# ERF | EMERGENCY RESPONSE FRAMEWORK

Internal WHO procedures

World Health Organization

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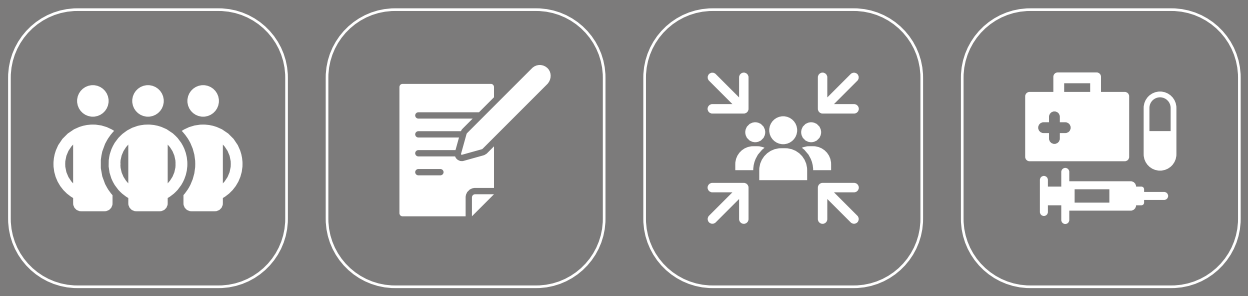


World Health Organization

*Emergency response framework: internal WHO procedures*

ISBN 978-92-4-005806-4 (electronic version)
ISBN 978-92-4-005807-1 (print version)



**Suggested citation.** *Emergency response framework: internal WHO procedures. Geneva: World Health Organization; 2024.* Licence: CC BY-NC-SA 3.0 IGO.

**Cataloguing-in-Publication (CIP) data.** CIP data are available at http://apps.who.int/iris.

# Contents

# Abbreviations

| | |
|---|---|
| **AAR** | After-Action Review |
| **CBCM** | Community-Based Complaint Mechanism |
| **CBM** | Country Business Model |
| **CFE** | Contingency Fund for Emergencies |
| **COVID-19** | Coronavirus Disease 2019 |
| **EIS** | Event Information Site |
| **EIOS** | Epidemic Intelligence from Open Sources |
| **EMS** | Event Management System |
| **EMT** | Emergency Medical Team |
| **EOC** | Emergency Operations Centre |
| **EMST** | Emergency Management Support Team (Protracted Emergencies) |
| **ERF** | Emergency Response Framework |
| **EWARS** | Early Warning, Alert and Response System |
| **GBV** | Gender-Based Violence |
| **GHEA** | Global Health Emergency Appeal |
| **GISRS** | Global Influenza Surveillance and Response System |
| **GLEWS** | Global Early Warning System for Major Animal Diseases, including Zoonoses |
| **GOARN** | Global Outbreak Alert and Response Network |
| **HeRAMS** | Health Resources and Services Availability Monitoring System |
| **HEPR** | Health Emergency Preparedness, Response and Resilience |
| **HRP** | Humanitarian Response Plan |
| **HWCO** | Head of WHO Office in Country, Territory or Area (see WR) |
| **IAR** | Intra-Action Review |
| **IASC** | Inter-Agency Standing Committee |
| **IDSR** | Integrated Disease Surveillance and Response |
| **IHR** | International Health Regulations (2005) |
| **IM** | Incident Manager |
| **IMS** | Incident Management System |
| **IMT** | Incident Management Team |

| | |
|---|---|
| **IMST** | Incident Management Support Team |
| **INFOSAN** | International Food Safety Authorities Network |
| **JOR** | Joint Operational Review |
| **KPI** | Key Performance Indicator |
| **MHPSS** | Mental Health and Psychosocial Support |
| **MIRA** | Multi-Cluster/Sector Initial Rapid Assessment |
| **MOSS** | Minimum Operating Security Standards |
| **NFP** | National Focal Point |
| **NGO** | Nongovernmental Organization |
| **ORRA** | Operational Risk Response Analysis |
| **OSL** | Operations Support and Logistics |
| **PEF** | Framework for Protracted Emergencies |
| **PHEIC** | Public Health Emergency of International Concern |
| **PHSA** | Public Health Situation Analysis |
| **PS** | Performance Standard |
| **PSEA** | Protection from Sexual Exploitation and Abuse |
| **PSEAH** | Protection from Sexual Exploitation, and Abuse and Harassment (also includes Prevention and Response to Sexual Exploitation, Abuse and Harassment) |
| **RED** | Regional Emergency Director |
| **RRA** | Rapid Risk Assessment |
| **SEAH** | Sexual Exploitation, Abuse and Harassment |
| **Sitrep** | Situation Report |
| **SOP** | Standard Operating Procedure |
| **UNDSS** | United Nations Department of Safety and Security |
| **VPD** | Vaccine-Preventable Disease |
| **WAHIS** | World Animal Health Information System |
| **WHE** | WHO Health Emergencies Programme |
| **WHO** | World Health Organization |
| **WOAH** | World Organisation for Animal Health |
| **WR** | WHO Representative (see HWCO) |

# Glossary

**Accountability.** The result of the process which ensures that the World Health Organization (WHO) takes responsibility for what it is obliged to do and is made answerable for its actions. WHO's primary accountability is to the populations it serves. Accountability is vital for the success of any organization, especially one that asks the nations of the world to entrust it with their funds, pledging to use them to improve health globally.

**Emergency.** A situation impacting the lives and well-being of many people or a significant percentage of a population and requiring substantial multisectoral assistance. For a WHO response, there must be clear public health consequences. An emergency can be acute (such as a cholera outbreak) or slow onset (such as a drought), and multiple emergencies can occur concurrently.

**Graded emergency.** An acute public health event or emergency that requires an operational response by WHO. There are three WHO grades for emergencies, signifying the level of operational response by the Organization: Grade 1 (limited response), Grade 2 (moderate response), and Grade 3 (major/maximal response).

**Incident management system.** The standardized yet flexible structure and approach that WHO has adopted to manage its response to public health events and emergencies, and to ensure that the Organization follows best practice in emergency management.

**Incident management team.** The in-country team responsible for managing and implementing the WHO response to the emergency. It is structured around the critical incident management system functions and their associated subfunctions. The size and composition of the team is flexible according to context.

**Incident manager.** The lead of the incident management team in-country, with counterparts leading the incident management support teams at regional and headquarters levels. The incident manager is responsible for day-to-day management of WHO's response to the emergency and has been delegated authority to manage the emergency response, including assigning responsibilities for other critical functions as they are established.

**Incident management support team.** The team providing technical and operational support to the in-country incident management team. It is composed of focal points – either fully dedicated or part-time – for critical functions. An incident management support team can be established at both regional offices and headquarters as per grade and other requirements, to ensure that resources from across the Organization can be accessed.

**Operational oversight.** Operational oversight is the responsibility of the Regional Emergency Director (RED) for Grade 1, 2 and 3 emergencies. For Grade 3 emergencies, operational oversight for the headquarters-level response is delegated by the Executive Director WHE to a Director in headquarters, depending on the type of event. This individual is responsible for monitoring the effectiveness of the Organizational response to the emergency, and has been delegated authority to make management decisions regarding the response, working closely with the WHO Representative (WR) and Incident Manager.

**Protracted emergency.** An environment in which a significant proportion of the population is highly vulnerable to death, disease and disruption of livelihoods over a prolonged period of time. Governance in these settings is often weak, with limited state capacity to respond to and mitigate the threats to the population or provide adequate levels of protection. Furthermore, WHO defines emergencies to be protracted when they have a Humanitarian Response Plan (HRP) and/or an active Inter-Agency Standing Committee (IASC) coordination mechanism in place for more than one year.

**Public health event.** Any event that may have negative consequences for human health. The term includes events that have not yet led to disease in humans but have the potential to cause human disease through exposure to infected or contaminated food, water, animals, manufactured products or environments.

**Sexual abuse.** Actual or threatened physical intrusion of a sexual nature, whether by force or under unequal or coercive conditions.

**Sexual exploitation.** Actual or attempted abuse of a position of vulnerability, differential power or trust, for sexual purposes, including but not limited to profiting monetarily, socially or politically from the sexual exploitation of another.

**Sexual harassment.** Any unwelcome conduct of a sexual nature that might reasonably be expected or be perceived to cause offence or humiliation, when such conduct interferes with work, is made a condition of employment, or creates an intimidating, hostile or offensive work or operational environment.

**Strategic response plan.** A high-level health sector response plan that is required to guide WHO and partners to respond to an event. It outlines the context and provides the latest situation update, a summary of current response activities, response strategic objectives and interventions and response plan (planning assumptions and summary of operations), resource requirements and a monitoring framework. Wherever possible, it should be part of the national plan, or closely aligned to that plan. WHO should clearly identify within this plan its priorities and resource requirements.

**Zero-tolerance policy.** The United Nations policy establishing that sexual exploitation, abuse and sexual harassment by United Nations personnel and collaborators is prohibited and that every transgression will be acted upon. WHO has zero tolerance towards sexual misconduct, inaction towards it, and for any form of retaliation against those who report, or participate in an investigation of allegations of sexual misconduct.

# Executive summary

World Health Organization (WHO) Member States face increasing numbers of emergencies with health consequences from all hazards, including biological hazards (e.g. epidemics and pandemics), societal hazards (e.g. armed conflicts, civil unrest), meteorological and hydrological hazards, geohazards (e.g. earthquakes), environmental hazards, chemical hazards, extraterrestrial hazards, and technological hazards. Emergencies can be complex, with more than one cause, and can have significant public health, social, economic and political impacts.

WHO has specific responsibilities and accountabilities for health emergency operations under the International Health Regulations (2005) (IHR) and the Inter-Agency Standing Committee (IASC), and as mandated in the WHO Thirteenth General Programme of Work 2019–2023.[1] Further efforts are underway to strengthen the global architecture for health emergency preparedness, prevention, response and resilience (HEPR), at the national and international levels.[2] This work is under development and will focus on global governance, financing and emergency preparedness and response systems. During this process, WHO's support to Member States will continue although the modality of delivery and responsibilities may evolve in line with the adoption and implementation of the HEPR architecture.

WHO's responsibilities begin with early detection, verification and risk assessment of an event (Chapter 1). Events that require a public health response by WHO which exceeds the usual country-level cooperation of the country office with the Member State are referred for grading to determine the level of WHO's operational response (Chapter 2). WHO's operational response to emergencies is managed through the incident management system (IMS) (Chapter 3), which is based on recognized best practices of emergency management and used by emergency responders globally, including within the health sector. Performance standards and emergency procedures are described in Chapter 4 and Chapter 5, respectively.

## Update from prior version

This update aims to further improve the predictability, timeliness and effectiveness of WHO's response to public health emergencies. It has been developed following consultation across the three levels of the Organization.

This revision updates and expands the concepts within the Emergency Response Framework (ERF) based on lessons learned in recent emergencies about effectively scaling up WHO response to acute public health events. Notable changes include the clarification of accountabilities in an emergency response; clarification of grading levels; and updated descriptions of the functions of the incident management system. Considerations have been added for mainstreaming protection from sexual exploitation, abuse and harassment in emergency operations; operational risk management; management of vaccine-preventable outbreaks; and protracted emergencies. There is also a checklist to aid use of the Contingency Fund for Emergencies (CFE). Performance standards, and associated indicators have been updated accordingly, as have the Organization's emergency response procedures. These updates will be reflected appropriately in the standard operating procedures (SOPs) for emergencies.

1 WHO's Thirteenth General Programme of Work. (https://www.who.int/about/general-programme-of-work/thirteenth).

2 Strengthening the global architecture for health emergency prevention, preparedness, response and resilience. (https://www.who.int/publications/m/item/strengthening-the-global-architecture-for-health-emergency-prevention--preparedness--response-and-resilience).

# Introduction

The consequences of public health emergencies can be devastating for the health and well-being of communities and societies, the resilience of health systems, the stability of national economies, and progress towards the Sustainable Development Goals.

The number of emergencies with health consequences will increase in the foreseeable future as risk factors increase. These include climate change; environmental degradation; urbanization; migration and international travel; State fragility; terrorism; and the lasting effect of the coronavirus disease 2019 (COVID-19) pandemic on health, societal and economic systems. Recent experience has highlighted the global risk of infectious disease outbreaks and demonstrated the need for more effective international collaboration on health security and pandemic preparedness. WHO and its partners must be ready and have the capacity to respond.

## Purpose of the Emergency Response Framework

The ERF is internal WHO guidance on how the Organization manages the assessment of, grading of, and response to public health events in support of Member States and affected communities. The ERF focuses primarily on scaling up and managing response activities for acute events and emergencies.[3] It adopts an all-hazards approach, applicable to all public health events and emergencies. It is complemented by the WHO emergency SOPs and is consistent with inter-agency emergency protocols and commitments. Many elements are aligned with similar internal guidance of partner agencies, and in line with best practices of the humanitarian community and the IASC.

## WHO Health Emergencies Programme (WHE)

WHO takes a comprehensive approach to all aspects of emergency management, embracing prevention and mitigation, preparedness and readiness, and response and recovery. WHO supports Member States to build their capacities to manage the risk of outbreaks and emergencies with health consequences. When national capacities are exceeded, WHO assists in leading and coordinating the international health response to contain outbreaks and to provide effective relief and recovery to affected populations.

## WHO's obligations under the International Health Regulations (2005) and Inter-Agency Standing Committee

While WHO manages risks and emergencies due to all hazards, it has special responsibilities with respect to infectious hazards, especially as custodian of the International Health Regulations (2005) (IHR). The IHR define the obligations of countries to assess, report and respond to public health events, and the procedures WHO must follow to uphold global public health security. Early detection, risk assessment and response are vital to ensuring that infectious disease events do not escalate into large-scale outbreaks or pandemics. The ERF has been developed with this central objective.

WHO works closely with Member States and partners – including through the Global Outbreak Alert and Response Network (GOARN) and other expert networks – to strengthen national, regional and global capacities to prevent, detect and respond to outbreaks, consistent with the IHR. WHO also has specific responsibilities and accountabilities within the global humanitarian system as the lead agency of the IASC Global Health Cluster. Similarly, WHO leads and coordinates the emergency medical teams (EMTs) initiative globally,

and assists ministries of health in coordinating the arrival, registration, licensing, reception and tasking of emergency medical teams when necessary. Operational partnerships such as GOARN, the Global Health Cluster and the EMT initiative have important roles in building national capacities for preparedness and response.

3 For a classification of hazards, see page 36 of: Health emergency and disaster risk management framework. Geneva: World Health Organization; 2019 (https://apps.who.int/iris/handle/10665/326106).

## WHO's core commitments in emergency response

WHO's core commitments in emergency response are those actions that the Organization will always deliver and be accountable for during the assessment of and response to public health events and emergencies. These actions are always undertaken in support of national health authorities and the affected population, and in close collaboration with national and international partners.

In response to public health events and emergencies, WHO will:

- undertake a timely, independent and rigorous risk assessment;
- deploy sufficient expert staff and material resources early in the event to ensure an effective assessment and operational response;
- establish a clear management structure for the response, based on the incident management system (IMS);
- develop an evidence-based response strategy, plan and funding appeal;
- ensure that adapted disease surveillance, early warning and response systems are in place;
- provide up-to-date information on the health situation and health sector performance;
- coordinate the health sector response to ensure appropriate coverage and quality of interventions and health services;
- integrate measures for prevention and response to sexual exploitation, abuse and harassment in the response operations for the protection of affected populations and of emergency responders, in line with the IASC protection from sexual exploitation and abuse (PSEA) outcome measures;[4]
- promote and monitor the application of technical standards and best practices;
- provide relevant technical expertise to affected Member States and all relevant stakeholders.

## WHO's guiding principles for emergency response

- **Country focus.** WHO supports national authorities in all aspects of the operational response, supports local actors and encourages active participation of communities. To do so effectively, WHO concentrates its resources as close to the affected population as possible. Regional offices and headquarters support the incident management team and WHO country offices in countries, territories and areas,[5] and coordinate regional and global events in a way that maximizes country support.
- **Humanitarian principles.** The fundamental humanitarian principles – humanity, neutrality, impartiality and independence – are central to WHO's emergency work. The humanitarian imperative of saving lives and relieving suffering supersedes all other considerations. In contexts where principled humanitarian action is constrained, WHO will work with partners to identify comparative advantages in addressing operational constraints.
- **Evidence-based and knowledge-based programming.** To ensure the quality and effectiveness of its emergency response, WHO applies evidence-based and knowledge-based programming. This includes the promotion of and adherence to technical standards and best practices, and close monitoring of key performance indicators (KPIs) to guide operations. It also includes the global coordination of knowledge-based development and operational research to fill vital knowledge gaps, including during the response.
- **Partnership.** Effective response is dependent on many dedicated partners. Recognizing that effectiveness is optimized through collective action, WHO prioritizes partnership at all levels. Key partners include Member States, United Nations agencies, the International Red Cross and Red Crescent Movement, GOARN, the Global Health Cluster and other clusters under the IASC, EMTs, expert networks, technical networks, Standby Partners and many others. At country level, WHO supports and strengthens local actors, including nongovernmental organizations (NGOs) and other civil society groups. The work of other sectors – especially water and sanitation, environmental public health, food, nutrition, protection, animal health and husbandry, and security – is also vital in improving health outcomes during emergencies. WHO is committed to the principles of partnership: equality, transparency, results-oriented approach, responsibility and complementarity of the global humanitarian platform.[6]

4 IASC PSEA outcome measures are i) prevention; ii) accessible, safe reporting; iii) quality assistance to victims; iv) leadership and accountability; and v) contributions to joint IASC PSEA network plan of action.

5 Referred to in the text as "country office."

6 https://www.icvanetwork.org/transforming-our-network-for-impact/principles-of-partnership/#:~:text=Leaders%20of%20UN%20agencies%2C%20NGOs,oriented%20approach%2C%20responsibility%20and%20complementarity

- **Protection.** The IASC principals (the heads of the organizations that form the IASC) have affirmed that protection must be at the heart of humanitarian action, and that all humanitarian organizations should commit to mainstreaming protection principles in all humanitarian/ emergency response operations and work towards collective outcomes.[8] By incorporating protection principles into health emergency interventions, WHO and its health partners are able to ensure that their activities target the most vulnerable individuals, enhance safety, dignity, and promote and protect the rights of the affected populations, encouraging inclusiveness without contributing to or perpetuating discrimination, abuse, violence, neglect and exploitation. Key protection principles to be considered in health emergency response operations include: i) prioritizing safety and dignity of affected populations; ii) ensuring meaningful access to services without discrimination; iii) integrating mechanisms for ensuring accountability to affected populations; and iv) promoting empowerment and participation of communities in the design and delivery of health interventions to enable them to claim and benefit from the interventions.
- **Gender, age and vulnerability sensitivity.** Various public health and sociocultural factors make certain groups more vulnerable to the health consequences of emergencies. Women and girls are at special risk, particularly in settings of conflict. Ensuring that they
- have ready access to reproductive health services and are protected from gender-based violence are humanitarian response priorities. The vulnerabilities and special needs of other groups, such as children, older people, people with disabilities, people living with HIV, ethnic or religious minorities and refugees must be addressed in the design and implementation of emergency operations.[8]
- **Protection from sexual exploitation, abuse and harassment (PSEAH*).** Enforcing and implementing the United Nations-wide policy on preventing and responding to sexual exploitation, abuse and harassment in emergency operations is essential to protect vulnerable populations and humanitarian workers from all forms of sexual misconduct, and to ensure accountability to populations served. The IASC PSEA core principles[9] apply to all United Nations personnel, regardless of their contractual or remuneration status, and to all collaborators and stakeholders.

