provided:** US\$ 993 000  
**Funding period:** 18 Nov 2015 – 19 May 2016  
**Goal:** To respond to malnutrition and disease threats in Ethiopia  
**Beneficiaries:** Up to 3.6 million people vulnerable to health and nutrition emergencies

## Rationale for CFE funding

The first disbursement from WHO's Contingency Fund for Emergencies was released in November 2015, when funds were mobilized for the response to malnutrition and disease in Ethiopia. An El Niño event off the east coast of Africa in 2015 exacerbated drought and flooding in parts of the country, causing up to 80% of the year's harvest to fail.

This food crisis increased the incidence of severe malnutrition and, consequently, people's vulnerability to diseases. Outbreaks of dengue fever, meningitis, measles, acute watery diarrhoea and scabies were reported.

## Achievements

WHO deployed a team of experts to coordinate the health response, assess health impacts and needs, and strengthen disease early warning and outbreak management systems. The Organization sent supplies to address some of the immediate needs for medical care for severely malnourished children, treat 7000 people with acute watery diarrhoea, and 10 000 people with other urgent health needs. WHO worked with the Ministry of Health and 22 partner organizations to respond to the crisis.



WHO provided  
**MEDICAL SUPPLIES** to treat  
**7000** people



WHO deployed  
**TECHNICAL EXPERTS**



WHO worked with  
**22 PARTNERS**  
 to coordinate the response

## EL NIÑO EFFECTS AND HEALTH CONSEQUENCES





# Conflict | Libya

Country:	Libya
Amount provided:	US\$ 350 000
Funding period:	3 Feb – 3 May 2016
Goal:	To provide medical supplies, mobile clinics, health teams and safe water
Beneficiaries:	20 000 people in need of life-saving health care

## Rationale for CFE funding

Five years of armed conflict and political instability have affected almost every part of Libya, claiming thousands of lives and leaving thousands more injured.

In 2016, an estimated 2.44 million people were in immediate need of protection and some form of humanitarian assistance, including almost 435 000 internally displaced people (IDPs) – many of whom have endured multiple displacements and lost homes, livelihoods and loved ones. Those affected but not displaced by the conflict included an additional 1.75 million people.

The continued conflict in Libya led to a collapse in health infrastructure and an exodus of health workers. Approximately 2 million people (one third of the population) had serious unmet health needs.

## Achievements

WHO shipped a plane loaded with life-saving medicines and supplies to Tripoli to meet the acute health humanitarian needs in Libya, particularly for people most heavily affected by the recent conflict.

The supplies included life-saving medicines, injectable antibiotics, trauma care supplies, intravenous infusions and kits. These medicines were sufficient for 20 000 patients for a minimum period of 3 months. WHO has stored these supplies in its warehouse in Tripoli and released the supplies based on actual needs and demands of hospitals and health centres in different parts of Libya, as well as calculations based on a health assessment conducted by WHO.

**The procurement of these supplies was made possible through funds allocated from the United Nations Central Emergency Response Fund and WHO's Contingency Fund for Emergencies.**



WHO delivered

**MEDICAL  
SUPPLIES** reaching  
**20 000** people



WHO stockpiled

**MEDICINES  
and  
COORDINATED  
distribution to  
HEALTH CENTRES  
and  
HOSPITALS**

# Cyclone Winston | Fiji

Country:	Fiji
Amount provided:	US\$ 448 000
Funding period:	26 Feb – 25 May 2016
Goal:	To support the Fijian Ministry of Health to address health needs, particularly access to clean water, trauma care, detecting and controlling increased communicable disease transmission
Beneficiaries:	350 000 people affected by Cyclone Winston

## Rationale for CFE funding

Tropical Cyclone Winston tore through Fiji on 20-21 February 2016, resulting in 44 deaths, over 125 injured, and thousands without shelter, food, and safe water. In total, the cyclone affected the lives of 350,000 people. At the time of the CFE request 34,629 people were seeking refuge in 424 evacuation centres around Fiji. There had been no communication yet with some areas of the islands. Power outages and damage to water and sanitation facilities, food spoilage and food shortages were a serious public health concern. There were early reports of diarrhoeal disease, and acute fever and rash illness.

In addition to these concerns caused by the cyclone, Fiji had been reporting increasing numbers of Dengue-Like Illness (93 confirmed cases as of 3 February), and Zika virus was circulating in the country.

## Achievements

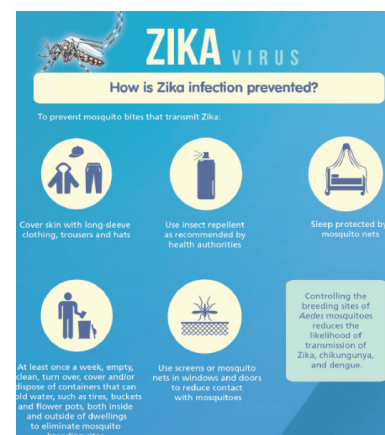
Immediate actions – financed by the CFE - included providing emergency medical supplies, deploying additional personnel to Fiji to help organize relief efforts for the survivors, and coordinating a rapid joint public health risk assessment. Overall achievements are summarized below:





# Zika | Global

**Country:** Global  
**Amount provided:** US\$ 3 185 000  
**Funding period:** 08 Feb – 30 Jun 2016  
**Goal:** To support national governments and communities to prevent and manage the complications and mitigate the socio-economic consequences of Zika virus infection  
**Beneficiaries:** Individuals, families, and communities affected or at risk of Zika virus



## Rationale for CFE funding

On 1 February 2016, WHO Director-General Margaret Chan convened an Emergency Committee of 18 experts to assess the level of threat to public health posed by the outbreak of Zika virus in the Americas, after increasing evidence that the virus was associated with neurological complications in new-borns. WHO declared a Public Health Emergency of International Concern (PHEIC) the same day, and published a comprehensive Strategic Response Plan (SRP) two weeks later. Donors were initially slow to commit, as the Zika outbreak was perceived to fall between the work of development agencies — who were waiting to gauge the implications of the outbreak for individuals and health systems — and humanitarian agencies who did not consider Zika to be a disease with sufficient levels of mortality to qualify as an emergency.

## Achievements

**175 experts** from PAHO and partners have been deployed on **80 separate missions to 30 PAHO countries and territories**. In addition, PAHO has convened **22 workshops** at regional level, reaching more than **400 participants**, on topics including pregnancy management, vector control methods, insecticide protocols and how to use Geographic Information Systems in targeting hotspots for vector control activities.

The WHO Regional Office for Europe convened a EURO Regional Technical Consultation on Zika virus in Lisbon, Portugal, in June 2016, following the publication of the **Zika Risk Assessment for European Region**. As a result of the consultation EURO developed a **training curriculum for health professionals** to increase awareness of invasive mosquitoes and vector-borne diseases.

In February, WHO launched the Pacific Zika Action Plan in consultation with regional development partners. Following a **regional risk-assessment exercise**, WHO supported Zika **preparedness and response** in Fiji, the Federated States of Micronesia, Republic of the Marshall Islands, and Samoa, all of which experienced outbreaks of Zika virus disease in 2016.

In the South-East Asia Region, WHO is supporting Member States with appropriate guidance on effective surveillance and management of Zika virus by helping countries to assess and strengthen their response capacities. In addition, the hospital surveillance network of the Maternal Child Health programme, established by WHO in South-East Asia Region in July 2014, has been strengthened and expanded so that **200 hospitals in nine countries are now screening babies for Zika-related microcephaly**.



# El Niño | Papua New Guinea

Country:	Papua New Guinea
Amount provided:	US\$ 483 000
Funding period:	29 Apr– 31 Oct 2016
Goal:	To support WHO's response to the health consequences of food and water shortages caused by the El-Niño climate event
Beneficiaries:	Up to 1.4 million people affected by food insecurity

## Rationale for CFE funding

Since April 2015, Papua New Guinea has experienced a combination of severe drought, heavy frosts, and sudden deluges of rain as a consequence of the El-Niño Southern Oscillation – a change to the normal surface temperature of the Equatorial Pacific Ocean. The resultant damage to crops, property and infrastructure has led to critical shortages of food and water and a lack of proper sanitation, and consequently to an increased incidence of communicable diseases. A vulnerability assessment by the World Food Programme in late March 2016 estimated that 162 000 people in Papua New Guinea faced extreme food insecurity, and an additional 1.3 million people faced a high degree of food insecurity.

