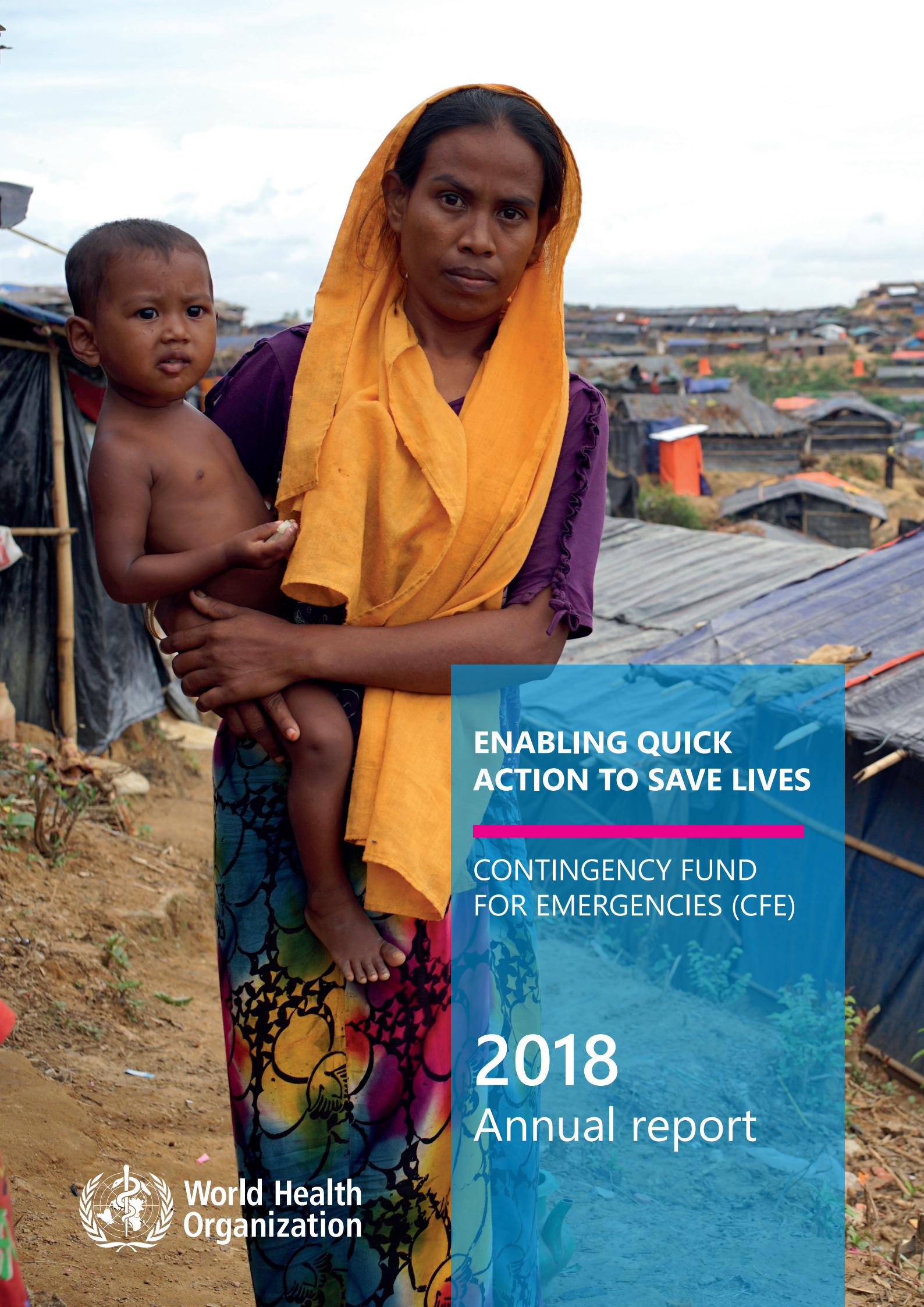

ENABLING QUICK ACTION TO SAVE LIVES

CONTINGENCY FUND FOR EMERGENCIES (CFE)

2018 Annual report

World Health Organization

WHO/WHE/EXR/2019.5

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ENABLING QUICK ACTION TO SAVE LIVES

CONTINGENCY FUND FOR EMERGENCIES (CFE)

2018
Annual report

World Health Organization

CFE CONTRIBUTORS 2015—2018


AUSTRALIA


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LUXEMBOURG


MALTA


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SWEDEN


SWITZERLAND


UNITED KINGDOM

THANK YOU!

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PHOTO: WHO/N. Alexander

FOREWORD

WHO has just started its Thirteenth General Programme of Work 2019–2023 (GPW 13) which will guide us for the next five years to promote health, keep the world safe, and serve the most vulnerable.

The GPW 13 will help chart our progress towards achieving the Sustainable Development Goals – including our commitment to ensuring that one billion people are better protected from emergencies.

The Contingency Fund for Emergencies (CFE) is an important part of this. In 2018 alone, the CFE provided more than US$ 37 million in rapid financing to kick-start the response to 29 disease outbreaks and health emergencies.

The CFE was critical in enabling WHO to respond to the two Ebola virus disease outbreaks in the Democratic Republic of the Congo; address the unprecedented outbreak of cholera across Africa; ensure hundreds of thousands of Rohingya refugees in Bangladesh had access to emergency health services; and respond to natural disasters in the Lao People's Democratic Republic, Somalia and the Pacific.

The CFE allows us to respond to an emergency within hours, when every second counts.

I have personally seen the immediate impact of the CFE over the past year. In May 2018, I visited the Mbandaka and the Bikoro health zones in Equateur Province of the Democratic Republic of the Congo within three days of an Ebola outbreak being declared. Senior technical staff had already reached the affected areas and supplies were arriving, including cold chain equipment to transport life-saving vaccines. The outbreak was declared over within one month.

Hardly one week later, the Democratic Republic of the Congo was struck by another outbreak of Ebola – this time in an active conflict zone in the eastern part of the country. Thanks to the CFE, we were ready to respond, providing US$ 2 million within 24 hours. I witnessed first-hand the impact early funding had in getting experts and equipment on the ground.

The Ebola outbreak in the Democratic Republic of the Congo is still ongoing, and the response is at a key juncture. The CFE continues to be a critical resource in providing cash flow to ensure we can continue to save lives and protect health while other funding is marshalled.

Last year, 13 Member States contributed more than US$ 38 million to the CFE. Your generosity allowed us to respond to the needs of some of the most vulnerable people in the world during periods of crisis – and for this I wish to thank each and every one of you.

The next health emergency may be just around the corner. We must be vigilant and ready to act quickly to save lives and prevent suffering. I count on your continued support to ensure the sustainability of this life-saving Fund.

Dr Tedros Adhanom Ghebreyesus
Director-General
World Health Organization

ABOUT THE CFE

The Contingency Fund for Emergencies (CFE) saves lives and dramatically reduces the costs of controlling outbreaks and emergencies. It has been a game-changer for WHO.

A GLOBAL PUBLIC GOOD

To better protect people, WHO needs to get on the ground the moment a disease outbreak or other health emergency is identified.

The CFE allows WHO to do just that. It enables WHO to take rapid action to save lives and reduce suffering in humanitarian emergencies, high-threat infectious disease outbreaks or natural disasters – often within 24 hours.

The CFE allows WHO to release initial resources to kick-start an emergency response before funding arrives from donors and other sources. It also allows WHO the flexibility to scale up operations in response to an escalation in a health emergency and provide bridge financing against donor pledges to ensure cash flow and continuity in an ongoing response.

This speed, flexibility and predictability not only saves lives, but also limits the numbers of people affected, and minimises longer-term social and economic damage. With infectious diseases, it can prevent a local outbreak going national or even global.

Since being established by the Sixty-eighth World Health Assembly in May 2015 – following a review of WHO's response to the 2014 Ebola outbreak in West Africa – the CFE has proved its value as a global public good.

Since 2015, 18 Member States have contributed nearly US$ 84 million to the CFE – allowing WHO to provide US$ 77 million for 60 emergencies in 46 countries and one global response.

WHO CONTINGENCY FUND FOR EMERGENCIES (CFE)

Funding can be released in **24 hours** for rapid emergency response to provide:

RAPID DEPLOYMENT OF TECHNICAL EXPERTS
To ensure that the right expertise is readily available.

DISEASE SURVEILLANCE, DETECTION AND REPORTING
To help prevent outbreaks.

COORDINATION WITH HEALTH PARTNERS
To ensure that the right partners provide the right help in the right place.

DISEASE VACCINATION
To protect vulnerable people in affected areas.

ACCESS TO HEALTH SERVICES
To ensure that health care facilities are functional and are staffed with health professionals.

ACCESS TO WATER AND SANITATION
To ensure that cholera and other waterborne diseases don't spread.

ESSENTIAL MEDICINES AND MEDICAL SUPPLIES
To ensure life-saving medicines and emergency health kits arrive rapidly where needed.

COORDINATED DISTRIBUTION OF MEDICINES
To ensure that the right medicines reach vulnerable populations.

CFE key facts

- Contributions to the CFE are pooled and not earmarked for specific activities – giving WHO crucial flexibility and rapid funding to take early action in the broadest possible range of emergencies.
- Tranches of up to US$ 500 000 can be fast-tracked for quick release. Larger amounts can be accessed in as little as 24 hours.
- No limit to the amount that can be requested from the CFE when an outbreak is declared, in the immediate aftermath of a natural disaster, or to support an escalation of action to protect lives and health in a protracted, complex emergency.
- Replenished through donor contributions outside of WHO's Health Emergencies Programme core budget – made directly to the Fund, or through reimbursement once donors contribute to specific emergency responses initially funded by the CFE.
- Robust accountability ensured by WHO's financial rules and regulations.
- Any unspent funds are returned to the CFE.