*includes prevention and response to sexual exploitation, abuse and harassment

- **Accountability.** WHO's primary accountability is to the populations it serves, including the principles
- enshrined in the Accountability to Affected Populations commitment.[10] Accountability also extends to Member States, partners and donors. WHO strengthens accountability through evidence-based programming; clarification of roles and responsibilities; transparent information sharing; participation of affected populations; securing feedback and involvement from communities and other stakeholders; and maintenance of a risk register.
- **Ensuring the safety and security of responders.** WHO strives to ensure that all emergency responders can operate safely and securely in the interests of the affected population, in line with the United Nations Security Management System and Safety procedures set by the United Nations Department of Safety and Security (UNDSS).[11]

  Clear procedures are in place to support and enable the effective conduct of activities by ensuring a coherent, effective and timely response to all security-related threats and other emergencies. WHO works with United Nations security personnel in the field and coordinates with security focal points of United Nations departments, agencies, funds and programmes, ensuring a unified and comprehensive response in the context of any given security environment.
- **Strengthening the humanitarian-development-peace nexus.** Consistent with the Grand Bargain and the New Way of Working,[12] WHO looks to engage more effectively with development partners to reduce risks and vulnerabilities of communities and to work towards collective outcomes. During the response to emergencies, WHO and its partners aim to lay the foundation for health sector recovery based on a health systems approach.

7 Inter-Agency Standing Committee Policy on Protection in Humanitarian Action. Geneva: IASC; 2016 (https://interagencystandingcommittee.org/iasc-protection-priority-global-protection-cluster/iasc-policy-protection-humanitarian-action-2016).

8 Mainstreaming gender within the WHO Health Emergencies Programme: 2022–2026 strategy. (https://apps.who.int/iris/handle/10665/360406).

9 IASC six core principles. (https://psea.interagencystandingcommittee.org/update/iasc-six-core-principles).

10 Operational guidance on accountability to affected populations (https://www.who.int/docs/default-source/documents/publications/operational-guidance-on-accountability-to-affected-populations.pdf?sfvrsn=ec7fb6c8_1)

11 UNDSS. (www.un.org/undss).

12 Bridging the divide: a guide to implementing the humanitarian-development-peace nexus. (https://iris.who.int/handle/10665/351260).

## WHO's no regrets policy

At the onset of all emergencies or verified public health events, WHO ensures that levels of staff and funds applicable to the nature of the emergency are made available to the country office, even if it is later realized that less is required, with full support from the Organization and without blame or regret. This policy affirms that it is better to err on the side of over-resourcing critical functions rather than risk failure by under-resourcing. The application of this policy – or in general of any special waivers and exceptions existing for acute emergencies – is based on the judgment of approvers that the operational benefit outweighs the additional risks to the Organization. If requests are not urgent and the situation does not require the additional speed and efficiency provided by the emergency provisions, it is expected that the transactions will follow normal WHO policy and human resources/financial rules and regulations processes. The no regrets policy does not imply a waiver of compliance requirements or operational risk management processes. All expenditures must be documented and justified at the time.

As regards financial resources, this policy provides the head of the WHO office in a country, territory or area (HWCO) or WHO representative (WR) and the incident manager with increased authority to authorize and approve expenditure, as defined in the WHO eManual.[13] The related procedures for accountability and documentation remain in place, as described in the emergency SOPs.[14] The incident manager is expected, as soon as possible, to plan and put in place processes that ensure that transactions can be implemented using normal WHO policy and human resources/financial rules and regulations.

Immediate access to funds is provided from either the regional office's rapid response accounts or the Contingency Fund for Emergencies (CFE). These should be replenished as funds are raised for the emergency. This no regrets policy applies to any expenditure incurred during the first three months of a graded emergency.

## Contingency Fund for Emergencies

The CFE was established in 2015 by the World Health Assembly to provide financing at the onset of an outbreak or other health emergency when other resources are not available. The CFE is designed to allow the rapid release of funds for incident managers to meet the early performance standards set out in the ERF. Based on this principle, the CFE has a performance target of releasing up to US$ 500 000 within 24 hours of approval of a request following grading.

The CFE has been designed to enable immediate action to prevent or minimize the escalation of the health consequences of emergencies while the requesting office is mobilizing resources from other financing mechanisms. The CFE provides financing for up to three months, which may be exceptionally extended up to six months if no other funding is available. The CFE is not meant to be used to finance ongoing operational costs. CFE allocations should be reimbursed to the extent possible through local resource mobilization efforts. In this regard, a local resource mobilization strategy should be part of every CFE request. It is a requirement that the receiving country office organize at least one briefing to donors during the first three months of the response, and brief on WHO's priorities and resource requirements.

Guidance and procedures to obtain funds from the CFE can be found in the WHO eManual.[15] A checklist has been provided in Annex 1 to assist in requesting funds from the CFE.

## Successful implementation of the ERF

The ERF review process highlighted that many challenges faced in response operations can be attributed to imperfect implementation of the ERF. Successful implementation requires:

- institutional readiness of WHO in line with standardized checklists at country, regional and headquarters offices and regular provision of training for staff on the ERF
- sufficient and sustainable core funding for the above
- sufficient and timely response funding
- access to the affected population
- rapid and transparent information sharing
- an outcomes-oriented attitude among all staff involved in the response
- transparent and collaborative partnerships between offices (country, regional and headquarters).

13 WHO eManual Section XVII.2.3: Delegation of Authority (https://emanual.who.int/p17/s02/Pages/XVII23delegationofauthority.aspx).

14 WHO eManual Section XVII: Health Emergencies SOPs (https://emanual.who.int/p17/Pages/default.aspx).

15 WHO eManual Section XVII.6.1: Contingency Fund for Emergencies (CFE) – Request for Support (https://emanual.who.int/p17/s06/Pages/XVII.6.1%20Contingency%20Fund%20for%20Emergencies%20(CFE).aspx)

# Rapid risk assessment and public health situation analysis

Early detection of events and rapid assessment are critical to prevent public health events from becoming emergencies and to inform decision-making for an effective response.

The most important assessments for guiding initial emergency response are the rapid risk assessment (RRA)[16] conducted for public health events, and the public health situation analysis (PHSA) conducted to determine the immediate needs of a population following sudden onset emergencies or humanitarian crises (Box 1).[17]

The decision to conduct an RRA/PHSA is context specific and signals the need to document the public health risks of an event or emergency, its likely impact and actions recommended by WHO. Events that may require an RRA/

PHSA include those that are likely to be notifiable under the IHR; potentially have serious public health consequences and exceed the response capacity of local authorities; and may require an operational response by WHO.

The RRA/PHSA provides information to understand and communicate the public health risk(s) represented by an event or emergency, and the potential requirements for a response by WHO and partners.

Whereas an RRA is more appropriate for individual events, aPHSA is often used as a comprehensive assessment of all public health issues in a given context, and is most applicable in settings with activated health coordination mechanisms (such as health clusters).

Box 1. Public health events and emergencies that may require risk assessment

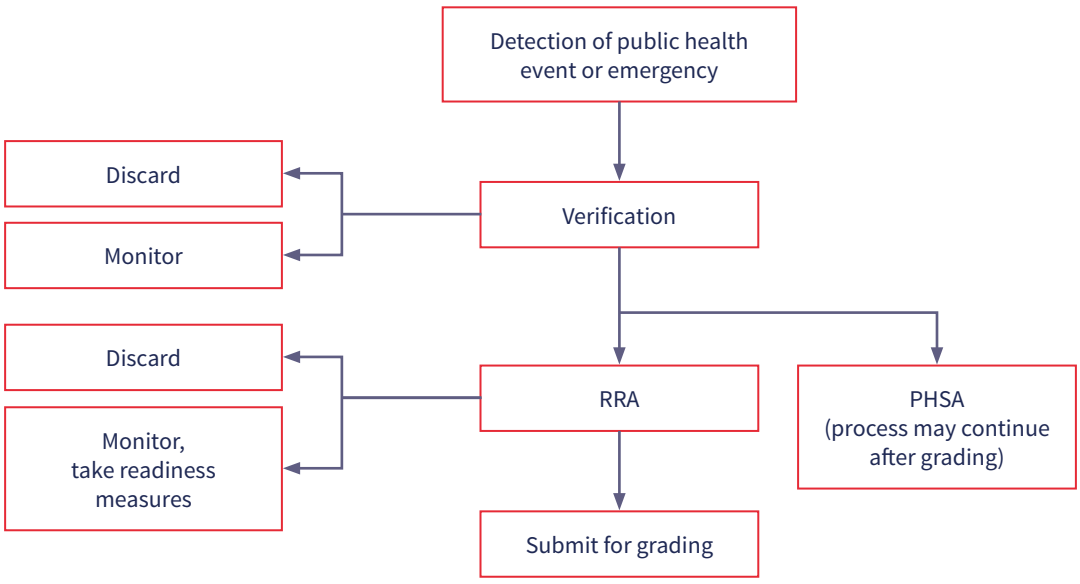
**Public health events**

- Outbreaks of infectious diseases: diseases of unknown origin, new emerging or re emerging diseases, epidemic-prone diseases or zoonoses.
- Events resulting from exposure to toxic or hazardous materials: falsified and counterfeit drugs or vaccines, unusual reaction to medications or vaccines, food or water contamination, environmental contamination or exposure, accidental release or deliberate use of biological and chemical agents or radio nuclear material.
- Other unusual or unexpected events representing a risk to public health.

**Sudden onset emergencies**

- Natural hazards: earthquakes, tsunamis, floods, landslides or avalanches, extreme temperatures, progressive drought and wildfires (Annex 7).
- Human-induced hazards: armed conflict, civil unrest, terrorism, transportation crashes, structural fires and industrial explosions (Annex 7).

Fig. 1. Signal detection, verification, risk assessment and links to next steps




16 Contact outbreak@who.int for detailed SOPs for conducting RRAs.

17 See the Public Health Information Services Toolkit (https://healthcluster.who.int/our-work/task-teams/information-management-task-team/public-health-information-services-toolkit).

## Information collection, analysis and event verification

The detection, verification and risk assessment experts at headquarters and regional levels work closely with country offices and IHR national focal points (NFPs) to detect and verify public health events of national or international concern and to conduct RRAs. The collection and analysis of information uses several approaches:

- searching public and open sources of information for key words across different electronic media using computer-aided algorithms such as Epidemic Intelligence from Open Sources (EIOS)[18] and through media monitoring systems (for example, ProMED, HealthMap);
- regular monitoring of threats through routine integrated disease surveillance systems (for example, Integrated Disease Surveillance and Response [IDSR]);
- maintaining direct, ongoing communication with country offices and NFPs at the ministries of health, United Nations partners, NGOs and other professional networks;
- receiving formal notification of events through IHR NFPs;
- sharing information about events through partner networks and databases including GOARN; the Food and Agriculture Organization of the United Nations; the World Organisation for Animal Health (WOAH), and WHO Global Early Warning System for Major Animal Diseases, including Zoonoses (GLEWS); the International Food Safety Authorities Network (INFOSAN); the IASC Early Warning, Early Action and Readiness working group; and the Global Influenza Surveillance and Response System (GISRS).

A signal is usually considered verified as an event following an official Member State notification, for example via email from the national IHR focal point, through direct reporting to WHO under the IHR, or via a government press release. A signal may require verification by WHO and partners when official information is not available. Verification is undertaken when the occurrence, nature, or cause and extent are not known or where the sources or content of non-official reports requires substantiation. Verification by the Member State should occur within 24 hours of WHO's request. Article 10 of the IHR lays out the provisions for initiating event verification by WHO without official reporting by a Member State. An absence of verification does not preclude an assessment by WHO.

Event verification is done through active and systematic information gathering from various sources for triangulation and technical review. These sources include:

- WHO reference person, for example the regional office IHR contact person, technical or disease focal point, or country office contact;
- country-level contacts, for example health authorities, national focal points, heads of laboratories and other technical experts, United Nations agencies and health sector partners;
- other sources, for example expert networks, published reports and media information.

If necessary, a team will deploy to the event location for verification, in-depth investigation and, as required, emergency risk assessment. The team will be composed of experts from country, regional or global levels, including from technical networks such as GOARN.

Exceptionally, the WHO emergency SOPs can be activated to facilitate rapid deployment for field investigation and risk assessment before an event is graded. For some natural hazards (such as a cyclone or drought) and societal hazards (such as civil unrest) an early warning may be issued by relevant authorities to alert about an impending emergency. In such instances, WHO may deploy staff, supplies and equipment to support in-country readiness and early action as part of its no regrets policy. In addition, the CFE – up to a maximum of US$ 50 000 – can be accessed to support these activities. Any additional WHO actions or expenditures require grading (see Chapter 2).



**18** Epidemic Intelligence from Open Sources (EIOS): saving lives through early detection. Geneva: World Health Organization (https://www.who.int/initiatives/eios).

## Rapid risk assessment (RRA)

The main objectives of the RRA are to characterize the risk to public health and to recommend the most effective public health actions – especially those that will prevent any further amplification of the event assessed. The RRA should be undertaken as quickly as possible – ideally within 72 hours of verification (or early warning for sudden-onset emergencies). The timing may vary by hazard, the accessibility of the affected areas, and the speed by which the acute event or emergency evolves.

The RRA is completed by a multidisciplinary team of WHO staff from the three levels of the Organization. The team should always include technical and operational expertise: risk assessment, epidemiology, relevant hazard and emergency management specialists. It should engage partners as appropriate (e.g. for zoonotic outbreaks).

The outputs of the RRA are internal and represent WHO's independent opinion. While the process may integrate data received from Member States and partners, it does not require approval or concurrence of a Member State or partners. The WHO country office (WCO) has the responsibility of ensuring that Member State data are appropriately included.

### Elements of the rapid risk assessment

Questions are developed around the following criteria to assess the level of risk of an event.

**Hazards:**

- identifying, characterizing and ranking hazards that could be causing the event and their potential impact.

**Exposure (or potential exposure) of individuals and populations:**

- health impact, including number of cases, deaths, hospitalizations, and case–fatality ratios;
- numbers of people known or likely to have been exposed or susceptible (disaggregated by age and sex where possible);
- extent and intensity of exposure;
- geographical distribution.

**Context analysis:**

- underlying causative factors and drivers, if known;
- health impact, including number of cases, deaths, hospitalizations, and case–fatality ratios;
- vulnerable groups of exposed or potentially exposed populations;
- functionality of the national health care system;
- primary and secondary effects, for example, displacement, impact on national health system;
- operational environment:
  - response capacity of local and national authorities, country office capacity, international capacities in country available for mobilization and coordination capacity;
  - occupational risks to responders, including physical, political and security access to affected area and coverage of essential services.

### Risk characterization and determination of risk level

Following the verification of a public health event, the likelihood of public health consequences and the severity of their impact are estimated. The RRA assigns an overall risk level of low, moderate, high or very high to the event at national, regional and global levels. The risk level is therefore a product of the likelihood of consequences and the public health impact of the event. The level assigned to the risk does not indicate the level of response required by WHO; this is determined by the grading process (Chapter 2).

### Recommendations following risk assessment

The RRA makes recommendations regarding follow-up actions in a standardized template (contact outbreak@who.int to access the latest template). Recommendations are provided below.

- Discard the event since it does not present a public health risk.
- Implement monitoring, mitigation and readiness measures. Most events can be effectively managed through standard prevention and mitigation measures using in-country resources. A proportion will require ongoing monitoring by WHO and partners, as well as active preparedness and readiness measures. These include slower-onset emergencies, such as drought, food insecurity and evolving political and civil crises.
- Submit the event for grading by WHO to decide on the level of the Organization's response. A grading process should always be initiated for all events assessed as high or very high risk at regional or global level. Moderate risks may also be referred for grading, at the discretion of the assessment team. The grading process will determine the need for a scaled-up operational response by WHO.
- Refer the event for consideration as a public health emergency of international concern (PHEIC) to be declared by the Director-General following a review of recommendations from an IHR Emergency Committee convened for the event.

# Public health situation analysis (PHSA)

A PHSA is conducted in response to a sudden-onset emergency or deterioration in a protracted crisis. It is one of the key outputs of WHO and/or the Health Cluster as stipulated in the Public Health Information Services Standards,[19] to which WHE and the Global Health Cluster adhere. The main objectives of the PHSA are to characterize the major needs and risks faced by a population, including elements of humanitarian response capacity. It is a holistic assessment of all the public health issues and response landscape in a given context, and is most applicable in settings with activated health coordination mechanisms (e.g. Health Clusters). The PHSA does not include recommendations about priority interventions, but rather functions as a platform for joint planning with partners.

- It provides a comprehensive analysis of the existing health status and potential health threats that the population may face over time, the functioning of the health system and humanitarian health system performance.
- It aims to provide all health sector partners, including local and national authorities, NGOs, donor agencies and United Nations agencies with a common understanding of the public health situation in an emergency in order to inform evidence-based collective humanitarian health response planning.

A PHSA is rarely used to determine the initial grade of an emergency but is useful when reviewing a grade to provide evidence on the scale of a health crisis.

## Elements of PHSA

Elements of the initial PHSA are provided below.

**Summary of the emergency and context:**

- key features and facts including population affected, duration of emergency, geographical areas affected, or most likely to be affected;
- major humanitarian consequences and concerns;
- underlying causative factors and drivers of the emergency (e.g. conflict, drought, earthquake, or other pre-existing vulnerabilities), including key operational constraints;
- major public health issues and/or disease outbreaks arising due to the emergency, and information on vulnerable groups, if applicable;
- level of destruction of health facilities, if applicable.

**Health status and priority threats:**

- the existing health status of the population and possible health threats, which indicate major areas for action;
- data disaggregated by sex and age, if available.

**Health system needs:**

- primary health-care coverage, health-care capacity, health workforce, availability of medical supplies.

**Humanitarian health response:**

- health response actors and coordination structure (3/4W matrix).[20]

**Information gaps and recommended information sources:**

- information and statistics both pre- and post-emergency are important to understand what could potentially be aggravated by the current emergency.

**Additional analysis that could affect the health and well-being of affected populations:**

- how the health response could pose risks of sexual exploitation, abuse and harassment.

## Overview of PHSA process

The PHSA is usually authored by the country office or regional office, with headquarters' inputs as needed. Occasionally it may be initiated by headquarters. Regardless of initial authorship, responsibility and primary ownership of the PHSA rests with the relevant country office.

An initial short-form PHSA should be completed within 72 hours of the onset of an emergency, or as soon as practicable. The release of the initial PHSA should not be delayed due to incomplete information; it should point to areas requiring additional data collection. Previous assessments can be used as an initial basis for the PHSA, as appropriate.

The comprehensive long-form PHSA should be initiated as soon as the short-form PHSA has been released, and should be completed within 14 days of the onset of an acute emergency or deterioration of a protracted crisis. See the Public Health Situation Analysis Standard Operating Procedures[21] within the Public Health Information Toolkit[22] for further information and templates.

The PHSA should be updated whenever significant changes to the situation occur and can be used when an emergency is being re-graded. In humanitarian crises, WHO also participates in inter-agency assessments.

19 Standards for public health information services. (https://healthcluster.who.int/publications/m/item/standards-for-public-health-information-services).
20 Health Cluster 3/4W tool. (https://healthcluster.who.int/publications/m/item/health-cluster-3-4w-tool).
21 Public health situation analysis standard operating procedures. (https://healthcluster.who.int/publications/m/item/public-health-situation-analysis-standard-operating-procedures).
22 Public health information services toolkit (https://healthcluster.who.int/our-work/task-teams/information-management-task-team/public-health-information-services-toolkit).

