

2019 annual report:

WHO CONTINGENCY FUND FOR EMERGENCIES

CFE CONTRIBUTORS 2018–2019


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FOREWORD



We are looking back on 2019 from a very different world.

Many things have been changed and will be changed by the global COVID-19 pandemic. This report is an important reminder that some things will stay the same.

There will always be new outbreaks and health emergencies for which we must remain vigilant and ready to respond. The Contingency Fund for Emergencies (CFE), now in its sixth year of operation, was established to help us do this and more.

The CFE has evolved into a flexible contingency fund that provides WHO with resources at the start of an emergency, allows WHO to scale up activities in response to an escalation in an ongoing crisis, and supports the continuity of critical, life-saving operations in the absence of specific funding.

This flexibility has seen the CFE play a key role in the response to the Ebola outbreak in eastern Democratic Republic of the Congo. From the start of the outbreak in 2018, the CFE was used to kick-start the response. Throughout 2019, the CFE has filled critical gaps in funding to sustain life-saving operations, and has been fundamental in ensuring a sustainable and effective response.

There have been very difficult moments. Civilians and health workers have lost their lives not just to the virus, but to violence. And WHO has mourned the loss of some of its own. Health workers and affected communities have sacrificed so much, but together we have beaten the virus. On 25 June 2020, the Government of the Democratic Republic of Congo declared the outbreak over, though we must stay alert to the threat of new outbreaks. The CFE ensured that we were able to keep going in the toughest of circumstances and keep helping those communities most in need.

In 2019, the CFE enabled WHO to respond to a diverse range of health emergencies. The CFE funded essential health operations in response to conflict in Libya; released funding within 24 hours following Hurricane Dorian in the Bahamas and Cyclones Idai and Kenneth in Mozambique; and supported preparedness and response activities to address the global measles outbreak. In all, the CFE released US$ 83 million for 23 emergencies in 22 countries.

The Fund's success is made possible by the continued generosity of the donor community. In 2019, 16 Member States contributed a record US$ 54 million to the CFE, and four new donors joined the list of contributors. We continue to look at ways to ensure that the CFE is sustainably funded and remains fit for purpose. The goal is a financing mechanism that continues to empower WHO to respond to the needs of affected countries swiftly and effectively.

The COVID-19 pandemic is a stark reminder of the need to invest in resilient health systems so that all countries are prepared to respond to emergencies. Stronger health systems and universal health coverage are cornerstones of a healthier society, one where people not only survive, but thrive.

It is also a reminder that we need flexible resources in place to respond rapidly and effectively to emergencies. In this regard, the CFE is uniquely positioned in the ecosystem of health emergency financing mechanisms and remains a key investment in global health security. We call on your continued generosity to ensure that we can continue to serve the most vulnerable in a world where the relationship between solidarity and security has never been clearer.



Dr Tedros Adhanom Ghebreyesus
WHO Director-General



A woman in Beni, one of the areas worst affected by the Ebola virus disease outbreak in north-east Democratic Republic of the Congo, cares for her child at a health care facility. Women in Beni took a leadership role in explaining how to stop the spread of the disease.

OVERVIEW

About the WHO Contingency Fund for Emergencies (CFE)

The WHO Contingency Fund for Emergencies (CFE) was established in 2015 with a simple goal: enable WHO and its partners to take swift action to save lives. Donors contribute to the fund because they know that rapid, flexible funding is the key to a rapid and effective response to health emergencies.

As soon as a request comes in from the field, the CFE can release up to US$500 000 immediately. Larger requests, subject to approval, can usually be released within 24 to 48 hours. The funding can be used to directly finance WHO response activities, personnel, and essential supplies, as well as funding some of the activities of implementing partners as part of a WHO operational plan.

The funds may be released rapidly, but they are subject to stringent oversight and robust accountability ensured by WHO's financial rules and regulations. Each new funding allocation is tracked through WHO's grant management system, with full financial reporting submitted to the World Health Assembly on an annual basis.

KEY FIGURES 2019

US$ 83 million released

43 separate allocations for 23 emergencies in 22 countries

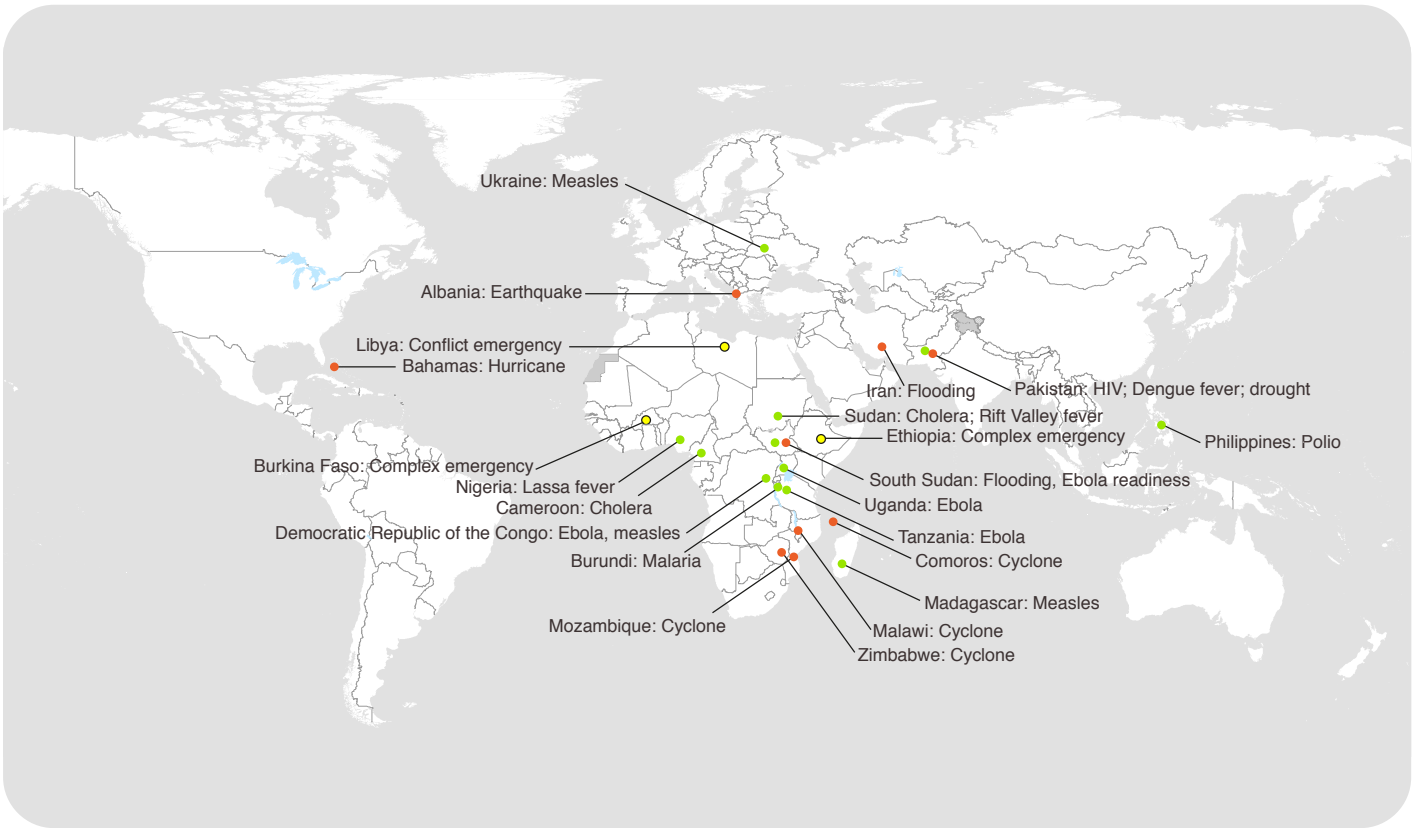
13 disease outbreaks

7 natural disasters

3 complex emergencies

84% of allocations released within 24 hours of request

Figure 1 CFE: overview of responses supported in 2019



Infectious disease outbreak
Complex emergency
Natural disaster

The boundaries and names shown ans 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 and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

Data: World Health Organization

2019 overview: CFE in health emergencies

The CFE enabled WHO to mount rapid and sustained responses to 23 separate emergencies in 22 countries (figure 1) in 2019. A total of US$83 million was released by the CFE, with US$54 million implemented – both figures the highest totals since the CFE was launched.

