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Abbreviations

CERF	Central Emergency Response Fund
ERF	Emergency Response Framework
ERT	Emergency Response Team (country level)
ERP	Emergency Response Procedure
EST	Emergency Support Team (international level)
ESTL	Emergency Support Team Leader
GEMT	Global Emergency Management Team
GEMT-R	Global Emergency Management Team for Response
GEN	Global Emergency Network
HCC	Health Cluster Coordinator
HCT	Humanitarian Country Team
HL	Health Emergency Leader
HQ	WHO headquarters
HWCO	Head of WHO Country Office
IASC	Inter-Agency Standing Committee
IHR	International Health Regulations (IHR) (2005)
RO	WHO regional office
WCO	WHO country office
WRC	WHO Response Coordinator

Executive summary

WHO's Member States face a broad range of emergencies resulting from various hazards and differing in scale, complexity and international consequences. These emergencies can have extensive political, economic, social and public health impacts, with potential long-term consequences sometimes persisting for years after the emergency. They may be caused by natural disasters, conflict, disease outbreaks, food contamination, or chemical or radio-nuclear spills, among other hazards. They can undermine decades of social development and hard-earned health gains, damage hospitals and other health infrastructure, weaken health systems and slow progress towards the Millennium Development Goals (MDGs). Preparing for and responding effectively to such emergencies are among the most pressing challenges facing the international community.

WHO has an essential role to play in supporting Member States to prepare for, respond to and recover from emergencies with public health consequences. WHO also has obligations to the Inter-Agency Standing Committee (IASC) as Health Cluster Lead Agency, to the International Health Regulations (2005) and to other international bodies and agreements related to emergency response.

The purpose of this Emergency Response Framework (ERF) is to clarify WHO's roles and responsibilities in this regard and to provide a common approach for its work in emergencies. Ultimately, the ERF requires WHO to act with urgency and predictability to best serve and be accountable to populations affected by emergencies.

First, the ERF sets out **WHO's core commitments** in emergency response which are those actions that WHO is committed to delivering in emergencies with public health consequences to minimize mortality and life-threatening morbidity by leading a coordinated and effective health sector response.

Second, the ERF elaborates the steps WHO will take between the initial alert of an event and its eventual emergency classification, including **event verification and event risk assessment**.

Third, the ERF describes **WHO's internal grading process** for emergencies including the purpose of grading, the definitions of the various grades, the criteria for grading, and the steps to remove a grade.

Fourth, this paper describes **WHO's Performance Standards** for emergency response: specific deliverables with timelines for completion that are used by WHO to measure its performance.

Fifth, the ERF outlines **WHO's four critical functions** during emergency response: leadership, information, technical expertise and core services.

Sixth, the ERF states **the role of WHO's Global Emergency Management Team (GEMT)** during emergency response, particularly related to the optimal use of Organization-wide resources, the monitoring of the implementation of relevant procedures and policies, and the management of WHO's internal and external communications.

Seventh, the ERF outlines **WHO's Emergency Response Procedures (ERPs)** that specify roles and responsibilities across the Organization to deliver on the four critical functions and the Performance Standards.

Finally, three essential emergency policies which will optimize WHO's response are detailed: the **surge** policy, the **Health Emergency Leader** policy and the **no-regrets** policy.

At the end of the document there are six complementary annexes. Annex 1 provides a flow chart of the grading process and Annex 2 a country-level timeline during emergency response. Annex 3 states WHO's obligations under an Inter-Agency Standing Committee Level 3 emergency; Annex 4 sets out WHO's Performance Standards in protracted emergencies; Annex 5 defines WHO's commitment to institutional readiness; and Annex 6 defines WHO's commitment to emergency risk management.