## Achievements

The funds released by the CFE enabled WHO to respond rapidly to mitigate a deterioration of the situation over the course of 2016, and contributed to a wider US\$ 37.57 million El Niño Response Plan that aimed to address critical needs in food assistance, nutrition, health, water sanitation and hygiene (WASH), agricultural recovery and early recovery. Activities as part of the Health sector response plan **reached 1.4 million people** in need, and focused on providing access to water and medical supplies, direct preventive and curative services to affected populations, and strengthening disease surveillance and outbreak preparedness.



WHO provided  
**ACCESS TO  
WATER  
AND  
SANITATION**



WHO facilitated  
**ACCESS TO  
ESSENTIAL  
HEALTH  
SERVICES**



WHO conducted  
regular  
**DISEASE  
SURVEILLANCE**

# Humanitarian Crisis | Nigeria

Country:	Nigeria
Amount provided:	US\$ 3 380 000
Funding period:	27 Aug 2016 – 28 Feb 2017
Goal:	To rapidly reduce excess mortality and prevent morbidity due to the humanitarian crisis predominantly in Borno state
Beneficiaries:	3.7 million people in need of emergency health services

## Rationale for CFE funding

Since 2009 the violent conflict in north-eastern Nigeria has led to widespread population displacement, violations of international humanitarian and human rights law, protection risks and a growing humanitarian crisis. In May 2013 the Nigerian President declared a state of emergency in the three worst affected states: Borno, Yobe and Adamawa. Health facilities in these areas have been systematically targeted by insurgent attacks, leading to complete or substantial partial damage to health infrastructure, which has resulted in a collapse of health care provision. In August 2016, gains by the Nigerian Army enabled limited access to 16 local government areas in Borno state that were previously cut off from humanitarian aid. Initial rapid assessments in these areas revealed shocking levels of need. More than 1.63 million people have been displaced in Borno; and 800 000 were estimated to be in need of urgent health care. Multiple disease outbreaks have been reported, including Acute Watery Diarrhoea, and notification of three wild polio virus cases for the first time in 2 years.

## Achievements

From the start of WHO's operations in Northern Nigeria in August until the end of 2016, **CFE funds were the only available source of funding**. The below achievements have only been possible thanks to this funding.

WHO has sent **10 Interagency Diarrhoeal Disease Kits, 10 full Interagency Emergency Health Kits** and 30 severe acute malnutrition (SAM) kits to support the Borno State Government's response.

**160 health facilities** enrolled, equipped and trained in Early Warning and Response System (EWARS). These sites cover 13 LGAs and 26 IDP camps.

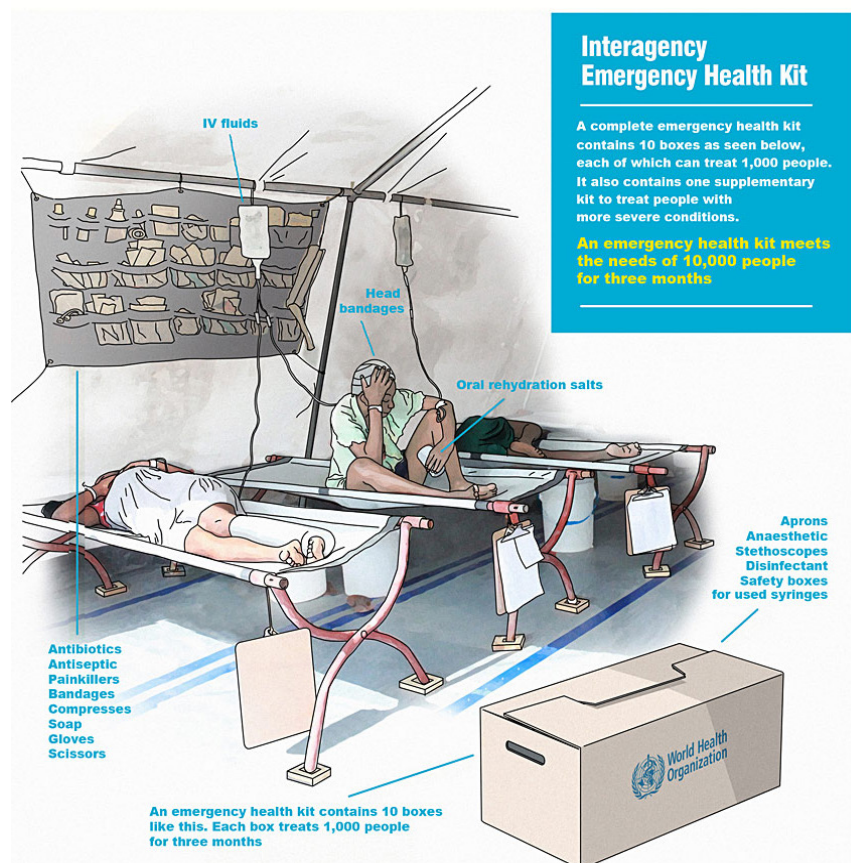
Training, equipping and deploying **218 community health workers**. These volunteers are charged with providing essential malaria, diarrhoea and ARI treatment to under 5s and have so far undertaken **4,430 consultations**.

Training, equipping, and coordination of **24 hard to reach teams (HRTs) - 89,000 consultations to date**. The HRTs are deployed to the most difficult areas and are directed to respond to IDP movements and areas that lack health facilities.

WHO is supporting a **measles vaccination campaign intended to cover 3.1 million children**.

**Sector coordination** has been established - 29 meetings held to date; **Information management**: WHO situation reports, EWARS and sector bulletins are being published weekly.

WHO has rapidly **rehabilitated a hospital ward and mobilized staff and training** to deal with a suspected viral haemorrhagic fever case.





# Cholera | Democratic Republic of the Congo

Country:	Democratic Republic of the Congo
Amount provided:	US\$ 1 838 000
Funding period:	30 Jul – 31 Oct 2016
Goal:	Reducing mortality and morbidity related to cholera
Beneficiaries:	Populations affected by and at risk of cholera

## Rationale for CFE funding

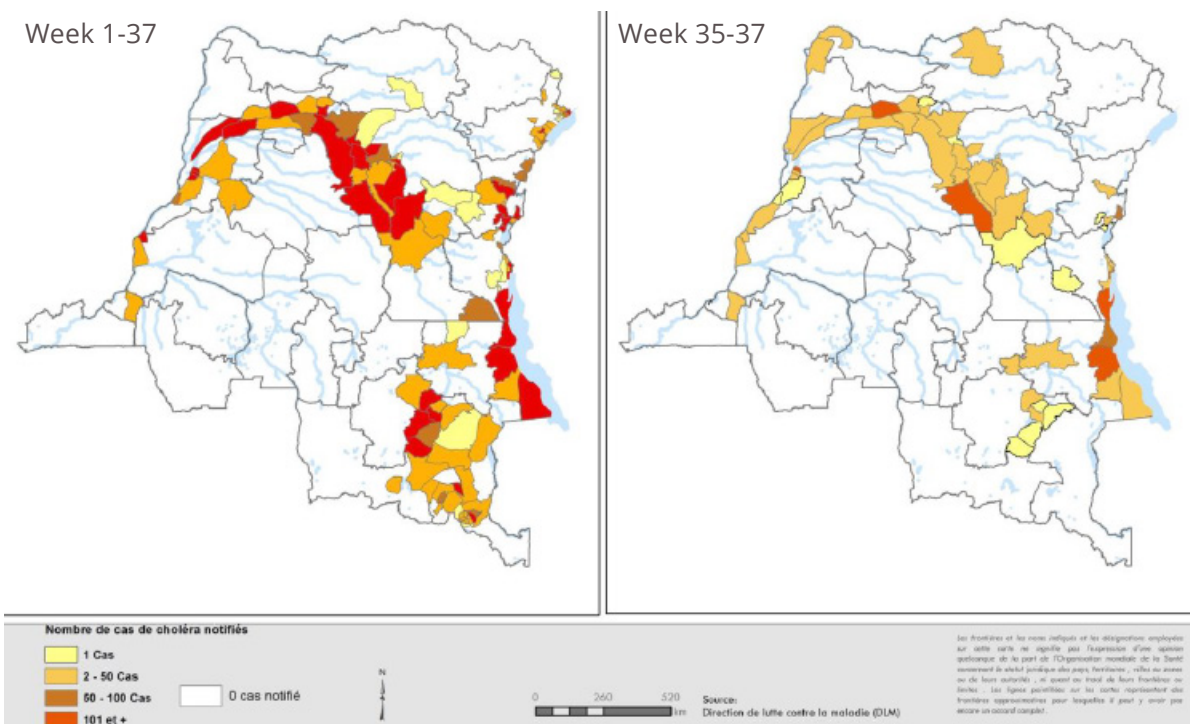
Over 20 000 cases of cholera and over 500 deaths were reported from Democratic Republic of the Congo during 2016, largely along the River Congo, from Kisangani in the north-east of the country, where the disease is endemic, to the capital Kinshasa in the west. The last time Kinshasa was affected by a cholera outbreak was 2011, and low levels of natural immunity to the disease usually result in a higher proportion of deaths among cases. In July 2016, over US\$1.8 million was released from the WHO Contingency Fund for Emergencies to respond to an increase in the rate of new cases along the northeast course of the river.