In 2019, the CFE released 78% of allocations of US$ 500 000 or less in 24 hours. 84% of all allocations – regardless of size – were released in 24 hours or less. The average release time for all allocations was just 36 hours.

In some countries, such as Democratic Republic of the Congo (DRC) and Pakistan, CFE funding was used to support WHO's response to more than one emergency. Some emergencies, such as the Ebola outbreak in DRC, had a regional impact and affected more than one country. In all, at least one response required CFE support in every one of the six WHO regions (African Region, Region of the Americas, South-East Asia Region, European Region, Eastern Mediterranean Region, and the Western Pacific Region) in 2019.

The majority (13) of emergencies that required CFE support were infectious disease outbreaks, followed by natural disasters (seven), and complex emergencies (three).

Response activities in DRC received by far the most funding from the CFE during 2019 (**figure 2**).

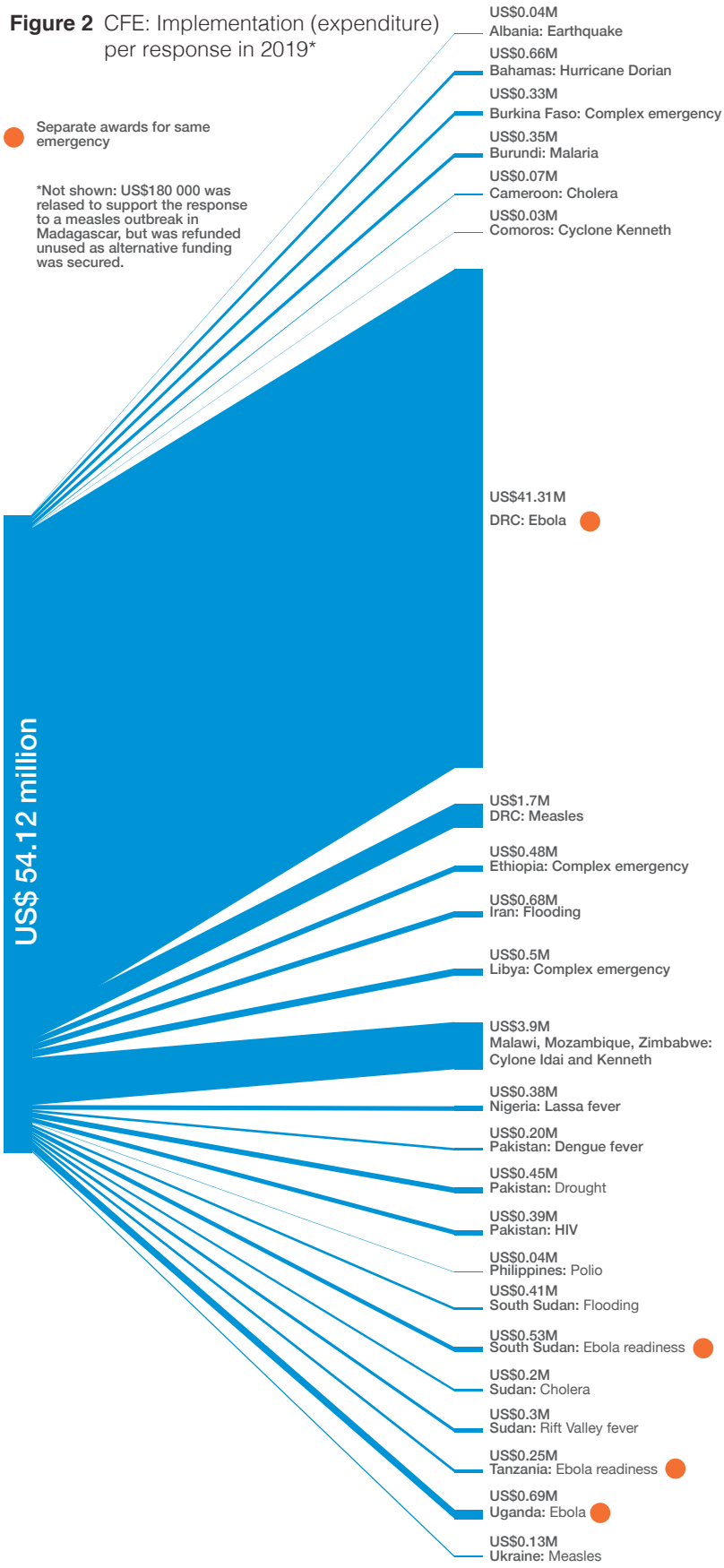
In 2019, the CFE continued to play a life-saving role in the response to the Ebola outbreak in eastern DRC. The CFE was used to bridge funding gaps at critical junctures to ensure the continuity of operations. This minimized disruptions and saved lives. In total, the response to the Ebola virus disease outbreak in DRC was supported and enabled by US$67.5 million released in ten tranches from the CFE throughout 2019, of which US$41.3 was implemented and the remaining US$26.2 million was refunded. This sustained support accounts for 76% of the total of US$54 million of CFE funds implemented in 2019.

In addition, the Ebola virus disease outbreak in DRC triggered CFE funding support for response and readiness activities in neighbouring Tanzania, Uganda, and South Sudan, totaling just over US$2.3 million, of which US$1.5 million was implemented and the remainder was refunded. The overall response to the Ebola virus disease outbreak therefore accounted for almost 80% of CFE funds used in 2019.

The CFE was also used to support health operations in response to the conflicts in Burkina Faso and Libya; released funding within 24 hours following Hurricane Dorian in the Bahamas and Cyclone Idai in Mozambique; and supported preparedness and response activities in response to the global measles outbreak.

Annex 1 contains a complete list of allocations in 2019.

Figure 2 CFE: Implementation (expenditure) per response in 2019*



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.

Table 1 provides a summary of how CFE funding was spent in 2019 by item. Annex 2 provides a more detailed breakdown by category in line with WHO financial statements.

Replenishing the CFE

The CFE was launched in 2015 as a revolving fund. Costs initially incurred against CFE allocations would be reimbursed by donor funding to the WHO emergency response at country level, whilst any unspent CFE funding would be returned. The idea was to have a self-sustaining fund that would not need to rely heavily on annual direct donor contributions.

In practice, it has proven difficult to raise the level of resources required at the country level to sustainably replenish the CFE in this manner. In 2019, only 33% of CFE allocations were refunded (as at March 2020). This matches the lowest proportion of allocations refunded since the CFE's inception, and is below the annual average of around 40% over the previous three years (33% of allocations were returned to the CFE in 2016; 38% in 2017; and 49% in 2018).

One need only look at two responses last year – Ebola in DRC and surrounding countries, and the tropical cyclones that struck Mozambique – to understand the impact that underfunding of emergency responses has on the CFE. Together, these two emergencies accounted for 90% of all CFE allocations in 2019 (US$74.5 million; see Annex 3). For Ebola response and readiness, the CFE allocated nearly US$70 million throughout the course of the year, or 84% of overall CFE allocations in 2019. This funding was critical, as it prevented operations from stopping due to gaps in funding, thus protecting vulnerable communities and saving lives. However, only 38% (US$26.7 million) was returned to the CFE. Similarly, of the US$4.6 million provided by the CFE to support essential life-saving operations for cyclone-affected communities in Mozambique, only 17% (US$776,000) was refunded.

In its December 2019 report to the WHO Executive Board, the Independent Oversight and Advisory Committee for the WHO

Table 1 CFE expenditure breakdown 2019

Item	Expenditure (US$)	Proportion	Example
Staff and personnel	22 194 000	41%	Salaries and per diem payments for technical experts
Direct operational costs	10 217 000	19%	Operational costs of emergency vaccination campaign
Medical supplies	4 988 000	9%	Vaccines, protective equipment, hospital and lab supplies
Travel	4 951 000	9%	International travel of technical experts
Implementing partners	4 935 000	9%	Grants to NGOs implementing health activities
General operating expenses	4 790 000	9%	Office rent, utilities, petrol
Equipment	1 463 000	3%	Vehicles, IT equipment
Security	571 000	1%	Expenses to ensure staff security and safety
Training	8 000	<1%	Training for WHO staff or organized by WHO
Total	**54 117 000**		

Reporting as at 1 March 2020; final figures will be included in WHO financial reports and submitted to the World Health Assembly.