Economic case

There is a powerful economic case for long-term investment in the CFE.

The 2014 West Africa Ebola outbreak claimed more than 11 000 lives over two years and cost the world at least US$ 3.4 billion. But in 2017 – supported by WHO and the CFE – the Democratic Republic of the Congo controlled an Ebola outbreak for less than US$ 2 million.

The May 2018 Ebola outbreak in the Democratic Republic of the Congo's Equateur Province received US$ 1 million in CFE financing less than four hours after the emergency was declared. Thanks in part to the quick response and the work of the country's Ministry of Health, WHO and partners, loss of life was minimized (33 lives lost), response costs contained (US$ 56 million), and the outbreak declared over in three months.

Direct costs of emergency response to epidemics, conflicts and natural disasters are significant – but the wider economic and social consequences are larger. The World Bank estimates the broader economic cost – based on probabilities of mild, moderate, and severe pandemics – at an annualized loss of US$ 60 billion. The most conservative estimates suggest a pandemic could wipe out 1–5% of global Gross Domestic Product (GDP) – comparable to global threats such as climate change.

The world is facing health threats and emergencies of unprecedented size and complexity. A risk anywhere can become a threat everywhere – which means we are all at growing risk.

Ensuring the CFE's sustainability strengthens global health security.

CFE ALLOCATIONS IN 2018

Overview

In 2018, a total of US$ 37.6 million was released by the CFE in 46 separate allocations. This allowed WHO to support the response to 29 events in 29 countries – including 21 disease outbreaks, six natural disasters and two complex emergencies.

The majority of allocations (85%) went to address disease outbreaks, with complex emergencies (12%) and natural disasters (3%) receiving the remainder of funding.

Countries in WHO's African Region received 84% (US$ 31.7 million) of CFE allocations in 2018. The Democratic Republic of the Congo was the largest single country recipient, with 60% (US$ 22.8 million) of total CFE allocations. The response to the two Ebola outbreaks in the Democratic Republic of the Congo – including regional preparedness – received 61% (US$ 23.1 million) of all CFE allocations in 2018.

Annex 1 contains a complete list of allocations in 2018.

CFE IN NUMBERS

US$ 37.6 million
released for rapid action in health emergencies

46 separate allocations

US$ 857 000
average allocation size

29 countries supported

29 emergencies responded to

21 disease outbreaks

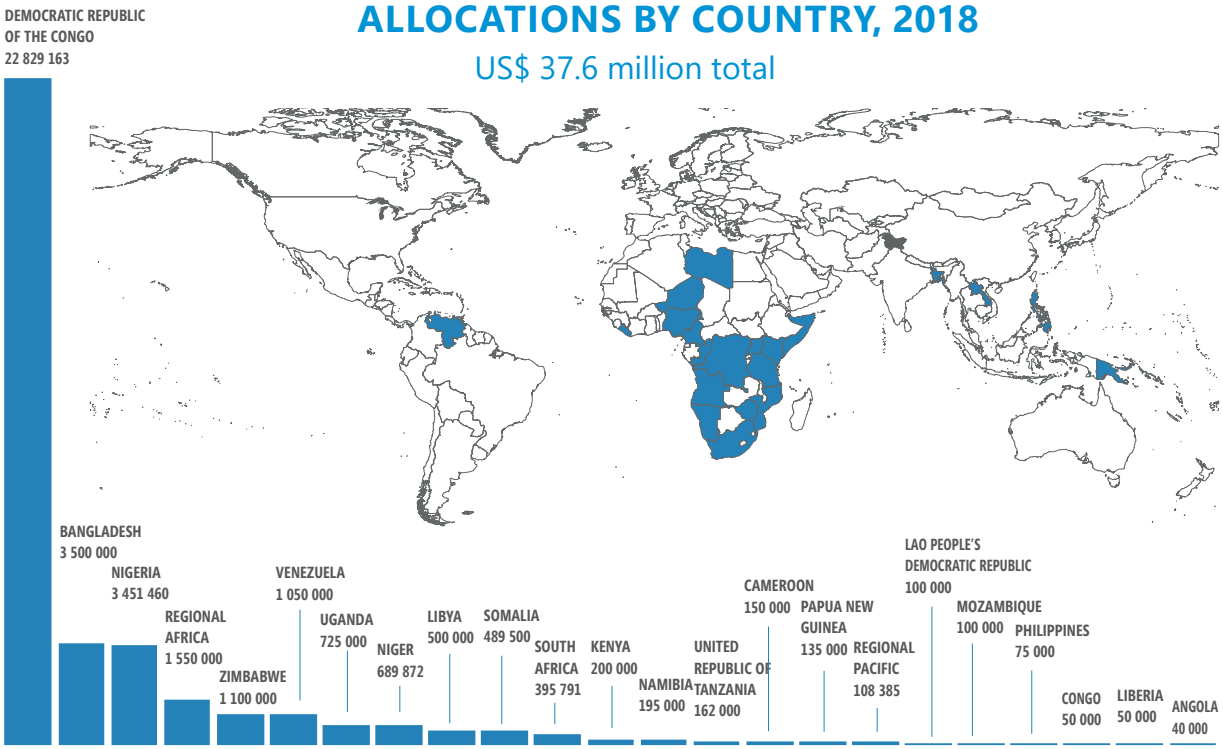
6 natural disasters

2 complex emergencies

1.8 average allocation release time, in days

ALLOCATIONS BY COUNTRY, 2018

US$ 37.6 million total



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Performance

In 2018, the CFE released 74% of allocations of US$ 500 000 or less in 24 hours. 65% of all allocations – regardless of size – were released in 24 hours or less. The average release time for all allocations was 1.8 days.

Expenditures

Every CFE allocation is administered in accordance with WHO's financial rules and regulations. Allocations are entered in WHO's corporate grant management system which allows for precise tracking of expenditures, monitoring of implementation, support to financial reporting, and auditing.

The CFE can fund activities and personnel in a WHO workplan supporting WHO's response to an emergency. External partners and WHO Member States cannot apply to the CFE directly. However, WHO can use CFE funds to procure goods and supplies or conclude agreements with external parties.

The table below shows how CFE funding was spent in 2018. It provides a consolidation of expenditure categories and types as per WHO financial statements, and presents them as an overall budget item, such as staff and personnel, together with – for each item – the amount spent; percentage of overall expenditure; and examples.

Annex 2 contains the expenditure breakdown by category and type as per WHO's financial statements.

Table: CFE Expenditure Summary 2018

ITEM	AMOUNT (US$ MILLIONS)	%	EXAMPLES
Implementing partners	4.17	22.5%	Grant to NGO implementing health activities in conflict zone
Staff & personnel	3.62	19.6%	Salaries and per diem payments for technical experts (consultants)
Medical supplies	2.95	15.9%	Vaccines, protective equipment, hospital and lab supplies
Direct operational costs	2.76	14.9%	Operational costs of emergency vaccination campaign
Travel	2.53	13.7%	International travel of technical experts
General operating expenses	1.7	9.2%	Office rent, utilities, maintenance
Equipment	0.66	3.6%	Vehicles, IT equipment
Training	0.12	0.6%	Training for WHO staff or organized by WHO

TOTAL US$ 18.51 million*

** Of the US$ 37.6 million in allocations in 2018, US$18.51 million was spent and US$18.49 million was reimbursed to the Fund. Reporting as at 31 December 2018. Final figures will be included in WHO Financial Reports and submitted to the Seventy-second World Health Assembly.*

IN FOCUS

We are still battling the second largest outbreak of Ebola the world has faced, in the conflict-riven eastern part of the Democratic Republic of the Congo. This outbreak — which began in August 2018 — is only one of more than two dozen health emergencies that the CFE helped tackle in 2018 – and illustrates a key challenge we face.

Year in, year out, around 80% of the major outbreaks we see in the world occur in countries – or parts of countries – facing conflict or fragility. And the same 20 or so countries account for more than 50% of most of the unmet Sustainable Development Goals – whether for mortality of under five-year-olds, maternal mortality, or under-immunized children.

This is no coincidence. Fragility is the primary cause of both internal displacement and refugee movement. And in turn, fragility fundamentally undermines development.

With its capacity to provide immediate funding for rapid action in emergencies, the CFE plays a key role in saving lives and alleviating suffering. But this is not enough.

The experience of the Democratic Republic of the Congo shows why we need to go beyond emergency relief: the country is caught in a vicious cycle of acute and protracted crises, which in turn hampers development. As a result, every year more than 300 000 Congolese children under five years old die of mainly preventable causes.

This is why WHO is working with partners to strengthen the health system in the Democratic Republic of the Congo and in other countries such as Yemen, Syrian Arab Republic and the Central African Republic to name a few. Stronger health systems – and universal health coverage – will ensure that they are not only better prepared when the next outbreak or emergency happens, but also that their people are healthier and able to thrive.