## Communication of event detection, verification and RRA/PHSA

**Regular reporting of events.** Information about verified events and decisions for subsequent action will be recorded in the WHO Event Management System.[23] Documentation of an event is done by the country and regional offices of the Organization, and is the responsibility of the detection, verification and risk assessment experts. Further uploading of information can be done by WHO staff granted administration rights for the event.

**Reporting on rapid risk assessments.** A completed RRA will be uploaded in the Event Management System and communicated by the assessment team to the HWCO/ WR, all Regional Emergency Directors (REDs), directors and Executive Director of WHE at headquarters, with a copy to other stakeholders as appropriate.

- **Informing the Regional Director.** The RED informs the Regional Director of the outcomes of the RRA and any proposed recommendation regarding convening a grading call.
- **Informing the Director-General.** The Executive Director informs the Director-General of events assessed as very high risk at global level, with a copy to members of the Global Policy Group. The Director-General may convene an Emergency Committee for consideration of whether the event constitutes a public health emergency of international concern.
- **Informing the United Nations system.** For all public health events assessed as very high risk at global level, or when WHO declares an internal Grade 3 emergency, the Director-General will notify the United Nations Secretary-General and the Emergency Relief Coordinator through a standard briefing memo within 48 hours of completion of the RRA, or grading.[24]
- **Informing national authorities.** The HWCO/WR can share the RRA with the ministry of health and other relevant national authorities, as appropriate. The regional office and headquarters will support the HWCO/WR in managing any sensitivities related to the outcomes of the RRA.
- **Informing partners.** The RRA can be shared externally through agreed partner networks and other communication channels. The communications team will ensure a statement is prepared if further dissemination or interest by media outlets is expected.
- **Events notifiable under the IHR.** The results of the RRA for a verified event that is notifiable under the IHR should be communicated through the Event Information Site (EIS), which is a restricted site available to all IHR NFPs. Sharing information publicly about events notifiable under the IHR is done in accordance with Article 11 of the IHR.

**Reporting on public health situation analyses.** All PHSAs will be posted to the WHO Global Emergency Dashboard[25] for access by authorized personnel. Prior to posting, agreement will be sought from the health cluster coordinator, the WHE team lead in country, and the HWCO/ WR. As the purpose of the PHSA is to provide a common understanding of the health situation among response partners, the country office will distribute the PHSA within the country health cluster or other health coordination architecture, at minimum.

23 The Event Management System is WHO's repository information system, designed and developed to serve as a single platform for all relevant information about an event.

24 In accordance with the IASC Standard operating procedure. Humanitarian system-wide scale-up activation: Protocol for the Control of Infectious Disease Events; 2019. (https://interagencystandingcommittee.org/system/files/190404_iasc_infectious_disease_scale-up_activation_protocol_web.pdf).

25 Emergency dashboard. (https://extranet.who.int/emergencydashboard).

# WHO grading of public health events and emergencies

Grading is an internal WHO activation procedure and is not dependent on consultation with Member States or official requests for assistance. The grade indicates the level of operational response required by WHO for that event, not its assessed level of risk.

## Purpose of grading

Grading is conducted to:

- inform the Organization of the level of WHO's operational response to an emergency and the need for mobilization of internal and external resources;
- activate WHO's incident management system (IMS) and emergency SOPs;
- determine the need for a surge of additional human and material resources;
- permit the use of resources from the CFE above US$ 50 000;
- convey to partners, donors and other stakeholders WHO's assessment of the scale of unmet needs within the health sector and, by extension, the requirement for additional international resources.

## Triggers for consideration of grading

The following criteria trigger the grading process:

- any public health event with a risk assessed as high or very high;
- any public health event where the RRA indicates a likely need for an operational response by WHO;
- any request for emergency assistance from a Member State.

## Timing of grading

For acute events, the grading exercise should be conducted within 24 hours of an RRA that characterizes the event as high or very high risk and indicates the likely need for an operational response by WHO. For slower-onset events due, for example, to conflict or drought, grading may happen several days after initial assessment and where applicable, use information from the PHSA to support decision-making.

## Responsibility for grading

Grading can be initiated by any level of the Organization; however, the primary responsibility lies with the RED. Representation at the grading call should include the HWCO/WR, the RED and senior representation from headquarters on behalf of the Executive Director. The grade of an emergency must be agreed across the three levels.

## WHO levels for graded emergencies

Table 1. Definitions of graded emergencies

| Grade | Description |
|---|---|
| Ungraded | The operational response **does not exceed the usual country-level cooperation** of the country office with the Member State. The event continues to be monitored as required. |
| Grade 1 | An event requiring a **limited response by WHO,** which exceeds the usual country-level cooperation that the country office has with the Member State. Organizational or external support required by the country office is minimal. The provision of support to the country office is coordinated by an incident manager counterpart in the regional office. |
| Grade 2 | An event requiring a **moderate response by WHO.** The level of response required by WHO always exceeds the capacity of the country office. Organizational or external support required by the country office is moderate. The provision of support to the country office is coordinated by an incident manager in the regional office. An incident manager counterpart is also appointed at headquarters to assist with the coordination of Organization-wide support as required. |
| Grade 3 | An event requiring a **major to maximal WHO response.** Organizational and external support required by the country office entails the mobilization of Organization-wide assets.<br>The provision of support to the country office is coordinated by an incident manager at regional office level. An incident manager is also appointed at headquarters to assist with the coordination of Organization-wide technical and operational support. The Executive Director of WHE and any involved regional directors may agree to coordinate the event from headquarters. For events or emergencies involving multiple regions, an incident manager at headquarters will coordinate the response across the regions.<br>System-wide scale up by the IASC automatically results in the declaration of a WHO Grade 3 emergency, if not already activated. |

## Grading process

Grading is conducted via teleconference with staff from the three levels of the Organization present.

1. The RED, or their delegate, arranges and chairs the grading call.
2. The country office provides a situation update based on the RRA, or where applicable PHSA, using the five IASC criteria[26] as a basis for the discussion:

- Scale:
  - large or increasing number of daily cases or deaths reported in a given place and time for the type of event;
  - number of affected areas or countries.
- Urgency:
  - serious public health impact;
  - significant risk of in-country or international spread;
  - significant risk of international travel and trade restrictions.
- Complexity:
  - event unusual or unexpected (for example, due to unknown agent or unknown mode of transmission);
  - multi-layered emergency, presence of a multitude of actors, lack of humanitarian access, high security risks to staff.
- Capacity:
  - external assistance needed to investigate, respond to and control event.
- Risk of failure to deliver effectively and at scale to affected population:
  - media and public attention and visibility, expectations on international community including the United Nations system by donors, the public, national stakeholders and partners;
  - additional risks, such as the risk of SEAH that could be additional threats to the well-being and rights of affected populations.

The grading decision should be based on the collective views of the three levels of the Organization on the operational requirements to manage the event. It is difficult to establish objective thresholds for these criteria. Some diseases in eradication, elimination or control phases, however, have existing criteria and targets that can be taken into consideration.

## Multiple countries with a single grade or single countries with multiple grades

Emergencies are graded, not countries. A single country may have multiple graded emergencies at any given time (e.g. an earthquake in one part of the country and a disease outbreak in another). Compounded burdens on the health system, and on country office and health partner capacities, would be expected to influence grading of subsequent events and emergencies. If a new event is directly associated with an ongoing emergency and can be managed under the existing grade, no further grading is required.

A multi-country emergency is graded collectively and has only one grade; however, the extent of the mobilization of staff and resources by country may differ depending on the country-specific response requirements.

## Documentation of the grading process

The outcome of the grading call is documented in a standard template (see Annex 2). The grading decision determines accountability for the event, agreed by the three levels. The RED is responsible for ensuring the grading template is complete and for sharing it with those who participated, within six hours of the call.

The following should be documented in the grading template:

- the agreed grade, with explanations based on the grading criteria;
- immediate response objectives over a specified period, until a more detailed response plan is established;
- name and contact details of the incident manager in country (or temporary focal point) and their counterparts at regional office and headquarters levels, as required,
- accountability;
- the initial assignment of extraordinary resources (staff, funding and supplies), especially for country level;
- for Grade 2 or 3 emergencies, an agreed timeline for delivering on WHO's performance standards;
- for Grade 2 or 3 emergencies due to infectious hazards, a recommendation to the Director-General of whether the emergency may represent a public health emergency of international concern;
- for Grade 3 emergencies due to infectious hazards, a recommendation regarding mobilization of IASC resources (e.g. through establishment of a United Nations crisis management team or system-wide scale-up);
- date and time of the next three-level meeting for the response.

26 IASC Standard operating procedure. Humanitarian system-wide scale-up activation: Protocol for the Control of Infectious Disease Events (2019). (https://interagencystandingcommittee.org/system/files/190404_iasc_infectious_disease_scale-up_activation_protocol_web.pdf).

## Declaration and communication of grades

- Informing the Regional Director and Executive Director:
  - The RED (or REDs, for multi-region emergencies) informs the Regional Director(s) and the Executive Director within 12 hours via email, copying other REDs and relevant stakeholders for information.
- Informing the Director-General:
  - The Executive Director informs the Director-General and all Regional Directors of all Grade 3 emergencies, along with recommendations for the leadership model and action plan within 48 hours of grading (see Chapter 3).
- Informing the United Nations system:
  - For Grade 3 emergencies, the Director-General will inform the United Nations Secretary-General within 24 hours of grading, with copy to the United Nations Emergency Relief Coordinator and the IASC Principals.

REDs ensure that all events that are not graded are recorded in Event Management System 2 (EMS 2)[27] after the grading exercise. Graded emergencies are tracked and published continuously on the WHE website and linked with the WHO eManual to guide administrative procedures.

## Removal of the grade or conversion to protracted emergency

After six months, emergency grades will be removed by default, except for emergencies for which the IASC scale-up or United Nations Crisis Management Team remains activated (in which case, WHO would maintain Grade 3), or if WHO determines to extend or modify the grade for a prescribed time frame based on the operational context and response requirements. The latter requires a new grading decision, as described above. Events for which the grade has been removed should be recorded in EMS 2 as "Grade removed" to indicate closure of the event.

WHO will consider whether an emergency meets the definition of a protracted emergency and, if so, whether a protracted grade should be applied (Annex 3).



27 WHE's platform for documenting event-related information (https://extranet.who.int/ems/)

# Incident management system

The grading of an emergency triggers the activation of WHO's IMS, which provides a standardized yet flexible approach to managing WHO's response. WHO applies the IMS regardless of the underlying hazard, scale or operational context of the emergency. The IMS approach is internationally recognized as best practice for emergency management.

## Key concepts and principles

**Standardized emergency functions.** These are key functions for any emergency response, brought together in a unified structure regardless of the number of people involved in the operations. For WHO, the core IMS functions are:

- leadership and coordination
- planning and monitoring
- operations support and logistics
- technical expertise and health operations
- health information and epidemiology
- partner coordination and engagement
- finance and administration.

**Flexibility, adaptability and scalability.** The IMS is applicable to all types and scales of emergencies. It can be easily adapted as needs evolve, while maintaining standards and predictability.

**Interoperability.** The IMS allows WHO to interact and work more effectively with operational partners. This includes functional interoperability (for example, use of standardized terminology and procedures) and technological interoperability (for example, standardized telecommunications). Interoperability is also promoted through WHO's adherence to interagency protocols and procedures.

## Activation of the IMS

Within 24 hours of grading, WHO will:

- ensure the safety and security of all staff;[28]
- appoint an incident manager in country (and at regional and headquarters offices as required) for a minimum initial period of three months;
- establish an incident management team (IMT) in country to cover critical IMS functions, which will be done initially through repurposing of country office staff, alongside ministry of health and field partners;
- activate the emergency SOPs;
- establish contact with government officials, partners and other relevant stakeholders;
- determine the need for surge support to the country for critical IMS functions. This determination is made following an assessment of country office capacity to manage the emergency during the grading call. Surge support may also be needed at regional office and headquarters;
- begin the deployment of surge support on a no regrets basis, as needed;
- designate an interim PSEAH resource person;
- elaborate the initial response objectives and action plan, until a more detailed plan is developed;
- establish an incident management support team (IMST) at regional and headquarters levels to mobilize and coordinate Organization-wide and partner support
- for Grade 2 and Grade 3 responses. The structure of IMSTs can vary, but always supports the in-country IMT functions as required. A focal point will be appointed at regional level, and if necessary, at headquarters level, to provide any required support for Grade 1 emergencies.

The IMT is established as close to the emergency as possible, and this is almost always in country. Flexibility may be required for:

- emergencies for which high levels of unacceptable risk or insecurity do not permit an in-country or on-site presence of staff, in which case elements of the IMT provide remote support;
- multi-country, multi-region emergencies, in which case the IMT may be established at regional or headquarters offices.



28 Ensuring the safety and security of staff is an ongoing activity and does not depend on grading.

## Tiers of WHO responsibility and accountability in operational response

The main tiers of WHO responsibility for managing a response to emergencies are as follows (see Table 2).

- **Technical and operational.** This is the primary responsibility of the appointed incident managers and includes day-to-day management of the response, assigning responsibility for critical functions and supervising IMT/IMST pillar leads. For outbreaks in particular, the incident managers across the Organization work closely with technical experts towards an aligned three-level approach in defining priority actions, designing the response strategy and specifying essential disease control interventions. The support of partner organizations should be sought for technical areas where they have relevant additional expertise, based on the type of event.
- **Operational oversight.** For Grade 1 and 2 emergencies, it is the responsibility of the HWCO/WR and RED to
- work with health authorities and partners to (a) agree on objectives for the health response; (b) determine how to use available resources to support strategic priorities; and (c) establish a coordination mechanism with the ministry of health and partners. The RED is responsible for monitoring the effectiveness of the organizational response to the emergency and has been delegated authority to make management decisions regarding the response. For Grade 3 emergencies, operational oversight responsibility will be delegated to the RED, or at headquarters to Director, Alert and Response Coordination or Director, Health Emergency Interventions depending on the type of event.
- **Accountability.** WHO strengthens accountability through evidence-based programming, clarification of roles and responsibilities, transparent information sharing, participation of affected populations, securing feedback and involvement from communities and other stakeholders, and maintenance of a risk register. The Director-General is accountable for the timeliness and effectiveness of all WHO emergency responses; on a day-to-day basis, accountability is with the Executive Director of WHE or the Regional Director, depending on the grade. The Executive Director, on behalf of the Director-General, has the delegation of authority to intervene under circumstances that he or she deems appropriate regardless of grade.
    - For Grade 1 emergencies, the Regional Director is accountable for the timeliness and effectiveness of the WHO emergency response. The incident manager will usually be appointed from the country office by the HWCO/WR. The incident manager reports directly to the HWCO/WR, who reports to the RED. This presupposes that the HWCO/WR has the capacity to oversee the response and supervise the incident manager. The operational oversight is delegated to the RED. A close working relationship must be established between the incident manager and the HWCO/WR, with each respecting the other's role and delegation of authority (Table 3).
    - For Grade 2 emergencies, the Regional Director is accountable for the timeliness and effectiveness of the WHO emergency response. The Regional Director appoints the incident manager. The operational oversight is delegated to the RED.
    - For Grade 3 emergencies, the Executive Director of WHE or the Regional Director is accountable for the timeliness and effectiveness of the WHO emergency response, to be agreed within 48 hours of grading. The Regional Director appoints the incident manager at the regional and country levels for Grade 3 emergencies, in consultation with the Executive Director of WHE.

Senior management may decide that the scale and complexity of the response exceeds the capacities of the country office. In such circumstances, they may agree to appoint the RED or relevant Director WHE/headquarters as the direct supervisor of the incident manager in country. The RED, or as delegated, provides oversight to the incident manager in the regional office. The relevant Director WHE/ headquarters provides oversight to the incident manager in headquarters.

In the regional offices and at headquarters, a strategic forum should be in place to regularly brief the Global Policy Group or its equivalent at the regional office on the operations, to ensure their full support to the IMT/IMST's activities.

Table 2. Organizational responsibilities and accountabilities for emergency response operations

| Grade | Responsibilities | | |
|---|---|---|---|
| | Technical and operational support | Operational oversight | Accountability* |
| 1 | IM at country office<br>As needed: IMST in regional office | Delegated to RED | Regional Director |
| 2 | IM at country office, and IMST in regional office<br>As needed: IMST in headquarters | Delegated to RED | Regional Director |
| 3 | IM and IMSTs at three levels | Delegated to RED or Director WHE/headquarters | Executive Director of WHE or Regional Director** |

* The Executive Director of WHE, on behalf of the Director-General, is operationally accountable for all emergency responses. Regardless of grade, the Executive Director of WHE has the delegation of authority to intervene under any circumstances that he or she may deem appropriate.

**To be agreed by the Executive Director of WHE and the Regional Director(s) within 48 hours of grading. For events where the Executive Director of WHE is accountable, operational oversight lies with a Director WHE/headquarters, to be specified depending on the type of event. For events where the Regional Director is accountable, operational oversight lies with the Regional Emergency Director.

Table 3. Indicative roles and responsibilities of incident manager (country office) and HWCO/WR

| HWCO/WR | Incident manager |
|---|---|
| • Facilitation of initial WHO response:<br>  • activation of WHO contingency plan and business continuity plan;<br>  • initial repurposing of WHO staff and assets, and assigning key functional roles;<br>  • placement of country office assets at disposal of response operations.<br>• Support of incident manager in their management of the response and supervision of the incident manager, when designated.<br>• Representation of WHO to ministry of health and other government ministries; and in United Nations humanitarian country team as cluster lead agency where applicable (may be delegated to incident manager).<br>• Creation of separate activity and human resource workplans and budgets for response; close workplans at end of the emergency.<br>• Leadership and management of ongoing WHO programmes not related to the emergency. May be responsible for concurrent emergency events. | • Management of overall WHO response and subsequent phase-out plan.<br>• Supervision of functional leads under the IMS.<br>• Technical and operational guidance to ministry of health and to health sector and health cluster on response operations.<br>• Tracking of progress towards meeting strategic and operational objectives; implementation of course corrections, as required.<br>• Establish a coordination mechanism with partners (can be delegated to deputy incident manager).<br>• Close collaboration and consultation with HWCO/WR and RED. |
| Shared responsibilities (WR ultimately accountable in country):<br>• staff security, safety, health and well-being;<br>• donor relations for the response;<br>• external communications;<br>• approval of expenditures, local procurements and cash advances as per SOPs;<br>• ensure PSEAH is mainstreamed and embedded in the emergency response operations from the outset of the response, including ensuring appropriate engagement with partners and national governments on PSEAH matters. | |

## Delegation of authority

Specific terms of reference, and when applicable a delegation of authority, should be developed for each post in relation to the emergency response; the existing templates in the eManual should be used to the extent possible. A delegation of authority can only be provided to WHO staff members, not consultants. Consultants cannot be assigned as incident managers, field coordinators or team leads, nor can they carry out supervisory or official representative functions.

Depending on the scale of the emergency, a deputy incident manager may be appointed to support the operational responsibilities of the incident manager. The responsibilities of the deputy incident manager are delegated in writing by the incident manager, as required. Any delegations beyond those set in the eManual should be communicated as soon as possible and in writing from the relevant authority (e.g. Director-General, Regional Director, Executive Director, RED, incident manager) to the officer delegated those functions, and to the finance and administration staff at the three levels of the Organization.

## Emergency SOPs

WHO's eManual defines the SOPs that are activated only during graded emergencies.[29] They provide guidance on managerial, operational, administrative and financial measures. Outside graded emergencies, emergency SOPs can only be activated for the investigation of unverified signals or as part of early warning or early action.