Health Emergencies Programme reiterated the importance for Member States to ensure the sustainability of the CFE . This not only requires a greater commitment to contribute directly to the CFE, but to WHO emergency operations at country level, the latter perhaps being more critical to ensuring a sustainably replenished fund.

Annex 3 contains a complete list of emergencies supported by the CFE, including overall allocation, implementation (expenditure) amount, and amount refunded.

2019 overview: CFE contributions

In 2019, 16 Member States made generous contributions to the CFE totaling almost US$54 million (table 2). This is the largest total annual contribution since the CFE was established (figure 3).

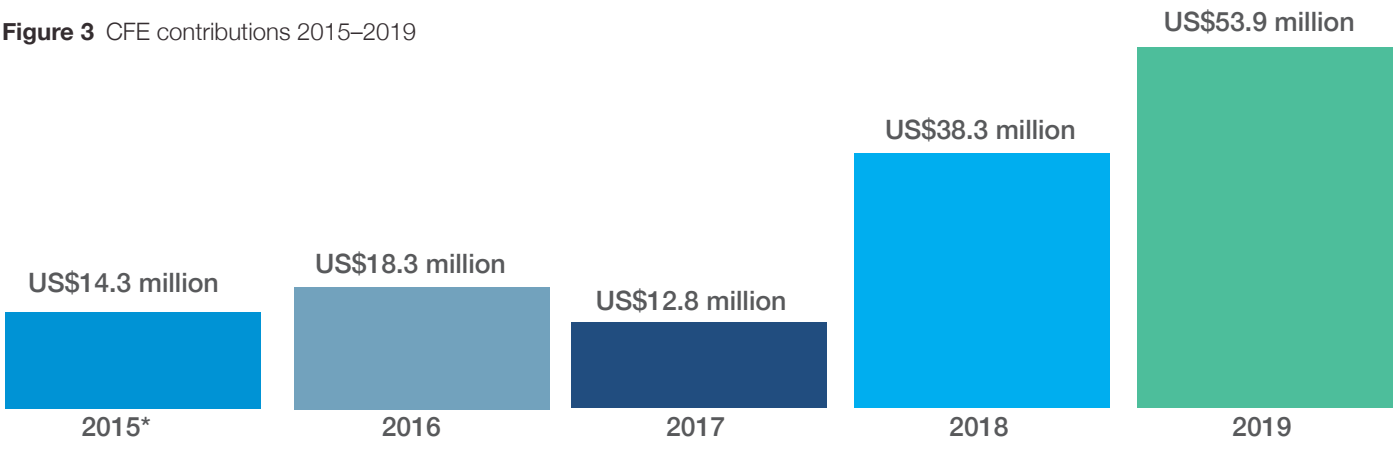
Four Member States made contributions for the first time: Finland, Georgia, New Zealand, and the Philippines. New Zealand made a three-year commitment to the Fund, and the Philippines became the first ever Member State to be a contributor to and recipient of CFE funding in the same year.

Contributions to the CFE have risen rapidly year on year since 2017 (figure 3). The total 2019 contribution of US$53.9 million represents a 40% year on year increase on the total contribution for 2018 of US$38 million, and is greater than the 2017 and 2018 totals combined. See Annex 4 for a complete list of CFE contributors since 2015

Table 2 CFE contributions 2019

Donor	Contribution (US$)
Japan	22 055 000
Germany	17 118 000
UK	5 236 000
Netherlands	2 353 000
Norway	1 173 000
Sweden	1 028 000
New Zealand	1 004 000
Korea	1 000 000
Canada	741 000
Finland	739 000
Luxembourg	556 000
Kuwait	500 000
Australia	354 000
Estonia	56 000
Georgia	5 000
Philippines	2 500
Total	**53 920 500**

Figure 3 CFE contributions 2015–2019



*Partial year.

ENABLING A SWIFT RESPONSE

Tackling dual crises in the Democratic Republic of the Congo: Ebola virus disease and measles

The CFE was established to fulfil two primary functions. The first is to ensure that WHO and key partners are able to quickly access funds to mount a rapid response in the event of a newly emerging health emergency. The second is to ensure that the response to an ongoing emergency can be sustained or expanded in the event of a deterioration of the situation on the ground, or there is an acute shortfall in funding for the emergency response plan. In the Democratic Republic of the Congo and its neighbours, both of these capabilities came to the fore. First, the fund was called on to support the ongoing response to the Ebola outbreak in the east of the country and in Uganda, whilst WHO and partners also drew on the fund to boost Ebola preparedness in South Sudan and Tanzania. At the same time, the fund was used to finance the initial rapid response to a deadly outbreak of measles in the Democratic Republic of the Congo – a response that now requires an urgent increase in funding as measles cases continue to rise around the world.

Context

Ebola is not new to the Democratic Republic of the Congo (DRC) – the vast country has had nine previous recorded outbreaks of Ebola virus disease (EVD) since the virus was first discovered in 1976. But the country's tenth outbreak, which started in August 2018 in North Kivu and Ituri, is unprecedented in the country's history.

By the end of 2019, almost 18 months since the outbreak was first declared, the toll stood at over 3000 confirmed and probable cases, and more than 2200 deaths. Second only in size and severity to the 2013–2016 West African epidemic, the outbreak has been a tragedy for affected communities. But the story of the outbreak is also one of hope, resilience, and courage in the face of hardship and adversity.

The response in the first weeks of August 2018 – by the government of DRC, WHO, donors and partners – was one of the fastest and best equipped in the history of EVD outbreak response. Many of the response assets from the country's most recent previous outbreak, in Equateur province, were still in place, having only been stood down days earlier. These included mobile laboratories (run by DRC's Institut National de Recherche Biomédicale: INRB); stockpiles of the safe and effective rVSVZEBOV experimental vaccine; cold chain equipment and vaccination teams; a Ministry of Health (MoH) emergency operations and coordination structure; and many of WHO's incident management team.

Using CFE funds, WHO was able to disburse rapid bridge financing to set up a new Incident Management Structure within 48 hours of the confirmation of the first cases.

The situation on the ground, however, was complicated. Eastern DRC has seen continuous conflict since the mid-1990s, fueled by ethnic violence, political grievances, and regional geopolitics. Civilians have not just been caught in the middle of these conflicts, they have been deliberately targeted.

A patchwork of homegrown and foreign rebel groups operate in Ituri and North and South Kivu, hostile to each other, the Congolese government, and the United Nations Organization Stabilization Mission in the Democratic Republic of the Congo (MONUSCO). Adding to the volatility are a multitude of local, ethnically and politically aligned armed militias, known as Mai Mai, whose activities and interests intersect, often opaquely, with local economies and politics.

To complicate matters further, the country is in the grip of a protracted humanitarian crisis, with the vast majority of the 9 million people targeted for humanitarian assistance concentrated in the east of the country.

Between August and December 2018, a series of horrific armed attacks on civilians and government and UN security forces resulted in a number of enforced shut downs of the response. Each unavoidable temporary shutdown of the response was akin to hitting the reset button on crucial interventions in the field, giving the outbreak opportunity to spread. In December, the postponement of national elections in the provinces of North Kivu and Ituri due to the outbreak led to increased threats and sporadic attacks against the response and affected communities.

By April 2019, the increase in security incidents and resistance to the response in affected communities was clearly having a marked negative impact on the trajectory of the outbreak. The geographical distribution of the outbreak was expanding as case incidence increased in the primary hotspots of Butembo, Katwa, Mabalako and Beni (figure 4, figure 5). The proportion of new cases who had been previously listed as contacts, a key indicator of the effectiveness of contact tracing, fell to under 30% throughout. And despite the vaccination of health workers and intensive efforts to improve standards of infection prevention and control in the hundreds of health facilities throughout the affected health zones, health workers were still being infected at a low but steady rate.



WHO Director-General Dr Tedros Adhanom Ghebreyesus (centre) meets health workers at an Ebola Treatment Centre in Katwa, Democratic Republic of the Congo.