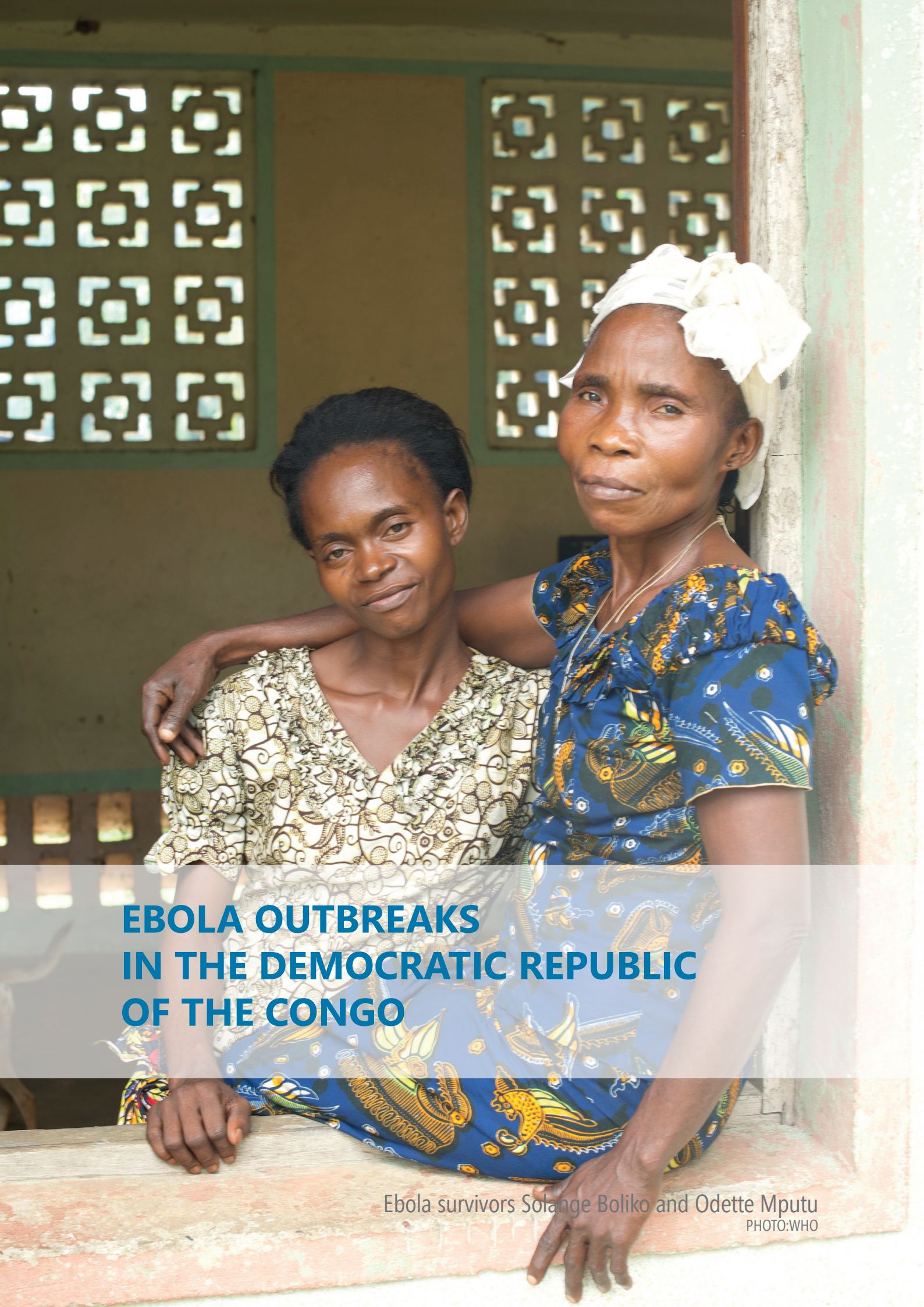
For this, we need multi-year, flexible financing that enables us to respond to emergencies —and to invest in resilient health systems in these countries that are so central to achieving the Sustainable Development Goals.

PHOTO: WHO/L. Mackenzie

> “With its capacity to provide immediate funding for rapid action in emergencies, the CFE plays a key role in saving lives and alleviating suffering. But this is not enough.”

The prize will be the restoration of hope for millions of people around the world who are currently barely surviving in conditions of poverty, conflict, hunger and disease.

Dr Michael J. Ryan
Executive Director
WHO Health Emergencies Programme



EBOLA OUTBREAKS IN THE DEMOCRATIC REPUBLIC OF THE CONGO

Ebola survivors Solange Boliko and Odette Mputu

PHOTO:WHO

Ebola outbreaks in the Democratic Republic of the Congo

The CFE enabled WHO to respond swiftly to two outbreaks of Ebola virus disease in the Democratic Republic of the Congo in 2018.

An outbreak in the northwestern Equateur Province was brought to an end in less than three months. This was followed by a much larger and more complex outbreak in the eastern Democratic Republic of the Congo's North Kivu province, which is ongoing at the time of writing.

EQUATEUR PROVINCE OUTBREAK

On 8 May 2018, the Democratic Republic of the Congo Government declared an Ebola virus outbreak in Bikoro in Equateur Province – the ninth time the country had been hit by the lethal disease.

Within four hours, the CFE released US$ 1 million to scale up operations and mobilize health partners to support the national response.

By the next day, the first WHO and Ministry of Public Health response teams were on the ground in Mbandaka – near the outbreak's epicentre – to strengthen coordination and investigations.

Mobile laboratory materials for rapid testing of Ebola, and equipment to set up the specialized "cold chain" to store vaccines, were needed quickly – and WHO was able to ship these to the Democratic Republic of the Congo in the emergency's first few days. The cold chain maintains vaccine quality from manufacture until administration by ensuring it is stored and transported within WHO-recommended temperature ranges.

Three days into the crisis, the CFE released a further US$ 1 million and teams were tracing contacts of all active cases, while WHO partners set up treatment centres in Bikoro. WHO's Early Warning, Alert, Surveillance and Response System (EWARS) was deployed.

During the next few days, an air bridge was established to Bikoro so that critical supplies could be delivered to the remote area, a mobile lab was speeding up testing for infection, 15 vaccination officers and two epidemiologists were on the scene, and the first 4300 vaccine doses were shipped.

PHOTO: WHO/E. Kabambi

EARLY WARNING, ALERT AND RESPONSE SYSTEM (EWARS)

Getting accurate information about infectious disease outbreaks in remote field settings – often lacking electricity – is a major challenge. WHO's answer to this partly lies in a rugged- looking black suitcase, known as "EWARS in a box". Inside the box is all the equipment needed to set up a disease surveillance system in difficult or remote field settings, within 24 hours. It has been configured to work in places without reliable internet or electricity.

STEPPING-UP ACTION

Subsequent CFE releases in May totalling US$ 2 million enabled the establishment of three field operations centers in Itipo, Bikoro and Iboko; surveillance; active case search in communities and health facilities; real-time investigation of alerts; and laboratory testing of all suspected cases.

Alongside this, infection prevention and control supplies – including personal protective equipment and disinfectants – were provided to health facilities in eight health areas. CFE funds also helped to strengthen disease preparedness in neighbouring Congo and other surrounding countries.

The first ring vaccination campaign – targeting those most likely to be infected – was launched in Mbandaka on 21 May, followed by campaigns in Bikoro and Itipo. Early June saw a major boost in risk communication and community engagement activities, with awareness raised by door-to-door visits to over 1000 households.

By July, WHO had deployed 332 experts – including epidemiologists, logisticians, clinicians, infection prevention and control specialists, risk communications experts and vaccination support teams – and more than 3300 people, including contacts and frontline workers, had been vaccinated.

In all, the CFE contributed just over US$ 6 million to the 11-week response.

Recognizing the Fund's critical role, Germany agreed for its US$ 5 million contribution to the response to be used to replenish the CFE. It also marked the first time that funding from the CFE, the UN Central Emergency Response Fund and the World Bank Pandemic Emergency Financing Facility were used in concert.

On 24 July, the Ministry of Health of the Democratic Republic of the Congo was able to declare the outbreak over.

RETURNING HOME AFTER SURVIVING EBOLA

"I can't explain to you now. It's too much for me. What I can say – what is in my heart – is joy," said Lucien Ambunga, Catholic Priest and Pastor for the remote rural community of Itipo.

Father Ambunga – whose nickname is Courage – was speaking after being given a clean bill of health, after being diagnosed with Ebola and taken to an Ebola treatment centre in the general hospital in the town of Bikoro.

On his return to Itipo, he was greeted by a joyous crowd, who carried him on their shoulders and chanted: "The hero this year is Courage."

ON THE HUNT FOR EBOLA – CONTACT TRACING

In 2018, Marie-Roseline Darnycka Bélizaire was on the frontlines of the battle against Ebola – leading the hunt for the virus in the Itipo area of northwest Democratic Republic of the Congo.

Rapidly tracing all the contacts of confirmed and probable Ebola cases was vital to controlling the outbreak, being the only way to stop the chain of transmission. WHO – with the Ministry of Health and other partners – rapidly set up an effective surveillance system during the 2018 outbreak.

But the communities at risk in the Itipo area were spread out over a wide area with bad roads, meaning that Marie-Roseline and her team of more than 20 field epidemiologists mostly used motorcycles to get around.

"We have to go sometimes as far as 80 km from the coordination base – so in a day we can do 160 km. The roads are not good so we have to be very careful. We go so slowly – so it is as if we are walking, but walking with a motorcycle," said Marie-Roseline.

One of her challenging journeys was to find Franck, who had been in contact with a confirmed Ebola case. Franck had left his home to visit relatives in a remote area. The road to the area had become so bad that Marie-Roseline and her colleague had to get off their motorcycles and hack their way through thick brush.

In the end, having discovered that Franck had returned home, Marie-Roseline caught up with him in his village closer to central Itipo. Franck – a pseudonym – was grateful for the surveillance team's persistence and dedication. "They found me and took my temperature and it was normal."

Marie-Roseline and her team also regularly visited health clinics to see if they were getting any suspicious cases of people who have Ebola-like symptoms.

"I know at the end of the road, I will see somebody and I will keep him safe from Ebola," said Marie-Roseline."- So I have to keep going – whatever the difficulty I'm facing on the road."

PHOTOS: WHO/L. Mackenzie

BRINGING EBOLA VACCINE TO REMOTE COMMUNITIES

Bosolo village in northwest Democratic Republic of the Congo is so remote that it had been nearly 20 years since its residents had seen a car.