Introduction

Over the decade 2001–2010, an average of more than 700 natural and technological emergencies occurred globally every year, affecting approximately 270 million people and causing over 130 000 deaths annually.¹ Twenty-five per cent of these emergencies, and 44 per cent of these deaths, occurred in less developed countries with limited capacities to prepare for and respond effectively to emergencies. These statistics do not include the high levels of mortality and morbidity associated with conflict-related emergencies. According to the World Bank, over 1.5 billion people – one quarter of the world’s population – live in countries affected by violent conflict.² These populations suffer from the consequences of societal disruption and increases in mortality and morbidity due to infectious diseases, acute malnutrition, trauma and complications from chronic diseases. Of the 20 countries with the highest childhood mortality rates in the world,³ at least 15 have experienced civil conflicts during the past two decades. Of the 10 countries with the highest ratios of maternal mortality,² nine have recently experienced conflict.

Over the same time period, risks to public health have increased due to globalization, and international travel and trade. Such risks might be transmitted by people (e.g. SARS, influenza, polio, Ebola), goods, food, animals (e.g. zoonotic disease), vectors (e.g. dengue, plague, yellow fever), or the environment (e.g. radio-nuclear releases, chemical spills or other contamination).

In all types of emergencies, the poorest and most vulnerable people suffer disproportionately. These negative impacts are complicated by the enormity of the resulting economic costs, averaging over US\$100 billion per year. The appropriate and timely management of these risks requires effective national and international capacities, intersectoral collaboration, the promotion of equity, the protection of human rights, and the advancement of gender equality.

WHO’s obligations under the International Health Regulations (2005)

The renewed and enhanced commitments of Member States and WHO under the International Health Regulations (IHR) (2005) have defined the obligations of countries to assess, report and respond to public health hazards, and established a number of procedures that WHO must follow to uphold global public health security. The IHR (2005) cover a wide variety of public health events and are not limited to infectious diseases. The IHR (2005) defines the term event as a manifestation of disease or an occurrence that creates a potential for disease. Disease means an illness or medical

¹World Disasters Report 2011. Geneva, International Federation of the Red Cross and Red Crescent Societies, 2011.

²World Development Report 2011: Conflict, security and development. Washington, DC, World Bank, 2011.

³State of the World’s Children Report 2011: Children in an urban world. New York, NY, UNICEF, 2011.

condition that presents or could present significant harm to humans, irrespective of origin or source. In addition, a public health risk is defined in IHR (2005) as the likelihood of an event that may adversely affect the health of human populations, with emphasis on those that may spread internationally or may present a serious and direct danger, and potentially require a coordinated international response. The definitions of these terms are the building blocks of the expanded surveillance and response obligations of Member States and WHO under the IHR (2005).

WHO's increased responsibilities under the IHR (2005) include:

1. designating WHO regional level IHR contact points;
2. coordinating global surveillance and assessment of significant public health risks and disseminating public health information to States Parties;
3. supporting States Parties to assess their existing national public health structures and resources, and to build and strengthen their core public health capacities for surveillance and response;
4. determining whether particular events constitute a public health emergency of international concern, with advice from external experts; and
5. developing and recommending measures for surveillance, prevention and control of public health emergencies of international concern for use by Member States.

WHO's obligations to the Inter-Agency Standing Committee (IASC) for humanitarian emergencies

In recent years, the management of humanitarian emergencies has undergone significant transformation. This transformation is based on over 40 years of international experience in multisectoral emergency management practice at country level during humanitarian emergencies and on lessons learned from recent humanitarian responses in Haiti and Pakistan in 2010, in Libya and the Horn of Africa in 2011, and in Syria and the Sahel region in 2012.

Key steps in this transformation took place in 2005 with the Humanitarian Reforms of the Inter-Agency Standing Committee.⁴ Among other measures, these reforms established the Cluster Approach to ensure predictability and accountability in international responses to humanitarian emergencies. The Cluster Approach clarifies the division of labour among agencies and better defines their roles and responsibilities

⁴The IASC, established in 1991 under United Nations General Assembly Resolution 46/182 on the strengthening of humanitarian assistance, is the primary inter-agency forum for coordination, policy development and decision-making involving the key UN and non-UN humanitarian partners.

within the different sectors of the response. The IASC designated global cluster lead agencies in 11 sectors, including WHO as lead of the Global Health Cluster.