## Achievements

Crucially, the funds enabled the establishment of a cholera Emergency Operations Centre, improving the overall coordination of the response.

The response included: **community engagement and social mobilisation campaigns** to inform affected populations about the risks of cholera and the need to use the sanitisation stations provided by WHO; provision of **kits to disinfect water**; **supplies to disinfect boats and homes**, and **provision of potable water**. In September and October WHO implemented an **oral vaccination campaign** that **targeted 300 000 people** in the capital Kinshasa and two camps sheltering refugees from neighbouring Burundi and the Central African Republic. The campaign was designed to prevent the spread of cholera in the areas at greatest risk during the rainy season.

With support from WHO and thanks to the CFE funds provided, the number of new cases that were notified per month started to decrease significantly by early September (see map below).



# Hurricane Matthew | Haiti

Country:	Haiti
Amount provided:	US\$ 250 000
Funding period:	10 Oct 2016 – 1 Apr 2017
Goal:	Providing urgently needed medical supplies including cholera kits
Beneficiaries:	30 000 people receiving essential medicines for 3 months

## Rationale for CFE funding

Hurricane Matthew hit Haiti as a Category 5 hurricane on 4 October 2016, causing enormous damage to the southern part of the country. This disaster is considered the largest humanitarian crisis in Haiti since the 2010 earthquake. At the time of the CFE request on 10 October 2016, the National Emergency Operations Centre reported 473 deaths, 754 missing persons, and 175 509 persons displaced in 224 temporary shelters. Initial assessments suggested that up to 90 per cent of houses and other infrastructure including schools and public facilities were destroyed in the worst affected areas. Health facilities had suffered physical damage. Water distribution systems had almost entirely collapsed in the main affected cities of the southern area. The impact of the hurricane increased the already high risk of waterborne diseases, particularly cholera, which had been present in several of the most affected areas before Hurricane Matthew hit.

The requested CFE funds were urgently needed to cover the rapid shipment of emergency supplies, including cholera kits and other medical equipment, and the deployment of WHO technical experts from across the Organization and GOARN, in support of and in coordination with PAHO operations.

## Achievements

The CFE funds enabled WHO to deliver **medical supplies to Haiti within only 5 days** from the initial request to reach their final destination where they helped to save lives.

CFE funding was requested from WHO HQ and approved. The Operations, Support and Logistics team in WHE liaised with the Humanitarian Response Depot in Dubai to bring together supplies and medicines.

The shipment was prepared in Dubai containing: 3 Interagency Emergency Health Kits; 4 Interagency Diarrhoeal Disease Kits, each with supplies to treat 100 severe cases of cholera and 400 moderate cases as well as a complete set of supplies to establish a cholera treatment centre. 9 supplementary modules containing supplies to combat malaria (including 800 diagnosis tests, 390 malaria treatments and 2000 quinine tablets) and enough medication to treat 150 people for post-exposure prophylaxis to prevent HIV infections.

The shipment was loaded on a donated flight from the United Arab Emirates that departed on 13 October. Once supplies landed, PAHO/WHO staff inspected the shipment, and supplies were immediately sent to the warehouse in Port-au-Prince.

The shipment was sorted by the PAHO/WHO response team of pharmacists and logisticians, and supplies were loaded onto trucks destined for Les Cayes and Jeremie, the communes hit hard by Hurricane Matthew and showing a significant increase in cholera cases and deaths.

The goods arrived in Les Cayes, where the director of the Hôpital Immaculée Conception received the urgently awaited medical supplies and medicines.

They were put to immediate use to treat patients both in the hospital's emergency clinic and the cholera treatment centre. Supplies to set up a new cholera treatment centre were also airlifted to the town of Randell which had been nearly completely destroyed.

10 OCTOBER



13 OCTOBER



14 OCTOBER



16 OCTOBER



# Yellow fever | African Region

**Country:** Democratic Republic of the Congo, Angola  
**Amount provided:** US\$ 4 454 000  
**Funding period:** 12 Feb – 30 Sep 2016  
**Goal:** To end yellow fever outbreaks in affected countries and limit international spread

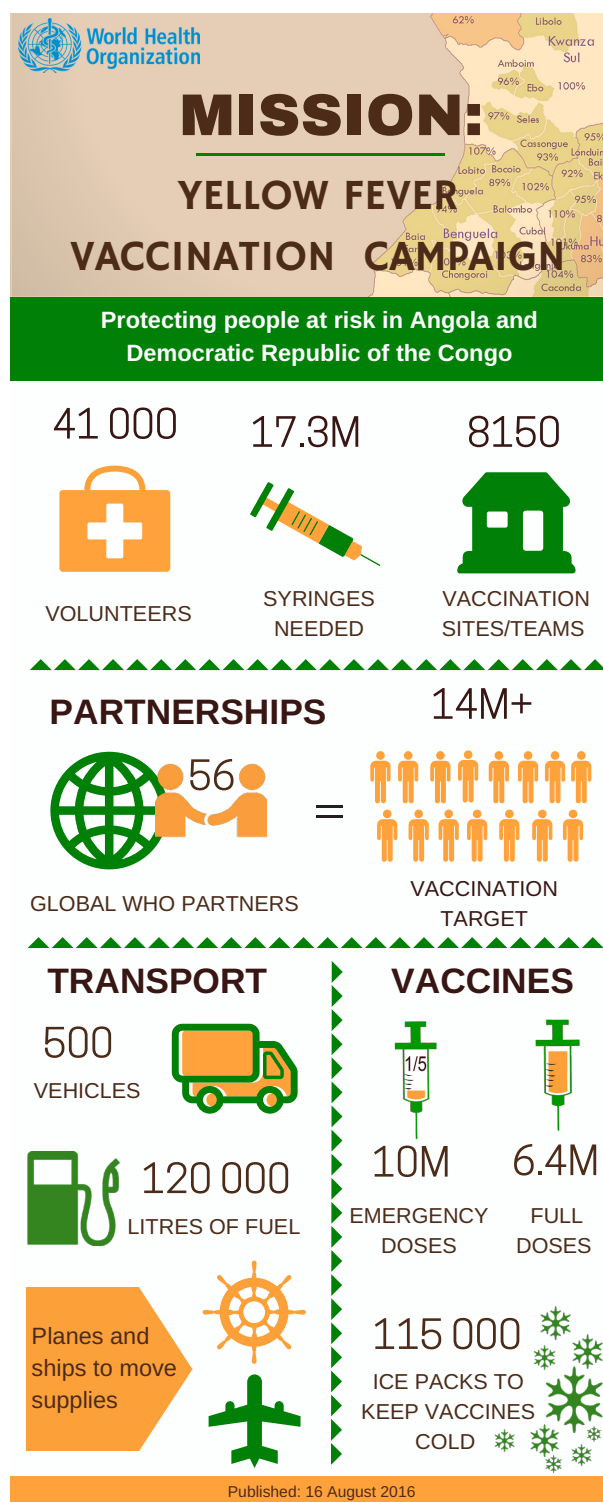
## Rationale for CFE funding

Yellow fever is endemic in tropical areas of Africa and Central and South America. Thirty-four countries in Africa and thirteen in Central and South America are either endemic for, or have regions that are endemic for, yellow fever. WHO received official notification of the outbreak in Angola on 21 January 2016. On 22 March 2016, DRC notified WHO that a number of imported cases had been detected in the capital, Kinshasa.

CFE funds were disbursed initially in order to set up an Incident Management System (IMS), and to cover key costs related to vaccination, disease surveillance, clinical management, and risk communication. Vaccination was crucial to the success of the response. Modelling indicated that vaccinating the population of the DRC capital Kinshasa and the population living along the Angola–DRC border would provide a buffer to halt any further expansion of the outbreak. However, delivering the vaccine to remote communities along the Angola–DRC border was a logistical challenge. Emergency stockpiles of the vaccine were also running low. In order to vaccinate the population of a large capital like Kinshasa, it was necessary to use a pioneering new approach in which each individual was vaccinated with a fraction of the usual vaccine dose. Funds were provided by Japan to purchase the specialised syringes required to deliver fractional doses, but further funds were required to get the vaccine to populations in need.

There was a significant time lag from the point WHO established the IMS and published the Strategic Response Framework to the receipt of donor funds. In the intervening period **multiple disbursements from the CFE were required to sustain essential response activities as the outbreak evolved**. Only Germany has agreed to refund part of these disbursements through a €200 000 contribution.