A turning point

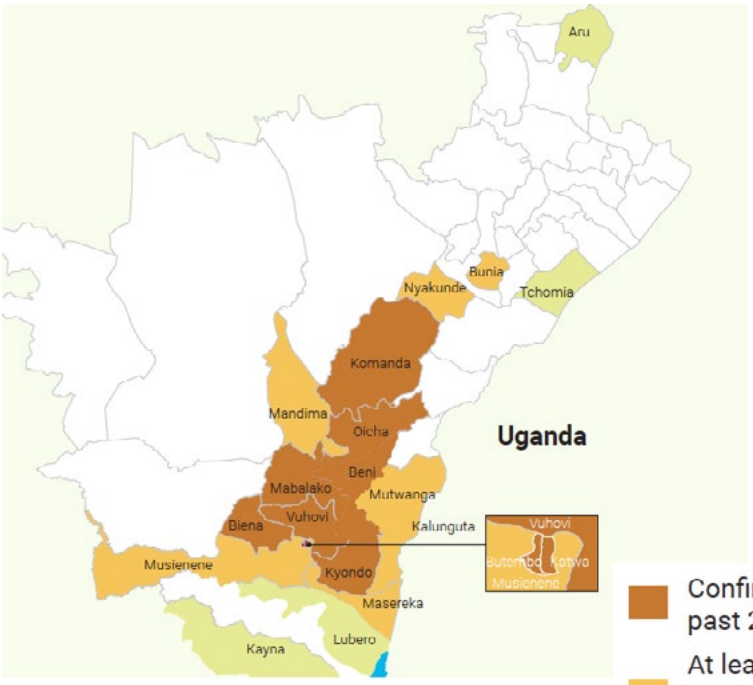
The murder of Dr Richard Valery Mouzoko Kiboung, a WHO epidemiologist, on 19 April 2019, marked a low point for the response. Dr Mouzoko died from a gunshot wound sustained during an attack by an armed group at Butembo University Hospital, where he was chairing a meeting with Congolese front-line health workers involved in the response. But the tragedy also marked a turning point.

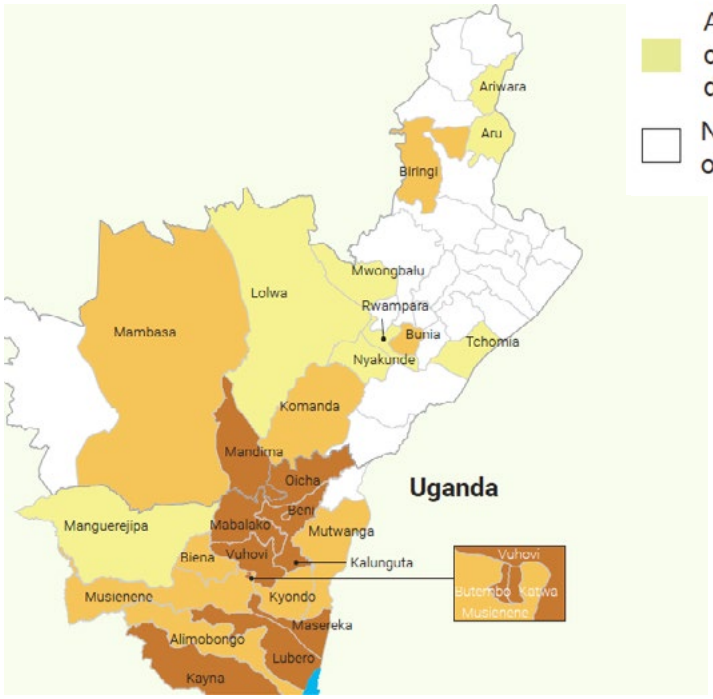
By June 2019, many of the operational changes set out in the third strategic response plan were starting to bear fruit, particularly in Butembo and Katwa, which were at the centre of the outbreak during its peak in April. The decision taken in April to decentralise response coordination to the health zone level meant that coordinators at the front line were able to more rapidly adapt to local challenges. This required massively scaling the response to ensure every affected and at-risk health zone had the resources needed to implement the full package of response measures, including:

- Rapid diagnosis, treatment and isolation of infected patients (often called “case management”);
- Strict adherence to infection prevention and control practices in health facilities;
- Disease surveillance, and the tracing and monitoring of any people who may have had contact with an infected person;
- An accurate and rapid laboratory service (a confirmed diagnosis relies on laboratory testing);
- Ensuring that communities are informed and equipped to conduct safe and dignified funeral rites (people are at their most infectious – that is their bodily fluids contain the heaviest load of viral particles – shortly after death);
- Social mobilization – making sure people are aware of the risk posed by the virus, and know the steps they can take to protect themselves;
- Vaccination.

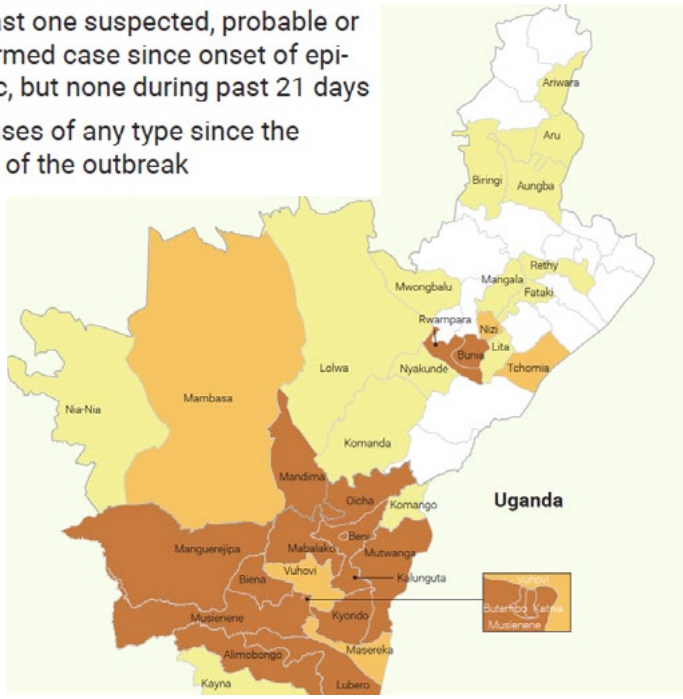
Figure 4 Geographical evolution of the outbreak from January to end June 2019

Distribution of cases at 6 January 2019 in North Kivu and Ituri



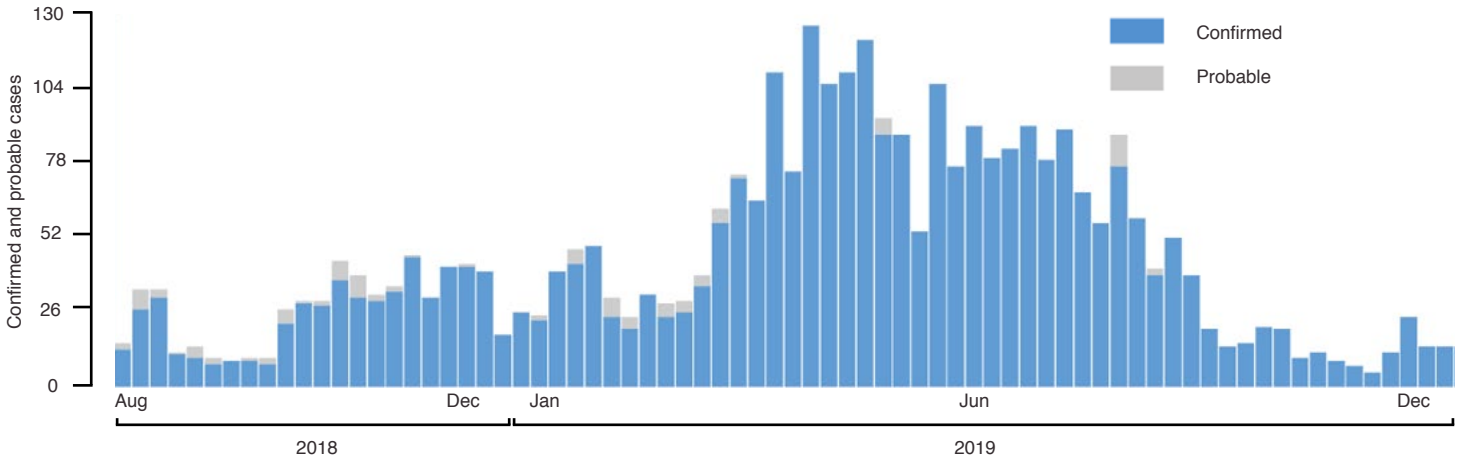


Distribution of cases at 1 April 2019 in North Kivu and Ituri



Distribution of cases at 26 June 2019 in North Kivu and Ituri

Figure 5 Weekly confirmed and probable cases of Ebola virus disease in the Democratic Republic of the Congo 2018–2019



From a peak of 120 cases per week in April and May 2019, the incidence of new cases steadily declined from July to December 2019.