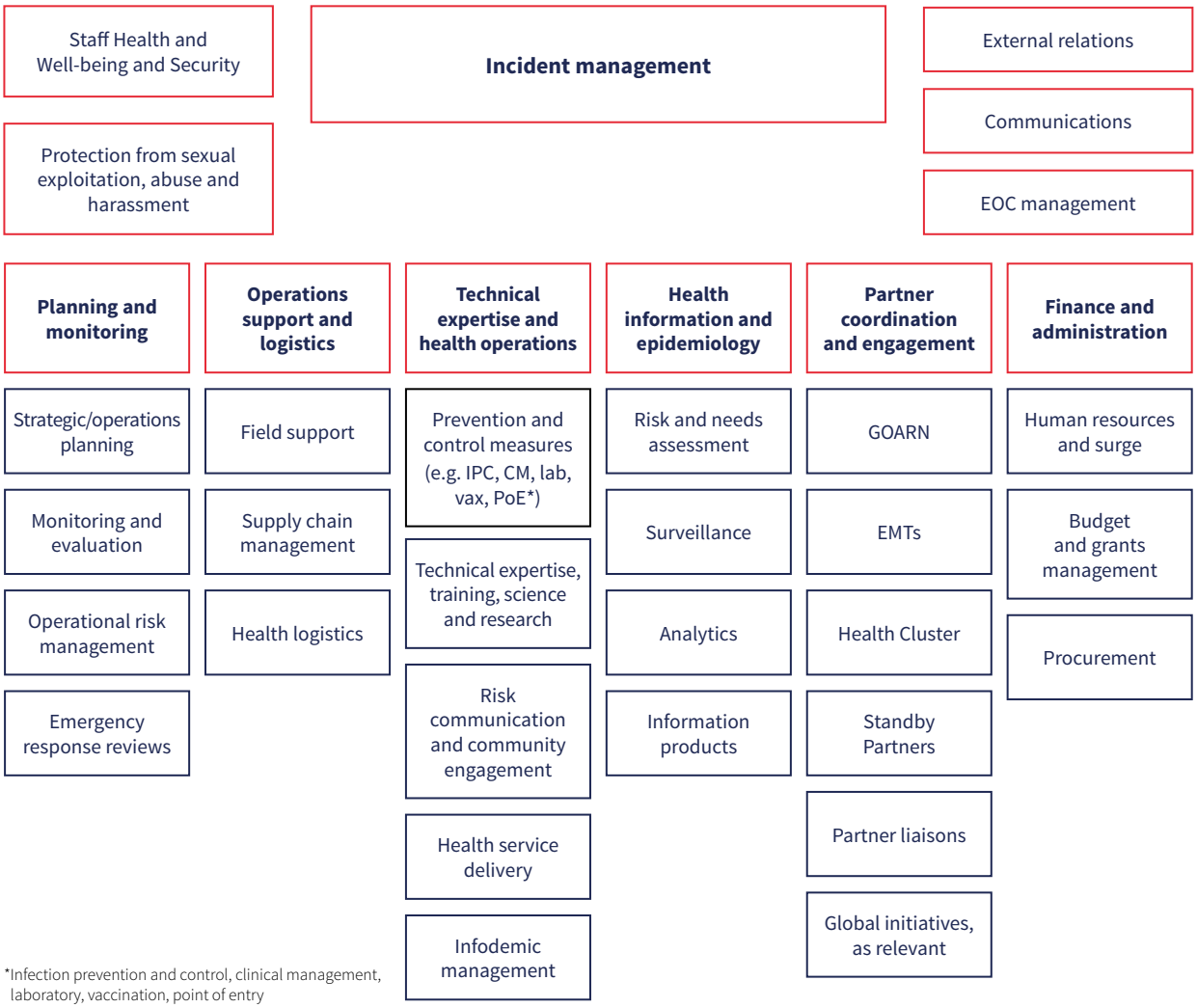
## WHO's critical functions in the IMS

WHO has key functions to fulfil to deliver an effective operational response. The IMS should be adapted to the specific hazard, and address expanding or shrinking needs for services and support (Figure 2 shows core and additional functions that can be included). Incident management structures for disasters may look different than those for disease outbreaks, but the critical functions and principles remain the same. The IMT should be located as closely as feasible to the event. Counterparts at regional and headquarters offices provide the requisite technical and operational support through the IMSTs.



29 WHO's emergency SOPs (https://emanual.who.int/p17/Pages/default.aspx).

Fig. 2. Functions of the IMS




*Infection prevention and control, clinical management, laboratory, vaccination, point of entry

## Leadership

The individuals in a leadership function are responsible for overall management of the WHO response, with several subfunctions.

### Incident management

The incident manager manages the day-to-day emergency response, including assigning responsibilities to individuals performing other critical functions as they are established, and supervising team leads for other IMS functions. Depending on the scale of the event, the incident manager may delegate specific duties to a deputy incident manager. The incident manager can be supported by an incident coordination team, working across the other pillars with coordination and response implementation, and monitoring follow-up of key deliverables.

### Staff health, well-being and security

WHO must ensure that concrete measures are taken for the health and physical and mental well-being of all personnel in the WHO response team. Reasonable occupational health measures should be in place, and WHO personnel should have ready access to medical care, medical evacuation, psychosocial services and counselling.

Security management and support for all WHO operations are conducted in accordance with the United Nations Security Management System and WHO security policies, protocols and guidelines, through a Security Risk Management Process. WHO security managers[30] must ensure that the IMS is effectively integrated into the UN Security Management System in all areas of emergency response and operations through prompt coordination at all levels as necessary, through the UN Designated Official for Security, the Security Management Team and the Department of Security and Safety (UNDSS). Based on a security assessment for a particular response, recommended security resources (security personnel and equipment) are integrated into the WHO response plan. When required, dedicated WHO field security officers are deployed at operational level to work closely with the UNDSS, which provides leadership, coordination, critical advice and rapid decision-making capacity on security policy and operational issues through the security management team.

WHO requires that all personnel have appropriate and up-to-date security training, receive an area-specific security briefing prior to deployment and continue receiving relevant security briefings while in the field. WHO will monitor adherence with the implemented security risk management measures and take appropriate action against non-compliance.

### Prevention and response to sexual exploitation, abuse and harassment

Mainstreaming and integrating measures for PSEAH to mitigate risks, ensure safe programming of response interventions, and collaborate with partners to ensure capacities for safe reporting and victim support services is obligatory and not optional. The incident manager must ensure that a PSEAH Technical Officer is designated full time and embedded in the IMT from the start of the response.

The dedicated PSEAH Technical Officer is responsible for risk-based planning and collaborating with all stakeholders to implement prioritized and contextualized PSEAH interventions. These interventions are aimed at achieving the key IASC PSEA outcome measures: i) SEAH prevention; ii) safe and accessible reporting mechanisms; iii) referral and victim support services; iv) enhanced leadership and accountability; and v) contributions to the joint IASC PSEA network plan of action. Efforts should be made to ensure implementation of the minimum interventions outlined in Annex 4 through internal mainstreaming and programming in WHO operations; supporting health partners with PSEAH mainstreaming in line with the *UN Protocol on allegations of sexual exploitation and abuse involving implementing partners*;[31] contributing to the implementation of the joint IASC PSEA network plan of action; and engaging with national governments on PSEAH measures.

In the context of an emergency covering a wide geographical area with multiple sub-national coordination mechanisms, consideration should be given to dedicated capacity for PSEAH in respective sub-national coordination mechanisms, and to aligning deployments with IASC PSEA network coordination structures where they exist.

**30** WHO Security Managers include the HWCO/WR who is a member of the security management team in country, heads of sub-offices who are members of Area Security Management Teams, and WHO Security Officers at all levels. When and where designated, incident managers, in coordination with the WR, must also be integrated within the UN Security Management System with active participation and engagement with the relevant Security Management Team for the duration of the response.

**31** IASC UN protocol on allegations of sexual exploitation and abuse involving implementing partners. (https://psea.interagencystandingcommittee.org/sites/default/files/UN%20Protocol%20on%20SEA%20Allegations%20involving%20Implementing%20Partners.pdf).

### Emergency operations centre management

The IMT usually works out of an emergency operations centre (EOC), which is a central facility for emergency management, compiling all relevant operational and contextual information, including monitoring of key process indicators against the emergency procedures.[32] Depending on the operational context, including the ministry of health's capacity to lead and coordinate the response, a large proportion of the IMT may be located in the government EOC, where one exists. When the ministry of health does not have an EOC, a specific area within the country office should be repurposed to function as one.[33] The facility manager of the EOC ensures that all of the centre's systems (hardware and software), and staff support tools are well maintained and operational when needed.

### Communications

Communications personnel coordinate WHO's response to media and public queries for information, and develop and disseminate both internal and external communication products and public messaging. Working with other response agencies and technical experts, the communications team takes a proactive approach so that risk and crisis communications are coherent and consistent.

### External relations

This function entails coordination of all activities related to resource mobilization, donor relations and advocacy to support the implementation of the strategic and operational response plans.

## Technical expertise and health operations

WHO works with the ministry of health and partners to ensure optimal coverage and quality of health services in response to emergencies. The Organization does this by promoting the implementation of the most effective, context-specific public health interventions and clinical services by operational partners. The team responsible for this pillar provides up-to-date evidence-based field operations, policies, technical guidance and expertise.

### Prevention and control measures

The purpose of this subfunction is to identify and develop clear recommendations, disseminate guidance and provide technical assistance to the ministry of health and partners on the most relevant actions to prevent and control public health risks. Depending on the hazard(s), these can include enhanced surveillance; point-of-care laboratory services; specimen transport and specialized laboratory tests; vaccination campaigns; mass prophylaxis; clinical management; infection prevention and control; safe and dignified burials; vector control; enhanced water, sanitation and hygiene; food safety and nutritional services; and linkages to the animal sector for zoonotic disease outbreaks and broader environmental health sectors. The recommended actions are defined based on a regular risk and needs assessment.

### Risk communication and community engagement

WHO collaborates with the ministry of health and partners to frame the event and risk, and provide authoritative information using all relevant communication platforms. The team assesses the social, cultural, economic, political, security and other relevant contexts of populations at risk; engages stakeholders at national and local levels; and develops a common narrative to the dialogue with affected and at-risk communities based on an understanding of the local context, new scientific knowledge and the evolving situation. It delivers health messages using the most effective means preferred by the target population in local languages, and monitors their effectiveness. Mechanisms should be established to regularly collect community feedback to adjust the response operations as needed. This team also develops risk communication materials, builds community engagement capacity in country and coordinates with key international and national partners.

### Health service delivery

WHO coordinates and collaborates with the ministry of health and partners, including through GOARN, EMTs, the Health Cluster and regional partners to ensure the delivery and continuity of essential health services. This includes service delivery for communicable diseases, reproductive health, gender-based violence, mental health and psychosocial support (MHPSS), noncommunicable disease care and trauma care. The function clarifies standards and defines an essential package of health services that covers community, primary and referral levels. The direct delivery of clinical care should be the responsibility of partners; however, there are often unfilled service delivery gaps during emergencies. As the lead agency of the Global Health Cluster, WHO has obligations as provider of last resort. WHO provides health services through financial, material or staffing support to health facilities. Much of this is done through NGO partners.

**32** This is different to the monitoring and evaluation sub-function in the Planning and Monitoring pillar, which evaluates indicators specific to the emergency's strategic response plan.

**33** For further details on the management of and standards for operating an emergency operations centre, see: Framework for a public health emergency operations centre. 2015. (https://www.who.int/publications-detail-redirect/framework-for-a-public-health-emergency-operations-centre).

WHO rapidly deploys staff to respond to acute escalations in outbreaks or other emergencies, to support country, regional or headquarters offices. For certain outbreaks, particularly those caused by high-threat pathogens, WHO frequently engages in clinical care of patients and management of contacts in close collaboration with front-line health care providers and partners. WHO also frequently distributes emergency kits, drugs, medical supplies and equipment, most often to support national authorities and national NGOs. For specific vaccine-preventable disease outbreaks, WHO also works with partners of the International Coordinating Group on Vaccine Provision to facilitate the deployment of vaccines (see Annex 5 for more information).

### Technical expertise, science and research

Health operations must be informed by the best available technical expertise and guidance and adhere to recognized standards and best practices. WHO often provides this technical expertise directly to the ministry of health and partners, or leverages expert networks and partnerships to do so, for example through GOARN and the R&D Blueprint. Strong technical input is required for all aspects of operations.

For outbreaks, technical expertise is important to identify the responsible pathogen and to ensure that the response is designed and implemented to manage this pathogen and is commensurate with the risk. This team also identifies knowledge gaps on the etiology, pathophysiology, transmission, diagnosis and effective prevention and control of the risks and causes of excess morbidity and mortality. It advises on key research, knowledge and product development issues that can address these gaps, and provides all available information that may accelerate results, including consideration of social, cultural and behavioural factors. It requires engagement with donors, academics, research institutions, the private sector and operational partners to promote, advise on and coordinate relevant research, knowledge or product development.

### Training and learning of response personnel

In most emergency responses, WHO supports the training of health staff, including local and international personnel. This training is based on the specific functions needed in the response, for example on information management, risk communication, disease surveillance, infection prevention and control, and various aspects of clinical care. The training and learning function includes real-time online training, face-to-face training, training of trainers and dissemination of knowledge to responders in relevant languages and formats.[34]

## Partner coordination and engagement

### Health and intersectoral coordination

Partner coordination ensures that collective action results in appropriate, quality health services and interventions for the affected population, especially the most vulnerable. Different coordination models can be developed, depending on the hazard, ministry of health's capacity and operational context.

A coordination model should be agreed at the outset of the response with clear roles and responsibilities between partners. Ideally, the health sector coordination mechanism is established and managed by the ministry of health EOC, with technical and operational support from WHO and key partners (where appropriate, including global initiatives). Partners deploying to outbreak response through GOARN operate under the leadership of WHO. In conflict and fragile settings, alternative, more independent coordination mechanisms may be required (see Annex 3). When a Health Cluster is formally activated, WHO has specific accountabilities for cluster performance to the Humanitarian Coordinator, as Cluster Lead Agency. Because the cluster coordination function requires a degree of independence from the Cluster Lead Agency, the Health Cluster Coordinator should coordinate the cluster, while the incident manager (or designee) should represent WHO in the cluster.

Regardless of the mechanism, the purposes of coordination are similar: to engage all stakeholders in risk assessments and needs assessments, planning, information management and sharing, service delivery, monitoring and quality assurance and advocacy.

### Liaison

A liaison officer brings inter-organizational issues and concerns to the attention of the incident manager with a recommended course of action. For large events, liaison officers from key partner organizations can be embedded in the WHO IMT/IMST to streamline communication and strengthen coordination, for both technical and operational purposes.



34 See OpenWHO online courses at https://openwho.org.

## Health information and epidemiology

This function involves the collection, analysis and dissemination of emergency-specific and contextual information and data, including on health risks and impacts, needs, service coverage and gaps. It uses information to develop and continually refine the response and inform recovery planning. The health information and epidemiology function includes the following subfunctions.

### Risk and needs assessment

Ongoing risk assessments allow stakeholders to make informed decisions on preventing or mitigating the impact of an emergency. Needs assessment, as part of the public health situation analysis, is the systematic process that determines the overall impact and health consequences of the emergency and the functionality and performance of health services. It also identifies progress and gaps in capacities and operations, thereby informing the prioritization and implementation of the response. Where there are gaps in information identified in the secondary data that comprise the PHSA, needs assessments may require additional primary data to be collected in the field.

### Surveillance and epidemiology

The surveillance subfunction strengthens the systematic collection, analysis and communication of any information used to detect, verify and investigate events and health risks. It supports the dissemination of data related to public health events and strengthening early warning, alert and response systems in the field.[35] In collaboration with the health operations and technical expertise team, this group establishes, strengthens and operationalizes rapid response teams that are responsible for the rapid investigation of alerts, field risk assessment and, when required, early operational response. It also includes active case finding, case investigation and contact tracing activities.

### Analytics

In-depth and integrated analysis throughout an outbreak is crucial to ensure that a response strategy is working. The team responsible for this subfunction works closely with all operational pillars to identify critical questions to better understand outbreak dynamics and adjust the response.

Data are collected in the field from multiple sources to synthesize and more holistically interpret epidemiological data to address those questions in a timely manner. The team provides regular reports and briefings to the leadership of the response; develops recommendations based on evidence with all response pillars; provides routine integrated analytical and epidemiological data visualization and presentation; and, at the request of the incident manager, coordinates, conducts and compiles and disseminates topic-specific reviews. It is a multi-disciplinary and multi-partner function that falls under the local coordination of the response with the support of GOARN experts.

### Information products and dissemination

This subfunction involves compilation of information from risk and needs assessments, early warning and surveillance systems, response monitoring mechanisms (for example, service coverage) and surveys to develop information products that allow stakeholders to monitor public health risks and needs and the effectiveness of the health sector response, and to take appropriate actions. Examples include dashboards, regular information products (such as internal and external situation reports) and intermittent products, such as Health Resources and Services Availability Monitoring System (HeRAMS) reports or Disease Outbreak News.

## Planning and monitoring

This team that fulfils this function is responsible for the development of response, recovery, and contingency plans as well as plans for demobilization, with detailed inputs from teams with other functional roles. The team monitors the performance of the response and provides periodic updates for the incident manager and IMS function leads, manages risks related to the response and determines the potential impacts of the emergency.

Effective planning requires contributions from governmental agencies, NGOs, civil society entities, the private sector and others, both within and outside the health sector. It involves the development of common strategic priorities, joint operational objectives and plans, and strong coordination within and among sectors. Emergency-specific plans include the following:

**WHO action plan.** An initial, brief action plan is developed following the grading to guide immediate response activities and support potential requests for funding from the CFE. The action plan can form the basis of projects and donor proposals. A more detailed version is elaborated once the strategic and joint operational plans have been developed (including human resources, supplies and budget planning). The detailed operational plan specifies WHO's priorities, strategy, objectives and activities in support of collective priorities. It details what WHO will do, and where and when.

**Strategic response plan.** A high-level health sector response plan that is required to guide WHO and partners to respond to an event. It outlines the context, provides the latest situation update, summary of current response activities, strategic objectives and planned interventions, resource requirements and a monitoring framework. Wherever possible, it should be a sub-element of the national plan or closely aligned to that plan. WHO should clearly identify within this plan its priorities and resource requirements.



35 WHE supports novel electronic early warning systems such as EWARS in a box (https://www.who.int/publications/i/item/9789240066762)

**Joint partner operational plan.** This plan integrates the contributions of key health partners working in an emergency to support the ministry of health most effectively. It should ensure that collective operations consistently address gaps and avoid duplication, ensure optimal coverage of health services, promote adherence to technical standards and best practices, and commit partners to common operational targets and reporting. It should also specify how health sector partners link with and complement other relevant sectors, such as water and sanitation, environment, nutrition and protection.

**Initial recovery needs and plan.** In most sudden-onset disasters, governments start assessing needs for recovery in the first month after the onset of the emergency. Depending on their capacities, they may request support from the international community. Support for formal post- disaster needs assessments is coordinated by the World Bank, the United Nations and the European Union. These assessments assess damage, loss and recovery needs, including aspects for risk reduction and improved resilience, and establish priorities for the recovery and its costing.