In addition to the support provided to DRC and Angola, the CFE released US\$ 93 000 to support the WHO Country Office in Uganda with its efforts to fight the local yellow fever outbreak.



## Achievements

WHO worked with a **total of 56 partner organizations** across Angola and the Democratic Republic of the Congo to support the ministries of health to implement the joint Yellow Fever Strategic Response Plan.

Within two weeks of Angola notifying WHO of an outbreak of yellow fever in January 2016, more than 1.7 million vaccines were shipped to the country from the emergency stockpile managed by the International Coordinating Group (ICG) for Vaccine Provision.

In addition to deploying around 27 million doses of the vaccine to Angola and DRC, WHO and partners strengthened laboratory capacity in the two countries, including sending mobile labs; supported governments to plan and implement mass vaccination campaigns; deployed more than 250 experts to affected countries; and provided technical guidance for clinical care, training and social mobilization.

As part of the response, the **biggest emergency yellow fever vaccination campaign** ever held in Africa took place in Democratic Republic of the Congo in August 2016. With high risk of transmission of the mosquito-borne disease in the densely populated capital city of Kinshasa, the vaccination campaign aimed to protect as many people at risk as possible and stop the outbreak before the rainy season began in late September. The logistics to vaccinate more than 10.5 million people in 32 health zones in Kinshasa provinces and 15 health zones in remote areas bordering Angola, was a complex and challenging logistical undertaking. WHO deployed 15 logisticians to plan and transport more than 10 million syringes, vaccine doses in more than 38 000 vaccine carriers by truck, car, motorcycle, by boat and often by foot to the targeted 8000 vaccination sites, many of them in remote and hard to reach areas.

In total, approximately **16 million people were vaccinated in 73 districts in Angola**. In **Democratic Republic of Congo close to 13.5 million** people received the yellow fever vaccine.

The last confirmed case reported in Angola was on 23 June and DRC's last case was on 12 July 2016. This is thanks to the joint response activities of national health authorities, local health workers, WHO and partners, and the funding provided by donors to the CFE.



# Rift Valley fever | Niger

<b>Country:</b>	<b>Niger</b>
<b>Amount provided:</b>	<b>US\$ 233 000</b>
<b>Funding period:</b>	<b>20 Sep – 21 Dec 2016</b>
<b>Goal:</b>	<b>To support the Ministry of Health to strengthen the response to Rift Valley fever (RVF) outbreaks and prevent further spread</b>
<b>Beneficiaries:</b>	<b>Populations affected by and at risk of RVF</b>

## Rationale for CFE funding

On 30 August 2016, WHO received reports from the Ministry of Health of Niger about unexplained deaths among humans, along with death and abortion in livestock in the north western parts of Niger and the areas bordering Mali. On 1 September, a multi-sectoral rapid response team (RRT) including members from the Ministry of Health, WHO, veterinary services and Centre de Recherche Médicale et Sanitaire (national referral laboratory) was deployed for field investigation. Blood specimens taken from humans and animals were confirmed in IPD Dakar, testing positive for RVF. The Ministry of Health officially declared the RVF epidemic on 21 September 2016.

From 2 August to 29 September 2016, a total of 76 cases including 26 deaths were reported in an area dominated by nomadic stockbreeders. Livestock was reportedly affected including deaths and abortions among cattle and small ruminants. The overall case fatality ratio of the outbreak was high (33.3%).

This was the first epidemic of Rift Valley fever occurring in Niger, and it had a potential to cause serious public health impact. Additionally, the outbreak was occurring during the “Cure Salée” annual event which involves mass gathering of humans and animals, hence being a high risk event conducive for further spread of RVF in livestock, and transmission to humans. At the end of the rainy season the nomadic population along with their herds progressively moves to other southern Sub-Saharan countries and irrigation systems along the Niger river where pastures may still be available. Additionally, given that the dynamics of RVF outbreaks differ between eco-epidemiological patterns and are modulated by eco-climatic factors, the current RVF outbreak in Niger may go beyond the borders. Also the associated severe socio-economic consequences were likely to go beyond the immediate effects on producers and public.

The CFE funding was needed to enhance prevention and preparedness, and to reduce the magnitude of the outbreak through timely detection of RVF infection and its possible consequences.

## Achievements

WHO supported the Ministry of Health to carry out the initial investigation for **confirmation of the outbreak** and notification in accordance with the provision of the International Health Regulations.

A joint field mission of the MoH and Ministry of Livestock was conducted to the affected areas to ensure **prevention and control measures** were being implemented and to begin community engagement regarding RVF.

WHO AFRO and GOARN **deployed additional personnel** to support the MoH in implementing outbreak and response activities, specifically in the areas of epidemiological investigation surveillance and response, case management, risk communication and social mobilisation activities in the country are in process.

GOARN deployed laboratory experts from Institute Pasteur Dakar **to provide training in laboratory capacity**. Six local experts were trained in lab testing (serology). AFRO supplied additional laboratory reagents, and provided triple packaging for specimen transport.

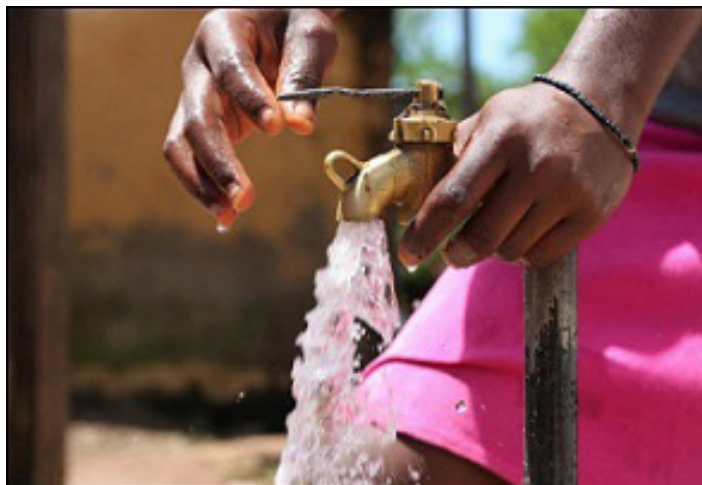
A comprehensive **outbreak investigation protocol** was developed by WHO country office with support from WHO headquarters and African region.





# Cholera | Yemen

Country:	Yemen
Amount provided:	US\$ 506 000
Funding period:	18 Oct 2016– 19 March 2017
Goal:	Reducing mortality and morbidity related to acute watery diarrhoea and cholera
Beneficiaries:	Health cluster partners aim to reach 3.8 million at-risk people



## Rationale for CFE funding

In mid-October 2016 the Ministry of Public Health and Population in Yemen confirmed additional cases of cholera and cholera-related deaths in the country. A total of 644 suspected cases of cholera, including 3 deaths, had been reported. 31 cases had been laboratory confirmed. Acute watery diarrhoeal diseases are endemic in Yemen. It is the second most common cause of death, especially among infants and school children. As a result of the ongoing conflict, two third of Yemenis do not have access to clean water, and sanitation services are limited, especially in cities, further increasing the risk of catching cholera.

As part of the joint HEALTH-WASH Cholera Response plan, WHO urgently needed over US\$ 8 million to respond to the ongoing outbreak and to prevent its spread in 15 governorates for 3 months. Out of this request, WHO received US\$ 506 000 in CFE funding to bridge the gap until further funding was received.

## Achievements

WHO has supported **the deployment of rapid response teams** to analyse and chlorinate water sources in Arhab district in Sana'a, including wells and water tanks. **Medical supplies have been distributed to the treatment centres** in Al Sabeen Hospital in Sana'a and four of the 26 diarrhoea treatment centres in Ibb and Hajjah governorates. The prevention and control efforts implemented so far have proven to be effective in reducing the number of cases in some governorates, while new cases continue to be reported in other governorates. WHO has also **strengthened supervision and mentoring of health workers** in the newly affected districts to ensure timely investigation, adherence to standard case definition, timely laboratory confirmation of suspected cases, proper case management, effective infection control practice, and proper solid waste disposal and drainage network management. **Essential supplies such as rapid diagnostic test kits, IV fluids, oral rehydration solutions and water chlorination tablets** have been provided to affected communities.

The cholera taskforce led by WHO, in partnership with the Ministry, UNICEF, OCHA and other partner organizations, continues to coordinate and strengthen cholera response activities at the national and governorate levels. The taskforce maintains two national health emergency control rooms in Aden and Sana'a.