The location's remoteness was a challenge for the WHO vaccination team who needed to get Ebola vaccine to some of the village's residents – as part of 'ring vaccination', in which the contacts of confirmed cases and the contacts of contacts are immunized.

"Bosolo is about 25 km from Iboko centre. But on this road, 25 km can take two or more hours to travel," said Dr Ismaila Ibrahim Mamane Sani, Coordinator of WHO's Ring Vaccination in the Democratic Republic of the Congo.

But the WHO vaccination team had to get there. In mid-May, the brother of a man who was confirmed with Ebola had stopped in the village to see relatives. This high-risk contact later died in the community without being tested because his family refused the Ebola test.

Dr Ismaila described the narrow path to Bosolo through thickly covered brush and over bridges as a "nightmare" even for motorcycles. But with the help of local residents, the WHO team was able to hack their way through the Equatorial forest.

"We had to slowly open up a path for the vehicle, together with the local people who helped cut down the branches," said Dr Fofana Thierno Oumar, of WHO's Ring Vaccination Team.

When the vehicle loaded with Ebola vaccine – and the medical supplies, tents, tables and chairs needed to conduct the vaccination – successfully reached Bosolo, it received a big welcome.

"It was surprising and quite emotional, because it was the first time for the children to see a vehicle," said Dr Ismaila.

Despite Bosolo's remoteness, the residents who were eligible for the Ebola vaccine were receptive – and by the end of the third day, the WHO team had vaccinated nearly 150 people.

The ring vaccination was led by the National Institute of Biomedical Research and the Democratic Republic of the Congo's Ministry of Health, which worked with partners including WHO, Medecins sans Frontières and UNICEF.

PHOTO: WHO/E. Kabambi

> "Ring vaccination is a new and vital tool in the control of Ebola. I just spent the day out with the vaccination teams in the community, and for the first time in my experience, I saw hope in the face of Ebola and not terror. This is a major milestone for global public health."
>
> - Dr Michael Ryan
> Executive Director,
> WHO Health Emergencies Programme

PHOTO: WHO/N. Alexander

NORTH KIVU OUTBREAK

Little more than a week after the Ebola outbreak in Equateur Province was declared over, another outbreak was declared in eastern Democratic Republic of the Congo. On 1 August, the Health Ministry informed WHO of four possible Ebola cases in North Kivu province. These were quickly confirmed, with cases also identified in Ituri Province.

The CFE released US$ 2 million within 24 hours, and WHO dispatched 20 staff and a mobile testing lab to the city of Beni, 30 kilometres from the outbreak's epicentre in the Mangina health area. Contact tracing, together with prevention and control work around health facilities, began immediately.

On 8 August – with 44 Ebola cases reported and 17 confirmed – the Ministry of Public Health announced the launch of Ebola vaccinations for high-risk populations. With CFE funding, WHO provided logistical support for establishing the cold chain and sent essential supplies for vaccinations.

Largest-ever vaccination programme

In a major challenge, responders had to work in a densely populated active conflict zone. Despite continuing attacks from armed opposition groups, the vaccination programme became the largest-ever use of Ebola vaccine during an emergency response. By late September – thanks in part to an additional US$ 4 million from the CFE – 11 700 high-risk contacts and frontline responders had been vaccinated.

During October, WHO was also using CFE funds to support Ebola readiness in neighbouring countries, with equipment and personnel. Action included vaccinating frontline health workers in Uganda, training Rapid Response Teams in South Sudan and constructing a new 24-bed Infectious Diseases Unit in South Sudan's capital.

> "Strong partnership is critical to stopping Ebola. Having WHO on the ground, within days, to play a leadership role and rapidly fund operational partners involved in the response, has made a huge difference. The CFE is an excellent investment."
>
> - Augustin Augier, CEO, ALIMA (The Alliance for International Medical Action)

PHOTO: WHO/N. Alexander

Antoinette Zawaldi. PHOTO: WHO/E. Ahassa

WORKING WITH THE COMMUNITY

Another major challenge has been overcoming mistrust of health professionals among affected populations in North Kivu – particularly women, who account for two-thirds of the province's Ebola cases.

Tackling this has meant stepping up communication about Ebola and its risks. In December, WHO educated over 130 local women leaders about vaccines, contact tracing, treatment, and women's and children's vulnerability to the disease. The women leaders then visited 2900 households in Beni neighbourhoods to spread the message – reaching 600 000 people through meetings at churches and markets.

"At the start of the outbreak, local women saw these men in jackets doing 'Ebola business' and thought, 'this doesn't really concern us'," explains Antoinette Zawadi, coordinator of the Collectif des Associations Feminines.

"Then as women leaders from Beni became involved, other women started to listen. They said, 'Okay, it's between us now'."

With the response ongoing at the time of writing, major challenges continue to be insecurity resulting from armed violence, pockets of mistrust among affected populations, and poor infection control in many public and private health facilities.

The more than US$ 16 million provided by the CFE in 2018 to the Ebola response in eastern Democratic Republic of the Congo has helped prevent hundreds perhaps thousands of people from falling ill. Almost every new patient now receives one of four investigational treatments – something never possible during an Ebola outbreak in the country before.

NIGERIA LASSA FEVER

PHOTO:WHO/Nigeria

NIGERIA LASSA FEVER

When Nigeria's largest recorded outbreak of Lassa fever struck, CFE funding allowed WHO to rapidly support the response to the outbreak.

EMERGENCY

The January 2018 outbreak of Lassa fever in Nigeria was the country's largest on record – with the 317 confirmed cases reported in the first eight weeks exceeding the total number reported in the whole of 2017.

RESPONSE

A release of US$ 950 000 from the CFE in January allowed WHO to act quickly to support the outbreak response led by the Nigeria Centre for Disease Control.

WHO provided technical support and co-ordinated international assistance by deploying specialized personnel through the Global Outbreak Alert and Response Network (GOARN) – mainly enhanced surveillance and case investigation, contact tracing, strengthening of diagnostic capacity, case management, infection prevention and control, and risk communication.

CFE funds supported surveillance enhancement through the Integrated Disease Surveillance and Response framework, as well as rapid assessments of case management centres in the three most affected states – Ebonyi, Edo and Ondo States.

"The CFE provided rapid support to activities which are critical to infectious disease outbreak control, including surveillance, case investigation and contact tracing," said Faith Ireye, WHO State Coordinator, Edo State.

"For example, if contact tracing is not done, people who come into contact with Lassa fever patients stay in their homes, become symptomatic, infect more people, and make the outbreak bigger and bigger. The CFE made a big difference."

CFE funding was used to procure laboratory reagents – used to confirm cases of Lassa fever – to replenish stocks in three testing labs which were running out fast due to the unprecedented high number of cases. CFE procurement also reversed the stock shortfall of ribavirin, used to treat the disease.

Another challenge was the high number of health care workers being infected because Lassa fever can also be contracted through direct or indirect contact with the bodily fluids of an infected person. To tackle this, 841 health care workers in the three case management centres were trained in standard infection protection and control, case management, and use of personal protective equipment – 7000 sets of which were purchased using CFE funding.

Lassa is a deadly viral haemorrhagic fever that is primarily transmitted to humans via contact with food or household items contaminated with rodent urine or faeces.

The overall case fatality is 1%, but mortality can be as high as 20% among patients with severe illness.

IMPACT

On 10 May, after six weeks of declining cases of Lassa fever, the emergency phase of the response was declared over by Nigeria's Ministry of Health. By the end of the programme on 30 June, some 7700 people – suspected cases and contacts – had benefitted directly from CFE funding, with more than four million people in affected areas benefited indirectly.

> "The sooner treatment is started, the greater the chances of survival for patients."
>
> - Dr Wondimagegnehu Alemu, WHO Representative in Nigeria

Early treatment saves lives

"I was scared the illness would kill me. I was bleeding through my nose, mouth and ears," said John, a mechanic from a rural community in southern Nigeria's Edo state.

When John – who prefers to go by a pseudonym – came down with Lassa fever in January 2018, it was one of the most terrifying experiences of his life.

Fortunately for John, he was quickly diagnosed and treated at the Institute of Lassa Fever Control – a renowned treatment and research centre in the Irrua Specialist Teaching Hospital, which was at the epicentre of Nigeria's response to the Lassa fever outbreak.

"The sooner treatment is started, the greater the chances of survival for patients," said Dr Wondimagegnehu Alemu, WHO Representative to Nigeria. "So it is absolutely crucial that we get patients as early as possible to the treatment facilities."

John knows early treatment saved his life. Within weeks, he was declared Lassa fever free and discharged from hospital. "This sickness does not have to kill people," he said.

NATURAL DISASTERS IN THE PACIFIC

PHOTO:WHO/PAPUA NEW GUINEA

NATURAL DISASTERS IN THE PACIFIC

During 2018, WHO's CFE supported responses to three natural disasters in the Pacific region. In all cases, a small amount of rapid funding had a major impact on the health of the populations affected.

PAPUA NEW GUINEA EARTHQUAKE

On 26 February 2018, a 7.5 magnitude earthquake struck the Highlands Region of Papua New Guinea – affecting around 540 000 people. Around 64% of health facilities were damaged and health workers were left traumatized and unable to work. With limited access to safe and clean water, waterborne diseases – such as diarrhoea – also represented a significant risk.

To support the response, US$ 135 000 was released by the CFE. Despite insecurity and tremendous access challenges, WHO was on the ground in 24 hours, deploying 19 technical staff for assessment and response. The health cluster was activated in 48 hours – allowing WHO to coordinate 25 NGO partners through three operations centres, which were established within the first two weeks.