### Monitoring and evaluation

The team that carries out this subfunction systematically tracks the evolution of the emergency and the progress of the WHO and health sector response in meeting the objectives of the operational response plan. It involves identifying technically sound indicators and sources of information; setting operational targets; gathering and interpreting data; and tracking progress to determine whether the response is meeting its objectives. If the response is not on track, personnel responsible for this subfunction analyse the reasons and make recommendations regarding corrective actions or modification of targets in collaboration with partners and other responsible areas. This team also supports other relevant internal or external performance evaluations.

### Operational risk management

The ERF has a strengthened focus on awareness of the risks to consider while designing, delivering and managing the operational response and on planning mitigation actions. Risk analysis and risk response planning involve foreseeing challenges and assessing their likelihood and impact on key areas of the response. Operational risk types can be categorized into institutional, programmatic or contextual risks, and should include an analysis of factors that could potentially result in sexual exploitation and abuse of the population to enable planning for mitigation measures. An operational risk response analysis should be conducted, which provides a methodology for the IMT/IMST to identify risks and plan mitigation actions for the response. After a risk is identified and assessed, designated staff decide how to respond to the risk. In line with WHO's risk management policy, while some risks must be avoided, a certain amount of risk may be necessary to respond successfully to an emergency. Detailed operational considerations regarding risk management, compliance, business continuity and contingency planning can be found in Annex 6.

### Emergency response reviews

WHO supports the use of different types of reviews to assess the capacities and performance of WHO, Member States and international partners to respond to health emergencies.[36] Some reviews take place during the emergency to inform course correction or monitor delivery against agreed response plans, others after the emergency is declared over or under control. Competent authorities then devise strategies to be better prepared for the future.

Intra/After-Action Reviews (IAR/AAR) are mainly led by Member States. WHO introduced the IAR methodology during the COVID-19 pandemic, a country-owned and country- led process aimed at supporting countries to reflect, adjust and improve national and subnational response strategies in real-time. By contrast, a joint operational review (JOR) is a WHO-led process that focuses on international efforts by WHO and its partners to support ministries of health in responding to public health events or outbreaks. The overall objective of a JOR is to ensure that the efforts and resources of WHO and its partners are aligned with the health emergency response plan. This involves reviewing the response against the strategic objectives within the response plan.

## Operations support and logistics

This function ensures that WHO staff – and, where agreed, operational partners – have a reliable operational platform to deliver effectively on the WHO action plan and joint operational plan. It may also support the logistics capacities of the ministry of health. The function comprises: supply chain management, field support, and health logistics. As with other critical functions, partnership is key to ensuring effective and efficient operational support and logistics. Leveraging the comparative advantages of other partners, for example in procurement, warehousing, convoy management and telecommunications, has clear advantages for WHO operations.

36 WHO is establishing a consistent approach to reviewing the preparedness and response to health emergency operations to foster a consistent use of standardized methodologies by countries and across all levels of WHO. This standard approach will clarify roles and responsibilities of different entities in WHO in relation to reviews, triggers to initiate reviews, the scope of the reviews, the procedures for engagement across the three levels of WHO and with the response stakeholders, and an accountability scheme to support the implementation of recommendations and the monitoring of impacts.

#### Supply chain management

This subfunction ensures an end-to-end, timely and efficient provision of consumables and equipment to support emergency operations. This includes selection, forecasting, procurement (working closely with the Finance and Administration pillar), transportation, customs clearance, storage and distribution of these material assets.

#### Field support

This subfunction involves provision of logistics strategy, management and field support to response teams. This includes secure and comfortable accommodation, functional and secure working spaces and equipment, capabilities for communications and information technology, safe staff transport and effective fleet management.

#### Health logistics

This subfunction involves provision of technical expertise, tools, methods and means to meet the specific logistical needs of medical facilities, cold chain management, laboratories and blood banks.

### Finance and administration

The finance and administration function entails finance, management and administrative support to enable the smooth functioning of the WHO response. It ensures that decisions made by the incident manager trigger the provision of management and administrative services according to WHO SOPs and performance standards. Prior to grading, it ensures the availability of funds (up to US$ 50 000) and activation of emergency SOPs to allow for risk assessments and detailed field investigations. It comprises the following subfunctions:

#### Finance, budget and grants management

This team develops WHO workplans and budgets based on WHO action plans as determined by the leadership; manages funding allocations and awards; tracks and reports on financing against internal budgets; and supports, monitors and reports on implementation of external grants. The team supports the resource mobilization function in the preparation of proposals and reports by monitoring and following up on donor proposals and reporting deadlines; and works closely with logistics to facilitate procurement and payment to suppliers. It oversees all financial transactions.

#### Human resources and surge

This subfunction entails filling the human resource needs of the WHO response team, as determined by the incident manager. Tasks include sourcing, recruitment, medical clearance, travel to the relevant duty station, entry formalities, briefing and training, on-site administrative support, debriefing and performance evaluation. The team tracks and reports on human resource requirements against plans, status of filled positions and vacancies, and projected human resource needs.

#### Procurement

This subfunction ensures procurement of all necessary supplies for the response and for the response team, and tracking of inventories, in close coordination with the logistics team and with operational partners.

## Scaling up the incident management teams

Additional functions beyond those described above may be needed to effectively manage a response as an event develops. This may include points of entry control, mass gathering risk assessments, infodemic management and epidemiological modelling. For events that are notifiable under the IHR, the team can include representation from the IHR Secretariat. WHO also collaborates with partners that support specific response areas (for example the World Food Programme for supply chain; UNICEF for risk communication and community engagement, and for areas related to maternal and child health).

For global events, core functions may remain similar across all regions or vary based on the scale of response needs. Staff dedicated to coordination between headquarters, regional and country offices can be embedded in the response for large-scale or global events.

# Emergency performance standards

Progress against meeting emergency response performance standards (Table 4) will be documented following the grading decision for Grade 2 and Grade 3 emergencies. The responsibility for reporting on progress lies with the country office, with oversight from the regional office. Timelines for performance standards may need to be adjusted based on the context.

WHO performance standards are monitored primarily through process indicators. To assess the effectiveness of the overall response, these are complemented by key performance indicators (KPIs), which measure the output or outcome level. The KPIs will be agreed on a case-by-case basis. They are typically reported monthly and can be adjusted based on the evolution of the emergency.

Table 4. WHO performance standards for emergency response

| Performance standard (PS) | IMS critical function | Primary responsibility | Indicators | Timeline from grading |
|---|---|---|---|---|
| **PS 1:** Ensure safety and security of all staff; activate system as per WHO guidance on business continuity planning to ensure safety and whereabouts of all WHO personnel, dependents and visitors, and liaise with UNDSS locally | Leadership | Country office | I. Safety and whereabouts of all WHO staff, dependents and visitors ensured | 12 hours |
| | | | II. System shared with UNDSS | 12 hours |
| **PS 2:** Activate incident management system (IMS); assign critical incident management team functions by repurposing country office staff; identify and communicate critical gaps in IMS functions | Leadership, finance and administration | Country office | I. Incident management team set up and communicated to regional office and headquarters | 24 hours |
| | | | II. Gaps in critical incident management team functions communicated to regional office and headquarters | 72 hours |
| **PS 3:** Assess the need for CFE support, review against checklist, issue request and clearance | Leadership | Country office and regional office<br>Headquarters | I. Assess need and request financial support as per CFE operating procedures | 24 hours |
| | | | II. Decision after reception of request as per CFE operating procedures | 48 hours |
| **PS 4:** Convene first meeting with stakeholders | Partner coordination | Country office | I. Meeting convened and minutes shared | 72 hours |
| **PS 5:** Issue initial internal situation report (sitrep) | Leadership, health information | Country office | I. Sitrep logged in EMS 2 | 72 hours |
| **PS 6:** Operations support ensured for critical items | Operations support and logistics | Regional office<br>Headquarters | I. Critical emergency supplies available at country level | 72 hours |

*(continues ...)*

Table 4. WHO performance standards for emergency response (continued)

| Performance standard (PS) | IMS critical function | Primary responsibility | Indicators | Timeline from grading |
|---|---|---|---|---|
| **PS 7:** Integrate and mainstream measures for PSEAH in the emergency response operations, in line with the IASC PSEA outcome measures | Leadership, planning and monitoring | Country office<br>Regional office<br>Headquarters | I. Dedicated PSEAH expert embedded in the IMT/IMST | 24 hours |
| | | | II. Develop PSEAH operational plan of action[37] to be integrated in emergency response plan | 72 hours |
| | | | III. Initiate and sustain PSEAH safeguarding measures[38] for personnel, volunteers, and collaborators | 48 hours and continuously through the response |
| | | | IV. Engage with communities and stakeholders to raise awareness on PSEAH, rights, reporting and victim support | Continuously |
| | | | V. Engage with IASC PSEA network to develop and implement joint PSEAH plan of action for the emergency | 5 days |
| **PS 8:** Develop strategic response plan, objectives and action plan | Leadership, planning and monitoring | Country office | I. Initial response strategy and action plan logged in EMS 2 | 72 hours |
| | | | II. Strategic response plan launched, logged in EMS 2 | 30 days |
| **PS 9:** Fill critical gaps in IMS | Leadership, finance and administration | Regional office<br>Headquarters | I. Deployment plan to fill critical gaps in IMS discussed with WHO country office and first deployments initiated | 5 days |
| **PS 10:** Issue donor alert | External relations, planning and monitoring, partner coordination | Regional office<br>Headquarters | I. Global donor alert issued | 5 days |
| **PS 11:** Issue external situation report or bulletin | Partner coordination, health information | Country office | I. External sitrep/bulletin issued | 7 days |

*(continues ...)*

37 The plan should be informed by a SEAH risks and needs assessment and should address the IASC PSEA outcome measures.

38 Safeguarding measures include screening and background check, PSEAH mandatory trainings, signing of PSEAH deployment checklist and code of conduct, community awareness and engagement on PSEAH.

Table 4. WHO performance standards for emergency response (continued)

| Performance standard (PS) | IMS critical function | Primary responsibility | Indicators | Timeline from grading |
|---|---|---|---|---|
| **PS 12:** Ensure operational risks are identified and mitigated | Leadership, planning and monitoring | Country office with inputs from headquarters and regional office for Grade 3<br>Country office with inputs from regional office for Grade 2 | I. Major risks identified and evaluated | 10 days |
| | | | II. Business continuity plan in place and updated as needed | 10 days |
| | | | III. Risk register completed with mitigation plans as per WHO risk policy, and regularly monitored | 30 days |
| | | | IV. Compliance plan in place and regularly monitored | 30 days |
| | | | V. Contingency plan in place | 30 days |
| | | | VI. Review of the risk register | Monthly for Grade 2 and every 2 weeks for Grade 3 |
| **PS 13:** Establish monitoring framework for response, including KPIs | Planning and monitoring | Country office | I. Monitoring framework logged in EMS 2 | 30 days |
| | | | II. Report monthly against KPIs from established monitoring and evaluation framework | Continuous |
| **PS 14:** Develop operations support and procurement plan | Operations support and logistics, finance and administration, planning and monitoring | Country office | I. Operations support and logistics and procurement plan developed, shared | 30 days |

# WHO emergency response procedures

Implementation of response procedures (Tables 5–12) is monitored during each Grade 2 and Grade 3 emergency to document the effectiveness of the WHO response and to inform course corrections, as appropriate.

The tables summarize expected activities and outputs from each level of the Organization by the IMS critical functions, with concrete deliverables and indicative timelines for the first 90 days. Responsibilities for a number of these activities may be shared by more than one level of the Organization. The timelines below represent those following a sudden-onset event or emergency, but timelines will vary according to context. In general, these response procedures apply from the time of grading. However, some procedures should be applied before grading in certain contexts, for example ensuring the safety and security of staff following a sudden-onset disaster.

Table 5. Leadership

| WHO country office | WHO regional office | WHO headquarters |
|---|---|---|
| **Within 24 hours of grading** | | |
| • **PS 1:** Ensure safety and security of all staff; liaise with United Nations Department of Safety and Security locally; activate country office contingency plan and business continuity plan where applicable<br>• **PS 2:** Activate IMS, assign critical functions by repurposing country office staff: appoint an incident manager in country, and request deployment of surge staff to fill IMS critical functions, as necessary<br>• Establish contact with key stakeholders (e.g. government officials, partners, United Nations country team, United Nations IASC PSEA Coordinator/Network, or others depending on context)<br>• Agree on initial response objectives<br>• Initiate and manage initial response activities | • Appoint incident manager counterpart<br>• Establish IMST for critical functions<br>• Identify surge staff<br>• Initiate processes for country-level deployment, in collaboration with finance and administration; seek assistance from headquarters, as needed | • Appoint incident manager counterpart<br>• Establish IMST for critical functions<br>• Consult with Director-General's office on need to inform United Nations system, as per IASC scale-up protocol<br>• Consult with Director-General's office on need to convene IHR Emergency Committee |

*(continues ...)*

Table 5. Leadership (continued)

| WHO country office | WHO regional office | WHO headquarters |
|---|---|---|
| **Within 24–72 hours of grading** | | |
| • **PS 3:** Assess the need for CFE support, review against checklist, issue request<br>• **PS 4:** Establish WHO presence at the site of the emergency and make contact with local officials and partners<br>• Agree on coordination mechanism with ministry of health and partners<br>• Where applicable, represent WHO at United Nations country team, United Nations humanitarian country team meetings, and IASC PSEA network<br>• Assist ministry of health with activation and establishment of its EOC<br>• **PS 5:** Issue initial internal sitrep<br>• Where applicable, lead health sector/cluster component of initial interagency situation analysis and multi-cluster/sector initial rapid assessment (MIRA)<br>• Receive surge team and transition IMS functions, as appropriate<br>• Issue local donor alert; commence outreach to donors in country | • Formalize IMST, with confirmation of focal points for critical functions<br>• Review request for regional emergency fund<br>• Establish teleconference schedule with country office<br>• Provide technical and operational support to country office, including on strategy and priority setting<br>• Issue initial press statement, as appropriate<br>• Provide regular briefings to senior management | • Formalize IMST, with confirmation of focal points for critical functions<br>• Coordinate response to requests from country office and regional office for surge, technical and operational support<br>• **PS 3:** Review CFE request and clear, as appropriate<br>• Support regional office with communications and press statement, as needed<br>• Provide regular briefings to senior management |

*(continues ...)*

Table 5. Leadership (continued)

| WHO country office | WHO regional office | WHO headquarters |
|---|---|---|
| **Within 3–10 days of grading** | | |
| • Update security assessment and identify needs for additional security services and equipment<br>• **PS 8:** Develop strategic response plan, objectives and action plan, integrating PSEAH action plan<br>• **PS 8:** Where applicable, submit health sector/ cluster contributions to flash appeal, including budget for initial funding from the UN Central Emergency Response Fund (3–5 days)<br>• **PS 8:** Compile and produce media brief and other communications products (ongoing, establish regular frequency)<br>• **PS 8:** Initiate monitoring progress against performance standards<br>• Consider need for establishment of subnational hubs | • Maintain regular communications with HWCO/WR and incident manager and coordinate technical and operational support<br>• Explore options for regional fundraising<br>• Monitor implementation of performance standards | • **PS 7:** Provide technical and operational support to country IMT and regional IMST to plan and integrate PSEAH priority actions and needs in the strategic plan<br>• **PS 10:** Issue global donor alert<br>• Support development of resource mobilization strategy<br>• Provide situation update for donors<br>• Monitor resource mobilization and provide support |
| **Within 10–30 days of grading** | | |
| • Review human resources plan<br>• Establish frequency of sitreps/bulletins<br>• Where applicable, oversee WHO contribution to the humanitarian response plan of the United Nations humanitarian country team<br>• Actively engage donors including through a briefing to donors on WHO's response priorities and needs | • Ensure health component of response plan adheres to technical standards and is of good quality<br>• Actively seek opportunities for regional fundraising | • Brief Member States and donors at global level, as needed<br>• Expand outreach to donors and media<br>• Review response plan, as required<br>• Actively seek opportunities for global fundraising |
| **Within 30–60 days of grading** | | |
| • Request second surge team as needed<br>• Finalize longer-term staffing plan<br>• Share WHO project proposals with donors and partners<br>• Explore options for transition and recovery planning, when appropriate | • Coordinate deployment of second surge team<br>• Assist with staffing plan<br>• Continue coordination of technical and operational support | • Contribute to second surge team, as needed<br>• Provide technical and operational support, as needed |
| **Within 90 days of grading** | | |
| • Initiate grading review<br>• Conduct operational review to assess the response, if appropriate | • Support the operational review, if appropriate | • Support the operational review, if appropriate |

Table 6. Health operations and technical expertise

| WHO country office | WHO regional office | WHO headquarters |
|---|---|---|
| **Within 24 hours of grading** | | |
| • Access existing technical guidance and risk communication material<br>• Assist the ministry of health to determine whether the event is notifiable under the IHR | • Share existing technical guidance and risk communication materials | • Share existing technical guidance and risk communication materials |
| **Within 24–72 hours of grading** | | |
| • Develop initial risk communication messages and initiate community engagement<br>• Contribute health operations and technical inputs into situation analysis and MIRA, where applicable<br>• Contribute health operations and technical inputs into initial response strategy, objectives and action plan | • Support the development of risk communication messages and community engagement approaches<br>• Coordinate technical support from regional office – ongoing<br>• Provide technical inputs for consideration by the Director-General of the need to convene an IHR Emergency Committee | • Support the development of risk communication messages and community engagement approaches<br>• Coordinate technical support from headquarters – ongoing<br>• Provide technical inputs for consideration by the Director-General of the need to convene an IHR Emergency Committee |
| **Within 3–10 days of grading** | | |
| • Agree with ministry of health and partners on priority interventions related to risk communication, community engagement, disease control measures, health services and health staff training<br>• Refine risk communication messages and develop community engagement strategy<br>• Collaborate with ministry of health and partners to rapidly address priority operational gaps<br>• Promote and monitor the application of standardized treatment protocols, technical standards and best practices<br>• Provide technical assistance and materials to ministry of health and partners | • Support refinement of risk communication messages and community engagement strategy, including for regional or global levels<br>• Promote application of standardized protocols, technical standards and best practices | • Support refinement of risk communication messages and community engagement strategy, including for regional or global levels<br>• Assess, adapt and, if necessary, fast-track high-priority technical guidance and operational research |
| **Within 10–30 days of grading** | | |
| • Ensure response plan is technically and operationally sound (e.g. strategic response plan, humanitarian response plan, or joint operations plan)<br>• Collaborate with ministry of health and partners to address gaps in coverage and quality of services<br>• Update risk communication messaging and community engagement<br>• Begin to address priority training needs of health staff<br>• Provide technical assistance and materials to ministry of health and partners | • Technical review and clearance of response plan<br>• Identify knowledge gaps related to the etiology, transmission, diagnosis and management of the event or emergency<br>• Support country office in meeting training needs, e.g. provision and development of materials | • Technical review and clearance of response plan<br>• Collaborate on identifying knowledge gaps related to the emergency<br>• Support country office in meeting training needs, e.g. provision and development of materials |

*(continues ...)*

Table 6. Health operations and technical expertise (continued)

| WHO country office | WHO regional office | WHO headquarters |
|---|---|---|
| **Within 30–60 days of grading** | | |
| • Expand training activities<br>• Contribute to transition and recovery planning when appropriate | • Engage regional partners to address research gaps, including diagnostics, vaccines, therapeutics<br>• Provide technical support and oversight | • Engage global partners to address research gaps, including diagnostics, vaccines, therapeutics<br>• Contribute to technical support and oversight |
| **Within 90 days of grading** | | |
| • Support the operational review, if appropriate | • Support the operational review, if appropriate | • Support the operational review, if appropriate |