As of 10 January, a total of 15 468 suspected cases of cholera, including 99 associated deaths have been reported, with a case-fatality rate of 0.64%. The government together with United Nations agencies and other partners are still combating the control of a major cholera outbreak which has so far affected 15 of the 21 governorates in the country. The current outbreak is unusual because of its vast geographical spread within a short period of time. The outbreak has disproportionately affected young children below five years of age as compared to other age groups.

# Legionnaires' disease | UAE

Country:	United Arab Emirates
Amount provided:	US\$ 18 000
Funding period:	23 December 2016 - 30 January 2017
Goal:	To conduct an investigation and risk assessment of Legionnaires' Disease

## Rationale for CFE funding

The CFE can be used once an event is graded, or confirmed, following verification. When the verification process indicates that further information is required, WHO's Emergency Standard Operating Procedures can be activated to facilitate rapid deployment for field investigation and risk assessment. CFE funds - up to a maximum of \$50,000 - can be accessed to support these activities.

In late December 2016, a CFE release of USD 18 000 was approved for WHO HQ and EMRO to undertake a joint verification mission to Dubai to conduct an investigation and risk assessment of Legionnaires' disease.

In December 2016, the European Centre for Disease Prevention and Control (ECDC) informed the WHO European Regional Office of an increase in cases from October through December 2016, reported to the European Legionnaires' Disease Surveillance Network (ELDSNet) with travel history to Dubai, United Arab Emirates. The report to EURO included 24 cases of Legionnaires' disease laboratory confirmed by urine antigen test, reported from eight European countries, and associated with 20 separate accommodation sites in Dubai, UAE. Two sites in Dubai were identified to have rapidly evolving clusters, which is defined as three or more cases with symptom onset within a three month period. The Health and Public Safety Department of Dubai Municipality reported that water samples from the identified accommodation sites tested by culture for *Legionella* were negative.

With the source of exposure being unconfirmed and the most recent case in Europe having date of illness onset on 4 December 2016, an ongoing exposure could not be ruled out, and a WHO team was deployed to Dubai to assist with the assessment of the situation.

## Achievements

WHO coordinated **the rapid deployment of five public health experts to Dubai from 27 December to 4 January**. The mission focused on supporting collaboration and information sharing between the public health authorities in Dubai and the European Centre for Disease Prevention and Control (ECDC) as well as Member States that have reported cases of Legionnaires' Disease with travel history to Dubai.

Going forward, ECDC together with European Member States will gather detailed exposure data from cases in Europe and share those data with the authorities in Dubai. These data, will in turn aid the Dubai authorities to guide their environmental investigations. The Dubai authorities will inform ECDC about the local context and potential exposures that should be included in a more in-depth investigation in Europe.

The mission was a successful example of strategic coordination of public health investigations in European countries and Dubai. Further development of investigation strategies and establishment of data sharing and future investigation procedures are planned.



# Recent allocations | 2017

## Necrotising Cellulitis | São Tomé and Príncipe

From September 2016, the Ministry of Health of the Democratic Republic of São Tomé and Príncipe (STP) reported to WHO an increasing number of cases of necrotizing cellulitis. As of 5 February 2017 a total of 1 221 cases have been reported to WHO with no deaths. All age groups are affected, however the majority of the cases are over 35 years of age. New cases have continued to be reported since the onset in September 2016. With a high attack rate of 6.3 cases per 1,000 inhabitants, the disease appears to have a rapid propagation in the country's population of approximately 200 000. All the seven districts of the country have reported at least one case. The health facilities are over-stretched with admitted patients. Over 17% of cases are admitted to (the only) general hospital requiring surgery; there are only two surgeons working at the hospital. The treatment is surgical removal of the dead tissue plus antibiotics. Large amounts of skin, tissue, and muscle must often be removed, and in some cases, an affected arm or leg may have to be amputated. Whilst no deaths have been reported, the short and long term economic impact of the disease is high as it affects young adults and has a lifelong impact.

A 3-level teleconference between the WHO Country Office in São Tomé and Príncipe, AFRO, GOARN and WHO HQ was held on 14 February 2017 to review the situation, assess the country response capacity and grade the outbreak of necrotizing cellulitis disease (Grade 2).

A **CFE request was approved for USD 150 000 on 21 February**. The objectives of the WHO response to be funded by CFE are to support coordination through strengthening legislation, leadership and overall coordination of preparedness and response to the spread of necrotising cellulitis; to enhance prevention, preparedness and control to reduce magnitude and enhance timely detection of necrotising cellulitis infection and its possible consequences; to enhance epidemiological and environmental surveillance; monitoring and confirmation of necrotising cellulitis in the country; to strengthen response to necrotising cellulitis outbreaks and prevent further spread. With support from the CFE the rapid deployment of technical experts, including nine specialists through the GOARN network, is currently underway.

## Humanitarian Crisis | Northern Cameroon

Since 2015, the recurrent attacks of the Boko Haram and the war against them in the four countries of the Lake Chad Basin have led to millions of people in need of humanitarian aid. In Cameroon, 100 000 Nigerian refugees, over 190 000 internally displaced persons, and approx. 400 000 people of the vulnerable host population are in need of support. A total of 25 health facilities (20%) have been damaged and are no longer functional, restricting access to basic life-saving health services of the affected population. Surveillance and preventative services essential to avoid epidemic-prone diseases are very limited. As a result, there has been an increase in measles outbreaks, a threat of the extension of the polio outbreak in Borno State Nigeria, as well as an increasing risk of cholera and Lassa fever outbreaks.

A recent deterioration of the situation is due to intensive fighting in the Ran camp that brought an additional 20 000 refugees into northern Cameroon. Most refugees arrived from areas in Nigeria that did not have health access for a long period of time, resulting in two measles outbreaks in Kolofata and Mora. In the Far North area, there was an alert of H5N8 epizootic avian flu among wild birds, as well as an eruptive fever of unknown origin. This outbreak is still under investigation and a rapid response team has been deployed to people in need.

A **CFE request was approved for USD 500 000 on 21 February**. The objective of the WHO response is to provide urgent healthcare assistance to the people in need in the far North region of Cameroon. Specific objectives include to provide vital primary health care services to affected population including sexual and reproductive health services; to increase surveillance and preventative services to respond quicker to outbreak alerts; to provide referral services for the life-threatening conditions to adequate level of care; and to support the coordination of the health sector in the Far North Region.

## 3. CFE Financing

### 3.1 In comparison: **CERF and World Bank Pandemic Emergency Financing Facility**

#### CERF

UN Central Emergency Response Fund (CERF) is one of the largest donors to WHO humanitarian appeals, and is an important partner of WHO. In 2016 alone WHO received US\$ 44 million from CERF covering 36 countries. However, CERF funding cannot cover all the activities that WHO is required to undertake in response to emergencies. The criteria for CERF funding are based on the idea of prioritizing life-saving assistance, and often exclude many of the preparedness, human resources, and capacity strengthening activities necessary during the initial phases of WHO's response to outbreaks and humanitarian emergencies. The different funding criteria used by the WHO CFE and CERF are contributory factors to the reluctance of CERF to approve funds for CFE reimbursement. CERF and the CFE are therefore distinct but complementary sources of early funding to emergencies.

CERF funds are allocated following a prioritization exercise among humanitarian sectors within the UN Country Team at country level. WHO is currently working to increase the capacity of country offices to better engage in those discussions, and ensure that the needs of the health sector are communicated strenuously and effectively so that opportunities for CERF funding are always maximized.

WHO is actively supporting CERF in its request to increase its funding to US\$1 billion by 2018. WHO is also advocating for a revision of CERF funding criteria to include key readiness activities such as pre-positioning of supplies in high-risk regions, surveillance strengthening, and vaccination campaigns as part of routine immunization. These activities are essential to reduce morbidity and mortality during emergencies.

#### World Bank Pandemic Emergency Financing Facility

The World Bank Pandemic Emergency Financing Facility (PEF) has been developed by the World Bank, with WHO, SwissRe, MunichRe (reinsurance agencies) and AIR Worldwide (economic modelling agency), to help fill the funding gap between early investigation, assessment and response to an outbreak and mobilization of disaster/ humanitarian relief funding. The PEF is an insurance-based mechanism designed specifically to respond to outbreaks from a defined set of viruses with pandemic potential.

The PEF complements the WHO CFE. The PEF is activated once an outbreak crosses a pre-defined threshold of severity, whereas the CFE is designed to respond to any type of emergency with health and humanitarian consequences, including natural disasters—not only outbreaks with pandemic potential. Because the funds from PEF are to be used for a particular response, not pooled as they are in the CFE, WHO is restricted as to which activities can be funded through the PEF. PEF funding will potentially be available only for a limited number of health emergencies. None of the 50 emergencies WHO is responding to at present would qualify for PEF funds.