WHO provided training for 145 health workers in WHO's Early Warning, Alert and Response System (EWARS). This allowed for 2000 suspected cases to be investigated. CFE funds also allowed the training of 149 health workers in psychosocial support and provision of that support to 1000 people, as well as the supply of essential medicines to 10 000 people and the vaccination of more than 75 000 children.

In all, a total of 300 000 people benefited directly or indirectly from the CFE-funded response.

TROPICAL CYCLONE GITA

Tropical Cyclone Gita hit the South Pacific in early February 2018, becoming a severe tropical cyclone on 10 February. For more than two weeks, the cyclone affected multiple island nations and areas across the Pacific. The Kingdom of Tonga was the hardest-hit, where an estimated 80 000 people – 80% of the population – were affected by the storm. Damage was also caused in Samoa and American Samoa.

CFE released US$ 108 000 in funds – allowing WHO to respond immediately to specific requests for assistance from the governments of Samoa and the Kingdom of Tonga.

A four-person WHO team based in Fiji was deployed to Tonga between 17 and 22 February to support the Ministry of Health with surveillance, partner coordination, information management and general response coordination.

Dr Viema Biaukula (right), WHO Surveillance Officer, explaining to Lupe 'Oliveti (left), Health Officer, Fua'amotu Health Centre, the use of mobile technology for EWARS.

"Thanks to funding from the CFE , we were able to establish early warning surveillance in 11 sentinel sites in Tonga using mobile phone technology," said Dr Biaukula. "This is a simple and cost-effective way to rapidly set up a post-disaster disease surveillance system."

PHOTO: WHO

ULIRA CARE CENTER IN TAMENDA, SOUTHERN HIGHLANDS. PHOTO:WHO/PAPUA NEW GUINEA

WHO's Early Warning, Alert, Surveillance and Response System (EWARS) was activated in 11 surveillance sites in Tonga – significantly strengthening infectious disease surveillance in affected areas.

At the same time, water, sanitation and mosquito control supplies were dispatched to Samoa and Tonga, as well as dengue and rotavirus test kits. Additionally, key health, hygiene and sanitation messaging was sent via 240 000 SMS messages to 20 000 people in the communities most affected.

Thanks to CFE funding, the support provided by WHO and the Ministry of Health protected 107 000 people – the entire population of Tonga.

TYPHOON MANGKHUT IN THE PHILIPPINES

Typhoon Mangkhut made landfall in the north-eastern Philippines in the early hours of 15 September 2018. The typhoon – the strongest storm to hit the country since Typhoon Yolanda in 2013 – caused flash flooding, storm surges and landslides.

Thanks to effective preparations, WHO staff were deployed to the affected areas within 24 hours – conducting joint rapid assessments of the typhoon's health impact, in close coordination with the Philippines Department of Health.

The CFE released US$ 75 000 to support the Department of Health with supplementary immunization activities in typhoon-affected areas. The aim was to prevent outbreaks of vaccine-preventable diseases among displaced populations by increasing the very low immunization coverage for measles and polio among children under five years old.

With WHO support, several regional Department of Health offices all delivered enhanced health responses to typhoon-affected areas in different ways:

- In Ilocos, there was a considerable increase in the overall coverage of measles vaccination of up to 70% – achieved by targeting high-risk areas such as slums and remote villages.
- Cagayan Valley's Department of Health office improved its cold chain facility by requesting 17 generators – ensuring adequate vaccine storage despite frequent power cuts.
- Itogon municipality in Cordillera Administrative Region was worst affected in terms of mortality, with 86 deaths and seven people missing. Thanks to supplementary immunization activities, over 5000 children aged between six and 59 months old were vaccinated against measles and polio.

BANGLADESH – PROTECTING HEALTH IN THE WORLD'S BIGGEST REFUGEE CAMP

PHOTO: WHO

BANGLADESH – PROTECTING HEALTH IN THE WORLD'S BIGGEST REFUGEE CAMP

Since August 2017, more than 706 000 Rohingya refugees from Myanmar have fled to Bangladesh – creating the world's largest refugee camp. In the face of serious risks to health, the CFE has played a key role by providing critical funding for WHO's response – helping to save lives and protect the health of the refugees and the host population.


PHOTO:WHO/Walter Owen

EMERGENCY

Following 2017's unprecedented influx of Rohingya refugees into Bangladesh from Myanmar's Rakhine State, 908 000 refugees were living in Cox's Bazar – the largest refugee camp the world has seen in decades.

Even as the pace of new arrivals slowed – with 15 247 reported between 1 January and 30 November 2018 – the health challenges remained huge, and urgent action was needed to detect and prevent disease outbreaks.

A serious outbreak of diphtheria claimed 44 lives, while overcrowding, poor living conditions and lack of basic amenities left the population extremely vulnerable to outbreaks of water- and insect-borne diseases.

RESPONSE

With donor pledges slow to materialize initially and little available cash to fund critical components of the health response, the CFE released US$ 3.5 million in early 2018. This enabled WHO to play its lead role in coordinating the health sector, working together with the Bangladesh Government and more than 100 health partners to target 1.3 million people in Cox's Bazar. This included taking action for the host community of 336 000 people living in the settlement's immediate vicinity.

WHO and health sector partners stepped up primary and secondary healthcare provision for the refugees – increasing the number of health facilities from 169 to 250. WHO also provided more than 200 metric tonnes of medical or surgical equipment and supplies to partners, for setting up and delivering healthcare services.

Five large-scale immunization campaigns were launched to protect the population from life-threatening diseases such as diphtheria, pertussis, measles, rubella, tetanus, polio, hepatitis and pneumonia. This included the world's second-largest oral cholera vaccine campaign – with 1 243 959 doses delivered.

Routine immunization, targeting children up to 23 months old and pregnant women, was established – with 780 outreach session sites by 65 outreach mobile teams carrying out regular vaccinations every month.

"Deadly diseases such as cholera have been prevented, and measles and diphtheria curtailed rapidly with quick roll-out and scale-up of health services and mass vaccination campaigns," said Dr Poonam Khetrapal Singh, WHO's Regional Director for South-East Asia, in August 2018.

Tackling diphtheria in Cox's Bazar

Diphtheria is a bacterial infection transmitted from person to person through close physical and respiratory contact. It can lead to breathing difficulties and death.

Thanks to the CFE, WHO was able to lead a rapid response to contain the diphtheria outbreak in Cox's Bazar. Action included immunization, early warning disease surveillance supported by a field laboratory, contact tracing, technical support, and health logistics support including diphtheria anti-toxins.

PHOTO: WHO/Mehak Sethi

"It is remarkable that not only has the mortality rate among the Rohingyas remained lower than expected in an emergency of such a scale, it has also reduced significantly in the last six months."

To improve early detection of and response to disease outbreaks, WHO established its EWARS – with 164 heath centres registered as reporting sites.

WHO also helped set up and operate a new field laboratory in Cox's Bazar.

> "I want my children to remain healthy. Since our arrival in Bangladesh, we have not missed a single vaccination opportunity. I have four children and my mother to care for. I cannot afford them falling sick. I not only get my family vaccinated, but also encourage my friends to do the same."
>
> - Rajuma Choton, a 25-year-old widow, who arrived in Cox's Bazar in September 2017 with her four children and elderly mother.

IMPACT

Support from the CFE has been vital to protect health during the Rohingya refugee crisis.

Thanks to WHO's increase in primary and secondary healthcare provision, the humanitarian Sphere standard on health facility utilization has been met: since August 2017, more than 5.7 million patient consultations in over 220 facilities have taken place.

WHO supported disease prevention, with control campaigns being key to avoiding high mortality among refugees. The diphtheria outbreak at the end of 2017 has now been successfully contained.

Action to detect and respond to disease outbreaks has ensured that 98% of the population is now under surveillance through EWARS, with all alerts – an average of 60-80 per week – received in 2018 responded to within 48 hours.

At the same time, the new field laboratory in Cox's Bazar has achieved a vital reduction in turnaround time for tests for diphtheria – this has been cut from six days to between 24 and 48 hours.

CONTAINING CHOLERA OUTBREAKS IN AFRICA

PHOTO:WHO/Wendy Julias

CONTAINING CHOLERA OUTBREAKS IN AFRICA

Cholera is a major global public health threat – but the burden and impact of the waterborne disease is greatest in Africa, where more than 40 million people are regularly affected.

In 2018, rapid CFE funding of more than US$ 4.3 million was vital in helping WHO take action in outbreaks in nine countries – with three-quarters of the funds going to outbreaks in the Democratic Republic of the Congo, Niger and Zimbabwe.

DEMOCRATIC REPUBLIC OF THE CONGO

The cholera outbreak in the Democratic Republic of the Congo has been ongoing since the end of 2015 and is considered the country's worst cholera epidemic since 1994. In January 2018, the CFE allowed WHO to take rapid action in the face of a worsening outbreak in and around the capital Kinshasa.

The US$ 1.3 million funding helped WHO improve surveillance and case reporting, and deliver diarrhoeal and emergency kits.

By February, the number of weekly reported cases declined to single figures from a peak of 100.

Following another cholera outbreak in the central Kasai region in August, another CFE release of US$ 477 000 helped WHO set up cholera treatment centres and improve case management and surveillance, and ensure water, sanitation and hygiene. The situation remains serious, and in November 2018 the first stage of a large vaccination campaign targeting six million people by 2020 started in the region.

NIGER

In September 2018, the CFE released US$ 690 000 – allowing WHO to ramp-up its response to another serious outbreak of cholera in Niger that resulted in more than 3800 cases and 78 deaths.

WHO helped establish dedicated cholera treatment centres, enhanced surveillance and early case detection laboratory support, hygiene promotion messages, strengthened risk communication, and distribution of water treatment tablets. Following this rapid action, during October there was a downward trend in numbers of cases reported, with the last case in 2018 reported on 19 November.