Table 7. Partner coordination

| WHO country office | WHO regional office | WHO headquarters |
|---|---|---|
| **Within 24 hours of grading** | | |
| • Establish contact with operational partners and ministry of health | • Commence outreach to regional partners<br>• Identify and begin deployment of candidates for in-country coordination roles | • Commence outreach to global partners (e.g. GOARN, Global Health Cluster, EMTs, Standby Partners)<br>• Support identification and deployment of candidates for coordination roles<br>• Engage GOARN partners in risk assessments, potential deployment and monitoring, if not already initiated |
| **Within 24–72 hours of grading** | | |
| • Support leadership function in determining coordination mechanism with ministry of health<br>• Where applicable, coordinate with humanitarian coordinator on activation of health cluster<br>• **PS 4:** Convene first meeting with stakeholders, including health cluster where applicable<br>• Establish EMT coordination cell within ministry of health, as needed<br>• Ensure partner contribution to initial situation analysis<br>• Map initial partner deployments (i.e. Partners' List)<br>• Work with partners to identify and address immediate priority gaps in service delivery and coverage creating a 4W exercise matrix (Who does What, Where and When) | • Expand outreach to regional partners and request mobilization and deployment, as necessary<br>• Lead or participate in global calls with partners<br>• Engage GOARN and other partners at regional level to contribute to monitoring of risks and evolution of situation | • Expand outreach to global partners and request mobilization or deployment, as necessary<br>• Engage GOARN and other partners at global level to contribute to monitoring of risks and evolution of situation, deployment<br>• Monitor deployment of EMTs through virtual on-site operations coordination centre or dedicated system |
| **Within 3–10 days of grading** | | |
| • Coordinate overall development of initial response strategy and action plan<br>• Work with health sector/health cluster and include in United Nations humanitarian country team flash appeal, where applicable<br>• Participate in partner meetings and activities<br>• **PS 11:** Issue external sitrep/bulletin | • Collaborate with regional partners to mobilize resources to address operational and technical gaps – ongoing<br>• Ensure quality of sitrep/bulletin | • Collaborate with global partners to mobilize resources to address operational and technical gaps – ongoing |

*(continues ...)*

Table 7. Partner coordination (continued)

| WHO country office | WHO regional office | WHO headquarters |
|---|---|---|
| **Within 10–30 days of grading** | | |
| • Conduct regular stakeholder meetings to review status of response needs, risks and activities<br>• Monitor effectiveness of health response, and engage partners to address gaps in service delivery and coordination<br>• Commence planning of more detailed health sector needs assessment<br>• Determine frequency of sitrep/bulletin<br>• Where applicable, lead in development and submission of humanitarian response plan of United Nations humanitarian country team, integrating PSEAH action plan<br>• Where applicable, finalize health section of MIRA | • Reach out to other sectoral partners regionally, including nutrition, water, sanitation and hygiene, environmental public health, protection, food security, and MHPSS<br>• Represent WHO response in regional forums, e.g. health sector/Health Cluster, IASC | • Reach out to other sectoral partners globally<br>• Represent WHO response in global forums, e.g. health sector/Health Cluster, IASC, GOARN |
| **Within 30–60 days of grading** | | |
| • Fill priority coordination gaps at subnational level<br>• Strengthen partner coordination mechanisms<br>• Contribute to transition and recovery planning when appropriate | • Engage regional partners on ongoing basis, exchange information and advocate for additional resources and mobilization | • Engage global partners on ongoing basis, exchange information and advocate for additional resources and mobilization |
| **Within 90 days of grading** | | |
| • Support the operational review, if appropriate | • Support the operational review, if appropriate | • Support the operational review, if appropriate |

Table 8. Health information

| WHO country office | WHO regional office | WHO headquarters |
|---|---|---|
| **Within 24 hours of grading** | | |
| • Undertake ongoing monitoring of risks and needs; update leadership regularly | • Provide methodologies and tools for risk assessment and situation analysis<br>• Provide technical support for monitoring of risks and evolution of situation | • Provide methodologies and tools for risk assessment and situation analysis<br>• Provide technical support for monitoring of risks and evolution of situation |
| **Within 24–72 hours of grading** | | |
| • **PS 5:** Issue initial internal sitrep<br>• Generate or update 4W matrix<br>• Continue public health risk assessment if not done before grading<br>• Where applicable, contribute to initial interagency situation analysis and MIRA | • Provide technical support on health information subfunctions<br>• Engage GOARN and other partners to contribute to monitoring of risks and evolution of situation (see partner coordination) – ongoing | • Provide technical support on health information subfunctions<br>• Engage GOARN and other partners to contribute to monitoring of risks and evolution of situation (see partner coordination) – ongoing |

*(continues ...)*

Table 8. Health information (continued)

| WHO country office | WHO regional office | WHO headquarters |
|---|---|---|
| **Within 3–10 days of grading** | | |
| • **PS 11:** Issue external sitrep/bulletin<br>• Continually monitor, analyse and disseminate health information related to emergency<br>• Where applicable, lead health sector/ health cluster section of MIRA (up to 14 days)<br>• Establish or strengthen response reporting systems<br>• Establish or strengthen outbreak surveillance system or Early Warning, Alert and Response System (EWARS) | • Consolidate situation analysis for multi-country emergency<br>• Provide technical support and tools for health information activities and products<br>• Review and clear sitrep, information products; disseminate to regional partners | • Consolidate situation analysis for multiregional emergency<br>• Disseminate external sitrep and information products to global partners<br>• **P7:** Coordinate with region and country office to agree on PSEAH dashboard indicators, and initiate regular collection and publication |
| **Within 10–30 days of grading** | | |
| • Establish frequency of main information products, e.g. epidemiological sitreps, disease outbreak news, health sector/ health cluster bulletins, PHSA<br>• Where applicable, finalize health sector/ health cluster section of MIRA<br>• Initiate detailed health sector needs assessment, e.g. HeRAMS | • Oversee quality of information products; disseminate regionally | • Oversee quality of information products; disseminate globally |
| **Within 30–60 days of grading** | | |
| • Refine and further develop reporting system and products | • Oversee quality of information products; disseminate regionally<br>• Continue to provide technical support | • Oversee quality of information products; disseminate globally<br>• Contribute to provide technical support |
| **Within 90 days of grading** | | |
| • Initiate update to the RRA (or PHSA if the situation has changed)<br>• Support the operational review, if appropriate | • Update the RRA (or PHSA if the situation has changed)<br>• Support the operational review, if appropriate | • Update the RRA (or PHSA if the situation has changed)<br>• Support the operational review, if appropriate |

Table 9. Planning and monitoring

| WHO country office | WHO regional office | WHO headquarters |
|---|---|---|
| **Within 24–72 hours of grading** | | |
| • Support leadership function in developing initial response strategy, objectives and action plan for WHO response | • Provide support for initial response strategy, objectives and action plan<br>• Propose KPIs for initial monitoring | • Provide technical support as needed |
| **Within 3–10 days of grading** | | |
| • Coordinate detailed strategic and joint operational planning<br>• Initiate monitoring against ERF performance standards<br>• **PS 12:** Ensure operational risks identified and mitigated: major risks evaluated, business continuity plan in place and regularly updated | • Provide technical support and tools for planning activities and products<br>• Review and clear planning products; disseminate to regional partners<br>• Provide inputs to operational risk management | • Coordinate detailed strategic and joint operational planning for multi-country or regional emergency, incorporating PSEAH actions<br>• Provide inputs to operational risk management |

*(continues ...)*

Table 9. Planning and monitoring (continued)

| WHO country office | WHO regional office | WHO headquarters |
|---|---|---|
| **Within 10–30 days of grading** | | |
| • **PS 8:** Finalize and issue strategic response plan<br>• **PS 12:** Complete risk register with mitigation plans as per WHO risk policy and regularly monitor; compliance plan in place; contingency plan in place<br>• **PS 13:** Establish monitoring framework for response, including KPIs | • Review and clear response plan; disseminate regionally<br>• Review progress of response against ERF performance standards<br>• **PS 12:** Provide inputs to operational risk management | • **PS 8:** Finalize and issue strategic response plans for multi-country or regional emergency; disseminate globally<br>• **PS 12:** Provide inputs to operational risk management (for Grade 3 events) |
| **Within 30–60 days of grading** | | |
| • **PS 13:** Report regularly against KPIs<br>• Refine strategy and planning, based on monitoring of KPIs and outcomes of needs assessment<br>• Coordinate transition and recovery planning when appropriate | • Track progress against KPIs; advise on course corrections<br>• Continue to provide technical support | • Track progress against KPIs, especially for multi-country or regional emergencies; advise on course corrections<br>• Continue to provide technical support |
| **Within 90 days of grading** | | |
| • Support the operational review, if appropriate | • Support the operational review, if appropriate | • Support the operational review, if appropriate |

Table 10. Operations support and logistics (OSL)

| WHO country office | WHO regional office | WHO headquarters |
|---|---|---|
| **Within 24 hours of grading** | | |
| • Rapidly review and maintain basic office support: communications, information technology and transport<br>• Review the United Nations Minimum Operating Security Standards (MOSS) compliance of office, vehicles, and accommodation (with security personnel)<br>• Start distribution of medical kits and supplies | • Review availability of regional stocks, including in regional United Nations Humanitarian Response Depot<br>• Identify staff for potential surge to support in-country OSL | • Review availability of stocks from global strategic stockpile, including from global vaccine stockpiles and United Nations Humanitarian Response Depot<br>• Identify staff for potential surge to support in-country OSL |
| **Within 24–72 hours of grading** | | |
| • Undertake rapid assessment of supply chain, health logistics and field support needs<br>• Review stock and storage capacity<br>• Initiate customs clearance procedures<br>• Participate in logistics partner meetings; explore options for in-country partnership | • **PS 6:** Initiate deployment of critical supplies from regional stocks | • **PS 6:** Initiate deployment of critical supplies from global stockpiles, as needed<br>• Initiate outreach to key global partners (e.g. UNICEF, World Food Programme) for coordinated OSL support<br>• Liaise with Global Logistics Cluster |

*(continues ...)*

Table 10. Operations support and logistics (OSL) (continued)

| WHO country office | WHO regional office | WHO headquarters |
|---|---|---|
| **Within 3–10 days of grading** | | |
| • Scale up field support, including accommodation, offices, fleet management, telecommunications and EOC facilities<br>• Begin process to strengthen supply chain (including forecasting, procurement, warehousing, transportation, distribution, partner coordination)<br>• Organize customs clearance and transport of supplies and material<br>• Advise and support ministry of health and partners on health logistics<br>• Participate in logistics sector assessment<br>• Disseminate health logistics standards and OSL guidance to partners | • Ensure OSL and procurement activities comply with WHO and donor rules and regulations<br>• Ensure adherence to health logistics standards and OSL guidance | • Share and promote technical standards for health logistics<br>• Share and promote OSL guidance and tools; update as required<br>• Provide specific technical expertise, as required, e.g. safe burials, health logistics<br>• Support procurement and delivery of medical supplies |
| **Within 10–30 days of grading** | | |
| • Undertake more detailed assessment of supply chain, health logistics and field support needs<br>• **PS 14:** Develop OSL and procurement plan (in collaboration with the finance and administration team)<br>• Expand field support to subnational level<br>• Provide training and capacity-building for ministry of health, WHO and partners on OSL<br>• Contribute to response planning | • Provide training and capacity-building on OSL<br>• Review and clear OSL contributions to response plan(s) | • Support training and capacity needs for OSL<br>• Further explore agreements with global partners |
| **Within 30–60 days of grading** | | |
| • Ensure full establishment of end-to-end supply chain<br>• Review and adjust logistics, supply and fleet needs<br>• Contribute to transition and recovery planning when appropriate | • Provide support for and oversight of OSL | • Provide support for and oversight of OSL |
| **Within 90 days of grading** | | |
| • Support the operational review, if appropriate | • Support the operational review, if appropriate | • Support the operational review, if appropriate |

Table 11. Finance and administration

| WHO country office | WHO regional office | WHO headquarters |
|---|---|---|
| **Within 24 hours of grading** | | |
| • Activate country office contingency plan and business continuity plan where applicable<br>• Release emergency cash on a no regrets basis | • Activate rosters and initiate surge deployment | • Activate rosters and support surge deployment, as needed<br>• Support activation of emergency SOPs |
| **Within 24–72 hours of grading** | | |
| • Facilitate arrival of surge team<br>• Provide emergency administrative, human resources, finance, grant management and procurement services – ongoing | • Advise on reprogramming of existing country office funds<br>• Facilitate release of financial resources from regional emergency fund, as appropriate<br>• Provide technical support on implementation of emergency SOPs | • Activate emergency workplan<br>• Create award or project code for new emergency<br>• Process approved CFE request and release funds<br>• Provide technical support on implementation of emergency SOPs |
| **Within 3–10 days of grading** | | |
| • Process critical activities approved by incident manager against the emergency workplan<br>• **PS 9:** Fill all IMS critical functions, through appropriate assignment of country office and surge staff<br>• Provide briefings for incoming surge staff<br>• Track donor contributions and ensure compliance and timely reporting | • Manage grants that come through the regional office<br>• Support deployment briefings (country context, accommodation, health, travel information)<br>• **PS 9:** Develop deployment plan to fill critical gaps in IMS over the first 6 weeks, in collaboration with headquarters; update regularly | • Manage grants that come through headquarters<br>• **PS 9:** Develop deployment plan to fill critical gaps in IMS over the first 6 weeks, in collaboration with regional office; update regularly |
| **Within 10–30 days of grading** | | |
| • Develop WHO emergency human resources and activity workplans and associated budgets<br>• Facilitate the rotation of personnel (deployment, arrival handover and departure) | • Support development of WHO emergency human resource and activity workplans, and associated budgets<br>• Continue to support emergency administrative, human resources, finance, grant management and procurement services | • Provide programme management support, as needed<br>• Continue to support emergency administrative, human resources, finance, grant management and procurement services |
| **Within 30–60 days of grading** | | |
| • Prepare for arrival of second surge team or longer-term staff<br>• Contribute to transition and recovery planning when appropriate | • Contribute to longer term staffing plan | • Contribute to longer-term staffing plan |
| **Within 90 days of grading** | | |
| • Support the operational review, if appropriate | • Support the operational review, if appropriate | • Support the operational review, if appropriate |

Table 12: PSEAH mainstreaming and operations

| WHO country office | WHO regional office | WHO headquarters |
|---|---|---|
| **Within 24–72 hours of grading** | | |
| • **PS 7:** Embed PSEAH expert in the IMT<br>• Develop preliminary PSEAH plan for incorporation into response plan<br>• Establish contact with key stakeholders (e.g. government officials, IASC PSEA coordinator/network partners) | • **PS 7:** Embed PSEAH expert in the IMST<br>• Provide technical and operational support as needed | • **PS 7:** Embed PSEAH expert in the IMST<br>• **PS 7:** Support regional and country office with mobilization and deployment of dedicated PSEAH technical specialist<br>• Provide technical and operational support as needed |
| **Within 3–10 days of grading** | | |
| • **PS 7:** Establish and implement systems for PSEAH safeguarding measures related to recruitment/deployments and contractual agreements<br>• Conduct and track PSEAH capacity-building of deployed personnel and volunteer and signing of PSEAH Code of Conduct | • **PS 7:** Establish and implement systems for PSEAH safeguarding measures related to recruitment/deployments and contractual agreements at regional level, and track country implementation | • **PS 7:** Establish and implement systems for PSEAH safeguarding measures related to recruitment/deployments and contractual agreements at global level, and track implementation at regional and country level |
| **Within 10–30 days of grading** | | |
| • **PS 8:** In coordination with PSEAH network partners, conduct a SEAH risk and PSEAH needs assessment; use outcome to update PSEAH strategy and develop plan integrated into the strategic response plan (SRP)<br>• Implement and sustain community awareness and engagement activities on PSEAH<br>• Initiate and sustain PSEAH capacity-building of implementing partners if indicated | • **PS 8:** Support development of the PSEAH Plan of Action integrated in the SRP<br>• Provide technical and operational support as needed | • **PS 8:** Support development of the PSEAH Plan of Action integrated in the SRP<br>• Track implementation of PSEAH dashboard indicators over time<br>• Provide technical and operational support as needed |
| **Within 30–60 days of grading** | | |
| • **PS 8:** Incorporate PSEAH comprehensive plan and budget in SRP, and in subsequent funding appeals and resource mobilization plans<br>• Strengthen WHO engagement and contribution to IASC PSEA network plan of action<br>• In collaboration with gender-based violence (GBV)/child protection areas of work, map out, streamline referral and strengthen GBV service provision<br>• Initiate and sustain ongoing advocacy with national government, and PSEAH networks for on-going capacity-building for PSEAH services adapted to local context<br>• Routinely monitor, track and report on PSEAH performance standards, on a monthly basis | • Provide technical and operational support as needed<br>• Support and facilitate monthly monitoring, tracking and reporting on PSEAH performance standards | • Provide technical and operational support as needed<br>• Support and facilitate monthly monitoring, tracking and reporting on PSEAH performance standards |
| **Within 90 days of grading** | | |
| • Conduct PSEAH operational review, if appropriate | • Support PSEAH operational review, if appropriate | • Support PSEAH operational review, if appropriate |

# Annex 1. Contingency Fund for Emergencies (CFE) checklist

The following checklist can be referenced when requesting funds from the CFE. This is not an exhaustive list and is meant for guidance only. More information on obtaining funds from the CFE can be found in the eManual.[39]

| Item | Yes | No | Notes |
|---|---|---|---|
| **Before requesting funding** | | | |
| Is funding immediately available from other sources? | | | |
| Has the request been discussed across the three levels taking an IMS approach and taking grading, severity and other criteria into consideration? | | | |
| **When a request is made** | | | |
| Has the CFE request template (available from the eManual section on the CFE) been used? | | | |
| Has a budget and plan of action been included? | | | |
| Has the plan and budget incorporated PSEAH priority actions? | | | |
| Has a local resource mobilization plan been included to facilitate reimbursement of the CFE? | | | |
| Have the request and subsequent correspondence been sent to the contingency-fund@who.int? | | | |
| **During implementation** | | | |
| Have proposals been submitted to donors to facilitate reimbursement of the CFE? | | | |
| Has recognition been given on the use and impact of the CFE, including acknowledgment of CFE donors (local press release, social media, etc.)? | | | |
| Have high-resolution pictures of activities funded by the CFE been taken with descriptive captions included? | | | |
| **After implementation** | | | |
| Has a short narrative report describing the use and impact of the CFE been submitted? (Report template is available from the eManual section on the CFE.) | | | |
| Has feedback been sent on improving the CFE allocation process? | | | |



39 WHO eManual Section XVII.6.1: Contingency Fund for Emergencies (CFE) – Request for Support (https://emanual.who.int/p17/s06/Pages/XVII.6.1-RequestCFE.aspx).

