The WHO Health Emergencies Programme has three main funding categories: the core budget that covers the essential functions of the programme; the appeals budget that covers the additional work that is done in response to protracted health emergencies; and the WHO Contingency Fund for Emergencies (CFE): a bridge fund designed to enable WHO to respond rapidly to health emergencies as soon as they are detected.

As of 18 October 2016 the CFE has raised US$ 31.5 million of its US$100 million target capitalization. Allocations to date total US$ 18.16 million in support of WHO activities in response to 10 health emergencies ranging from public health emergencies of international concern (Zika virus disease) to localized humanitarian crises such as the health emergency in northern Nigeria (figure 1).

This paper provides a brief overview of why the CFE was established and the work of the CFE to date; addresses questions that member states have asked about how the CFE fits with other funding available for emergencies; and provides recommendations on how to ensure the CFE is financed sustainably in the future.

Establishment of the CFE: learning lessons from the Ebola response
The CFE was established by the World Health Assembly in May 2015 following a review of WHO’s response to the 2014 Ebola outbreak in West Africa. Before the CFE, WHO had no central fund capable of rapidly disbursing funds to pay for early emergency response activities – a particular problem when dealing with a fast-moving disease outbreak. During the early stages of the response to the Ebola outbreak in West Africa, funding from donors took many months to disbursed. That lack of funding hampered WHO’s ability to take action that would have helped to save lives.

Figure 1 | Emergency responses enabled by CFE funds: May 2015 through October 2016
Case Study 1: Accelerating International Response to Zika
On 1 February 2016, WHO Director-General Margaret Chan convened an Emergency Committee of 18 experts to assess the level of threat to public health posed by the outbreak of Zika Virus in the Americas, after increasing evidence that the virus was associated with neurological complications in new-borns. WHO declared a Public Health Emergency of International Concern (PHEIC) the same day, and published a comprehensive Strategic Response Plan two weeks later.

Figure 2 shows how funds were disbursed over time to pay for the response outlined in the Zika Strategic Response Plan. CFE funds were disbursed within 24 hours of the declaration of the PHEIC, and were crucial in the early stages of the response, enabling a full Incident Management Structure (IMS) to be implemented in WHO headquarters in Geneva and all WHO regional offices. Without this bridge funding the response would have been delayed until the first contributions from Japan and Australia were received, 6 weeks after the declaration of the PHEIC. Donors were initially slow to commit as the Zika outbreak was perceived to fall between the work of development agencies — who were waiting to gauge the implications of the outbreak for individuals and health systems — and humanitarian agencies that did not consider Zika to be a disease with sufficient levels of mortality to qualify as an emergency.

Nine months after the declaration of the PHEIC, and after strong advocacy work from WHO, WHO’s requirement in the revised Zika Strategic Response Plan is now 60% funded. However, WHO has been unable to replenish the initial disbursement from the CFE for several reasons:
1. Some donors are not willing to replenish the CFE.
2. Some donors will not permit funds to be back-charged to cover activities funded by the CFE.
3. Funds are narrowly earmarked for specific future activities.
4. The evolution of the outbreak has meant that activities originally funded by the CFE are now completed (e.g., risk assessments in Latin America). New activities therefore appear more immediately relevant and attractive to donors e.g. research on a vaccine against Zika virus.

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

Figure 2 | Total funds received for Zika response versus time since declaration of Zika as a public health emergency of international concern

Time since declaration of public health emergency of international concern

It took approximately 9 months before donor funds plus CFE funding matched the initial requirements of the Zika Strategic Response Plan (SRP).
Case Study 2: Ending the Yellow Fever Outbreak in Angola and DRC

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

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

Vaccination was crucial to the success of the response. Modelling indicated that vaccinating the population of the DRC capital Kinshasa and the population living along the Angola–DRC border would provide a buffer to halt any further expansion of the outbreak. However, delivering yellow fever vaccine to the remote communities along the Angola–DRC border was a logistical challenge. Emergency stockpiles of the vaccine were also running low. In order to vaccinate the population of a large capital like Kinshasa, it was necessary to use a pioneering new approach in which each individual was vaccinated with a fraction of the usual vaccine dose. Funds were provided by Japan to purchase the specialised syringes required to deliver fractional doses, but further funds were required to get the vaccine to populations in need.