## 3.2 Going forward: Sustainable Financing

The speed at which financial resources can be marshalled and mobilized is one of the key factors that determine the ability of WHO to mount a rapid response to a health emergency. With this in mind, on 26 May 2015 WHO's governing body the World Health Assembly instructed WHO to create the CFE.

To ensure that the CFE functioned as a rapid disbursement mechanism, the process of requesting and approving funds was designed to be as streamlined and as flexible as possible. Requests for amounts under US\$ 500 000 can be made by WHO staff via phone or email. The aim is to mobilize funds within 24 hours of a request — this rapidity is essential in fast-moving emergency situations, when deploying responders to the theatre of operations is an urgent priority. Requests for more substantial amounts (>US\$ 500 000) must be under-pinned by a WHO response plan and budget.

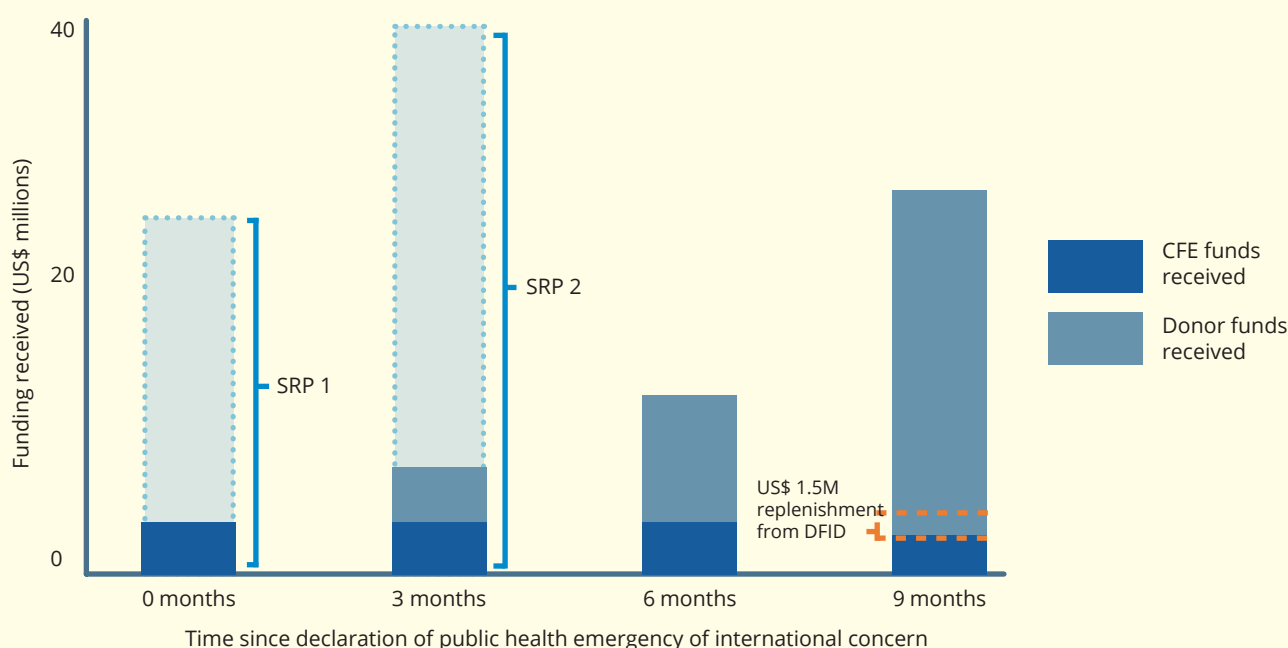
### Case Study 1: The global Zika response

On 1 February 2016, WHO Director-General Margaret Chan convened an Emergency Committee of experts to assess the level of threat to public health posed by the outbreak of Zika virus in the Americas, after increasing

evidence that the virus was associated with neurological complications in new-borns. WHO declared a Public Health Emergency of International Concern (PHEIC) the same day, and published a comprehensive Strategic Response Plan two weeks later.

Figure 1 shows how funds were disbursed over time to pay for the response outlined in the Zika Strategic Response Plan. CFE funds were disbursed within 24 hours of the declaration of the PHEIC, and were crucial in the early stages of the response, enabling a full Incident Management Structure (IMS) to be implemented in WHO headquarters in Geneva and all WHO regional offices. Without this bridge funding the response would have been delayed until the first contributions from Japan and Australia were received, 6 weeks after the declaration of the PHEIC. Donors were initially slow to commit as the Zika outbreak was perceived to fall between the work of development agencies — who were waiting to gauge the implications of the outbreak for individuals and health systems — and humanitarian agencies that did not consider Zika to be a disease with sufficient levels of mortality to qualify as an emergency.

**Figure 1** | Total funds received for Zika response versus time since declaration of Zika as a public health emergency of international concern



It took approximately 9 months before donor funds plus CFE funding matched the requirements of the first Zika Strategic Response Plan (SRP1).

Nine months after the declaration of the PHEIC, and after strong advocacy work, WHO has secured funding for 60% of the activities set out in the revised Zika Strategic Response Plan. However, up to now WHO has been unable to replenish the initial disbursement from the CFE for several reasons:

1. Some donors are not willing to replenish the CFE.
2. Some donors will not permit funds to be back-charged to cover activities funded by the CFE.
3. Funds are narrowly earmarked for specific future activities.
4. The evolution of the outbreak has meant that activities originally funded by the CFE are now completed (e.g., risk assessments in Latin America). New activities therefore appear more immediately relevant and attractive to donors.

To date, the UK Department for International Development is the only donor that has been willing to help refund the CFE disbursements for Zika.

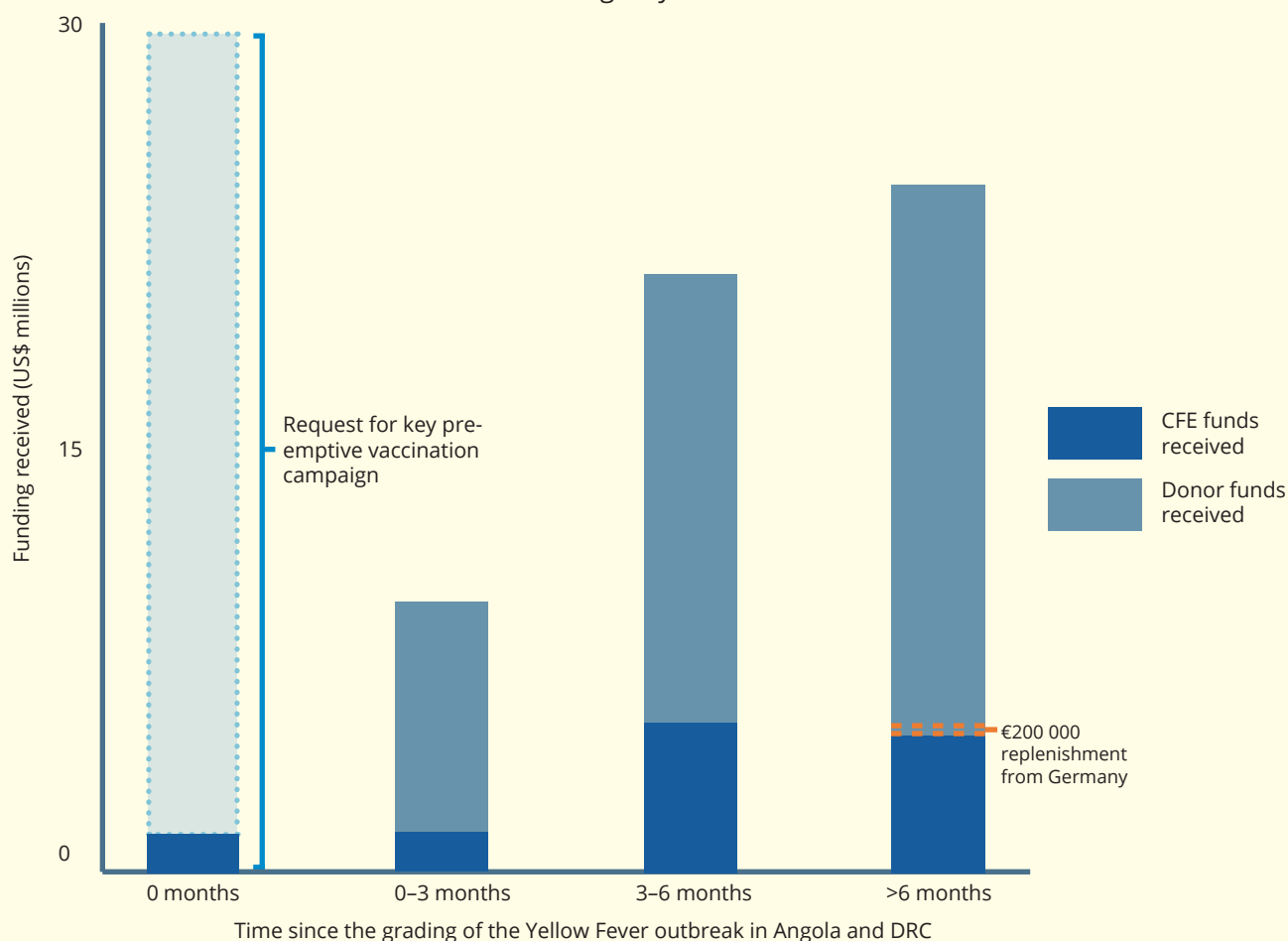
### Case Study 2: Ending the Yellow Fever Outbreak in Angola and DRC

In late December 2015 several cases of Yellow Fever were reported from the Angolan capital Luanda. WHO received official notification of the outbreak in Angola on 21 January, and on 22 March the Democratic Republic of the Congo (DRC) notified WHO that a number of imported cases had been detected in the capital, Kinshasa.