# Annex 2. Emergency grading template

| WHO emergency grading document | |
|---|---|
| Date:<br>Time: | Chair:<br>Participants:<br>• WHO country office(s)<br>• Regional office(s)<br>• Headquarters |
| Country/Region:<br>Emergency type: | |
| Grading decision<br>(not graded, Grade 1, 2 or 3): | |
| Agenda: | • Update on situation<br>• Discussion of RRA findings<br>• Assessment of grading criteria<br>• Immediate actions to be agreed:<br>  • activation of IMS<br>  • need and eligibility for contingency funds<br>  • surge – staff and critical supplies<br>• Any other business |
| Situation analysis summary: | |
| Risk assessment summary: | |
| Assessment of grading criteria<br>(see ERF Chapter 2): | Scale:<br>Urgency:<br>Complexity:<br>Capacity:<br>Risk of failure to deliver effectively and at scale:<br>Rationale for change in grade (if applicable): |
| Names and contacts of key staff: | • WHO Representative:<br>• Incident manager (WHO country office):<br>• Incident manager (Regional office):<br>• Incident manager (Headquarters):<br>• Accountability:<br>• Other, as required: |
| Immediate WHO and health sector objectives/priorities: | List here: |

| Agreed next steps | | | |
|---|---|---|---|
| **Action** | **Details** | **Person responsible** | **Due date** |
| Surge of staff | | | |
| CFE application (if eligible) | | | |
| Dispatch of supplies | | | |
| Outreach to partners | | | |
| Timeline for performance standards | | | |
| Does this emergency warrant referral to the IHR Emergency Committee for consideration as a public health emergency of international concern? | | | |
| Should a memo be sent to the UN Secretary-General and Emergency Relief Coordinator? | | | |
| Date and time of next teleconference | | | |
| Other | | | |

# Annex 3. Protracted emergencies

## Introduction

This annex provides a summary of processes to guide the WHO emergency response when emergencies become protracted. The timing and frequency of processes need to be adapted, for example to align with multi-year IASC humanitarian response planning cycles, or to support shifts in IMS functions to a longer-term emergency management structure with core predictable country capacities (see Table A3.1 for a comparison between acute and protracted emergencies). Further guidance on WHO's response in protracted emergencies, including performance standards and related monitoring tools, are developed in the Framework for Protracted Emergencies (PEF).

WHO must have the capacity to respond predictably to the health needs of people living in humanitarian settings, balancing investments and support for response to acute and prolonged health needs as well as the resilience and recovery of health systems. The WHO Core Predictable Country Presence model acknowledges that in countries with protracted emergencies, country offices require minimal standard structures and capacities to ensure emergency preparedness, response and recovery capacities.

## Definition

Protracted emergencies are defined as events in "those environments in which a significant proportion of the population is acutely vulnerable to death, disease and disruption of livelihoods over a prolonged period. The governance of these environments is usually very weak, with the state having a limited capacity to respond to, and mitigate, the threats to the population, or provide adequate levels of protection."[40]

Predictors for emergencies that are likely to become protracted are those characterized by large-scale population movement or socio-political conflict, resulting in a United Nations coordinated response and the activation of the cluster system or its equivalent. In 2022, about 1.9 billion people (24% of the world's population) lived in countries with fragile contexts, but this figure is projected to grow to 2.2 billion by 2030.[41] The number of countries experiencing protracted crises (5 or more years of UN appeals) has more than doubled over the last 15 years, from 13 to 31.[42] When acute events such as outbreaks or sudden-onset disasters happen in fragile, conflict-affected or vulnerable settings, the response applies the same risk assessment, situational analysis, grading and response procedures as described for acute events. In some cases, an acute response may be required for more than six months.

WHO will consider whether an emergency persisting for longer than six months meets the definition of a protracted emergency, and whether or not the response requires adaptation. WHO can transition from an acute emergency grade to a protracted grade provided that the following criteria are met:

- adequate resources have already been deployed to meet the acute emergency needs;
- there is agreement among the three levels of the Organization that a sustained operational response is required by WHO beyond six months;
- the emergency is no longer an IASC Level 3 emergency or public health emergency of international concern (PHEIC).

Within the scope of the PEF, WHO defines emergencies to be protracted when they have an HRP and/or an active IASC coordination mechanism in place for more than one year. Some Grade 3 emergencies may retain acute grading when IASC system-wide scale-up or United Nations Crisis Management Team remain activated.

## WHO commitment in protracted emergencies

WHO commits to addressing the health needs of those impacted by protracted emergencies, and the prolonged disruption of health services systems, by improving the quality and coverage of health services, strengthening the consistency and predictability of emergency operations as well as through risk reduction, readiness and preparedness to protect communities from acute health emergencies, while strengthening the health system and building on local capacities for longer term resilience and recovery. WHO will ensure risk-informed and conflict-sensitive health programming that fosters trust and social cohesion in communities, including integration of PSEAH measures to achieve the IASC PSEA outcome measures.

40 Harmer A, Macrae J. Beyond the continuum: The changing role of aid policy in protracted crises. ODI HPG report, 2004.

41 OECD 2022. (https://www.oecd-ilibrary.org/sites/c7fedf5e-en/1/2/6/index.html?itemId=/content/publication/c7fedf5e-en&_csp_=ed992425c7db5557b78226a6c98c6daf&itemIGO=oecd&itemContentType=book#section-d1e694).

42 Global humanitarian assistance report 2020. (https://reliefweb.int/report/world/global-humanitarian-assistance-report-2020).

## WHO protracted grades

The main purpose of WHO's protracted grades is to indicate the level of operational response to be sustained by WHO over a prolonged period. They also communicate to external stakeholders WHO's assessment of the need for sustained international resources in the health sector to assist the affected communities.

- **Protracted 1:** an emergency that persists for longer than six months and is associated with limited ongoing health consequences, but still requires a sustained WHO response. Most of the WHO response can be managed with in-country assets. Organizational or external support required by the country office is limited. Support to the country office is coordinated by an emergency coordinator in the regional office.
- **Protracted 2:** an emergency that persists for longer than six months and is associated with moderate ongoing public health consequences that require sustained WHO operational response that exceeds the capacity of the country office. Moderate organizational or external support is required by the country office. Support to the country office is coordinated by an emergency coordinator in the regional office and an emergency management support team as required. A counterpart emergency officer may also be appointed at headquarters to support the response.
- **Protracted 3:** an emergency that persists for longer than six months and is associated with major ongoing health consequences that require sustained WHO operational response. Major organizational or external support is required by the country office. Support to the country office is provided by an emergency coordinator in the regional office and an emergency management support team. A counterpart emergency officer is also appointed at headquarters to coordinate Organization-wide support with an emergency management support team as required.

## Grading of protracted emergencies

- A protracted grade requires a review every 12 months.
- Emergencies are graded, not countries.
- Additional event-based risk assessments or situation analysis and grading may be needed for new acute events in the context of a protracted emergency.

## Emergency management system and predictable presence of emergency staff in country offices

Emergency management in WHO offices in countries with protracted and recurrent emergencies is based on the global 2017 Country Business Model (CBM). The CBM provides further details on core predictable staffing, and the 2023 Category E (all humanitarian crises where there is an HRP) and Category D (countries with recurrent emergencies and high risk of climate-related emergencies) countries in the Core Predictable Country Presence.

- The role of the incident manager will transition to a longer-term emergency team lead, and the IMST will transition to an emergency management team. Emergency operations still follow IMS principles.
- Similarly to an IMST, the emergency management team needs to be adapted in line with evolving needs, context, access and operational requirements. This principle may be applied to WHO's response structure as well as to health cluster coordination and its equivalents for humanitarian and emergency partner coordination.[43]
- Consideration should be given to creating positions for in-country PSEAH Technical Officers integrated in the CBM.
- The team will work closely with the country office health policy/systems adviser and the IHR focal point to provide information on strategies for health system strengthening and emergency and disaster risk management, that will support progress towards universal health coverage and health security, building on capacities put in place during the humanitarian response where possible.
- Operational responsibilities and accountabilities are consistent with those in Chapter 3.
  - These include cluster lead agency responsibilities and accountabilities for as long as the health cluster remains activated.[44]
  - For multi-regional protracted emergencies, the WHE Executive Director or the RED of one of the involved regions may be assigned for operational oversight following a three-level discussion.
- The emergency management structure may be reviewed regularly by all engaged levels to keep it fit-for-purpose and monitor progress. This may be done through:
  - joint strategic, operational and thematic reviews aligned with the pace of the operation at least every 12 months, or as per requirements, taking into account previous recommendations for improvement;
  - functional reviews every two years or as per requirements.

**43** See WHO guidance in the *Health cluster guide,* second edition, 2020. (https://iris.who.int/handle/10665/334129)
**44** Health Cluster coordination guidance for HWCO/WRs as cluster lead agency: (https://www.who.int/health-cluster/capacity-building/HWCO-guidance/en/)

## Emergency management functions and procedures

Managing multi-year operations requires dedicated, context-adapted, longer-term capacities at country level, notably on programmatic planning, monitoring and evaluation, coordination with donors and partners, resource mobilization, administration and reporting, human resource planning, supply chains, advocacy and communication, and PSEAH. This should be done with coordinated support from the regional office and headquarters.

All critical functions of the IMS remain activated, but may require adaptation to ensure an effective and sustained emergency response to protracted emergencies. Examples include the following.

- **Leadership.** The ministry of health should have a coordination platform for the response with external partners, or the health cluster approach is used. EOCs are not usually used to manage the ongoing response. Appropriate strategic and operational connections with health development coordination need to be established, and PSEAH mainstreamed and integrated in the response operations.
- **Health information.** Many of the information tools used in acute emergencies need to be maintained during protracted emergencies, though the frequency may change. For the agreed minimum information tools and indicators for monitoring, see the Public Health Information Services Standards and Toolkit.[45] They are complemented with more health system performance assessments, assessments of quality of services, surveys of barriers to health services and conflict analyses. Countries at risk should establish monitoring systems on attacks on health care, and use different media for advocacy messages.
- **Planning and monitoring and evaluation.** This should be synchronized with the IASC Humanitarian Programme Cycle[46] and with multi-year planning and resource mobilization cycles. Crosscutting IASC policies, such as on Accountability to Affected Populations, must be mainstreamed and operationalized in the health sector response plans. In some contexts, the government may request a recovery plan based on a recovery and peacebuilding assessment.[47] Monitoring and evaluation of progress towards meeting stated objectives is vital, as is following trends in key indicators over time, and tracking performance against targets, standards and thresholds.
- **Resource mobilization is integrated within the Humanitarian Programme Cycle.** Complementarities will be sought with resources invested in fragile settings by global health partners (e.g. the World Bank; Gavi, the Vaccine Alliance; and the Global Fund to Fight AIDS, Tuberculosis and Malaria). In line with the humanitarian-development-peace nexus approach, development donors and/or the development branches of emergency donors will be also approached. Efforts should be made to ensure that all resource mobilization efforts have incorporated needs for PSEAH priority actions.
- **Health operations and technical expertise.** This will be largely based on the definition of a package of high-priority health services, adapted to the context and based on the primary health care approach, and development of an implementation plan with local health authorities, partners and donors. Technical assistance and expertise will be required across WHO technical units. Training of national staff should consider building national and local capacities.
- **Operations support and logistics.** Supply chain management should shift from the use of medical kits or push systems used in acute emergencies to consumption-based or pull systems with a more developmental/resilience-building approach.
- **Security.** Security management and support for all WHO operations continue to be conducted in accordance with United Nations Security Management System and WHO security policies, protocols and guidelines.

## Application of WHO emergency SOPs during protracted emergencies

WHO's emergency SOPs continue to apply to protracted emergencies for the first 12 months of the grading period for Protracted 1 and 2, and for the full duration of the grading period for Protracted 3. Emergency SOPs apply when an acute event is graded in the context of a protracted emergency. When the situation stabilizes, there should be a phased transition of emergency procedures toward normal procedures when possible.

45 https://healthcluster.who.int/our-work/task-teams/information-management-task-team/public-health-information-services-toolkit
46 https://emergency.unhcr.org/coordination-and-communication/interagency/humanitarian-programme-cycle-iasc
47 https://www.recoveryandpeacebuilding.org/content/rpba/en/home.html

## All-hazard emergency risk management during the protracted emergency

While the overall objective in protracted emergencies is to support effective coverage of the affected population with a priority package of quality health services, strong emergency risk management capacities need to be maintained to be prepared for concurrent acute emergencies. A high level of operational readiness should be maintained in all protracted emergency settings.

Contingency planning should anticipate all events that can lead to sudden increased health needs, notably outbreaks, but also changes in conflict dynamics (including increased violence, population movements or the destruction of health facilities); occurrence of droughts and other disasters; deliberate events with chemicals or other agents; and seasonal changes (such as preparing for harsh winter conditions or cyclones).

- Annual contingency planning should be based on all-hazard vulnerability and risk mapping, or in accordance with the specific hazard and risk.
- Business continuity planning is vital in protracted emergencies. Repurposing of the health workforce for scaling up response capacities, including measures and supplies for their safety and protection, may need to be included in the planning process.
- Where possible, local capacities need to be strengthened in emergency risk management functions and harmonized with national IHR core capacities.
- Investment in additional essential public health functions that contribute to health risk reduction and prevention is important, such as water quality, hygiene and sanitation, and environmental public health.

## Humanitarian-development-peace nexus

As appropriate to the context, connections will be fostered with health development coordination and programming towards the collective outcomes of universal health coverage based on the primary health care approach and health security. This will be informed by joint analyses and integrated in national health sector strategic plans as well as planning under the Humanitarian Programme Cycle. For examples of entry points for the implementation of the nexus, see Chapter 6 of the Health Cluster guide.[48]

Building on humanitarian response planning cycles and the interventions required to support access to essential health services and preparedness for all hazards, capacity-building and health system strengthening approaches will be integrated into the response.

At country level, the emergency manager will work with the Universal Health Coverage policy adviser to develop humanitarian development profiles and action plans that identify entry points for collaboration to put the humanitarian-development-peace nexus into practice.

## Link with peacebuilding: the WHO Health and Peace Initiative

Conflicts are a major obstacle to health, while a lack of access to health and basic social services can lead to feelings of exclusion, which are in themselves a major driver of conflict and violence. WHO will provide guidance on how peace-relevant health interventions can help improve the prospects for local peace in at least four ways:[49]

- at minimum, by mainstreaming conflict sensitivity into humanitarian analyses and assessments, recruitment, programming, and monitoring and evaluation;
- by working to improve trust and communication between citizens and the state by making health care more accessible and equitable;
- by building collaboration between all sides in a conflict on common topics such as health governance and the delivery of care;
- by promoting community healing and social cohesion through inclusion and open communication.

**48** Health Cluster Guide (https://fctc.who.int/publications/i/item/9789240004726).
**49** WHO Health and Peace Initiative (https://www.who.int/initiatives/who-health-and-peace-initiative).

Table A3.1 Comparing acute and protracted emergency responses

| Category | Acute ERF | PEF |
|---|---|---|
| Overall objective | Effectively and rapidly respond to acute public health events through early detection, risk assessment, targeted interventions and coordination to save lives, protect the vulnerable, minimize adverse health effects and preserve dignity | Optimize the quality and coverage of health services provided to affected populations collectively by all health actors using all available resources, while laying the foundation for longer-term health system resilience and recovery, and supporting health emergency risk management capacities |
| Special responsibilities | Under IHR for public health events, aligned with IASC Scale-up Protocols | Under IASC, and as cluster lead agency for health |
| Focus | Event-specific increased health needs and risks<br>Time-limited surge response | Settings with IASC HRPs and/or associated protracted emergency Core Predictable Country Presence country offices<br>Support health system resiliency based on primary health care approach<br>Support country readiness for rapid response to new health threats<br>Restore and maintain a package of prioritized health services<br>Long-term human resources support capacities |
| Coordination | IMS based in EOC | Through Health Cluster or its sector coordination equivalent as per the evolution of the humanitarian system |
| Management system | IMS | Core Predictable Country Presence /Country Business Model<br>Emergency management (support) team |
| Grading | G 1–3 | P 1–3, a guide for Core Predictable Country Presence Category E and a reference for Category D country offices |
| WHO SOPs for emergencies | Always | SOPs apply for the first year of P1 and P2 emergencies, and for the duration of P3 |
| Health information | RRA and situation analysis specific to the event | Most ERF information services continue, but with different frequency. Plus:<br>All-hazard risk analysis<br>Health system performance analysis |
| PSEAH | Dedicated PSEAH capacity deployed for the duration of the emergency | Considerations given to creating and filling the post of in-country PSEAH Technical Officer in a staff position to provide sustained PSEAH operational capacities |
| Performance standards | Outlined in Chapter 4 | Most ERF performance standards apply but different frequency and reporting timeline<br>Setting-specific KPIs should be developed |
| Government | Always work through health authorities | Work with national health authorities, and with local authorities where needed (for example, areas not under government control), strengthening the integration of a whole-of-society approach into the public health system |
| Resource mobilization | CFE, Central Emergency Response Fund, regional emergency funds, fundraising through strategic response plans and emergency/flash appeals under the umbrella of WHO's Global Health Emergency Appeal (GHEA) and HRPs | Through the GHEA, which aligns with the HRPs, Humanitarian Programme Cycle annual resource mobilization cycles<br>Humanitarian and development donors<br>Core Predictable Country Presence ensured with assessed and voluntary contributions to WHO funds |
| Humanitarian-development-peace nexus | Relevant when an event occurs in a humanitarian context | Establish connection for longer-term health system strengthening, universal health coverage and primary health care. Build on existing emergency risk management capacities and National Action Plans for Health Security. Apply conflict sensitive programming |
| Resilience and recovery | Work through national systems<br>Multisectoral post disaster recovery | More emphasis on building local and national capacities through the response<br>Multisectoral recovery and peacebuilding |

# Annex 4. PSEAH implementation framework in graded emergencies

## Applicable contexts

The framework for mainstreaming and integrating protection from sexual exploitation, abuse and harassment in emergency response operations is applicable to all graded health emergency response operations. The operational strategy and the detailed activities may be modified according to context, scale of response and type of emergency (humanitarian, conflict, disasters, refugee response operation, and public health emergencies).

A PSEAH programme integrated in emergency response operations aims to prevent incidences of SEAH, promote reporting of allegations, and ensure capacities for response in case of allegations, thereby minimizing harm and instilling trust in the emergency response operations. Implementation of PSEAH in the humanitarian- development-peace nexus will need to be adapted to the context, while maintaining a victim and survivor-centred approach to ensure that the interest and well-being of victims remains at the centre of all interventions.

## IASC PSEA outcome measures and activities in graded emergency operations to guide planning

PSEAH implementation in emergency operations is a collective responsibility of all United Nations and humanitarian partners. The IASC has developed a PSEAH implementation framework to guide implementation at country level focusing on five outcome measures. WHO uses the same framework to guide planning for PSEAH implementation at country level (Table A4.1).

Table A4.1. IASC PSEA outcome measures

| No. | IASC PSEA outcome measures | PSEAH activities |
|---|---|---|
| 1. | Leadership and accountability, including investigation capacity | • PSEAH dedicated capacity integrated in the IMT/IMST<br>• SEAH risks and PSEAH needs assessment conducted<br>• PSEAH action plan integrated in SRP<br>• Facilitate WHO engagement and contribution to IASC PSEA network action plan<br>• PSEAH tools and SOPs developed, reproduced and disseminated<br>• Monitoring and evaluation, joint operational reviews and after-action reviews |
| 2. | Prevention | • PSEAH recruitment safeguarding measures implemented and tracked<br>• PSEAH in contractual arrangements<br>• PSEAH induction briefings, and other trainings<br>• PSEAH awareness and sensitization targeting communities, partners, and government stakeholders<br>• PSEAH capacity of implementing partners (partner mapping, PSEAH capacity assessment and capacity-building, tracking of capacity development) |
| 3. | Safe and accessible reporting | • Establishment and management of PSEAH reporting at country level<br>• Participation in interagency PSEAH reporting SOPs at country level<br>• Mapping and integration into existing community-based complaint mechanisms<br>• Capacity-building for referral |
| 4. | Victim support services | • Mapping and establishment of GBV referral pathways<br>• GBV/PSEAH capacity-building for service providers |
| 5. | PSEAH network plan of action | • Support to the IASC PSEA network action plan development and implementation (specify areas to be supported by WHO) |

## WHO PSEAH roles and responsibilities in graded emergencies

Various units, programmes and functions in WHO contribute to PSEAH mainstreaming. This section summarizes the roles and responsibilities for PSEAH in graded emergency operations.

