Enabling quick action to save lives

CONTINGENCY FUND FOR EMERGENCIES

2017 year in review
Introduction

In today’s interconnected world, health emergencies can affect anyone, anywhere – and the ability to respond early can make the difference between saving lives and containing emergencies or seeing them cause avoidable deaths, illness or injury, as well as losses to the economy.

WHO is preparing to embark on a bold and ambitious General Programme of Work to deliver our mission, rooted in the Sustainable Development Goals.

These strategic priorities take on particular importance in health emergencies. The world looks to WHO to lead the international community’s response to lessen the impact of outbreaks and other emergencies with health consequences.

WHO needs to get on the ground the moment that a disease outbreak or other health emergency is identified to guide and coordinate rapid action – which is the most effective way to minimize impact.

The Contingency Fund for Emergencies (CFE) enables WHO to do just that – take quick action to save lives.

I thank all our partners and donors who make this possible by investing in the CFE and subsequently in our response plans at country level. I look forward to their continued support to ensure the sustainability of this life-saving Fund.

Dr Tedros Adhanom Ghebreyesus
Director-General
World Health Organization
Map of CFE allocations in 2017

DISCLAIMER: The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted, dashed and orange lines on maps represent approximate border lines for which there may not yet be full agreement.

Foreword

On 9 May 2017, WHO was alerted to a cluster of unexplained deaths in a remote part of the Democratic Republic of the Congo. Just a day later, a WHO team was on the ground investigating the cause of the deaths and providing expert support to the country’s Ministry of Health. By 11 May, only 48 hours after the alarm was first raised, rapid laboratory testing confirmed our initial suspicions – the Ebola Virus Disease (EVD) was responsible for at least one of the deaths.

WHO was able to deploy the team so quickly thanks to the Contingency Fund for Emergencies (CFE).

The confirmation of EVD triggered more CFE funding, enabling WHO to rapidly expand its footprint in the affected area: a substantial challenge due to the inhospitable terrain and geographical isolation of the region. Over the next two months, WHO and our partners worked non-stop with the Ministry of Health to contain the outbreak. By July, the outbreak was over.

The contrast between the 2017 Democratic Republic of the Congo Ebola outbreak and the 2014 West Africa Ebola epidemic is stark. The former claimed four lives, lasted two months, and cost US$ 2 million to contain. The latter claimed more than 11,000 lives over almost two years, at a cost of more than US$ 3.6 billion.

Clearly no single factor can account for such a vast disparity in mortality and morbidity between two outbreaks. But equally, there can be no doubt that the speed of the response in the Democratic Republic of the Congo was the decisive factor in the swift containment of the outbreak — something that would simply not have been possible without the CFE.

The CFE can release funds very quickly, often weeks and months before other streams of emergency funding can be secured. In 2017, 88% of allocations of US$ 500,000 or less were transferred to the WHO offices in the affected countries within 24 hours of the request.

This clearly distinguishes the CFE from other funding sources, and strengthens the international community’s overall ability to prevent outbreaks and health emergencies from spiralling out of control. Over the course of 2017, the CFE demonstrated that a small investment can pay life-saving dividends and dramatically reduce the direct costs of containing outbreaks and responding to emergencies. The CFE is the model of emergency funding that the international community needs for a new era in emergency response, and it is needed now more than ever.

As this report illustrates, the CFE has proven its value as a global public good that should be underwritten by long-term investment.

Dr Peter Salama
Deputy Director-General
Emergency Preparedness and Response
CFE Contributors

Canada
China
Estonia
France
Germany
India
Japan
Kuwait
Netherlands
Republic of Korea
Sweden
United Kingdom of Great Britain and Northern Ireland

Thank you for your generous contributions.
The WHO Contingency Fund for Emergencies

The Contingency Fund for Emergencies (CFE), established by the World Health Assembly in May 2015 following a review of WHO’s response to the 2014 Ebola outbreak in West Africa, rapidly makes available small amounts of funding for WHO’s initial response activities.

The CFE provides funding during the critical gap between the moment the need for an emergency response is identified and the point at which funds from other mechanisms can be released. The CFE’s capacity to release funds (in an initial tranche of up to US$ 500 000) within 24 hours of an emergency request sets it apart from other complementary financing mechanisms such as the Central Emergency Response Fund (CERF), the World Bank’s Pandemic Emergency Financing Facility (PEF), and other pooled funds that have different funding criteria and slower disbursement cycles.

The CFE is replenished through donor contributions outside of the WHO Health Emergencies Programme (WHE) core budget either directly to the CFE or through reimbursement from donations against specific WHO response plans. Contributions to the CFE are pooled and, crucially, are flexible rather than being earmarked for specific activities. This enables the CFE to rapidly fund the initial response to the broadest possible range of health emergencies. Accountability is ensured through adherence to the Organization’s financial rules and regulations, including standard financial reporting. Any unspent funds are returned to the CFE.
CFE financial breakdown

Contributors
The World Health Assembly set a US$ 100 million funding target when it established the CFE in 2015. Since the CFE’s inception in 2015, 12 Member States have generously contributed US$ 45 million to the fund.