Figure 3 shows the time lag from the point the WHO Incident Management System was established and Strategic Response Plan was published to the receipt of donor funds. In the intervening period multiple disbursements from the CFE were required to sustain essential response activities as the outbreak evolved. To date, disbursements total US$ 6.43 million. Only Germany has agreed to refund part of these disbursements through a €200 000 contribution. The last confirmed case of yellow fever linked to the outbreak was reported from DRC on 12 July.

Over 6 months since the outbreak of yellow fever in Angola was declared a grade 2 emergency, Germany remains the only donor to have replenished the CFE (€200 000).
Case study 3: Responding to the humanitarian emergency in northern Nigeria

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

WHO declared a Grade 3 emergency on 19 August. A strategic response plan was developed focussed on addressing the immediate health needs of newly accessible populations. A request for CFE funds was made on 29 August, with US$ 2.1 million released within 24 hours (figure 4). The funds were required for the initial response including the establishment of a forward operating base in Borno State.

The total funding that WHO requires, as shown in figure 4, is just under US$ 12 million through to the end of December 2016, including reimbursement of the initial CFE funding. The funding is required to meet a number of strategic objectives, including: the referral to a nutritional programme of over 95% of children under 5 with severe acute malnutrition; the vaccination against polio and measles of over 80% of children under 5 years, and the capacity to investigate all new infectious disease alerts within 24 hours. WHO has already had positive conversations with key donors in Nigeria. However, no donors are able to provide funds before the end of 2016. Therefore WHO is heavily reliant on the CFE as the main source of funding until then. No donors have yet agreed to replenish the CFE.

CERF: A necessary but not sufficient donor

The UN Central Emergency Response Fund (CERF) is one of the largest donors to WHO humanitarian appeals, and is an important partner of WHO. In 2016 alone WHO has received US$ 32.5 million from CERF for 41 grants covering 36 countries (Annex table 1).

However, CERF funding cannot cover all the activities that WHO is required to undertake in response to emergencies. The criteria for CERF funding are based on the idea of prioritizing life-saving assistance, and

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**Figure 4 | Actual funding and projected* funding scenario for WHO’s response to the health emergency in northern Nigeria**

*Projection based on pledges received and negotiations in progress as on 26 October 2016.*
often exclude many of the preparedness, human resources, and capacity strengthening activities necessary during the initial phases of WHO’s response to outbreaks and humanitarian emergencies. The different funding criteria used by the WHO CFE and CERF are contributory factors to the reluctance of CERF to approve funds for CFE reimbursement. CERF and the CFE are therefore distinct but complementary sources of early funding to emergencies.

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

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

**World Bank Pandemic Financing Facility: will this address WHO underfunding in emergencies?**

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

The PEF complements the WHO CFE. The PEF is activated once an outbreak crosses a pre-defined threshold of severity, whereas the CFE is designed to respond to any type of emergency with health and humanitarian consequences, including natural disasters—not only outbreaks with pandemic potential. Because the funds from PEF are to be used for a particular response, not pooled as they are in the CFE, WHO is restricted as to which activities can be funded through the PEF. PEF funding will potentially be available only for a limited number of the health emergencies. None of the 47 emergencies WHO is responding to at present would qualify for PEF funds.