ZIMBABWE

In September 2018, CFE funding enabled WHO to scale-up its response to a rapidly expanding outbreak of cholera in Zimbabwe's capital, Harare. Within 10 days of the first reported case on 1 September, 2000 suspected cholera cases had emerged – including 58 confirmed cases and 24 deaths.

Supported by US$ 1.1 million from the CFE, WHO helped mobilize national and international health experts to form a cholera surge team. The experts moved quickly to track down cases, providing technical support to laboratories, and helping strengthen infection and prevention control.

WHO also provided cholera treatment centres with kits containing oral rehydration solution, intravenous fluids and antibiotics.

Despite the emergence of new cholera cases in Mashonaland Central province, the country's overall situation has now improved. Since 11 December, no new cholera cases have been reported in the outbreak hotspot of Harare.

PHOTO:WHO/Chima Onuekwe

Cholera is an acute diarrhoeal disease that can kill within hours if left untreated. It is spread when people consume contaminated food or water – and the best way to prevent cholera is to invest in and maintain community-wide water, sanitation and hygiene facilities. But there are also inexpensive, efficient treatments like oral rehydration solution, and newer tools to prevent infection such as oral cholera vaccine.

OTHER CHOLERA OUTBREAKS – A SMALL AMOUNT MAKES A BIG DIFFERENCE

During 2018, the CFE released smaller sums – allowing WHO to rapidly tackle cholera outbreaks in Angola, Cameroon, Congo, Mozambique, Nigeria, Uganda and United Republic of Tanzania.

US$ 40 000
– outbreak around Angola's central city of Uige

US$ 225 000
– outbreak in Uganda's Hoima district close to the Democratic Republic of the Congo

US$ 162 000
– outbreak centred on northern United Republic of Tanzania's Arusha region

US$ 150 000
– outbreak centred in north Cameroon

JANUARY | FEBRUARY | MARCH | APRIL | MAY | JUNE | JULY | AUGUST | SEPTEMBER

US$ 50 000
– cholera preparedness activities in Congo

US$ 100 000
– outbreak in two adjacent provinces in northern Mozambique

US$ 100 000
– WHO supported preparations for first-ever cholera vaccination campaign in the northern Nigerian state of Adamawa

CFE CONTRIBUTIONS 2018

PHOTO:WHO/S.OKA

Since the Fund's inception in 2015, 18 Member States have generously contributed nearly $84 million to the CFE.

The generosity of our resource partners makes the CFE a fast and flexible financing instrument.

In 2018, 13 Member States contributed more than US$ 38 million, the largest annual total since the Fund's inception in 2015 and more than triple the contributions in 2017.

Seven new donors joined the list of contributors in 2018.

See Annex 3 for a complete list of CFE contributors since 2015.

> "Norway is happy to contribute to the CFE. It has proven a very effective tool to respond within days, even hours, to emergencies, preventing suffering and saving lives."
>
> Ine Eriksen Søreide
> Minister of Foreign Affairs, Norway

CFE CONTRIBUTORS IN 2018

COUNTRY	AMOUNT (US$)
Germany	15 216 968
United Kingdom	5 641 749
Sweden	4 412 089
Denmark*	3 185 011
Australia*	3 044 140
Republic of Korea	2 000 000
Norway*	1 253 761
Netherlands	1 165 501
Canada	753 012
Luxembourg*	578 704
Switzerland*	502 008
Kuwait*	500 000
Estonia	56 818
Malta*	20 000
TOTAL	**38 329 761**

**New contributor in 2018*

REPLENISHING THE CFE AND STRENGTHENING WHO'S RESPONSE CAPACITY

The Sixty-eighth World Health Assembly set a US$ 100 million funding target per biennium when it established the CFE in 2015. Achieving this is a priority for WHO during 2018–2019.

Reaching US$ 100 million

WHO is implementing a robust replenishment strategy for the CFE as part of a broader, sustainable model for financing life-saving action in health emergencies.

Reimbursement at country level

At the heart of WHO's strategy for replenishing the CFE is the reimbursement of allocations from the Fund by donor contributions to WHO's country response plans. Costs initially incurred against the CFE can be covered by incoming contributions in line with donor agreements and conditions. Furthermore, donor funding can immediately be programmed to cover some or all of the activities being addressed by the CFE – allowing unspent CFE funding to be returned.

In 2018, 49% of CFE funding allocated was reimbursed to the Fund. This compares favorably with previous years (33% in 2016 and 38% in 2017).

Overall CFE reimbursement in 2018

Allocation amount	**US$ 37 646 171**
Reimbursement amount	**US$ 18 498 486**
% reimbursed	**49%**

This is largely due to the two Ebola outbreaks in the Democratic Republic of the Congo, which received 60% of overall CFE allocations in 2018 (US$ 22.6 million of US$ 37.6 million) and accounted for 80% of all reimbursement (US$ 14.8 million of US$ 18.5 million).

Reimbursement of CFE allocations to Ebola outbreaks in 2018

EVENT	ALLOCATION (US$)	REIMBURSEMENT (US$)	%
Equateur Province	**6 172 534**	**4 632 700**	**75%**
North Kivu	**16 480 000**	**10 187 586**	**62%**
TOTAL	**22 652 534**	**14 820 296**	**65%**

Generous and flexible donor contributions to both Ebola outbreaks allowed WHO to release larger and more tranches than usual against committed donor funding. This ensured early and regular cash flow to get experts, equipment and supplies on the ground early, and to ensure continuity and minimal disruption during emergency operations.

There was less success in reimbursing CFE allocations for underpublicized and underfunded emergencies – such as malaria control in Nigeria, a hepatitis outbreak in Namibia, a cholera outbreak in the Democratic Republic of the Congo, and flooding in Somalia.

EVENT	ALLOCATION (US$)	REIMBURSE-MENT (US$)	%
Democratic Republic of the Congo Kinshasa Cholera	**1 250 000**	**20 865**	**2%**
Namibia Hepatitis	**195 000**	**4446**	**2%**
Nigeria Malaria	**2 341 000**	**295 622**	**13%**
Somalia Flooding	**489 500**	**129 808**	**27%**

It should be stressed that the CFE is particularly critical in these cases because it is often the only source of funding to respond to these less publicized yet very dangerous threats.

Annex 4 contains a complete list of reimburse-ments by event.

Strengthening resource mobilization capacity at field level

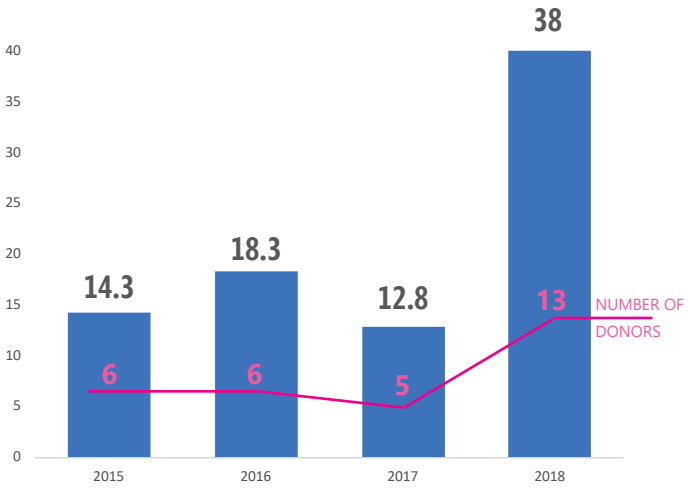
WHO is ensuring long-term country-level capacity to prepare for, detect, respond to and recover from health emergencies in priority countries through the implementation of its 'Country Business Model'. This includes strengthening WHO country office capacity to raise funds, so more money can be mobilized at country level, enabling these offices to repay their CFE grants.

There are now dedicated resource mobilization officers in all 10 priority countries – Afghanistan, Democratic Republic of the Congo, Ethiopia, Iraq, Mali, Nigeria, Somalia, South Sudan, Syrian Arab Republic and Yemen.

Broadening the donor base and strengthening partnerships

In 2018, WHO enjoyed considerable success in broadening and deepening the base of support for the CFE. Seven new Member States joined the list of CFE contributors – Australia, Denmark, Kuwait, Luxembourg, Malta, Norway and Switzerland – bringing the total number of contributors to 18 since the Fund's inception.

Contributions 2015–2018 in US$ millions



Seven new Member States joined the list of CFE contributors in 2018 – Australia, Denmark, Kuwait, Luxembourg, Malta, Norway and Switzerland.

WHO will continue to engage with new partners. For example, WHO is supporting the G20 in 2019 to address international financing mechanisms for rapid emergency response capacity – namely the CFE, the UN Central Emergency Response Fund (CERF) and the World Bank Pandemic Emergency Financing Facility (PEF), underscoring their impact and ensuring that these complementary financing mechanisms are all adequately funded.

WHO is also engaging donors who have limited resources but who want to demonstrate their commitment to rapid action in health emergencies and to achieving global health security. The CFE – with its simple, pooled fund structure reducing transaction costs and making every dollar go further – is a good investment for donors wanting to maximise the impact of their contributions.

Alternative sources of funding

Contributions from Member States - either directly to the CFE or through reimbursement from donations against specific WHO response plans – will continue to provide most of the sustainable funding to the CFE for the time being. But WHO is exploring other ways of replenishing the CFE to diversify the resource base and so ensure the Fund's sustainability.

For example, the transfer of unspent funds from completed projects offers a modest yet regular potential source of additional resources. The United Kingdom included a clause in its contribution agreement for the Ebola response in the Democratic Republic of the Congo to transfer unspent funds to the CFE. Other donors have agreed to this in principle, and WHO is looking at ways to formalize this arrangement in donor agreements.