Allocations
In 2017, the CFE made 36 emergency allocations totalling almost US$ 21 million to 23 countries and one multi-country response. Nearly 70% of allocations were for amounts of US$ 500 000 or less. Of these approved requests, 88% were fulfilled within 24 hours. The mean allocation for 2017 was just over US$ 580 000.

Over half (56%) of allocations were made to fund responses in the WHO Africa Region, with 28% going to responses in countries in the WHO Eastern Mediterranean Region. Of the remaining allocations, four (11%) were for responses in the WHO South-East Asia Region, with one going to a response in the WHO Western Pacific Region.

CFE impact in 2017
The following overview demonstrates the wide range of responses to outbreaks and health emergencies enabled by the CFE in 2017, including disease outbreaks, complex emergencies, or natural disasters. The report illustrates the difference that the fast, flexible, and predictable funding provided by the CFE makes in saving lives and reducing suffering.
BANGLADESH

More than 600,000 Rohingya have fled violence in Rakhine State, Myanmar, and sought refuge in Bangladesh since August 2017, creating one of the largest refugee crises in the world. The CFE was essential in strengthening WHO’s initial health response to the crisis and, later, to control a diphtheria outbreak in the refugee camps, helping to contain an emergency within an emergency.

An initial allocation of US$ 1.5 million allowed WHO to rapidly expand its response and quickly get the right people and critical medical supplies on the ground. WHO water and sanitation experts were deployed to the main refugee camps at Cox’s Bazar, providing two million water purification tablets, and prepositioning cholera kits for 20,000 people.

Due to a lack of funding, an additional CFE allocation made in mid-December (US$ 1.5 million) allowed WHO to continue to support ongoing operations to address the health and livelihoods needs of the displaced population, and to respond to the diphtheria outbreak.

Since September 2017, CFE funding has supported the administration of 900,000 doses of oral cholera vaccine (the second largest emergency oral cholera vaccination campaign in history after Haiti in 2016); measles vaccination of 335,000 children; diphtheria vaccination of nearly 500,000 children; and the establishment of a much needed disease surveillance system in Rohingya camps and host communities.

Key achievements
- 900,000 doses of oral cholera vaccine
- 335,000 children vaccinated against measles
- 500,000 children vaccinated against diphtheria
- Disease surveillance systems established in refugee camps and host communities

Amount provided: US$ 3,000,000
Funding period: Sep – Dec 2017
Emergency type: Complex emergency (complicated by diphtheria outbreak)
The Burundi Ministry of Health declared a malaria epidemic in March 2017 after a marked increase in cases that affected all 18 of the country’s provinces. By the end of June, more than 4.3 million cases of malaria and nearly 2000 deaths had been reported. Although malaria is common in Burundi, a deterioration of the country’s socio-economic situation since the beginning of 2016 has resulted in disruption to health services and substantial population displacement, contributing to the increased incidence of the disease. A lack of funding for the country’s 2017 humanitarian response plan meant emergency CFE funding was required to arrest the spread of the epidemic. Beginning in April 2017, two separate CFE allocations totalling US$ 428 000 were used to strengthen coordination and technical support across the nine most-affected provinces. Sanitation operations were scaled up to control mosquito breeding sites, and funding was also used to purchase malaria treatment and prevention kits and other medical equipment.

**Key achievements**

- Coordination and technical support to the Burundi Ministry of Health
- Provision of medical supplies and equipment including anti-malarial drugs
CAMEROON

By early 2017, conflict between government forces and Boko Haram militants in the four countries of the Lake Chad Basin had resulted in the forced displacement of millions of people. In Cameroon, 100,000 refugees from Nigeria, over 190,000 internally displaced persons, and 400,000 members of the host population were affected. Poor or damaged health facilities resulted in restricted access to life-saving health services, while surveillance and preventive services were insufficient to guard against the emergence of epidemic-prone diseases.

In February 2017, a surge of 20,000 refugees into northern Cameroon threatened to overwhelm already fragile health systems in the area. The escalation of the situation triggered a CFE request of US$ 500,000 to enable WHO to expand urgent healthcare assistance to the displaced population, including through the emergency provision of primary healthcare services, strengthened disease surveillance and preventive services, and strengthened coordination of the health sector response.

Key achievements

- Emergency provision of primary healthcare services
- Establishment of a disease surveillance system
- Health-sector coordination
Around 40% of the population of the Central African Republic requires humanitarian assistance. A deterioration of the security situation in 2017 led to the internal displacement of a further 100,000 people, and forced a number of key humanitarian partners to leave the country. A CFE allocation of US$ 360,000 in August allowed WHO to reinforce the health response in key areas. First, funding was used to strengthen security at WHO field offices to ensure the continuity of essential services to populations in need. The funds also enabled WHO to boost its field coordination capacity to support health sector partners and improve disease surveillance. WHO was also able to secure and position stocks of emergency medical supplies, including enough essential medicines and trauma kits, to last for three months in the event of health centres being cut off from supply sources.