In 2011, the IASC's Transformative Agenda identified five areas for additional reforms:

1. experienced humanitarian leadership deployed in a timely and predictable way;
2. more rapid and more effective cluster leadership and coordination;
3. accountability at the head of country office level;
4. better national and international preparedness for humanitarian response;
5. more effective advocacy, and communications and reporting, especially with donors.

As an active member of the Inter-Agency Standing Committee, WHO has played a leading role in these reform processes and fully assumes the responsibilities, as agreed within the IASC, regarding leadership, coordination, accountability, effectiveness and predictability.

WHO's commitment to its leadership role in emergency response

WHO's leading role in emergencies has been documented and strengthened by Article 2(d) of WHO's Constitution and World Health Assembly Resolutions: 34.26, 46.6, 48.2, 58.1, 59.22, 64.10, 65.20.

As the United Nations agency for health, as a member of the IASC, as lead agency of the Global Health Cluster, and as the guardian of the IHR (2005), it became imperative for WHO to adapt its organizational commitments and procedures to respond to these growing demands from Member States.

The WHO reform process of 2011–2012 provided WHO's leadership with the opportunity to redefine the Organization's commitment to emergency work, focusing on building an Organization-wide approach to improve health outcomes at the country level.

WHO began the development of this Emergency Response Framework (ERF) by establishing a Global Emergency Management Team (GEMT) to provide overall policy, strategy and management guidance to WHO's work in emergencies. The GEMT developed this ERF, based largely on its vast experience and expertise, and is responsible for its implementation.

The purpose of the Emergency Response Framework

The purpose of the Emergency Response Framework is to clarify WHO's roles and responsibilities in emergency response and to provide a common approach for WHO's work in emergencies. Recognizing that the principles of emergency management apply to all emergencies, WHO has developed the ERF to describe its core commitments, grading process, Performance Standards, critical functions, role of the GEMT, essential policies for optimizing its response, and Emergency Response Procedures in all emergencies with public health consequences. Ultimately the ERF requires WHO to act with urgency and predictability to best serve and be accountable to girls, boys, women and men affected every year by the public health consequences of emergencies.

Critical assumptions for successful implementation of the ERF

Successful implementation of the ERF requires:

1. sufficient risk reduction and preparedness capacities in Member States;
2. institutional readiness of WHO in line with standardized checklists at country, regional and headquarters offices;
3. sufficient and sustainable core funding for the above;
4. sufficient and timely response funding; and
5. access to the affected population.

WHO's core commitments in emergency response

WHO's core commitments in emergency response are those actions which the Organization will always deliver and be accountable for during emergencies with public health consequences. This will ensure a more effective and predictable response to and recovery from natural disasters, conflict, food insecurity, epidemics, environmental, chemical, food and nuclear incidents, political or economic crises and all other types of emergencies with public health consequences.

In all countries experiencing emergencies, to support Member States and local health authorities to lead a coordinated and effective health sector response together with the national and international community, in order to save lives, minimize adverse health effects and preserve dignity, with specific attention to vulnerable and marginalized populations, WHO will:

1. develop an evidence-based health sector response strategy, plan and appeal;
2. ensure that adapted disease surveillance, early warning and response systems are in place;
3. provide up-to-date information on the health situation and health sector performance;
4. promote and monitor the application of standards and best practices; and
5. provide relevant technical expertise to affected Member States and all relevant stakeholders.

1

Determining if an event has public health impact

1.1 Monitoring events

1.1.1 WHO continually monitors events happening worldwide to determine their potential impact on public health and whether an emergency response is required.

1.1.2 Such events happen suddenly or develop progressively over time. **Sudden-onset** events include earthquakes, tsunamis and chemical spills. **Slow-onset** events include deteriorating situations where the public health risk may increase over time, such as prolonged armed conflict, progressive disease outbreak, drought or food insecurity.