Putting these resources in place would not have been possible without a huge injection of funds from the CFE to both sustain and scale the response.

The appointment in May of an Ebola Emergency Response Coordinator gave the response another important asset: a high-level leader empowered to supervise the totality of the international support effort, working at a strategic level to engage with the national government, provide strategic direction to the UN bodies working on the response, strengthen security, and free up WHO's field operation to focus on its core strengths supporting the public health response. Also in May, the UN Inter-Agency Standing Committee opted to activate the IASC Humanitarian System-Wide Scale-Up Protocol for the Control of Infectious Disease Events, in order to boost the humanitarian response to the outbreak. These developments helped put the response on the front foot. The fourth strategic response plan (SRP4), for the period July 2019 to end of December 2019, enabled the response to leverage the comparative strengths of a broad base of partners to tackle the key drivers of the outbreak.

A broad coalition of national authorities, UN agencies, international and national non-governmental organizations, and donors were invited to provide their input into SRP4 via an operational review that took place on 14 and 15 June in Goma. This broad input was essential for the response to evolve from a disease-focused effort to one that placed managing the EVD outbreak as the top priority within a broader set of humanitarian and public health needs, including improving the security situation. Addressing these broader needs had multiple direct and indirect benefits for the strengthened public health response, which continued to be led by WHO in support of the national government.

The new structure, strategic plan, and UN-wide scale-up gave the response the platform to capitalize on the gains made in May and push on towards the end of the outbreak. But the lack of funding for the response plan was a major issue. WHO's funding needs for the response under SRP4 were US$98 million, only US$44 million had been received by the end of June 2019, leaving a gap of US$54 million. The funding shortfall was immediate and critical, requiring CFE funds to be used to sustain the response rather than reducing or halting operations as some partners were forced to.

The lack of funding not only affected operations in DRC, but also hampered preparedness activities in neighbouring countries. Uganda had already shown the value of strengthened preparedness with its rapid detection of and response to three people who crossed into Uganda from DRC before testing positive for Ebola and sadly dying. No further cases were confirmed in Uganda. In the absence of adequate funding, CFE funds were called on to boost preparedness activities in South Sudan, Tanzania, and high-risk areas of Uganda that border DRC.

From July onwards there was a sustained fall in the incidence of new cases (figure 5), with only 14 new cases reported in the final week of 2019 compared with over 120 cases per week at the peak of the outbreak across a vast area. Insecurity has continued to be a challenge. In all there have been more than 400 attacks on health facilities in DRC, resulting in 11 deaths and 86 injuries among health care workers and patients since the outbreak was declared in August 2018. But the resilience of communities and health workers in the face of these challenges has paid off. After coming within touching distance of the end of the outbreak in April, only for new cases to be detected, on 25 June 2020 the outbreak was finally declared over by the Government of DRC.

The end of the outbreak is a moment for joy, and a time to pay tribute to the bravery, dedication, and sacrifice of all those who made it possible. But it is also a time for caution, and for vigilance. There is always a risk of new cases, so it is critical to maintain surveillance and rapid response capacities, which will not be possible unless the US $20 million funding gap is resolved. In the longer term, it is essential that the international community keeps its promises to the communities that have been ravaged by conflict and disease to build a stronger health system. A health system that can stand up not only to Ebola, but to malaria, measles, cholera, and now COVID-19.

Meanwhile, the work to support survivors continues, with a Survivor Programme that provides follow-up care for almost all of the 1169 survivors in 26 health areas in North Kivu and Ituri, and helps to reduce the risk of re-introduction events.

Key figures (as at end 2019)


11 labs set up to test around 3500 samples each week


11 Ebola treatment centres were set up to care for people with Ebola


300 000 people vaccinated


250 000 contacts registered


23 000 safe and dignified burials conducted


More than 3000 health facilities were identified for infection prevention and control support


More than 1000 metric tonnes of supplies delivered


An Ebola vaccine was licensed, and two treatments found to be highly effective


Almost 160 million screenings for Ebola symptoms at borders or other points of control

Supporting survivors of Ebola to make a difference in DRC

On 1 November Faustin Kalivanda, a father of four, was discharged from an Ebola treatment centre after he tested free of the virus. Both his wife and their five-year-old daughter Ester died from the disease. To support survivors like Kalivanda, the DRC Ministry of Health, WHO and partners have put in place a programme that covers three fields: clinical, biological, and psychosocial. The programme was established in Beni in November, just as Kalivanda was released.

Each survivor is provided with follow-up visits every month over a period of six months and then every three months for a year. More than 1000 people have survived Ebola in the North Kivu and Ituri outbreak, and almost all participate in the programme where they are supported by more than 40 staff trained to support the medical, biological, and psychological needs of survivors.

The disease had a devastating impact on Kalivanda's life, but the treatment and help he received at the Ebola Treatment Centre also left a positive impression. Since his recovery, he has decided to bring his experience to the service of other people infected with the virus. Now he works at the treatment centre himself as a nurse assistant, carrying patients from ambulances to the treatment centre and cleaning patient rooms. He believes that as a survivor he has a mission to help change the perception of Ebola in his community, by showing how survivors can contribute.

"I want to thank all the doctors in the Ebola treatment centre, all the hygienists, who kept the treatment room clean, the psychologists who gave us advice on the disease and psychological support to bring us back to life. And all others who are part of the response team, for helping us, for providing food", he said. "For all that, I want to thank them."

Funds from the CFE have enabled the Survivor Programme to provide a broad range of follow-up care to more than 1000 survivors like Faustin in North Kivu and Ituri as part of the response. Maintaining this vital service as response moves to recovery will ensure that survivors and their families continue to receive the support they need to move on from the disease.

People line up to use a handwashing station during the Ebola virus disease outbreak in the Democratic Republic of the Congo.





Children line up at a vaccination station to receive the measles vaccine, as part of the campaign that saw 18 million children under 5 years of age vaccinated in the Democratic Republic of the Congo throughout 2019.

Racing to protect children from the world's largest measles outbreak in the Democratic Republic of the Congo

The world is in the midst of a surge in measles. 2019 saw large outbreaks in Chad, Madagascar, Nigeria, Philippines, Ukraine, and Yemen, several of which (Madagascar and Ukraine) triggered CFE funding. But it was the Democratic Republic of Congo (DRC) that saw by far the largest outbreak. Of the more than 400 000 cases reported worldwide in 2019, more than 300 000 were reported from across every one of DRC's 26 provinces, including many of the towns and villages in the east of the country affected by the outbreak of Ebola. This is the largest outbreak of measles ever reported from DRC, and by the end of 2019 had resulted in the deaths of more than 6000 people, most of whom were young children under the age of 5 years. The true toll is likely to be far higher. Not only is measles often underreported, it can cause lifelong disability and lasting immunological damage that increases susceptibility to other infectious diseases.

A total of US$2 million was released from the CFE in two tranches to support the DRC Ministry of Health response to the outbreak, which launched an emergency vaccination programme in September 2019. In total, more than 18 million children under the age of 5 were vaccinated across the country through the initiative led by the DRC Ministry of Health and supported by WHO, Gavi, the European Civil Protection and Humanitarian Aid Operations (ECHO), Médecins du Monde, Médecins Sans Frontières, UNICEF, and other health partners.

The campaign succeeded in slowing transmission. However, in some areas, routine vaccination coverage remains low, and there is an urgent need to find sustainable solutions to the long-standing issues that contributed to the outbreak. Malnutrition, weak and fragmented public health systems, insecurity, and lack of access to remote communities contributed to the epidemic and posed difficulties to the response in some areas. In December 2019, CFE funds contributed to the training of 60 health professionals from the DRC Ministry of Health to conduct a range of services, including community engagement, health education and surveillance, in a push to build more sustainable capacity.