- The HWCO/WR maintains overall accountability for PSEAH, advocates for, and facilitates implementation, and is the Agency PSEA focal point in the United Nations Country Team/Humanitarian Country Team.
- The incident manager ensures the integration of PSEAH in the IMT/IMST, facilitates implementation, advocacy and resource mobilization.
- The PSEAH focal points, designated by HWCO/WR, support PSEAH implementation in the response operations.
- The PSEAH technical specialists designated and embedded in the IMT/IMST are responsible for planning, implementing, monitoring and reporting on progress for PSEAH in the emergency response operations.
- Human resource personnel in the IMT/IMST are responsible for implementing and reporting on PSEAH safeguarding recruitment measures in the response operations, and including PSEAH in contractual agreements.
- The Health Cluster coordinator collaborates with the designated PSEAH specialist to support health cluster partners with PSEAH awareness and capacity-building.
- WHO units GBV, Sexual and Reproductive Health and MHPSS collaborate with the PSEAH technical officer to build capacities for GBV referral services for victim support.
- The IMT/IMST planning officer coordinates with the PSEAH technical officer to ensure a PSEAH action plan is integrated in the emergency response plan.
- The IMT/IMST resource mobilization officer ensures PSEAH is in advocacy materials, resource mobilization strategies and funding appeals.
- The Preventing and Responding to Sexual Misconduct regional coordinators collaborate with the PSEAH technical unit in WHE to mobilize operational capacities and to provide technical support to field operations.
- Internal Oversight Services receive and investigate SEAH allegations, and provide recommendations for disciplinary measures.
- The WHO Staff Health and Well-being department and ombudsperson provide medical and non-medical support to victims of sexual harassment.
- The WHO Preventing and Responding to Sexual Misconduct department manages and disburses funds for victim support services.
- REDs coordinate with headquarters, regional and country offices to ensure the integration of PSEAH measures in graded emergency operations.
- The WHE PSEAH technical unit leads and oversees PSEAH mainstreaming in WHO emergency operations, including preparation and implementation of strategic plans, PSEAH human resources management, and capacity-building. The unit reports quarterly to the WHE Executive Director's Office on achievements and gaps.

# Annex 5. Vaccine-preventable disease outbreaks

## Introduction

Strong and equitable vaccination programmes and timely responses to outbreaks of vaccine-preventable diseases (VPD) such as measles and polio form a strong defence against public health threats. Investment in vaccination programmes has prevented millions of illnesses and deaths from VPDs, as seen most spectacularly by the eradication of smallpox, the near eradication of poliomyelitis, and progress in the elimination of measles. However, progress on the Global Vaccine Action Plan targets has slowed in recent years. Basic immunization coverage has stagnated, and VPDs have started resurging due to multiple factors, including vaccine hesitancy, weakening of immunization programmes as a result of conflict, chronic underinvestment in primary health care, and the impact of the COVID-19 pandemic on service demand and delivery.

As identified in the Immunization Agenda 2030, outbreaks of VPDs act as strong signals in identifying countries and areas with population immunity gaps from weak immunization programmes, and as proxy indicators for gaps in the health system in general and risks to global health security.

WHO has a strong mandate to work with Member States on immunization and the response to VPD outbreaks. Detecting, preventing and responding to these outbreaks are part of the core capacities required by the IHR, and key to achieving global health security. WHO will work with partners and Member States to sustain and enhance vaccination coverage, ensuring that no child is left behind, even in the most remote and inaccessible areas.

This annex provides guidance on how WHE, the Polio Eradication Initiative and the Immunization, Vaccines and Biologicals department (the latter two henceforth referred to as technical programmes) will coordinate on preparedness for, investigation of, and emergency response to VPD outbreaks.

## ERF key components pertaining to vaccine-preventable diseases

The technical programmes continue building the capacity of Member States to anticipate, prepare for, detect and rapidly respond to any VPD outbreaks or events, and carry out regular risk assessments through well-established indicator-based surveillance programmes. WHE conducts event-based surveillance for all hazards, including VPD outbreaks, and verifies signals, working with relevant technical programmes at regional office and headquarters levels. Technical programmes are also requested to share additional signals with the detection, verification and risk assessment team.

In the context of a verified VPD outbreak, an RRA can be undertaken when an outbreak is likely to be notifiable under the IHR, exceeds the response capacity of local authorities, or when multiple countries are affected. An RRA outside the regular risk assessments done by the technical programmes should follow the reporting lines and timelines laid out in Chapter 1, with inputs provided by the technical programmes as appropriate. Based on the outcomes of the RRA, the technical programme and WHE teams will agree to proceed with grading or not. The grading process and SOPs are fully outlined in Chapter 2. Grading of an emergency triggers the activation of WHO's IMS. For VPD outbreaks, it is envisaged that WHE will provide the operational platform for managing the incident response, with the technical oversight provided by the technical departments in support of the country office, and scaled according to their capacity and the capacity of the regional office. As soon as the acute response needs of the outbreak are met, WHE will transition remaining activities back to the responsibility of the technical programmes, and remove the grading following agreement across the three levels. The specific roles and responsibilities for each outbreak response should be agreed at the start of the response, and this information disseminated to the relevant teams.

### Performance standards and timelines

The response to a graded event follows the performance standards laid out in Chapter 4. Overall accountability and monitoring of performance will remain with the technical programmes, taking into account specific technical programme timelines and targets as outlined in relevant strategic documents. The technical programmes are responsible for ensuring that any appropriate operational reviews are completed, in close coordination with WHE.

# Annex 6. Operational risk management and compliance

## Operational risk response analysis

### Purpose of the operational risk response analysis

The operational risk response analysis (ORRA) provides a methodology to identify risks and plan mitigation actions for a response. It provides a detailed analysis of the risks to consider while designing, delivering and managing the operational response on a day-to-day basis. The ORRA and its risk response plan are embedded within the overall operational plan and management process by integrating into existing monitoring activities.

The emergency response procedures (Chapter 5) set out activities requiring more detailed analysis of the risk responses that can be included in the ORRA. Risks are generally grouped around the functions of the IMS.

The risk analysis and risk response planning consider foreseen challenges and assess their:

- likelihood of occurrence at the current time and context
- scale of impact on key areas of the response, for example:
  - response delivery and quality
  - safeguarding and ethics
  - financial stewardship
  - partnership and reputation
  - staff safety and well-being.

After a risk is identified and assessed, delegated staff decide whether to respond to the risk by tolerating it or treating it (by mitigation actions, transfer or termination of activities). In line with WHO's risk management policy, while some risks must be avoided, certain risks may need to be taken to respond successfully to an emergency.

The WHE risk catalogue[50] contains non-exhaustive examples of risks that exist across different types and scales of response, and supports identification of the key risks that could affect the response. It also describes proven risk responses that can be adopted or adapted to the current setting.

Following the initial ORRA, an agreed action plan should be finalized that addresses identified risks, including those for which an inadequate level of response has been implemented.

### Who performs the ORRA, and when

Operational oversight of an emergency response includes responsibility for preparing the ORRA with input from all levels, and for managing it throughout the response. Monitoring the effectiveness of risk response plans is also part of the operational oversight function. Where the response is multi-country or multi-site, specific tasks can be delegated to other IMT staff (such as the in-country field coordinator and IMS function leads).

The IMT includes a risk management focal point as part of the planning and monitoring function to ensure ongoing revision and reporting. Risk owners are appointed to monitor risks allocated to them and report back on their status. For large-scale responses, it is recommended that a risk management committee be established to oversee the risk register. This committee should include the incident manager and the leads of the critical IMS functions. It may include additional support from WHO regional offices and headquarters. Drawing on past experiences and operational reviews, the committee should consider the key risks in their respective IMS function relevant to the emergency or event.

An initial ORRA should take place between 10 and 30 days from the sudden onset of an event or grading of an emergency, with a responsible focal point identified within 10 days. Additional consultation with partners and national health authorities can be incorporated in the operational plan where relevant but should not delay the initial ORRA, which is shared with the regional office and the respective HWCO/WR.

Depending on the grade of the event, the initial ORRA will include discussion with the regional office or WHO headquarters on the risk appetite. This includes an assessment of whether the target residual risk levels identified for each risk fall within the accepted range of risk tolerance. This ensures that mitigation measures will address the remaining gap between the current risk and the target risk level.

### Monitoring the implementation and effect of the risk response plan

Following the initial assessment, periodic monitoring of the risk response plan is critical. This involves:

- confirming *adherence* by ensuring actions planned in a set timeline are carried out as part of day-to-day implementation activities;
- evaluating *effectiveness* by identifying indicators that can inform managers – through measurement of positive outcomes or absence of negative outcomes – that the risk response has worked.

Whenever possible, this should be achieved using relevant response measures that are already collected (for example, funding stream and rate of implementation, completeness of delivery, feedback on effect of support provided, stock-outs and timeliness of reporting).



50 The risk catalogue will be added to the eManual when finalized.

### When to evaluate and revise the ORRA

The frequency and depth of the ORRA review depends on the initial grading of the emergency response and is required immediately if the grade of the event escalates.

| | |
|---|---|
| Grade 1 | **It is recommended that the identification and assessment of risks in the ORRA is reviewed after one month and then quarterly thereafter by the RED.**<br>The incident manager is expected to monitor and report on adherence to the risk response plan (e.g. in IMT meetings) |
| Grade 2 | **It is recommended that the ORRA is reviewed monthly by the RED to confirm that risk assumptions remain valid.**<br>The incident manager is expected to monitor and report on adherence to the risk response plan (e.g. in IMT meetings) |
| Grade 3 | **It is recommended that the ORRA is reviewed every two weeks (considering new risks and changes to the old risks) by the RED.**<br>This involves regional and headquarters inputs to confirm the identification of relevant risks and the related risk response plan, and reconfirmation of the risk tolerance levels.<br>The incident managers at each level are expected to monitor and report on adherence to the risk response plan (e.g. in IMT/IMST meetings). |

## Compliance

### Compliance during acute emergencies

Compliance with WHO regulations, policies and procedures is critical to preserve the integrity of the response and to safeguard the assets and human resources assigned to the IMT. During graded emergencies, the IMT needs to have in place a compliance plan to outline, record and consolidate key issues of compliance identified and actions to be taken, including responsibilities and timelines.

The compliance plan can be prepared with the country office local compliance and risk management committee, which will systematically monitor compliance matters on a monthly basis and help ensure effective internal control and optimum use of resources.

The compliance plan needs to cover the areas below.

- **Administration, finance and planning:** direct financial cooperation; direct implementation; letters of agreement; grants; donor reporting; awards management; performance management development system; adherence to human resource procedures regarding surge deployment, consultants' recruitment and use of existing rosters; travel; Framework for engagement with non-state actors[51] procedures in an emergency;
- **Operations support and logistics:** compliance with logistical and supply chain management, including warehousing, for public health emergencies;
- **Procurement:** to be authorized and approved according to WHE workplans, terms and conditions of the related donor agreements and standards related to quality assurance;
- **Emergency operations:** the emergency readiness checklist is to be updated on a monthly basis.

### Compliance in protracted emergencies

As emergencies shift to protracted crises, country offices need to reassess their operational and programmatic requirements to more sustainable models of response and programme delivery. Funding typically decreases, and the annual planning cycle is replaced by a multi-year strategic plan to move from crisis response to resilience-building and more sustainable solutions.

As a result, compliance requirements must be revised into systems for longer-term application. The most important requirements include those below.

- Activate a compliance team (at least one officer) to coordinate the development of a risk-based plan identifying direct implementation and direct financial cooperation requiring specific post facto verification of expenditure-supporting documentation (such as vouchers and invoices) to ensure completeness and adequacy. The plan should be reviewed monthly for Protracted Grade 2 and 3 emergencies or quarterly for Protracted Grade 1 emergencies.
- Review the emergency operations annually to revalidate programme priorities and update the human resource structure, keeping in mind the evolution of needs and requirements of subnational offices and hubs; projected funding for emergency and non-emergency programmes; and changes to the operating, humanitarian, security and political context.
- For country offices that have relied on a mixed structure of WHO personnel and non-personnel (that is, personnel contracted through a special service agreement, consultancy or agreement for performance of work) during an acute crisis response, have a transition plan to clearly define the parameters and conditions for the phase-out of non-personnel and personnel, depending on the reassessment of the emergency programme.



51 WHO's framework for engagement with non-state actors. (https://iris.who.int/handle/10665/324850?locale-attribute=en).

- Ensure that WHE essential and critical positions are in place with at least one full year's deployment to cover essential functions.
- Have in place a retention and development plan for country office staff, particularly for staff who have been serving at subnational level during the phase of acute emergency response.
- Activate regular and systemic quality assurance of the performance of implementing partners through longer-term outsourcing of third-party monitoring in financial and programme performance. Depending on availability of resources in the country office, use existing third party monitoring available through other United Nations partners to reduce contractual costs.
- Activate long-term agreements to gain efficiency in the area of procurement (goods and services).
- Conduct warehousing stock management and procurement plan revisions on a quarterly basis for forecasting and prepositioning.

## Business continuity

Business continuity[52] planning increases the resilience of each country office to continue operating when emergencies arise. It contributes to three main objectives: ensure the safety of WHO staff, premises and assets; preserve and maintain in place critical WHO programmes and operations; and ensure WHO can deliver its emergency operations by reassessing and readjusting, in a timely manner, the capacity and capabilities of the office and partners and counterparts.

The HWCO/WR is responsible for developing, updating and implementing the business continuity plan, as well as deciding on the conditions to deactivate it and when staff can return to their respective functions. The plan must address the risks most likely to affect the functioning of a country office, which will be included in the ORRA and incorporated into the country office risk register.

The HWCO/WR needs to ensure that all staff members are familiar with the plan and with their roles and responsibilities when the plan is activated, including identifying their replacement for handover. The plan should be regularly reviewed and tested on a quarterly basis for Protracted Grade 3 emergencies, and on an annual basis for Protracted Grade 1 and 2 emergencies.

The first part of the plan covers the safety of WHO staff, premises and assets. Readiness measures and SOPs must be in place to cover emergency communications, staff security, medical evacuation, coordination of the operations between the main or central office and sub-offices or hubs, and safe management of the office premises, including relocation.

The second part of the plan covers the continuity and critical operations of WHO programmes, which need to be identified ahead of time. Operations are classified into three main groups: critical and needing to be maintained in the country; can be relocated or performed remotely; or can be temporarily suspended. Identification of critical operations should be based on criteria such as lifesaving activities, maintenance of essential health services, and vital enabling functions such as logistics and security. The plan should define the minimum number of qualified staff required to continue the critical programmes and activities, and the minimum resources, including funds and assets, needed to maintain critical functions. The plan maps out and identifies partners that can provide assistance if and when the business continuity plan is activated.

The third part of the plan includes measures needed to respond to a public health emergency, in line with the ERF.

## Contingency planning

Contingency planning is led by the resident coordinator or humanitarian resident coordinator's office with the members of the United Nations country team or humanitarian country team. Each country office contributes to the contingency planning process.

Contingency planning is activated when risk levels remain medium or high for a longer period, or the hazard that triggered the response worsens. The minimum components of contingency planning include risk profile (current and emerging risks or events); vulnerability and capacity assessment mapping; identification of financial resources and resource mobilization plan; and training of United Nations country team or humanitarian country team staff, including WHO staff. The minimum components need to cover both national- and subnational-level requirements and needs.

To prepare a contingency plan, the IMT needs to cover the areas listed below.

- **Situation and risk analysis.** This includes operational and programmatic assumptions underlying the content development of the plan.
- **Strategic approach.** This includes the objectives and strategic approach leading to their achievement. The response plan builds on the situational analysis and risks.
- **Operational response plan.** The plan defines interventions, modality of implementation (including partnerships) and requirements (identified through a needs assessment). It also includes coordination and management structures to be activated within the office and in relation to other partners and counterparts.
- **Preparedness gaps and response actions.** The plan needs to include measures that the team will put in place to address identified gaps in resources and capacity (national or subnational).
- **Definition of funding requirements.** Funding needs are to be grouped into two main categories: budget needs for the interventions identified in the operational response plan; and budget needs to address the preparedness gaps.

52 WHO guidance for business continuity planning. Geneva: World Health Organization; 2018. (https://iris.who.int/handle/10665/324850?locale-attribute=en)

# Annex 7. Classifications of hazards[53]

| CLASSIFICATION OF HAZARDS | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Generic Groups[1] | 1. Natural | | | | | | 2. Human-Induced[2,3] | |
| Groups | 1.1 Geological[4] | 1.2 Hydro-meteorological | | | 1.3 Biological[5] | 1.4 Extraterrestrial[4] | 2.1 Technological | 2.2 Societal |
| Subgroups | | 1.2.1 Hydrological[4] | 1.2.2 Meteorological[4] | 1.2.3 Climatological[4] | | | | |
| Main Types<br>• subtypes<br>[sub-subtypes] | Earthquake (G1):<br>• Ground Shaking<br>• Tsunami<br><br>Mass movement (G2)<br><br>Liquefaction (G3)<br><br>Volcanic activity (G4):<br>• Ash Fall<br>• Lahar<br>• Pyroclastic Flow<br>• Lava Flow | Flood (H1):<br>• Riverine flood<br>• Flash flood<br>• Coastal flood<br>• Ice jam flood<br><br>Landslide (H2):<br>• Avalanche [snow, mud floe debris, rockfall]<br><br>Wave action (H3):<br>• Rogue wave<br>• Seiche | Storm (M1):<br>• Extra-tropical Storm<br>• Tropical Storm<br>• Convective Storm<br><br>[e.g. storm/surge, tornado, wind, rain, winter storm/blizzard, derecho, lightning/ thunderstorm, hail, sand/dust, storm]<br><br>Extreme temperature (M2):<br>• Heatwave<br>• Cold wave<br>• Severe winter condition [e.g. snow/ice, frost/ freeze]<br><br>Fog (M3) | Drought (C1)<br><br>Wild Fire (C2):<br>• Land Fire [e.g. Brush, bush, pasture]<br>• Forest Fire<br><br>Glacial lake outburst (C3) | Emerging diseases (B1)<br><br>Epidemics and pandemics (B2)<br><br>Insect Infestation (B3):[4]<br>• Grasshopper<br>• Locusts<br><br>Foodborne outbreaks (B4)[7] | Impact (E1):<br>• Air Burst<br><br>Space Weather (E2):<br>• Energetic Particles<br>• Geomagnetic Storms<br>• Shockwave | Industrial hazards (T1):[8]<br>• Chemical spill, Gas leak, Collapse, Explosion, Fire, Radiation<br><br>Structural collapse (T2):[8,9]<br>• Building collapse, Dams/ bridge failures<br><br>Transportation (T3):[8,11]<br>• Air, Road, Rail, Water<br><br>Explosions/Fire (T4)[8]<br><br>Air pollution (T5):[8]<br>• Haze[10]<br><br>Power outage (T6)[11]<br><br>Hazardous materials in air, soil, water (T7):[12,13]<br>• Biological, Chemical, Radionuclear<br><br>Food contamination (T8)[7] | Armed conflicts (S1):[14]<br>• International<br>• Non-international<br><br>Civil unrest (S2)<br><br>Terrorism (S3)<br>• Chemical biological,<br>• radiological, nuclear,and explosive weapons (CBRNE) (S4)[15,16]<br>• Conventional weapons<br>• Unconventional weapons<br><br>Financial crisis (S5):<br>• Hyperinflation<br>• Currency crisis |

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