1.2 Triggers for event verification and event risk assessment

1.2.1 For sudden-onset events, the reporting or detection of the event serves as the trigger for event verification and risk assessment.

1.2.2 For slow-onset events, the trigger to conduct an event risk assessment may not always be obvious. In such cases, triggers to initiate or repeat a risk assessment include the following:

- a. **new information available**, e.g. through trend analysis of key health indicators in high-risk countries, and from inter-agency work on early warning;
- b. **new developments**, e.g. escalation of scale, urgency or complexity, and political, social or economic changes;
- c. **new perceptions** e.g. headline news, government concern, UN agency or non governmental organization (NGO) statements, decisions by other agencies on grading.

1.3 Event verification and event risk assessment

1.3.1 Once triggered, WHO will support the Member State to verify the event and assess the potential public health impact of the event or, if necessary, conduct an independent WHO risk assessment, within 48 hours, based on the following criteria: ⁵

- a. **scale** (of the event): consider the number and health status of people affected (with attention to vulnerable and marginalized groups), proportion of population affected or displaced, size of geographical area affected, level of destruction of health structures, post-event national health capacities, number of countries affected,

⁵The criteria for the WHO grading process include the IHR (2005) criteria. While the IHR criteria are used by Member States to determine the need for event notification to WHO, WHO grading criteria are used internally to define the level of organizational support an event requires and to trigger specific WHO procedures.

extent of international disease spread, interference with international trade and travel, degree of deviation from the norm in the case of annual predictable events (e.g. seasonal outbreaks, annual floods or drought);

- b. **urgency** (of mounting the response): consider the threat of or actual increase and degree of increase in mortality, morbidity, or global acute malnutrition, degree of transmissibility of pathogen, speed of international spread, case fatality ratio, degree of environmental or food contamination (chemical, radiological, toxic), speed of population displacement and potential for further displacement, intensity of armed conflict or natural disaster, potential for further communal or intrastate conflict, or for prolonged effects of a natural disaster (e.g. on-going rains causing prolonged flooding).

1.4 Using results from event risk assessments

1.4.1 If the event risk assessment suggests that the public health **impact of the event is negligible or if no WHO response is required** at either country or international level, WHO will:

- a. issue any required communications to Member States and to relevant in-country and global partners; **immediately following the event risk assessment**;
- b. close the event.

1.4.2 If the event risk assessment suggests that the public health impact of the event has the **potential to become significant in the future**, WHO will:

- a. classify the event as **ungraded**;
- b. support the Member State to conduct on-going monitoring and periodic follow-up risk assessments; as required, but **at least every 30 days; until the event is graded or closed**;
- c. support the Member State to undertake relevant preparedness measures to mitigate the future impact of the event, **commencing immediately following the event risk assessment**;
- d. support the Member State to develop/update sectoral contingency plans, **commencing immediately following the event risk assessment**;
- e. develop/update WHO country office (WCO) business continuity plans, **commencing immediately following the event risk assessment**;

- f. issue any required communications to Member States and to relevant in-country and global partners, **immediately following the event risk assessment**.

1.4.3

If the risk assessment suggests that the public health impact of the event **might constitute an emergency requiring WHO response**, at either country or international level:

- a. relevant WHO staff involved in the risk assessment will notify relevant Regional Advisers and/or contact points, who in turn will notify relevant Directors in regional offices and headquarters (HQ) who are part of the WHO's Global Emergency Management Team (see part 5), **immediately following the event risk assessment for sudden-onset and within five days for slow-onset events**;
- b. relevant Directors at HQ who are part of the GEMT will convene a teleconference of the relevant members of the GEMT to review the results of the event risk assessment, determine if grading is necessary and, if so, grade the emergency **within 24 hours of the event risk assessment for sudden-onset and within five days for slow-onset events**;
- c. WHO issues any required communications to Member States and to relevant in-country and global partners **immediately following the event risk assessment for sudden-onset and within five days for slow-onset events**.