It is clear that very substantial risks remain. A lack of funding remains a huge impediment to ending the outbreak. By the end of 2019 US$27.6 million had been mobilized, but a further US$40 million are required for a six-month plan to extend the vaccination to children between six and 14 years and to reinforce elements of the outbreak response beyond vaccination, including improving treatment, health education, community engagement, health system strengthening, epidemiological surveillance and response coordination. All of these activities will be even more of a challenge to undertake in the context of COVID-19.



WHOWHO/H Cunningham

Twin disasters in Mozambique: tropical cyclones Idai and Kenneth

In March 2019, Tropical Cyclone Idai struck the coast of Mozambique as a category 4 tropical cyclone, and the subsequent flooding resulted in an estimated 1.85 million people in need of humanitarian assistance and protection in Sofala, Manica, Zambézia and Inhambane provinces. The official death toll was more than 900 people, with thousands more injured and more than 400 000 people displaced. Over 160 000 people were forced to take refuge in 164 collective temporary accommodation centres.

Just five weeks later, on 25 April, Mozambique was struck again. The category 3 Tropical Cyclone Kenneth made landfall on the Mozambican coast in the northern province of Cabo Delgado. More than 45 people died as a direct result of the storm, and more than 45 000 houses were either totally or partially destroyed, leading more than 18 000 displaced people to seek shelter in accommodation centres. Access to the affected districts was difficult due to the road conditions, lack of reliable telecommunications networks, and electricity outages.

In the immediate aftermath of the cyclones, CFE funds were rapidly released so that WHO could support the Government of Mozambique to mount an effective emergency response. A total of 80 WHO staff and consultants were rapidly deployed to affected areas, with the majority of funds used to procure essential medical supplies, ensure access to primary health care, and establish infectious disease surveillance and rapid response capacity.

The cyclones devastated water, sanitation and hygiene infrastructure, giving rise to a sharp increase in the risk of waterborne infectious diseases such as cholera and typhoid. In the days following Cyclone Idai, WHO joined Gavi, UNICEF, Médecins Sans Frontières (MSF), International Federation of the Red Cross and Red Crescent Societies (IFRC), Save the Children, and 1200 community volunteers to assist the Ministry of Health to undertake a successful six-day emergency cholera vaccination campaign that reached more than 800 000 people in four districts affected by Cyclone Idai. The oral cholera vaccines, which were donated by Gavi from the Global Cholera Vaccine Stockpile, arrived in the affected areas on 2 April, with the first doses administered less than 24 hours later. This feat was echoed in response to cyclone Kenneth, with over 285 000 people given the oral cholera vaccine over a five day campaign launched on 16 May by the Ministry of Health with support from WHO and other health partners. The combination of the

◄ The cyclones destroyed homes, health facilities, and vital water, sanitation and hygiene infrastructure, resulting in an increased risk from waterborne diseases including cholera and typhoid.



Amelia Mateos, a preventive medicine technician, leads the cholera vaccination campaign at a vaccination station in Dondo district in Mozambique.

vaccination campaigns and the establishment of dedicated cholera treatment centres in affected areas resulted in an overall case fatality rate of just 0.1%.

The cyclones also destroyed vital health infrastructure, with over 100 facilities either destroyed or rendered inoperable due to damage to equipment and supplies. WHO worked to ensure that at least 80% of the vulnerable population could access primary healthcare in temporary settlements by constructing prefabricated facilities to ensure there was at least one healthcare facility per 10 000 people, at least one community health worker per 1000 people, and that all facilities had access to essential medical supplies. On average, supplies were available on 26 out of every 30 days in the affected areas. WHO worked with partners to rapidly establish surveillance for infectious diseases using the Early Warning Alert and Response (EWARS) mechanism, which aimed to ensure that outbreak alerts are verified and investigated within 24 hours for at least 90% of cases.

As the acute phase of the response gave way to recovery throughout October, efforts were focused on supporting the early warning system in the priority districts during a transition to a more sustainable enhanced electronic surveillance system, with technical support from WHO and other partners. Funds to support the recovery were provided by the UK Department for International Development, USAID, Gavi, the Canadian Government, and the UN Central Emergency Response Fund (CERF).



Conflict in Libya

Fighting broke out in Tripoli, the capital of Libya, in early April 2019, following the advancement of Libyan National Army (LNA). In the weeks that followed, the use of heavy weapons and airstrikes had caused more than 300 deaths and wounded more than 1600 people, forcing an estimated 40 000 people to flee their homes. This figure would rise as the conflict progressed, with more than 120 000 people displaced from their homes. This took place in the context of a wider humanitarian emergency in Libya, with an estimated 823 000 people, including around 248 000 children, in need of humanitarian assistance as a result of persisting political instability, conflict and insecurity, the breakdown of the rule of law, a deteriorating public sector, and a dysfunctional economy.

WHO rapidly responded to the crisis by activating and coordinating field hospitals and field ambulance teams that acted as first-line and second-line responders. As the conflict continued, WHO remained the only entity in the country able to provide medical supplies, leading to the depletion of the WHO Country Office contingency stocks. CFE funds were essential in enabling the procurement of emergency medical supplies, the deployment of Emergency Medical Teams (EMTs), and the activation of Rapid Response Teams.

Between April and the end of July 2019, CFE funds enabled WHO to:

1) Procure and distribute 15 trauma kits to first-line and second-line responders. The supplies enhanced the response capacities of field hospitals, trauma centres and tertiary hospitals. Approximately 1500 trauma-related injuries were treated as a result of the trauma kits.

2) Procure and distribute five surgical kits to five hospitals in Tripoli, Tarhouna, Al Jufra, Gharyan and Misrata. The surgical kits supported 500 surgical interventions in the hospitals.

3) Five full modules of non-communicable disease kits were procured and distributed to five primary health care facilities in Tripoli, Gharyan, Tarhouna, Al Jufra and Misrata to support the health of the more than 120 000 people displaced by the conflict.

4) Four EMTs consisting of surgeons, orthopaedists and anaesthetists were deployed to four frontline hospitals. The EMTs performed 1973 surgical procedures and 1136 consultations.

5) Rapid response teams implemented a community surveillance and rapid response system to prevent, detect and respond to outbreaks of infectious diseases.

Further CFE funding was not required from July onwards, as alternative funding was put in place. However, the low level of funding of the Humanitarian Response Plan for Libya, at just 22.3% of needs, means CFE funding is likely to be required again in the future as the country continues to struggle with the impact of protracted conflict.

Rift Valley Fever in Sudan

Sudan is in the midst of a protracted, complex emergency with challenges ranging from chronic internal conflict and movement of internally displaced persons, to natural disasters such as droughts and floods and related outbreaks of vector and water borne diseases. It was in this context that an outbreak of Rift Valley fever (RVF) occurred in the southern states of Gezira and South Kordofan in October 2018, although there is a high probability that other states have underreporting or missed cases. By the end of 2018 nine localities in Gezira and South Kordofan states had reported a total of 60 cases and 28 deaths.

RVF is a viral zoonosis that primarily affects animals but can also infect humans, with most human infections the result of contact with the blood or organs of infected animals. Human infections can also be caused by bites of infected mosquitoes, but no human-to-human transmission of RVF virus has yet been documented. The case fatality rate (CFR) has varied widely between different epidemics. The CFR based on all documented cases is under 1%, although the more severe haemorrhagic form of the disease causes death in approximately 50% of cases.

RVF is difficult to distinguish from other diseases that cause fever, including malaria, shigellosis, typhoid fever, and yellow fever. Definitive diagnosis requires testing that is available only in reference laboratories. Laboratory specimens may be hazardous and must be handled with extreme care. In February 2019, CFE funds enabled WHO to support the Sudanese Ministry of Health to control the outbreak by achieving four objectives: strengthening case management and surveillance; vector control (reducing the population of mosquitos); promoting public health and awareness; and ensuring the continuity of essential supplies for outbreak response.

In order to improve case management and strengthen disease surveillance, WHO contracted and provided technical support to the Blue Nile Institute to train: 30 medical doctors in case management of viral haemorrhagic fevers, with a focus on RVF; and 30 medical doctors and 15 public health officers on case definition, contact tracing, reporting and community surveillance. As a result, sentinel surveillance in both affected states increased to cover 100% of the affected and at-risk locations. WHO also procured and distributed medicines and supplies to health facilities in affected areas.