Key achievements
- Strengthened coordination
- Establishment of disease surveillance systems
- Provision of essential medicines and trauma kits
On 14 February 2017, the Chad Ministry of Health declared an outbreak of hepatitis E virus (HEV) in the city of Am Timan, with a population of around 65,000 people. The disease, which causes acute jaundice syndrome, is spread by the faecal contamination of water supplies. Suspected cases had been reported since August 2016. By 21 February over 1000 suspected cases had been reported, making this HEV outbreak the largest in sub-Saharan Africa outside a refugee camp setting.

Using CFE funds, WHO was able to expand emergency health and sanitation operations to stop the spread of the disease. CFE funds were also used for a vital socio-anthropological study to better understand and overcome the refusal of some affected and at-risk communities to use treated water. Technical assistance and community sensitization activities were tailored accordingly. The outbreak was declared over in April 2017.

**Key achievements**

- Technical support to establish field coordination
- Emergency health and sanitation interventions, including hygiene kits
- Technical support for community mobilization
On 9 May 2017, WHO was alerted to a cluster of deaths from an unknown illness that seemed to have symptoms consistent with a viral haemorrhagic fever. The country has a history of outbreaks of Ebola virus disease (EVD), so as a precautionary measure CFE funding was used to send an investigation team from the WHO Country Office in the capital, Kinshasa, 1300 kilometres north to the remote area of Likati, where the cluster was detected. Shortly after the team arrived, on 11 May, the Ministry of Health informed WHO that samples taken from one of the dead bodies in the cluster had tested positive for EVD.

The confirmation of EVD triggered the release of a further US$2 million of CFE funding to launch a full-scale rapid response. The logistical challenge involved was substantial. The affected area has limited communication and poor transport infrastructure. The densely forested area can only be accessed by helicopter or by dirt roads that are usually only passable by motorbike. Security considerations included the presence of the Lord’s Resistance Army in the north and east of the province. Nevertheless, the funding provided by the CFE enabled WHO to get the surveillance, treatment, and logistics teams to where they were needed.

The end result of that comprehensive rapid response was an equally rapid end to the outbreak, which was declared over by WHO in July 2017.

Key achievements

• WHO investigation team deployed to the field within 24 hours of alert detection
• WHO surge team deployed within 4 days of laboratory confirmation of EVD to provide technical support to the Ministry of Health (including surveillance, case investigation, case management and infection prevention and control), as well as coordination and logistical support
• Outbreak declared over 2 months after the first confirmation of EVD
A shortage of funding for health partners threatened to turn a cholera outbreak in two non-endemic provinces in the Democratic Republic of the Congo into a crisis. Funding from the CFE meant WHO could quickly bridge the gap and expand its technical support to health partners and health sector coordination in the affected provinces. CFE funds were also used to provide support for the clinical management of cases, surveillance, and social mobilization activities. The funds supported the salaries of 45 health staff in three cholera treatment centres in affected areas for three months. Cholera treatment kits were also procured to treat hundreds of patients.

**Key achievements**

- Deployment of coordination teams and improved coordination in six sites
- Employment of 45 health workers to provide essential treatment
- Provision of cholera treatment kits for hundreds of patients

The intensification of conflict in the Kasai region of the Democratic Republic of the Congo during 2017 led to the displacement of 1.9 million people. Damage to health facilities in Kasai and an increased prevalence of malnutrition led to an increased risk of outbreaks of communicable diseases, at the same time as the escalating violence limited humanitarian access to affected communities.

In November 2017 CFE funding of US$ 500 000 enabled WHO to strengthen the coordination of emergency health interventions in the affected provinces, including the establishment of a national coordination mechanism for the public health response in Kasai. WHO also reinforced disease surveillance systems, provided essential medical supplies, and supported local partners to provide basic health services in the region. CFE funding was also crucial for keeping 10 cholera treatment centres staffed, equipped and operational.

**Key achievements**

- Expansion of a comprehensive humanitarian health response in Kasai region, including strengthened coordination
- Establishment of disease surveillance systems
- Staffing and supply of 10 cholera treatment centres
In April 2017, an outbreak of suspected cholera cases struck Ethiopia. The rapid spread of the disease, with case numbers quickly climbing to over 50,000 cases in the Oromia and Somali regions, and the unusually high rate of deaths triggered a CFE allocation of US$ 2,300,000 to enable WHO to provide comprehensive support to the Government of Ethiopia.

The funding allowed WHO to deploy multidisciplinary surge teams of experts in surveillance; case management; water, sanitation and hygiene (WASH); nutrition; risk communications; and administration and logistics to the affected regions to support the Government’s response. WHO also provided vital supplies including vehicles, medicines, case-management protocols, laboratory reagents, treatment kits, targeted training, and supported the operation of 22 health and nutrition mobile clinics in the Oromia and Somali regions.