1.5 Recording events

1.5.1

WHO will systematically record all events with current or potential public health impact, along with the results of the event risk assessment, in a registry and/or in WHO's Event Management System (EMS), **immediately following the event risk assessment**.

1.6 Closing events

1.6.1

An event is considered closed when the relevant members of the GEMT determine that a WHO response is (a) not required or (b) no longer required and that the internal emergency grade should be removed.

2

WHO's internal grading process for emergencies

2.1 Purpose and parameters of grading

2.1.1 Grading is an internal WHO process that is conducted to:

- a. inform the Organization of the extent, complexity and duration of organizational and or external support required;
- b. prompt all WHO offices at all levels to be ready to repurpose resources in order to provide support;
- c. ensure that the Organization acts with appropriate urgency and mobilizes the appropriate resources in support of the response of the affected Member State, partners and the WHO country office;
- d. trigger WHO's Emergency Response Procedures and emergency policies;
- e. remind the Head of the WHO country office (HWCO) to apply WHO's Standard Operating Procedures (SOPs) as per the Director General's memorandum of 15 January 2008; and
- f. expedite clearance and dissemination of internal and external communications.

2.1.2 Whilst the following factors must be taken into consideration, grading is not directly dependent upon:

- a. consultation with Member States;
- b. official requests for international assistance;
- c. other international emergency classification processes such as those of the IASC or the IHR (2005). However, an IASC Level 3 (L3) is a WHO Grade 3 emergency unless determined otherwise by the relevant members of the GEMT at grading. Regardless of the WHO grade, WHO will comply with its obligations in an IASC L3 system-wide activation (see Annex 3).

2.2 Grade definitions

2.2.1 WHO has the following grade definitions:



Ungraded: an event that is being assessed, tracked or monitored by WHO but that requires no WHO response at the time.



Grade 1: a single or multiple country event with minimal public health consequences that requires a minimal WCO response or a minimal international WHO response. Organizational and/or external support required by the WCO is minimal. The provision of support to the WCO is coordinated by a focal point in the regional office.






Grade 2: a single or multiple country event with moderate public health consequences that requires a moderate WCO response and/or moderate international WHO response. Organizational and/or external support required by the WCO is moderate. An Emergency Support Team, run out of the regional office,⁶ coordinates the provision of support to the WCO.



Grade 3: a single or multiple country event with substantial public health consequences that requires a substantial WCO response and/or substantial international WHO response. Organizational and/or external support required by the WCO is substantial. An Emergency Support Team, run out of the regional office, coordinates the provision of support to the WCO.

⁶The Emergency Support Team is only run out of HQ if multiple regions are affected (see 4.3).

Type of support			
Technical	Remote technical assistance from international level	Time-limited missions; remote input to strategic plans; technical advice	In-country on-going technical assistance through surge; issuance of hazard-specific and country specific guidance
Financial	Minimal to none (handled with financial resources available at country level)	Access to regional WHO financial resources; international resource mobilization on request	Access to global and regional WHO financial resources; international resource mobilization and donor outreach
Human Resources	Minimal to none (handled with human resources available at country level)	Surge of emergency experts, as required	Surge team deployed on a no-regrets basis

2.3 Grading process

- 2.3.1 Grading occurs **within 24 hours** of completion of a risk assessment **for a sudden-onset** event, and **within five days** of an updated risk assessment **for a slow-onset** event.
- 2.3.2 A Grade 1 may be determined by the HWCO and regional office without convening the GEMT (with the expectation of minimal to no international support). A potential Grade 2 or Grade 3 emergency must be referred to the GEMT for grading.
- 2.3.3 Any member of the GEMT may convene a teleconference to grade an emergency. However, the relevant Directors at HQ who are part of the GEMT are ultimately responsible for convening a GEMT teleconference to consider (or reconsider) grading upon notification of the results of an event risk assessment.
- 2.3.4 If the event is considered to be a potential Grade 3 emergency, the Director General and WHO Regional Director of the affected region are invited to participate in the GEMT grading teleconference.