To prevent infections from occurring, WHO supported a vector-control strategy and entomological surveillance to suppress populations of the Ades Egyptaie mosquito. A total of 90 environmental health officers, workers and volunteers were trained, and went on to implement 21 separate vector-control campaigns that involved fogging, spraying, the treatment of breeding sites, and awareness-raising activities in affected communities. Each campaign covered more than 10 000 people, with more than 210 000 benefitting in total. In addition, WHO assisted the Ministry of Health in Gezira and South Kordofan to undertake around 170 environmental and sanitation vector control campaigns, during which all probable vector breeding sites were eliminated.

The equipment used and the training provided for these vector-control activities should provide a lasting legacy of the response. As will the house-to-house health promotion campaign that reached 56 500 households in South Kordofan and Gezira states. Health promoters trained by WHO and the Ministry of Health visited each household to raise awareness about RVF, viral hemorrhagic fevers, and other common diseases, and empower households to take action to protect themselves. The public health information campaign also included three radio messages in Arabic and local languages on prevention of RVF, which were repeated on local radio channels six times a day for a month.

The outbreak was brought under control, but many challenges remain to prevent and build resilience to further outbreaks of RVF and similar diseases. We need to further our understanding of RVF, and particularly the potential impacts that climate change may have on its spread and expansion.



Flooding in Iran

On 18 March 2019, a flood hit the eastern part of Mazandaran and Golestan provinces in Iran after four days of heavy rain. A few days later, additional floods in the west, southwest, and northeast of the country affected thousands of people. Shortly after, a third wave of heavy rains commenced. By 9 April, a total of 28 provinces out of the country's 31 provinces had been affected by the floods, affecting more than 42 million people. Almost 400 000 people were displaced, 84 died, and around 20 573 persons were injured. In total, approximately 3 million people required health care assistance in the aftermath of the flooding, but large swathes of health infrastructure were damaged or destroyed by the disaster, with more than 1000 facilities, including the Emergency Operations Centre, damaged in the most affected areas.

As a trusted partner, WHO was officially requested by the Ministry of Health and Medical Education (MOHME) to provide technical and logistical support to respond to the floods and strengthen outbreak surveillance. Thanks to CFE funds, the WHO Country Office was able to ensure that more than 282 000 people benefitted from WHO assistance between April and June 2019.

The majority of activities took place in Lorestan and Golestan provinces, where WHO delivered emergency medical supplies to a total of four rural and urban comprehensive health care facilities covering around 140 000 people, four rural health centres covering around 20 000 people, and two hospitals covering around 100 000 people. In addition, WHO installed a generator in the Agghala health centre to provide power and light. WHO undertook a comprehensive health system damage assessment in Lorestan province in April 2019.

Road blocks, running water, landslides, and standing water in buildings limited access to health facilities and affected populations.

In the longer term, the impact of flooding on the health system will further add to sanction-related challenges in Iran, which also had a negative impact on the effectiveness and efficiency of the emergency response to the flooding. WHO continues to work closely with the MOHME to scale up disease surveillance, fill gaps in critical medicines, and preposition supplies for possible disease outbreaks.


WHO

LOOKING AHEAD

CFE 2.0: towards a more sustainable, effective and accountable fund

WHO is committed to the continual improvement of the CFE, and discussions are underway to build a more financially sustainable, accountable CFE 2.0 fit for the new challenges of a world learning to live with COVID-19.

Despite success in deepening and broadening the resource base for the CFE, the current replenishment model, which is mainly dependent on direct donor contributions from a few traditional donors, may not be sustainable. More must be done to attract new donors and to deepen existing relationships. Alternative sources of funding for the CFE, both via internal mechanisms and external partnerships (such as with the private sector and foundations), must also be explored. Perhaps most importantly, the reimbursement model – whereby contributions to WHO emergency operations at country level are used to pay back CFE allocations – must be strengthened through an improved corporate approach to resource mobilization.

While the CFE's core function is seen as providing rapid funding in the initial response phase of new health threats, the CFE has also been used over longer periods to fill funding gaps to ensure continuity of life-saving operations. This has been the case in response to the Ebola outbreak in DRC, for which the CFE has made US$100 million in allocations since the outbreak started in 2018. CFE operating procedures are designed to allow it to function in various contexts, and the CFE's ability to sustain life-saving operations attests to its flexibility, but it was never envisaged to fill such large gaps in funding. Rather than restrict the Fund's use, CFE 2.0 is an opportunity to clarify existing operating procedures, including how allocations are prioritized, and ensure that appropriate mechanisms are in place to safeguard funds.

Donors have demonstrated their confidence in WHO and the CFE by investing nearly US$137 million in the Fund since it was launched. They deserve to know that their resources are being used properly. 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. Furthermore, 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. CFE 2.0 is an opportunity to further strengthen accountability, for example, by providing more granularity in current financial reporting. A results framework specific to the CFE could be developed and systematically reported against. Furthermore, improved impact reporting would allow donor governments to demonstrate to their constituencies that the CFE offers good value for money. Finally, in addition to accountability, donors must be recognized for their generosity through improved visibility, and this could be integrated in the new strategy.

WHO is developing a roadmap to CFE 2.0, including a set of actions, target dates, and expected outcomes, for consultation with Member States and other stakeholders. The goal is to provide WHO and its Member States with a financially sustainable, operationally agile, and accountable financing mechanism that continues to save lives.

The CFE in the context of COVID-19

The CFE was called on to release some US$83 million for 23 separate emergencies in 2019. The Fund performed its role of providing immediate, predictable and flexible funding to help WHO respond quickly and effectively to health emergencies around the globe. Whether in response to a disease outbreak like measles, to keep critical Ebola operations going in DRC, or to support the delivery of emergency health activities following a natural disaster or conflict, the CFE continued to save lives and provide donors with excellent value for money.

Looking ahead, we are now forced to confront a world altered by COVID-19. This is a world in which epidemics of vaccine-preventable diseases will increase as a result of the interruption and delay of immunization services and disruption to surveillance systems. Vital health services have been stretched to the breaking point around the world. The ability of governments and vulnerable communities to cope with economic shocks has been undermined. Drivers of conflict have been magnified. Resilience to natural disasters has been weakened.

The above factors that have made health emergencies more likely also make responding to those emergencies more challenging, for WHO, national governments, and our many partners. Getting people and equipment to where they are needed has never been more difficult.

In this altered world, the CFE has an even more important role to play in ensuring WHO has the flexibility and agility to respond rapidly and effectively to new emergencies. But it is also important to consider the limitations of the CFE, and its use in the broader context of preparedness and response to health emergencies.

The CFE can only be truly effective if it as seen as one part of a broader solution. The tragedy of COVID-19 demonstrates beyond any doubt the dividends paid by committed and effective preparedness and prevention, and rapid response. We know that natural disasters will strike and complex emergencies will continue. We know that vaccine-preventable diseases will persist without committed action to build health systems and improve access to immunization. And we know that without committed action to achieve the goal of One Health and address risk at the human–animal interface, we will continue to see zoonoses like Zika, Ebola, and COVID-19 spill over into the human population. Unless and until we have all of these capacities in place, the CFE will remain the world's most essential insurance policy to prevent outbreaks and health emergencies from becoming epidemics and humanitarian crises. And like any insurance policy, the CFE can only function with sustainable funding.