WHO established emergency command posts in five regions — Afar, Amhara, Oromia, Somali, and Tigray — enabling WHO’s health sector coordination team to provide leadership and support to 18 partners. The team published regular Health Sector Bulletins to ensure information-sharing, coordination and collaboration amongst partners.

As a result of the response, the incidence of suspected cholera cases began to decline by the end of 2017. The short-term, high-impact CFE-funded WHO response has laid the groundwork for long-term emergency-management capacity in the affected regions.

**Key achievements**

- Rapid deployment of 30 experts to coordinate and strengthen the response
- Establishment of an Incident Management System
- Coordination of 18 health partners
- Provision of essential medicines and medical supplies, and targeted training of health workers
- Support for the operation of 22 health and nutrition mobile clinics in the Oromia and Somali regions
IRAQ

In 2016, hundreds of thousands of civilians fled the northern Iraqi city of Mosul as government security forces continued their military offensive to reclaim the city from armed opposition groups. The city, which had more than one million people, was besieged on all sides by a coalition of Iraqi and Kurdish troops, with additional support from Western forces. The Government announced in January 2017 that eastern Mosul had been retaken; however, the western part of the city, with its narrow, winding streets, presented a more difficult challenge. Many civilians caught up in the brutal fighting were killed or seriously injured. Civilians attempting to leave the city faced the threat of landmines, booby-trapped buildings and snipers.

From April 2017 onwards, two separate CFE allocations of US$ 1.5 million enabled WHO to establish and sustain two emergency field hospitals near the outskirts of Mosul. The first, the Hammam Al-Alil field hospital, was established to the south of the city, and began receiving its first trauma patients on 23 April 2017. The Bartella emergency field hospital was established a short distance to the east of Mosul. Between April and September, CFE funds enabled the hospitals to provide vital emergency trauma, medical, surgical, obstetrics, and nutritional care, saving lives and reducing the suffering of the many civilians caught up in the fighting, including over 50 000 internally displaced people living in nearby temporary camps. CFE funding allowed the Bartella hospital to provide almost 1500 episodes of care for these extremely vulnerable populations, while almost 7000 patients between April and October 2017 received care at Hammam Al-Alil. The funding also ensured that both hospitals were operating at optimal capacity prior to the handover of the facilities to the local Department of Health. The success of the field hospitals in the face of incredibly challenging circumstances has been described as a game-changing model for humanitarian response – and it would not have been possible without CFE funding.
Key achievements

- Nearly 1500 episodes of care provided at Bartella; 7000 patients treated at Hammam Al-Alil, most of whom were in a critical condition
- Increased access to life-saving and disability-reducing surgery for individuals affected by the war through emergency trauma, medical and surgical interventions
- Strengthened capacity of national health workers in preparation for the handover to the local Department of Health

KENYA

In July 2017, a number of concurrent cholera outbreaks in Kenya triggered the need for a rapid, coordinated response to stem the rise in cases and prevent the further spread of the disease to at-risk populations. Outbreaks of the disease were reported in 12 counties, including in the capital Nairobi, and in the Kakuma and Dadaab refugee camps. An increased rate of arrivals fleeing renewed conflict in Somalia and South Sudan at Kakuma and Kalobeyei exacerbated the situation: an estimated 500–1300 South Sudanese refugees arrived at the camps each week from June onwards. The outbreaks were a particular cause for concern because of the high population density of the affected areas, their proximity to neighbouring countries, and the fact that the majority of cases occurred among infants and women.

CFE funding of US$ 300 000 enabled WHO to provide rapid and targeted emergency support to the Kenyan Government. In particular, strengthened coordination at the national and county levels, including for rapid response teams, ensured that alerts of possible new cases were investigated quickly and thoroughly so that preventive measures could be taken before small outbreaks had the chance to spread. This was aided by WHO technical and logistical support to ensure that there was an uninterrupted supply chain of essential reagents for laboratory diagnosis, and essential drugs and products for treatment.

Key achievements

- Improved coordination at the national and county levels, including information management and coordination of rapid response teams
- Scaled-up primary healthcare and targeted health-promotion interventions to prevent disease spread
- A robust supply chain established for laboratory diagnostics and essential drugs
Plague is endemic in Madagascar, but the most severe pneumonic form of the disease is rare. By contrast with the more common bubonic form, pneumonic plague attacks the lungs of patients, quickly leading to death if untreated. And unlike bubonic plague, pneumonic plague can be spread from person to person through the air. The severity of the disease and the high risk of further spread triggered an immediate emergency response from WHO after the Malagasy authorities detected an outbreak of the disease in August 2017. The outbreak was particularly unusual in that it had spread to the capital of the country, significantly increasing the risk of a large outbreak.