**Internal Emergency Funds: models used by other UN agencies**

Several of WHO’s key UN partners operate internal funding mechanisms similar to the CFE. WFP has the Immediate Response Account (IRA). The Allocations from the IRA are made as loans to eligible operations in anticipation of receiving donor contributions. If no such donations are received, the loan is deemed to be a permanent, non-reimbursable grant from the IRA. The IRA serves as both a replenishable and a revolving fund. Revolving means that funds allocated from the IRA to an operation may subsequently be reimbursed to the IRA account with donor contributions received for that operation. Contributions that are used to revolve the IRA are accounted for and reported under the operation to which the donor pledged them. Donors provide contributions directly to the IRA to replenish it.

UNICEF established the Emergency Programme Fund (EPF) in 1971, which continues to be the primary mechanism for UNICEF country offices to scale up their emergency response in the first days of a crisis. The EPF has continued to be an effective means of providing funds to UNICEF offices in a timely manner, and enables the organization to initiate its response to crises before donor funds become available. In 2015 the Executive Board approved an increase of the finding ceiling to US$ 75 million per year. UNICEF disbursed a total of US$ 28.8 million in 15 countries during 2015.

**Next steps for the CFE: sustainable financing**

The CFE has been a critical tool to enable WHO to quickly respond to emergencies, rather than wait for funds through appeals and applications to external donors. The CFE has saved lives and helped avert disease outbreaks and their associated social and economic consequences through small, targeted interventions. To continue this work requires sustainable financing. The main challenge faced by WHO with respect to the CFE is the inability to replenish it.

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

There are four main options for funding the CFE:

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

Continuing with the current model is not feasible: at the current rate of use the CFE may be completely depleted within 12 months or less. Identifying an income stream within WHO to pay for the fund has proven difficult. WHO has limited core funding to begin with, and there are already multiple other demands for flexible funds. Globally, interest rates earned on deposits are too low to provide a viable income stream.

Establishing an annual pledging cycle would enable WHO to draw attention to the impact of the fund at country, regional and global level, and feed into a wider discussion on funding for WHO and for the programme. A number of UN agencies already use this model and the CERF also has an annual pledging cycle. The target capitalization of the CFE is of an order of magnitude lower than CERF, for example, but the past 12 months has amply demonstrated the crucial role that rapid access to relatively small amounts of funding plays in preventing the escalation of health emergencies by enabling an early and proportionate response. One option, therefore, is that WHO presents a request for CFE replenishment to the World Health Assembly in 2017, and annually thereafter. In the meantime, WHO will continue to work with donors to secure additional funding for the CFE, and will negotiate with donors to provide funds to reimburse the costs of activities already paid for by the CFE.
Annex

WHO contingency fund for emergencies income and expenditure:
May 2015 through October 2016

Funding status
- 68% Funding gap
- 31% Funds received
- 1% Pipeline
US$ 100 million

Contributions (US$ millions)
- Germany: 3.73
- India: 1.00
- Canada: 0.73
- China: 2.00
- Estonia: 0.03
- United Kingdom: 9.44
- Japan: 10.83
- Sweden: 1.12
- Netherlands: 1.12
- France: 1.47

Allocations (total US$ 18.16 million)
- Yellow Fever: 6.34
- Cholera outbreak: 0.51
- Nigeria crisis: 2.20
- Rift Valley fever: 0.5
- Haiti: 0.25
- Cyclone Winston, Fiji: 0.52
- Libya conflict: 0.37
- Ethiopia: 1.13
- China: 3.85
- Yemen: 0.51
- DRC: 1.97
- Papua New Guinea: 0.48
- El Nino: 0.48
- Haiti Cholera: 0.51

Zika virus:
- 3.85
- Nigeria crisis: 2.20
- Libya conflict: 0.37

Cholera outbreak:
- 0.51
- Yemen: 0.51
- DRC: 1.97

Nigeria crisis:
- 2.20

El Nino:
- 0.48
- 1.13
- 1.97
- 1.47

Haiti:
- 0.25
- 0.52

Zika virus:
- 3.85
- 0.52
- 0.25

Libya conflict:
- 0.37
- 0.52
- 0.25
### Table 1a | CERF grants to WHO: Feb–May 2016

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