- 2.3.5 The GEMT determines the grade by reviewing the results of the event risk assessment (**scale, urgency** – see 1.3.1) and by considering the following additional criteria:⁷
- a. **complexity:** consider the range of health consequences, including potential downstream public health consequences, concurrent emergencies, unknown pathogen or chemical/toxin, specialized technical knowledge and skills required, presence of non-state actors or anti-government elements, problems of humanitarian access, issues of staff security, conflict, number of countries and regions involved; and
 - b. **context:** consider the level of health systems resources, population vulnerabilities, public perception, reputational risk, degree of panic, level of preparedness and capacities of national authorities, level of international capacities and readiness in-country (including those of WCO) to manage the emergency, and robustness of civil society coping mechanisms.
- 2.3.6 The grading decision takes effect immediately upon completion of the GEMT grading teleconference, at which time the ERPs are activated and the timeline to deliver on WHO's Performance Standards begins.
- 2.3.7 In the case of grading a slow-onset emergency, the GEMT, at the grading call, sets appropriate timeframes for delivery of the Performance Standards for that specific emergency.
- 2.3.8 The GEMT ensures that the grading decision is transmitted to the Regional Director in a Grade 2 and the Director General in a Grade 3.
- 2.3.9 The grading is announced officially throughout the Organization by e-mail from the Regional Director in a Grade 2 and the Director General in a Grade 3, within 24 hours of the grading.
- 2.3.10 The HWCO and relevant members of the GEMT continue to monitor the situation and revise the grade as the situation evolves and as more information becomes available from both internal and external sources.

⁷The criteria for the WHO grading process include the IHR (2005) criteria. While the IHR criteria are used by Member States to determine the need for event notification to WHO, WHO grading criteria are used internally to define the level of organizational support an event requires and to trigger specific WHO procedures.

2.4 Removal of grade

- 2.4.1 Eventually, the GEMT determines that the acute phase of the emergency has ended and an internal grade is no longer required. This is generally expected to happen within three months of the initial grading.
- 2.4.2 The removal of grade is announced by e-mail from the relevant Directors at HQ who are part of the GEMT.
- 2.4.3 In some cases, when an emergency situation appears likely to continue for more than six months, the GEMT may redefine the emergency as ‘protracted’ but decide to maintain WHO’s repurposed staffing structure and Organization-wide support structure. These decisions would be included in the e-mail that announces the removal of grade as described above in 2.4.2. In such a case, the GEMT would continue to review the situation on a three-monthly basis to make further decisions related to staffing structure and support.
- 2.4.4 In humanitarian situations where the Cluster Approach has been activated, and WHO removes the grade and thus deactivates the ERPs, the HWCO informs the Humanitarian Coordinator, other cluster lead agencies and Health Cluster partners about the consequent changes to WHO staffing and activities. The HWCO also discusses with the Member State(s) and partners about a possible deactivation and exit strategy of the Health Cluster and whether the recovery plan could be implemented with more traditional means of health sector coordination.
- 2.4.5 A grading flowchart can be found in Annex 1.

3

WHO's Performance Standards in emergency response

3.1 WHO's Performance Standards

3.1.1 To ensure an effective and timely health sector response to reduce mortality, life-threatening morbidity, and disability in the affected areas, with special attention to vulnerable and marginalized groups, and to assist the Member State, WHO will take the following action:

Within 12 hours

1. Designate the WHO emergency focal point and share contact details with relevant staff throughout the Organization.
2. Repurpose the WHO country office and/or other relevant offices, mobilizing its existing staff to form the Emergency Response Team (ERT), to initially perform WHO's four critical functions in emergency response, and to deliver on the first Performance Standards, until the emergency grade is removed, or until the staff are replaced by newly arriving (deployed) staff.