CFE funding of US$ 1.4 million enabled WHO to quickly send experts and supplies, including 1.2 million doses of essential antibiotics, to Madagascar, while at the same time supporting at-risk countries to increase surveillance and take other preventive measures. The CFE funds enabled WHO to support specialized plague treatment units to ensure patients received top-quality care and to reduce the risk of spread from patients to health workers. Equally important to prevent the further spread of the disease was the establishment of a surveillance network of contact tracers, who monitored the health of anyone thought to have come into contact with a confirmed case. Contact tracing ensures that contacts receive care as soon as they start to show symptoms, and minimizes the risk of the disease spreading in the community. Nine teams of contact tracers trained and led by WHO epidemiologists tracked over 7000 contacts between August and the end of the outbreak in November, providing counselling and prophylactic antibiotics. Only 11 of the 700 contacts developed symptoms. This deadly disease exacted a high toll: 209 people died during the outbreak. However, the decisive action funded by the CFE prevented the outbreak from claiming even more lives, and avoided potentially severe damage to the economy of Madagascar and neighbouring countries.

**Key achievements**

- Rapid deployment of experts and 1.2 million doses of antibiotics
- Establishment of specialized treatment units
- Over 7000 contacts traced and treated
MALDIVES

In March 2017, the Maldives reported an unusual increase in respiratory infections, including cases of 155 cases of Influenza A (H1N1). A small CFE allocation of US$ 100 000 enabled WHO to provide rapid technical and material support to the Maldives’ Ministry of Health to implement outbreak control measures, including prevention and treatment.

In addition to the deployment of expert personnel, WHO delivered 1200 doses of Oseltamivir antiviral medication to treat patients severely ill with influenza; 5500 universal transport media and 1000 rapid test kits required to diagnose influenza; 21 500 doses of influenza vaccines; infection prevention and control supplies; and training to 40 doctors and nurses in the critical care of patients with severe respiratory disease. WHO also provided technical support for a public awareness campaign through social and mass media.

Key achievements

• Delivery of 1200 doses of antiviral medication to treat severe cases, and 21 500 doses of vaccines
• Delivery of 1000 rapid diagnostic kits
• Provision of infection prevention and control supplies including 1000 masks, 500 gowns and 500 shields for health workers
• Training of 40 doctors and nurses in critical care management
• Public awareness campaign
A meningitis outbreak first detected in December 2016 quickly escalated in 2017, and reached alarming proportions by the spring, with over 2524 cases and 328 deaths reported by April. The outbreak was centred on the north-western state of Zanfara, and predominantly caused by meningitis type C. Nigeria is more commonly affected by type A meningitis, and a lack of available vaccine against type C disease complicated initial response efforts.

Funding from the CFE enabled WHO to provide substantial support to the Ministry of Health, including through strengthened field coordination of disease surveillance, case management, laboratory capacity and logistics. Training was provided to rapid response investigation teams, health workers, laboratory personnel and vaccination teams. WHO ensured that capacity for the storage, distribution and management of vaccines was in place before mass vaccination campaigns commenced in the worst-affected areas, with more than 1.3 million doses of vaccine delivered by WHO. The Nigerian Federal Ministry of Health declared an end to the outbreak on 23 June 2017.

**Key achievements**

- Strengthened surveillance and case management
- Delivery of 1.3 million doses of vaccine

Photo: WHO/AFRO
OCCUPIED PALESTINIAN TERRITORY

In April 2017, electricity cuts left public hospitals in Gaza, in the occupied Palestinian territory, on the verge of collapse and reliant on a dwindling supply of back-up fuel for power. The health system was also undermined by the shortages of essential drugs and disposables. Of the 516 medications on the essential drugs list, 175 (33.9%) were reported in April to have zero stock levels, and a further 62 medications (12%) only had enough stocks to last three more months. Newborn babies formed one of the most vulnerable groups, with an acute shortage of medicines essential for maternal and child health. The hospitals serve a population of 2 million people, including 1.1 million refugees. CFE funds enabled WHO to address problems on both fronts.

From May, WHO was able to provide fuel to all 14 of Gaza’s public hospitals, including its largest (and only) trauma hospital in Shifa, which handles up to 80% of all emergency cases in Gaza. This enabled the hospitals to provide emergency care to 103,700 people. The fuel was used to sustain key emergency departments, including intensive care units across Gaza and six neonatal intensive care units, supporting 452 neonates. In addition, a total of 658 patients undertaking dialysis sessions twice or three times a week were able to continue their treatment, with over 7800 sessions taking place with support from WHO. And a total of 3300 children were able to receive treatment in paediatric units.

WHO procured and distributed essential drugs and disposables, including 2380 items of essential disposables for haemodialysis units in Gaza. WHO also procured and supplied almost 15,000 units of essential lifesaving drugs used in the emergency departments in Gaza’s largest hospital, Shifa Hospital.