CFE funds were disbursed initially in order to set up an Incident Management System, and to cover key costs related to vaccination, disease surveillance, clinical management, and risk communication. Vaccination was crucial to the success of the response.

Modelling indicated that vaccinating the population of the DRC capital Kinshasa and the population living along the Angola-DRC border would provide a buffer to halt any further expansion of the outbreak.

**Figure 2** | Total funds received since the Yellow Fever outbreak in Angola and DRC was classified a Grade 2 emergency



Over 6 months since the outbreak of Yellow Fever in Angola was declared a Grade 2 emergency, Germany remains the only donor to have replenished the CFE (€200 000).

However, delivering Yellow Fever vaccine to the remote communities along the Angola–DRC border was a logistical challenge. Emergency stockpiles of the vaccine were also running low. In order to vaccinate the population of a large capital like Kinshasa, it was necessary to use a pioneering new approach in which each individual was vaccinated with a fraction of the usual vaccine dose. Funds were provided by Japan to purchase the specialised syringes required to deliver fractionate doses, but further funds were required to get the vaccine to populations in need.

Figure 2 shows the lag in time from the point WHO established its IMS and published a Strategic Response Plan to the receipt of donor funds. During the intervening period multiple disbursements from the CFE were required to sustain essential response activities as the outbreak evolved. To date, disbursements from the CFE total US\$ 4.45 million.

Only Germany agreed to refund a portion of these disbursements through a €200 000 contribution. The last confirmed case of yellow fever linked to the outbreak was reported from DRC on 12 July.

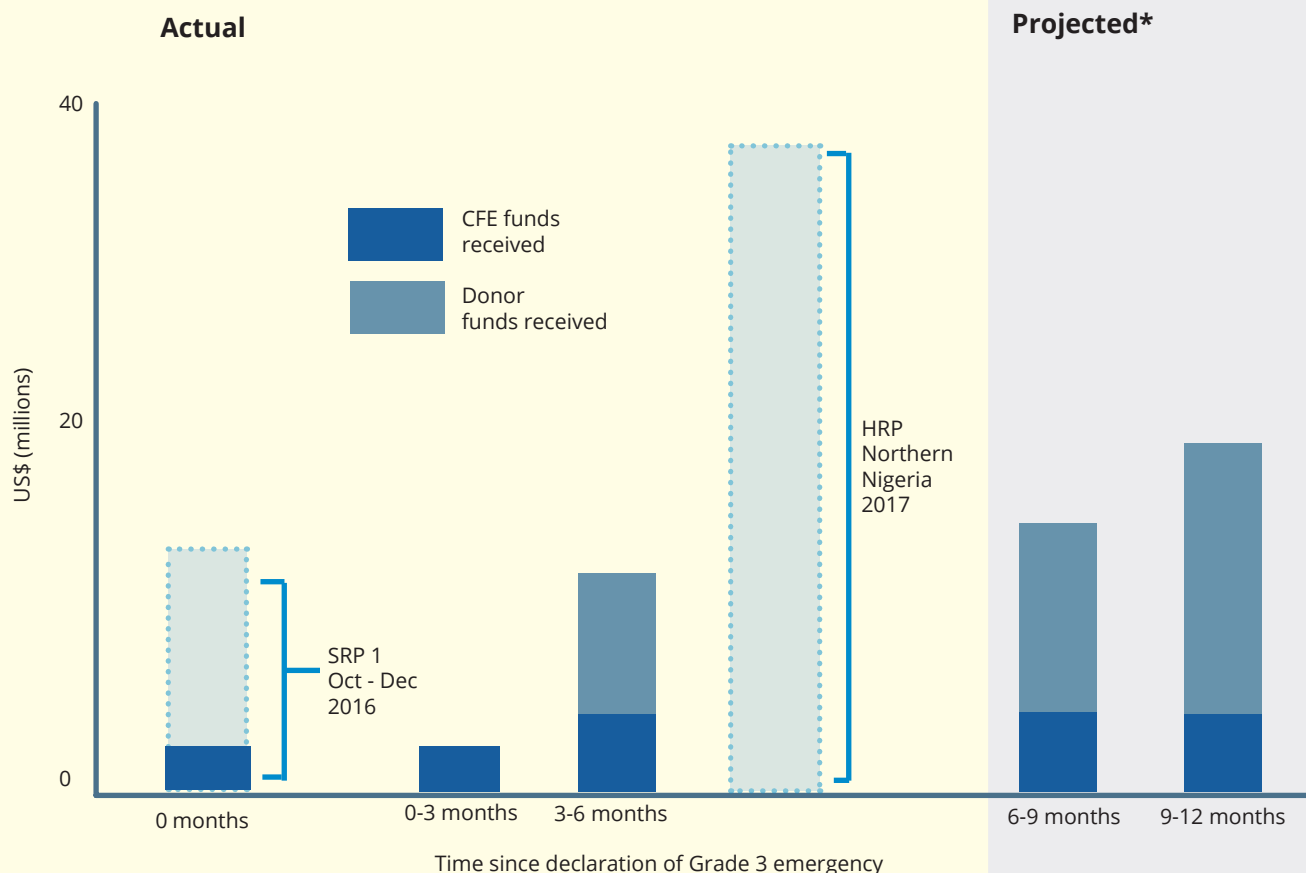
### Case study 3: Responding to the humanitarian emergency in northern Nigeria

In late August humanitarian access became possible to several regions in northern Nigeria that had previously been cut off by conflict. Initial rapid assessments indicated an urgent need for essential health services, including immunisation and child and maternal health services, in the newly accessible areas.

On 19 August, WHO declared the situation a Grade 3 emergency. An initial request for CFE funds was made on 29 August, with US\$ 2.1 million released within 24 hours (figure 3). The funds were required for the initial response, including the establishment of a forward operating base in Borno State and the deployment of the EWARS disease surveillance system, which rapidly scaled up capacity to detect disease outbreaks in newly accessible areas.

Assessment missions funded through the CFE informed the development of a strategic response plan to address the immediate health needs of newly accessible populations. The total funding that WHO required through to the end of December 2016 was just under USD 12 million.

**Figure 3 |** Actual funding and projected\* funding for WHO's response to the health emergency in northern Nigeria



\*Projection based on pledges received and negotiations in progress as on 28 Feb 2017.



By the end of December, the only funding received was USD 250 000 from ECHO. A second CFE request was therefore necessary to sustain WHO's operations, until further pledges from USAID and OFDA would convert into signed contribution agreements. The additional CFE funding was required to meet a number of strategic objectives, including: the referral to a nutritional programme of over 95% of children under 5 with severe acute malnutrition; the vaccination against polio and measles of over 80% of children under 5 years, and the capacity to investigate all new infectious disease alerts within 24 hours.

From the start of WHO's operations in northern Nigeria in August 2016 until the end of December, CFE funds were the only available source of funding. In 2017, WHO has appealed for US\$37 million for its operations in Northern Nigeria. WHO is still merely 10% funded.

### 3.3 Internal Emergency Funds: models used by other UN agencies

Several of WHO's key UN partners operate internal funding mechanisms similar to the CFE.