As noted in the 2016 high-level panel report on addressing the humanitarian financing gap[1], Islamic Social Financing in its many forms (*zakat, sadaqah, waqf*) offers a great deal of untapped potential if brought to scale and properly aligned to humanitarian principles and requirements. WHO is currently part of a community of practice looking at the experiences of UN and NGOs who have successfully partnered with Islamic charities to channel funding towards humanitarian causes. Ongoing discussions are looking at ways the UN can work collectively to channel these funds, possibly through joint funding mechanisms. The CFE could be used as a direct channel for Islamic charitable giving or could be reimbursed through contributions to specific response plans in countries of mutual interest.

Further engagement with foundations and the private sector also remains a priority. WHO will explore partnership opportunities with the UN Foundation that leverage charitable giving and corporate philanthropy around health emergencies, including funding for the CFE.

> "The recent progress in deepening and broadening the donor base of the CFE is a very encouraging step forward. The Fund has enabled a paradigm shift in WHO's emergency response and gives its investors excellent value for money."
>
> H.E. Mr. Jamal Al-Ghunaim, Ambassador Extraordinary and Permanent Representative of the State of Kuwait to the UN Office in Geneva

A wider mechanism for contingency financing

The CFE is part of a broader mechanism for contingency financing of health emergencies. Different funding mechanisms – with different disbursement cycles and funding criteria – can be accessed for health emergencies. These include the CERF and the World Bank's Pandemic Emergency Financing Facility (PEF). When financing from these mechanisms is coordinated and operates holistically, they offer maximum efficiency, impact and value.

The Ebola response in Equateur Province in the Democratic Republic of the Congo in May 2018 was the first time that the CFE, CERF and PEF were activated in one response. This led to discussions between WHO, CERF and the World Bank on lessons learned – including how best to harmonize these funds in future crises. WHO, CERF and the World Bank continue to work together on joint advocacy to ensure these complementary mechanisms are fully financed and work seamlessly in emergency response operations.

[1] https://reliefweb.int/report/world/high-level-panel-humanitarian-financing-report-secretary-general-too-important-fail

WHO and sister agencies will also continue to work with CERF on the revision of its life-saving criteria – to include early action for disease outbreak containment and response, and to maximize the cost-effectiveness of health interventions.

WHO and CERF have already agreed that CERF funding can be used to cover some of the costs borne by the CFE at the onset of a response, by backdating the CERF project start date by up to six weeks before the disbursement date. WHO country offices have been given specific guidance on this – including on which activities are eligible to be covered by CERF. This reinforces the principle of CFE reimbursement to help ensure the sustainability of the Fund.

Investing in WHO

The CFE is part of WHO's first-ever Investment Case launched in 2018 to help deliver the Organization's GPW13 over the next five years (2019–23).

WHO has an ambitious "Triple Billion" vision for 2019-2023, to help achieve Sustainable Development Goal 3 – better health and well-being for all, at all ages. WHO's vision is for:

- **1 billion** more people benefiting from universal health coverage
- **1 billion** more people better protected from health emergencies
- **1 billion** more people enjoying better health and wellbeing.

The investment case shows how a stronger, more efficient, and results-oriented WHO will serve and guide governments and partners in their efforts to improve the health of their populations.

One of GPW13's three pillars is better protecting one billion more people from health emergencies. By providing flexible and rapidly accessible funding for emergency response, the CFE will play a key part in helping WHO deliver on this goal.

> "The consequences for the world's response to health emergencies could not be more severe and the responsibility to ensure this does not happen, lies with all of us. The United Kingdom of Great Britain and Northern Ireland has studied the CFE and we are convinced it has a vital and unique role to play in the global effort to prevent and mitigate health emergencies."
>
> - The Rt Hon Alistair Burt MP, Minister of State for International Development, United Kingdom

ACCOUNTABILITY

Every dollar that goes into the CFE is administered in line with WHO's financial rules and regulations.

Standard procedures across all of WHO's three levels – its headquarters, regional offices and country offices – ensure the CFE's effective operation and management, sustainability, and accountability to donors.

The CFE's income and expenditure are included in WHO's Financial Reports, are submitted to the World Health Assembly annually, and are subject to internal and external auditing.

- Every allocation from the CFE — regardless of size — is entered in WHO's grant management system to track expenditures, monitor implementation, and support financial reporting.
- For emergencies graded by WHO as 1, 2 or 3, depending on severity, WHO's Incident Management System kicks in – guiding WHO's operational response, and identifying critical roles and responsibilities, including financial management. WHO's emergency standard operating procedures are also activated. This ensures resources — including from the CFE — are used as effectively as possible, with the highest levels of financial monitoring and accountability across WHO.
- For ungraded events, allocations of up to US$ 50 000 can be used to undertake risk assessments.

CFE operating principles

Standard procedures governing the CFE are articulated around the following operating principles.

The foundation of a CFE request is an initial plan of action for the acute response – including budget, and accompanied by a local donor alert
This needs to cover support required across WHO's three levels. Evidence that a local donor alert is being prepared must accompany the request.

Allocations are reimbursed from contributions raised for the emergency response – the critical pillar of the Fund's replenishment strategy
Allocations for a single event exceeding US$ 50 000 must be fully reimbursed in so far as possible without jeopardizing the response operation.

Within five days of the CFE request, a donor alert or appeal must be issued, and a resource mobilization effort initiated. Activities financed by the CFE must be included in proposals to donors to facilitate reimbursement of the CFE.

The CFE is used to initiate or support WHO's operations in an acute phase – but not to maintain operations in the medium to long term
Funds primarily support an emergency response's first three months. If required and requested, funds can be reprogrammed according to reprioritization of critical actions, and based on timing of new contributions.

The CFE can fund activities and personnel in a WHO workplan supporting WHO's response to an event. External partners and WHO Member States cannot apply to the CFE directly. However, WHO can use CFE funds to procure goods and supplies or conclude agreements with external parties. Funds unused after the first 90 days should be returned to the CFE.

A technical report must be submitted for every allocation from the Fund
At the end of a funding period, a short report must be submitted on the use and impact of the CFE allocation. WHO country offices spotlight the Fund's allocations and donors through media releases and web stories, and aim to document the Fund's impact through photos and video footage.

Donor visibility and information sharing

WHO has provided CFE contributors due visibility for their generous support to the Fund. CFE donors have been recognized in regular media releases, on corporate information platforms and through social media.

Moreover, sharing information with donors regularly and systematically reporting on impact are important for building the CFE's profile and donor confidence. An annual report is produced at the end of the first quarter with periodic updates produced throughout the year – highlighting the Fund's use and effectiveness.

A dedicated CFE web portal (www.who.int/emergencies/funding/contingency-fund/en/) provides up-to-date information on the CFE's allocations, contributions, impact stories and media releases.

https://twitter.com/PeteSalama/status/1001854612503252992

CFE AND GENDER

WHO adheres to gender-sensitive programming in outbreaks and health emergencies, including those which receive funding from the CFE.

This includes the use of the Inter-Agency Standing Committee (IASC) gender marker to grade all emergency projects. WHO is also expanding its activities to address issues around sexual reproductive health, gender-based violence, and adolescent health in emergencies. This is shown through WHO's leadership in the Every Woman Every Child initiative; the launch of a new project on addressing gender-based violence in key priority countries; and upcoming work of research on maternal, child and adolescent health in humanitarian emergencies.

WHE recently launched a major project on delivering integrated sexual reproductive health rights services in emergencies through the Health Cluster. The goal of the project is to meet the immediate sexual reproductive health needs of vulnerable women, adolescents and girls in acute and protracted humanitarian crises. This project will be implemented in three countries currently experiencing major protracted humanitarian crises – Bangladesh (Cox's Bazar), Democratic Republic of the Congo and Yemen.

Furthermore, WHO has increased its attention to gender-based violence issues. Technical Officers have been hired at WHO's headquarters, Regional Office for Africa and Regional Office for the Eastern Mediterranean to train WHO and health cluster partners in selected countries on gender-based violence management, as well as working to ensure gender-based violence is properly addressed in ongoing emergency operations. In 2018, gender-based violence technical advisors were deployed to seven emergencies: Afghanistan, Bangladesh (Cox's Bazar), Democratic Republic of the Congo, Iraq, Jordan, Nigeria and Syria.

WHO helps schoolchildren protect themselves and their families against Ebola. WHO/Dalia Lourenço

LOOKING AHEAD

In 2018, the CFE continued to be a sound investment and a global public good. The Fund proved instrumental in enabling WHO to support government-led responses to disease outbreaks, take the lead in coordinating health sector partners in complex emergencies, and provide emergency health services to the victims of natural disasters.

This saved countless lives, reduced operational costs, and mitigated other social and economic impacts.

Record-level funding in 2018 and a broader level of support underscored donor confidence in the CFE and WHO's work in emergencies. At the time of writing (through 1 March 2019), the CFE had already drawn more than US$ 28 million in contributions for 2019 – including US$ 22 million from Japan, the largest-ever single contribution to the Fund – and added Finland as a new contributor. This bodes well for the CFE to reach the US$ 100 million target capitalization set by Member States for 2018–2019.

WHO will continue to work with key Member State contributors to the CFE to leverage their voice and influence with other countries and in different fora in support of WHO's emergency work – to highlight the CFE's unique enabling role in preventing emergencies from escalating, and to help make the CFE's message that "quick action saves lives" accessible and compelling to broader audiences.

WHO remains vigilant to emerging health threats around the world. Continued financial support from Member States will ensure that WHO has the resources needed to respond rapidly and effectively to the next disease outbreak or health emergency.