Key achievements

• Provision of essential lifesaving medical and non-medical supplies
On 23 May 2017, armed clashes broke out between Government military forces and militants of the Maute group. The conflict resulted in over 350,000 internally displaced persons (IDPs) living in evacuation centres and other temporary accommodation in Lanao del Sur and Lanao del Norte. A lack of safe water and sanitation facilities and low immunization coverage significantly increased the risk of communicable diseases, and triggered a small allocation from the CFE to fund emergency deployments from the WHO Country Office.

WHO supported the deployment of mobile teams to provide health services, including medical services, nutrition, psychosocial support, and UNFPA-supported reproductive health services, to IDPs in four underserved municipalities. WHO also provided logistical support to the Department of Health, delivering rapid diagnostic test kits for cholera and jerry cans of clean water.

WHO trained local health workers from 39 municipalities on the Surveillance in Post Extreme Emergencies and Disasters (SPEED) disease early warning system, and provided technical support to analyse and interpret the disease surveillance data. No outbreaks of any disease were detected throughout the duration of the conflict. On October 2017, the Philippine Government declared the end of the Marawi conflict.

Key achievements

- Nearly 40,000 patients provided with health services through mobile health clinics
- 9 rural health units provided with additional medicines and supplies
- 50 health workers trained on SPEED
- 5000 jerry cans of clean water provided to the IDPs through the Department of Health
- 1000 rapid diagnostic test kits for cholera donated to the Department of Health
SIERRA LEONE

Heavy rains in Sierra Leone in August 2017 resulted in severe flooding and mudslides, killing hundreds and affecting thousands. Limited resources prompted the Government to request international assistance in response to the disaster.

A CFE allocation of US$ 107 000 allowed WHO to support surveillance and case management of water-borne diseases; infection prevention and control; the management of safe burials; water quality monitoring; psychosocial support; and overall coordination of the response.

Key achievements
• Package of health services provided, including disease surveillance, WASH, safe burials and psychosocial support

SOMALIA

In early 2017, an escalation of a cholera cases in Somalia, combined with a number of outbreaks in surrounding countries, led to an allocation of US$ 100 000 from the CFE to support critical technical functions in the Somali Ministry of Health. The funding was used to deploy a technical team to conduct a rapid risk assessment and guide the expansion of the response. The team supported 12 cholera treatment centres/units and trained over 240 health workers in cholera case management, surveillance, and clean water and sanitation. Armed with increased knowledge and skills, front-line health workers were able to deliver better care to cholera patients. Funding also supported the purchase of diagnostic laboratory equipment. The response laid the groundwork for a cholera vaccination campaign in Somalia, which reached 453 000 people: the largest cholera vaccination campaign to date in Africa.
Key achievements

• Deployment of experts to support training in cholera case management, surveillance and testing for 12 cholera treatment centres/units and 240 health workers

Somalia once again faced the threat of famine in 2017. In addition to worsening food security and nutrition outcomes, Somalia was also gripped by ongoing outbreaks of measles, acute watery diarrhoea and cholera. CFE funding enabled WHO to expand its presence and activities in Somalia to respond to the increasing health needs. Experts were rapidly deployed to strengthen the national, federal and regional levels of Ministry of Health structures to enable them to conduct active disease surveillance and regular monitoring of health service availability. Working with partners and the Somali Government, WHO supported the establishment of Drought Operations Coordination Centres and a Ministry of Health-led Cholera Task Committee.

CFE funding also supported the operation of 79 cholera treatment centres established by health authorities and partners to manage acute watery diarrhoea and cholera cases, and 275 sentinel sites to collect real-time data for epidemic-prone diseases, including cholera. CFE funding also enabled WHO to provide emergency support to 300 primary healthcare centres and 15 hospitals in six regions.

Key achievements

• Improved disease surveillance and monitoring
• Support to cholera treatment centres
• Support to health centres and hospitals for improved service delivery
In South Sudan, years of poverty and underdevelopment have been compounded by a major food security crisis. In 2017, almost 5 million people – more than 40% of the population – were severely food insecure, placing a heavy burden on the nation’s healthcare system. In response to the increased risk of famine and the alarming nutritional emergency in children, WHO used CFE funds to rapidly distribute 50 severe acute malnutrition (SAM) kits to treat over 2500 children suffering from SAM with medical complications. The provision of SAM kits is part of an innovative strategy to support stabilization centres with a standard set of quality medicines to manage common medical complications linked to SAM in children. Each WHO SAM kit is designed for the management of medical complications from severe malnutrition for 50 children for around three months.

Key achievements
- Rapid distribution of 50 severe acute malnutrition (SAM) kits, to treat over 2500 children suffering from SAM with medical complications
Marburg virus disease (MVD) is a severe and often lethal disease caused by a virus from the same family as the Ebola virus. As with Ebola virus disease, outbreaks of MVD are rare but have the potential to spread rapidly through person-to-person contact, putting healthcare workers at high risk. In early October, WHO was alerted by the Ugandan authorities that they had detected a laboratory-confirmed case in a remote, mountainous area near the country’s border with Kenya. As with the response to the outbreak of Ebola virus disease in Democratic Republic of the Congo, the rapid release of just over US$ 600 000 from the CFE enabled WHO to deploy a surge team to the affected community within 24 hours.