**WFP** has the Immediate Response Account (IRA). Allocations from the IRA are made as loans to eligible operations in anticipation of receiving donor contributions. If no such donations are received, the loan is deemed to be a permanent, non-reimbursable grant from the IRA. The IRA serves as both a replenishable and a revolving fund. Revolving means that funds allocated from the IRA to an operation may subsequently be reimbursed to the IRA account with donor contributions received for that operation. Contributions that are used to revolve the IRA are accounted for and reported under the operation to which the donor pledged them. Donors provide contributions directly to the IRA to replenish it. In 2015, the IRA received US\$ 85.9 million in replenishments inclusive of a WFP board-approved transfer from the Programme Support and Administrative Equalization Account to the IRA of US\$ 50 million. This additional injection into the IRA was intended to create a minimum revolving/lending capacity of US\$ 50 million for emergencies. In 2015, advances made to projects totalled US\$ 165.8 million and repayments by projects amounted to US\$ 98.5 million. The IRA balance at 31 December 2015 was US\$ 59 million, which is below the target level of US\$ 200 million. In 2014, this target level was raised from US\$ 70 million to US\$ 200 million with Executive Board Decision.

The United Nations Central Emergency Response Fund (**CERF**) was introduced in 2006 as the UN's global emergency response fund to deliver funding quickly to humanitarian responders and kick-start life-saving action whenever and wherever crisis hit. CERF has proven to be one of the most effective ways to provide time-critical assistance, including supplies, basic services and protection to millions of people in need. It is also an important funding source for providing life-saving assistance to those caught up in the world's most neglected, underfunded and long-lasting crises. In December of each year, donors to CERF gather in UN Headquarters in New York for a High-Level Pledging Conference to promote high-level commitment to CERF as the UN global fund on emergencies and to generate pledges for the following year.

**UNICEF** established the Emergency Programme Fund (EPF) in 1971, which continues to be the primary mechanism for UNICEF country offices to scale up their emergency response in the first days of a crisis. The EPF continues to be an effective means of providing funds to UNICEF offices in a timely manner, and enables the organization to initiate its response to crises before donor funds become available. The EPF is financed with UNICEF regular resources (contributed without restrictions on their use). Allocations from the EPF are primarily made to eligible countries as reimbursable loans in anticipation of receiving donor contributions to humanitarian appeals. From 2008–2013, EPF funds amounting to more than \$355 million were allocated to humanitarian crises to enable an immediate response by UNICEF. Countries have been in a position to reimburse 68 per cent of this total outlay. The remaining amount of close to \$113 million was converted to a contribution of UNICEF core funding to deliver on the organization's core commitments for children in humanitarian action. In 2015 the Executive Board approved an increase of the funding ceiling from US\$ 75 million per biennium to US\$ 75 million per year, UNICEF disbursed a total of US\$ 28.8 million in 15 countries during 2015.

## 3.4 Next Steps for the CFE

### Proposals to improve the fund's performance

The CFE has been a critical tool to enable WHO to quickly respond to emergencies, rather than wait for funds through appeals and applications to external donors. The CFE has saved lives and helped avert disease outbreaks and their associated social and economic consequences through small, targeted interventions. To continue this work requires sustainable financing. The main challenge faced by WHO with respect to the CFE is the inability to replenish it. Since the first disbursement in November 2015, the CFE has disbursed on average US\$ 1.3 million per month. Over the same period the CFE has received a total replenishment of approximately US\$ 1.7 million. At current rates the US\$ 37 million capitalization will be exhausted by September 2017.

The original model of the CFE—front-loading funds and then asking WHO teams to fundraise to reimburse—has not been successful. Replenishment through reimbursement has not occurred because appeals are not fully financed or donors do not agree to direct their funds to reimburse the CFE but only for “additional” activities.

There are four main options for funding the CFE:

1. Continuing with the current model of ad hoc donations
2. Establishing an annual pledging cycle to secure additional funds
3. Identifying an income stream within WHO that could be used to replenish the fund
4. Using CFE funds deposited by donors to earn interest to help replenish the fund

Continuing with the current model is not feasible: at the current rate of use the CFE may be completely depleted within 6 months or less. Identifying an income stream within WHO to pay for the fund has proven difficult. WHO has limited flexible corporate funding to begin with, and there are already multiple other demands for flexible funds. Globally, interest rates earned on deposits are too low to provide a viable income stream.

Establishing an annual pledging cycle would enable WHO to draw attention to the impact of the fund at country, regional and global level, and feed in to a wider discussion on funding for WHO and for the WHE Programme. A number of UN agencies already use this model and the CERF also has an annual pledging cycle.

The target capitalization of the CFE is of an order of magnitude lower than CERF, for example, but the past 12 months has amply demonstrated the crucial role that rapid access to relatively small amounts of funding plays in preventing the escalation of health emergencies by enabling an early and proportionate response.

One option, therefore, is that WHO presents a request for CFE replenishment to the World Health Assembly in 2017, and annually thereafter. In the meantime, WHO will continue to work with donors to secure additional funding for the CFE, and will negotiate with donors to provide funds to reimburse the costs of activities already paid for by the CFE.

### Dialogue with donors

A meeting was held on 2 March 2017 with Member States that have supported the CFE, and others who may be interested in supporting the fund (Canada, France, Japan, UK, Germany, China, India, Republic of Korea, Sweden, Norway, Netherlands, Luxembourg, Australia, New Zealand). The aim was to provide donors with an overview of what the CFE has achieved to date, discuss the future work of the fund, and how WHE and donors can work together to promote the CFE to other potential supporters.

During the meeting Member States expressed support for the CFE and the way in which it has been used to quickly respond to humanitarian emergencies and to prevent disease outbreaks. Member States stressed the importance of the production of regular reporting on the fund's performance to make the case for further and/or regular investment by Member States. It was noted that reports on the CFE had been produced for the financing meeting with Member States in June 2016, the Financing Dialogue in October 2016 and for the Executive Board meetings in January 2017. It was further noted that there would be a report produced for the World Health Assembly.

Various replenishment models were discussed and suggestions were made by donors how to further raise the fund's profile, especially to the wider humanitarian donor community. Recommendations included for WHE to organize a call with missions and capitals to discuss the CFE with both health and humanitarian stakeholders (both Ministries of Health and Foreign Affairs); organize a side event on the CFE in the margins of the WHA; and for WHE to raise the CFE's profile as an investment in global health security.

Member States did not express an appetite for the establishment of an annual pledging cycle or CFE-specific pledging event, but preferred the Secretariat continue to seek ad hoc donations. Other options discussed were for donors to individually agree to fund the CFE through innovative means such as directing that any remaining balances from funding agreements to WHE could be transferred to the CFE. This is an approach that Germany is exploring for example.

Overall the meeting was inconclusive on how best to accelerate fundraising for the CFE. The Secretariat noted that it has been working with a number of Member States (including many at the meeting) to reach out beyond Ministries of Health to Ministries of Foreign Affairs. The Secretariat thanked those Member States who had helped with such efforts and called on other Member States to do likewise e.g. by inviting humanitarian attachés to accompany them to meetings on the CFE, and by encouraging their humanitarian colleagues in donor capitals to meet with WHE representatives. The Secretariat noted it would continue to advocate for support for the CFE including through intra-governmental processes such as the G7 and G20 where appropriate and to highlight the need for funds through bilateral meetings.

#### **Action by the WHO Health Emergencies Programme**

The WHO Health Emergencies Programme will continue to explore sustainability options for the CFE and will provide annual financial reports on its website that will highlight key achievements and challenges.

**Table 1** | CFE alloctions, as of 31 Mar 2017

Allocations 2015 (USD in thousands)			
1	El Nino- Ethiopia	993 000	completed
	Total 2015	993 000	
Allocations 2016 (USD in thousands)			
2	Conflict - Libya	350 000	completed
3	Zika virus - Global*	3 185 000	completed
4	Cyclone Winston - Fiji	448 000	completed
5	Yellow fever- Angola, DRC	4 454 000	completed
6	Yellow Fever - Uganda	93 000	completed
7	El Niño - Papua New Guinea	483 000	completed
8	Cholera - Democratic Republic of Congo	1 838 000	completed
9	Legionnaires` disease - UAE	18 000	completed
10	Rift Valley fever - Niger	233 000	completed
11	Humanitarain crisis - Nigeria	3 380 000	completed
12	Hurricane Matthew - Haiti	250 000	completed
13	Health and nutrition needs - Yemen	506 000	completed
14	Cholera - Yemen	1 000 000	completed
	Total 2016	16 238 000	
Allocations 2017 (USD in thousands)			
15	Humanitarain crisis - Cameroon	500 000	ongoing
16	Necrotising Cellulitis - São Tomé and Príncipe	150 000	ongoing
17	Cholera - Somalia	100 000	ongoing
18	Hepatitis E - Chad	150 000	ongoing
19	Famine Response – South Sudan	626 000	ongoing
20	Famine Response – Horn of Africa (HQ)	250 000	ongoing
21	Influenza - Maldives	100 000	ongoing
	Total 2017	1 876 000	