> "The CFE provides a compelling return on investment as compared to the estimated cost of allowing outbreaks and other health emergencies to escalate."
>
> - Ambassador Rosemary McCarney, Permanent Representative of Canada to the UN in Geneva

ANNEX 1. CFE ALLOCATIONS IN 2018

EVENT NO.	COUNTRY	EMERGENCY	TYPE	AMOUNT APPROVED (US$)	DATE
1.1	Bangladesh	Rohingya	Complex emergency	1 500 000	Jan-18
1.2	Bangladesh	Rohingya	Complex emergency	2 000 000	Jan-18
2	Nigeria	Botulism	Disease outbreak	60 000	Jan-18
3	Democratic Republic of the Congo (Kinshasa)	Cholera	Disease outbreak	1 250 000	Jan-18
4	Angola	Cholera	Disease outbreak	40 000	Jan-18
5.1	South Africa	Listeriosis	Disease outbreak	15 000	Jan-18
5.2	South Africa	Listeriosis	Disease outbreak	22 571	Mar-18
5.3	South Africa	Listeriosis	Disease outbreak	358 220	Mar-18
6	Congo	Cholera (Preparedness)	Disease outbreak	50 000	Jan-18
7.1	Nigeria	Lassa fever	Disease outbreak	50 000	Feb-18
7.2	Nigeria	Lassa fever	Disease outbreak	900 460	Feb-18
8	Regional Pacific*	Cyclone Gita	Natural disaster	108 385	Feb-18
9	Mozambique	Cholera	Disease outbreak	100 000	Mar-18
10	Papua New Guinea	Earthquake	Natural disaster	135 000	Mar-18
11	Uganda	Ebola and cholera	Disease outbreak	225 000	Mar-18
12.1	Venezuela	Regional crisis	Complex emergency	50 000	Apr-18
12.2	Venezuela	Regional crisis	Complex emergency	1 000 000	Jul-18
13	Somalia	Flooding	Natural disaster	489 500	May-18
14.1	Nigeria	Malaria	Disease outbreak	1 100 000	May-18
14.2	Nigeria	Malaria	Disease outbreak	1 241 000	Jul-18
15.1	Democratic Republic of the Congo	Ebola (Equateur)	Disease outbreak	1 000 000	May-18
15.2	Democratic Republic of the Congo	Ebola (Equateur)	Disease outbreak	1 000 000	May-18
15.3	Democratic Republic of the Congo**	Ebola (Equateur)	Disease outbreak	1 550 000	May-18
15.4	Democratic Republic of the Congo	Ebola (Equateur)	Disease outbreak	1 000 000	May-18
15.5	Democratic Republic of the Congo	Ebola (Equateur)	Disease outbreak	1 622 534	Jun-18
16	United Republic of Tanzania	Cholera	Disease outbreak	162 000	Jun-18
17	Liberia	Flooding	Natural disaster	50 000	Jul-18
18	Kenya	Rift Valley Fever	Disease outbreak	200 000	Jul-18
19	Nigeria	Cholera	Disease outbreak	100 000	Jul-18
20.1	Lao People's Democratic Republic	Flooding	Natural disaster	50 000	Aug-18
20.2	Lao People's Democratic Republic	Flooding	Natural disaster	50 000	Aug-18
21.1	Democratic Republic of the Congo	Ebola (North Kivu)	Disease outbreak	2 000 000	Aug-18

EVENT NO.	COUNTRY	EMERGENCY	TYPE	AMOUNT APPROVED (US$)	DATE
21.2	Democratic Republic of the Congo	Ebola (North Kivu)	Disease outbreak	4 000 000	Sep-18
21.3	Democratic Republic of the Congo	Ebola (North Kivu)	Disease outbreak	200 000	Oct-18
21.4	Democratic Republic of the Congo	Ebola (North Kivu)	Disease outbreak	100 000	Nov-18
21.5	Democratic Republic of the Congo	Ebola (North Kivu)	Disease outbreak	3 500 000	Nov-18
21.6	Democratic Republic of the Congo	Ebola (North Kivu)	Disease outbreak	6 000 000	Nov-18
21.7	Democratic Republic of the Congo	Ebola (North Kivu)	Disease outbreak	680 000	Nov-18
22	Democratic Republic of the Congo	Cholera	Disease outbreak	476 629	Aug-18
23	Cameroon	Cholera	Disease outbreak	150 000	Aug-18
24	Namibia	Hepatitis	Disease outbreak	195 000	Sep-18
25	Zimbabwe	Cholera	Disease outbreak	1 100 000	Sep-18
26	Niger	Cholera	Disease outbreak	689 872	Sep-18
27	Libya	Measles	Disease outbreak	500 000	Sep-18
28	Philippines	Typhoon	Disease outbreak	75 000	Oct-18
29	Uganda	Ebola (preparedness)	Disease outbreak	500 000	Oct-18
			TOTAL	**37 646 171**	

** Fiji, Samoa, Tonga.*

*** Regional Ebola preparedness: Angola, Burundi, Central African Republic, Rwanda, South Sudan, Uganda, United Republic of Tanzania, Zambia*

ANNEX 2. CFE EXPENDITURES BY CATEGORY AND TYPE AS PER WHO'S FINANCIAL STATEMENTS

CATEGORY	AMOUNT (US$, MILLIONS)	DESCRIPTION
Contractual Services	**5.4**	
513-Contractual Serv, General	1.77	Contracts for services provided to WHO (e.g. technical reports, editing, translations)
517-Training	0.12	Training for WHO staff or organized by WHO
524-Security Expenses	0.02	Expenses to guarantee the security of WHO staff and premises
525-SSA Expenses	0.73	Special Service Agreements (SSA) to individuals (e.g. technical and administrative support for health campaigns)
527-Direct Implementation	2.76	To cover operational costs of activities when not feasible to implement activities through other contractual arrangements
Equipment	**0.47**	Vehicles, IT equipment, office furniture, telecom equipment
General Operating expenses	**1.68**	Rent, utilities, maintenance, office supplies, etc
Medical Supplies and materials	**2.95**	Vaccines, health kits, protective equipment, hospital & laboratory supplies
Staff and other personnel costs	**1.12**	Regular staff costs, daily paid staff (e.g. interpreters)
Transfers and grants	**4.36**	
511-Direct Financial Cooperation	0.49	Transfers made to government partners (e.g. per diems and operational costs of public health activities, such as immunization campaigns)
526-Agreements with UN and NGO	3.68	Grants to international and national implementing partners
555-Equip for third Parties	0.19	Equipment and supplies for third-party implementation
Travel	**2.53**	Duty travel on mission for WHO (international staff travel, etc)
GRAND TOTAL (US$)	**18.51**	

As at 31 December 2018. A final reconciliation of all expenditures will be included in WHO Financial Reports and submitted to the Seventy-second World Health Assembly.

ANNEX 3. CFE CONTRIBUTIONS 2015–2018

	2015	2016	2017	2018	Total (US$)
Germany	1 096 491	3 728 495	9 876 113	15 216 968	29 918 067
United Kingdom	9 436 834		1 100 000	5 641 749	16 178 583
Japan		10 833 800			10 833 800
Sweden		1 159 555		4 412 089	5 571 644
Denmark				3 185 011	3 185 011
Australia				3 044 140	3 044 140
Korea			1 015 192	2 000 000	3 015 192
Netherlands		1 082 514		1 165 501	2 248 015
Canada	729 927		751 880	753 012	2 234 819
China	2 000 000				2 000 000
France		1 418 218			1 418 218
Norway				1 253 761	1 253 761
India	1 000 000				1 000 000
Kuwait				500 000	500 000
Luxembourg				578 704	578 704
Switzerland				502 008	502 008
Estonia	32 967	53 078	59 242	56 818	202 105
Malta				20 000	20 000
TOTAL (US$)	**14 296 219**	**18 275 660**	**12 802 427**	**38 329 761**	**83 704 067**

ANNEX 4. REIMBURSEMENT OF CFE ALLOCATIONS IN 2018

EVENT	AMOUNT APPROVED (US$)	REIMBURSEMENT (US$)	PERCENT REIMBURSEMENT
Angola Cholera	40 000	7 963	20%
Bangladesh Rohingya	3 500 000	1 502 223	43%
Cameroon Cholera	150 000	32 647	22%
Congo Cholera	50 000	50 000	100%
Democratic Republic of the Congo Cholera	476 629	36	0%
Democratic Republic of the Congo Cholera (Kinshasa)	1 250 000	20 856	2%
Democratic Republic of the Congo Ebola Equateur	6 172 534	4 632 700	75%
Democratic Republic of the Congo Ebola North Kivu	16 480 000	10 187 596	62%
Kenya Rift Valley Fever*	200 000	0	0%
Liberia Flooding	50 000	87	0%
Libya Measles	500 000	8 207	2%
Mozambique Cholera	100 000	6 482	6%
Namibia Hepatitis*	195 000	0	0%
Niger Cholera	689 872	38 272	6%
Nigeria Botulism	60 000	60 000	100%
Nigeria Cholera	100 000	25 257	25%
Nigeria Lassa fever	950 460	350 991	37%
Nigeria Malaria	2 341 000	295 622	13%
Papua New Guinea Earthquake	135 000	96 964	72%
Lao People's Democratic Republic Flooding	100 000	0	0%
Philippines Typhoon	75 000	3 468	5%
Regional Pacific Cyclone Gita	108 385	85 511	79%
Somalia Flooding	489 500	129 808	27%
South Africa, Listeriosis	395 791	322 700	82%
Uganda Ebola	500 000	96 848	19%
Uganda Cholera	225 000	2 773	1%
United Republic of Tanzania Cholera	162 000	0	0%
Venezuela Regional Crisis*	1 050 000	0	0%
Zimbabwe Cholera	1 100 000	541 475	49%
GRAND TOTAL US$	**37 646 171**	**18 498 486**	**49%**

**Data reconciliation incomplete as operations are ongoing. As at 1 March 2019.*

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