ANNEXES

Annex 1: Approved releases from the CFE in 2019

Country	Region	Emergency	Type	Funds released (US$)	Date
Albania	EURO	Earthquake	Natural Disaster	50 000	Nov-19
Bahamas	AMRO	Hurricane Dorian	Natural Disaster	1 000 000	Sep-19
Burkina Faso	AFRO	Conflict	Complex Emergency	329 319	Jul-19
Burundi	AFRO	Malaria	Disease Outbreak	350 000	Aug-19
Cameroon	AFRO	Cholera	Disease Outbreak	81 382	Sep-19
Comoros	AFRO	Tropical Cyclone	Natural Disaster	50 000	Apr-19
Democratic Republic of the Congo	AFRO	Ebola (North Kivu)	Disease Outbreak	10 500 000	Jan-19
Democratic Republic of the Congo	AFRO	Ebola (North Kivu)	Disease Outbreak	10 000 000	Feb-19
Democratic Republic of the Congo	AFRO	Ebola (North Kivu)	Disease Outbreak	6 074 766	Mar-19
Democratic Republic of the Congo	AFRO	Ebola (North Kivu)	Disease Outbreak	8 000 000	Apr-19
Democratic Republic of the Congo	AFRO	Ebola (North Kivu)	Disease Outbreak	15 000 000	Apr-19
Democratic Republic of the Congo	AFRO	Ebola (North Kivu)	Disease Outbreak	5 000 000	Jun-19
Democratic Republic of the Congo	AFRO	Ebola (North Kivu)	Disease Outbreak	2 000 000	Jun-19
Democratic Republic of the Congo	AFRO	Ebola (North Kivu)	Disease Outbreak	2 000 000	Jun-19
Democratic Republic of the Congo	AFRO	Ebola (North Kivu)	Disease Outbreak	4 000 000	Jul-19
Democratic Republic of the Congo	AFRO	Measles	Disease Outbreak	498 603	Aug-19
Democratic Republic of the Congo	AFRO	Ebola (North Kivu)	Disease Outbreak	5 000 000	Nov-19
Democratic Republic of the Congo	AFRO	Measles	Disease Outbreak	1 508 040	Dec-19
Ethiopia	AFRO	Gedeo-West Guji IDP Response	Complex Emergency	484 942	Apr-19
Iran	EMRO	Flooding	Natural Disaster	223 971	Mar-19
Iran	EMRO	Flooding	Natural Disaster	498 025	May-19
Libya	EMRO	Conflict	Complex Emergency	500 000	Apr-19
Madagascar	AFRO	Measles	Disease Outbreak	180 000	Jan-19
Mozambique	AFRO	Tropical Cyclone	Natural Disaster	50 000	Mar-19

Mozambique	AFRO	Tropical Cyclone	Natural Disaster	4 000 000	Mar-19
Nigeria	AFRO	Lassa fever	Disease Outbreak	400 000	Feb-19
Pakistan	EMRO	Drought	Natural Disaster	466 000	Feb-19
Pakistan	EMRO	HIV	Disease Outbreak	200 000	May-19
Pakistan	EMRO	HIV	Disease Outbreak	200 000	Jul-19
Pakistan	EMRO	Dengue	Disease Outbreak	200 000	Oct-19
Philippines	WPRO	Polio	Disease Outbreak	50 000	Oct-19
Regional Africa*	AFRO	Tropical Cyclone	Natural Disaster	624 710	Mar-19
South Sudan	AFRO	Ebola (North Kivu) - Readiness	Disease Outbreak	219 750	Jul-19
South Sudan	AFRO	Ebola (North Kivu) - Readiness	Disease Outbreak	700 000	Nov-19
South Sudan	AFRO	Flooding	Natural Disaster	500 000	Nov-19
Sudan	EMRO	Rift Valley Fever	Disease Outbreak	300 000	Jan-19
Sudan	EMRO	Cholera	Disease Outbreak	205 632	Sep-19
Tanzania	AFRO	Ebola (North Kivu) - Readiness	Disease Outbreak	500 000	Sep-19
Uganda	AFRO	Ebola (North Kivu)	Disease Outbreak	898 858	Jun-19
Ukraine	EURO	Measles	Disease Outbreak	198 500	Aug-19
Total				83 042 498	

Annex 2: CFE expenditures by category (as per WHO financial statements)

Category	Expenditure (US$)	Description
Contractual Services	**32 280 000**	
General Contractual Services	18 746 000	Contracts for services provided to WHO
Training	8000	Training for WHO staff or organized by WHO
Security	571 000	Expenses to guarantee the security of WHO staff and premises
SSA Expenses	2 738 000	Special Service Agreements (SSA) to individuals (e.g. technical and administrative support for health campaigns)
Direct Implementations	10 217 000	To cover operational costs of activities when not feasible to implement activities through other contractual arrangements
Equipment, vehicles, and furniture	**840 000**	Vehicles, IT equipment, office furniture, telecom equipment
General operating expenses	**4 790 000**	Rent, utilities, maintenance, office supplies, etc
Medical supplies and materials	**4 988 000**	Vaccines, health kits, protective equipment, hospital & lab supplies
Staff and other personnel costs	**710 000**	Regular staff costs, daily paid staff (e.g. interpreters)
Transfers and grants	**5 558 000**	
Direct Financial Cooperation	300 000	Transfers made to government partners, (e.g. per diems and operational costs of public health activities, such as immunization campaigns)
Agreements with UN and NGOs	4 635 000	Grants to international and national implementing partners
Equipment for third parties	623 000	Equipment and supplies for third-party implementation
Travel	**4 951 000**	Duty travel on mission for WHO (international staff travel, etc)
Total	**54 117 000**	

Annex 3: CFE approved releases, implementation, and amount refunded in 2019

Event	Amount approved (US$)	Implementation (US$)	Refunded (US$)	
Albania Earthquake *	50 000	42 815	NA	NA
Bahamas Hurricane Dorian *	1 000 000	666 075	NA	NA
Burkina Faso Complex Emergency	329 319	329 319	0	0%
Burundi Malaria	350 000	349 347	653	0.2%
Cameroon Cholera	81 382	75 470	5 912	7.3%
Comoros Kenneth Cyclone	50 000	28 672	21 328	42.7%
DRC Ebola North Kivu	67 574 766	41 313 387	26 261 379	38.9%
DRC Measles	498 603	495 962	2 641	0.5%
DRC Measles* (Dec 2019)	1 508 040	1 246 812	NA	NA
Ethiopia Complex Emergency	484 942	484 942	0	0.0%
Iran Flooding *	721 996	685 608	NA	NA
Libya Complex Emergency	500 000	499 944	56	0.0%
Madagascar Measles	180 000	0	180 000	100.0%
Mozambique & Southern Africa Cyclone Idai	4 674 710	3 898 769	775 941	16.6%
Nigeria Lassa Fever	400 000	379 356	20 644	5.2%
Pakistan Dengue	200 000	199 652	348	0.2%
Pakistan Drought	466 000	459 170	6 830	1.5%
Pakistan HIV	400 000	393 216	6 784	1.7%
Philippines Polio	50 000	41 106	8 894	17.8%
South Sudan Ebola *	700 000	311 090	NA	NA
South Sudan Ebola Readiness	219 750	217 533	2 217	1.0%
South Sudan Flooding *	500 000	415 331	NA	NA
Sudan Cholera	205 632	205 632	0	0.0%
Sudan Rift Valley Fever	300 000	299 926	74	0.0%
Tanzania Ebola Readiness & Response	500 000	255 145	244 855	49.0%
Uganda Ebola	898 858	688 486	210 372	23.4%
Ukraine Measles	198 500	134 268	64 232	32.4%
Total	**83 042 498**	**54 117 032**	**27 813 161**	**33.5%**

*Data reconciliation incomplete as operations are ongoing. As at 1 Mar 2020.

Annex 4: CFE contributions (US$) 2015–2019

	2015	2016	2017	2018	2019	Total
Germany	1 096 491	3 728 495	9 876 113	15 216 968	17 117 838	47 035 905
Japan		10 833 800			22 055 107	32 888 907
United Kingdom	9 436 834		1 100 000	5 641 749	5 235 602	21 414 185
Sweden		1 159 555		4 412 089	1 028 383	6 600 027
Netherlands		1 082 514		1 165 501	2 352 941	4 600 956
Australia				3 044 140	353 857	3 397 997
Denmark				3 185 011		3 185 011
Korea			1 015 192	1 000 000	1 000 000	3 015 192
Canada	729 927		751 880	753 012	741 290	2 976 109
Norway				1 253 761	1 173 434	2 427 195
China	2 000 000					2 000 000
France		1 418 218				1 418 218
Luxembourg				578 704	555 556	1 134 260
New Zealand					1 004 016	1 004 016
Kuwait				500 000	500 000	1 000 000
India	1 000 000					1 000 000
Finland					739 283	739 283
Switzerland				502 008		502 008
Estonia	32 967	53 078	59 242	56 818	55 556	257 661
Malta				20 000		20 000
Georgia					5 000	5 000
Philippines					2 500	2 500
Total	**14 296 219**	**18 275 660**	**12 802 427**	**37 329 761**	**53 920 363**	**136 624 430**



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WHO in Emergencies:
www.who.int/emergencies/en

CFE Web Portal:

www.who.int/emergencies/funding/contingency-fund/en/