CFE funding enabled WHO to provide technical and material support for laboratory testing and, crucially, training and supervision for almost 500 contact tracers who monitored at-risk members of the community for signs of the disease. Enhanced infection prevention and control measures at health facilities, building on several years of WHO training for hospital staff in the country, ensured that not a single health worker was infected during the outbreak.

WHO support also included a logistics hub to coordinate response operations, including management of the vehicle fleet, pre-positioning of 20-bed hospital tents in case of escalation, and the provision of satellite communication equipment, viral haemorrhagic fever treatment kits, and 10 motorcycles to cover the terrain impassable by four-wheel drive.

Strong coordination and information-sharing with surveillance teams across the border in Kenya ensured that the threat of cross-border spread of the disease was minimized. The outbreak was declared over in December. Three people had died.

After the EVD outbreak in the Democratic Republic of the Congo, the MVD outbreak in Uganda was the second time in less than six months that a rapid WHO response funded by the CFE was able to stop a potentially catastrophic outbreak of viral haemorrhagic fever in its tracks.
Key achievements
- Strengthened infection prevention and control measures resulting in zero cases of health worker infections
- 500 contact tracers trained and supervised to monitor signs of transmission in the community
- Strong cross-border coordination and zero cases of cross-border transmission

VANUATU
In May 2017, Cyclone Donna left many people in remote areas of Vanuatu without access to health services. A small but crucial allocation from the CFE (US$ 80 000) allowed WHO to support the Ministry of Health to coordinate the health response, conduct assessments, distribute nutritional supplements, and send medical staff to the worst-affected areas, reaching some 11 000 people.

Key achievements
- Improved coordination and needs assessment
- Medical treatment and nutritional supplies delivered to 11000 residents in remote areas

Other allocations in 2017
The CFE also provided allocations in response to the following emergencies in 2017:

- Dengue fever outbreak in Pakistan (US$ 282 159)
- Famine response in the Horn of Africa (US$ 995 000)
- Health response in Syria (US$ 292 000)
- Suspected cholera outbreak in Sudan (US$ 500 000)
- Malaria outbreak in Nigeria (US$ 296 000)
- Necrotizing cellulitis outbreak in São Tomé and Príncipe (US$150 000)
Replenishing the CFE and strengthening WHO’s response capacity

Member States recognize the importance of providing WHO with the resources to quickly mount an effective response to outbreaks and emergencies.

Replenishing the CFE to the target of US$ 100 million set by the World Health Assembly must remain a priority for WHO and Member States. Over the next biennium (2018-2019), WHO will implement a robust replenishment strategy for the CFE, integrated into a broader, sustainable model for health emergency financing.

Retroactive donor contributions to WHO country response plans

Central to a sustainable replenishment strategy is the reimbursement of CFE allocations by donor contributions to the WHO country response plans. WHO is building its capacity to mobilize resources for response including at country level. WHO needs sufficient donor support for country response plans, with retroactive start dates to be able to replenish the CFE.

Draw-down facility

WHE is exploring with partners the setting up of a draw-down facility for a pre-determined fixed amount which the CFE could access once its balance drops below a pre-agreed level. This facility would ensure that the CFE has a minimum operating balance at all times which in turn safeguards WHO’s rapid response capability.

Developing a coordinated mechanism for contingency financing

The CFE needs to be seen as part of a broader contingency financing ecosystem for health emergencies. Different funding mechanisms, such as the UN’s Central Emergency Response Fund (CERF), also have a vital role to play. One of the objectives of CERF when it was established in 2005 was to promote early action to reduce loss of life. WHO is engaged with CERF and sister agencies in a discussion to review CERF’s life-saving criteria (LSC) to include specific activities linked to early warning and early action as an integral part of the LSC. With emergency operations becoming increasingly complex and costly, an expansion of the criteria would help maximize CERF’s impact.

WHO Financing Campaign

WHO will soon launch a campaign to finance its General Programme of Work, including the full spectrum of the work of the WHO Health Emergencies Programme. As part of the campaign WHO will seek the commitment of partners to help minimize the impact of health emergencies and outbreaks by ensuring the CFE has an adequate operating balance on a rolling basis. WHE will also ask G20 partners to demonstrate, through financial support, the commitment they made in Hamburg, Germany, on 7 and 8 July 2017 when they signed the G20 Leaders’ Declaration “Shaping an Interconnected World”.
Advocacy: “Friends of WHE”
The group of partners who were early supporters of the Programme has re-launched the “Friends of WHE” initiative. WHO will work with the group to leverage their voice and influence in different fora in support of WHO’s emergency work, and to highlight the unique, enabling role of the CFE in preventing emergencies from escalating.

Beyond the 2018-2019 biennium: Exploring new sources of financing
As part of a sustainable financing model for the CFE, WHO will continue to diversify its donor base including drawing support from foundations, the private sector and Islamic humanitarian funding. WHO will work with the UN Foundation and other partners to explore partnership opportunities around health emergencies campaigns that leverage charitable giving and corporate philanthropy.
## CFE ALLOCATIONS IN 2017

<table>
<thead>
<tr>
<th>Country</th>
<th>Emergency</th>
<th>Amount (US$)</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cameroon</td>
<td>Conflict</td>
<td>500 000</td>
<td>Feb-17</td>
</tr>
<tr>
<td>São Tomé and Principe</td>
<td>Necrotising Cellulitis outbreak</td>
<td>150 000</td>
<td>Feb-17</td>
</tr>
<tr>
<td>Chad</td>
<td>Hepatitis E virus outbreak</td>
<td>100 000</td>
<td>Feb-17</td>
</tr>
<tr>
<td>South Sudan</td>
<td>Food insecurity</td>
<td>625 545</td>
<td>Mar-17</td>
</tr>
<tr>
<td>Somalia</td>
<td>Cholera outbreak</td>
<td>99 940</td>
<td>Mar-17</td>
</tr>
<tr>
<td>Maldives</td>
<td>Influenza A (H1N1) outbreak</td>
<td>100 000</td>
<td>Mar-17</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>Suspected cholera outbreak</td>
<td>2 300 000</td>
<td>Apr-17</td>
</tr>
<tr>
<td>Burundi</td>
<td>Malaria outbreak</td>
<td>100 000</td>
<td>Apr-17</td>
</tr>
<tr>
<td>Nigeria</td>
<td>Meningitis outbreak</td>
<td>540 400</td>
<td>Apr-17</td>
</tr>
<tr>
<td>Regional Africa</td>
<td>Famine response</td>
<td>995 000</td>
<td>May-17</td>
</tr>
<tr>
<td>occupied Palestinian territory</td>
<td>Complex emergency</td>
<td>362 000</td>
<td>May-17</td>
</tr>
<tr>
<td>Vanuatu</td>
<td>Cyclone Donna</td>
<td>80 000</td>
<td>May-17</td>
</tr>
<tr>
<td>Democratic Republic of Congo</td>
<td>Ebola virus disease outbreak</td>
<td>2 000 000</td>
<td>May-17</td>
</tr>
<tr>
<td>Somalia</td>
<td>Famine response</td>
<td>1 442 339</td>
<td>May-17</td>
</tr>
<tr>
<td>Philippines</td>
<td>Conflict (Marawi)</td>
<td>48 760</td>
<td>Jun-17</td>
</tr>
<tr>
<td>Sudan</td>
<td>Suspected cholera outbreak</td>
<td>500 000</td>
<td>Jun-17</td>
</tr>
<tr>
<td>Democratic Republic of Congo</td>
<td>Cholera outbreak</td>
<td>280 000</td>
<td>Jun-17</td>
</tr>
<tr>
<td>Iraq</td>
<td>Conflict</td>
<td>1 500 000</td>
<td>Jun-17</td>
</tr>
<tr>
<td>Nigeria</td>
<td>Malaria outbreak</td>
<td>296 000</td>
<td>Jul-17</td>
</tr>
<tr>
<td>Kenya</td>
<td>Cholera outbreak</td>
<td>300 000</td>
<td>Jul-17</td>
</tr>
<tr>
<td>Burundi</td>
<td>Malaria outbreak</td>
<td>328 830</td>
<td>Jul-17</td>
</tr>
<tr>
<td>Iraq</td>
<td>Conflict</td>
<td>1 500 000</td>
<td>Jun-17</td>
</tr>
<tr>
<td>Central African Republic</td>
<td>Conflict</td>
<td>360 867</td>
<td>Aug-17</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>Mudslides</td>
<td>107 000</td>
<td>Aug-17</td>
</tr>
<tr>
<td>Pakistan</td>
<td>Dengue Fever outbreak</td>
<td>282 159</td>
<td>Sep-17</td>
</tr>
<tr>
<td>Syrian Arab Republic</td>
<td>Conflict</td>
<td>292 000</td>
<td>Sep-17</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>Rohingya Crisis</td>
<td>1 500 000</td>
<td>Sep-Nov 17</td>
</tr>
<tr>
<td>Madagascar</td>
<td>Pneumonic plague outbreak</td>
<td>1 451 248</td>
<td>Sep-Oct 17</td>
</tr>
<tr>
<td>Uganda</td>
<td>Marburg viral disease outbreak</td>
<td>623 000</td>
<td>Oct-17</td>
</tr>
<tr>
<td>Democratic Republic of Congo</td>
<td>Complex emergency</td>
<td>500 000</td>
<td>Nov-17</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>Rohingya Crisis (Diphtheria)</td>
<td>1 500 000</td>
<td>Dec-17</td>
</tr>
</tbody>
</table>

**TOTAL**: 20 765 088