Within 48 hours

3. Ensure a continuous WHO presence at the site of the emergency and make initial contact with local authorities and partners (or as soon as access is possible).
4. Negotiate access and clearances with the government (where relevant) on behalf of health sector partners (and then on-going).
5. Make widely available the preliminary health sector analysis based on the most recent event risk assessment.
6. Compile and produce the first situation report (using a standard format), media brief and other communications and advocacy products relevant to the emergency.

Within 72 hours

7. Ensure the arrival in-country of a team of experienced professionals to reinforce or replace the repurposed WCO staff to fulfil WHO's four critical functions as part of WHO's Emergency Response Team (ERT). In a Grade 3, and possibly in a Grade 2, a Health Emergency Leader (HL)³ is deployed on a no-regrets basis to lead the ERT.
8. Establish and deliver emergency administrative, human resources, finance, grant management and logistics services (and then on-going).

³Pre-qualified, experienced staff deployed in grade 3 emergencies to lead the health sector response and WHO response activities.

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9. Establish health sector/cluster leadership and coordination; conduct a health sector/cluster meeting; update the 4W matrix (a database of who is doing what where and when), and plan next steps.
 10. Represent WHO and the health sector/cluster at meetings of the UN Country Team (UNCT),⁹ Humanitarian Country Team (HCT),¹⁰ inter-sector/cluster coordination and other relevant sectors/clusters (such as water/sanitation/hygiene, logistics and nutrition), (and then on-going).
 11. Use preliminary health sector analysis (see 5 above) to identify major health risks and health sector objectives and priorities for the first three months, including potential downstream public health consequences.
 12. Engage health sector partners to participate in a joint health assessment as part of a multisectoral process (see 21 below).

Within five days

13. Develop a flexible, short-term health sector response strategy and action plan, in collaboration with the Ministry of Health (MoH) and partners that addresses health needs, risks and capacities, with appropriate preventive and control interventions, for the first three months (and then review and update as required).

Within seven days

14. Develop, in collaboration with the MoH and partners, a funding appeal, if required (revise it at 30 days and as necessary thereafter).
15. Provide coordinated, specialized, international technical assistance as required, including logistics for implementation of prevention and control interventions (and then on-going).
16. Adapt/strengthen surveillance and early warning systems for diseases and other health consequences in the affected area (or ensure its establishment within 14 days), and produce the first weekly epidemiological bulletin.
17. Promote and monitor the application of national, and where applicable international, protocols, health standards, methodologies, tools and best practices (e.g. IHR, other WHO, Global Health Cluster, IASC, SPHERE¹¹), (and then on-going, as required).

⁹Composed of heads of UN agencies in a country.

¹⁰UNCT plus representatives of non-UN agencies including NGOs, and the Red Cross/Crescent movement.

¹¹Sphere Project: Humanitarian Charter and Minimum Standards in Humanitarian Response (SPHERE).

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18. Compile and produce a second situation report, media brief and other communications and advocacy products relevant to the emergency (and then on-going at least twice per week).
 19. Monitor and share relevant information for decision-making on health indicators, using appropriate parameters of measurement, (and then weekly).
 20. Monitor the response of the health sector and address gaps in implementation of prevention and control measures, service delivery and cluster leadership (and then weekly).

Within 15 days

21. Make widely available the results of the joint health assessment (see 12 above).

Within 60 days

22. Lead the health sector/cluster in conducting an in-depth health-specific assessment (after day 15 and before day 60).
23. Develop a health sector transition strategy from response to recovery, in collaboration with MoH and partners.

3.2 Application of WHO's Performance Standards

- 3.2.1 WHO's Performance Standards take effect upon grading an emergency.
- 3.2.2 These Performance Standards apply for all graded emergencies.
- 3.2.3 From the moment that WHO grades an emergency due to a sudden-onset event, WHO will deliver on the Performance Standards within respective timeframes described below.
- 3.2.4 From the moment that WHO grades an emergency due to a slow-onset event, WHO will deliver on the same Performance Standards, within emergency-specific timeframes designated by the GEMT at grading.
- 3.2.5 In some types of emergencies, an international WHO response may be required in the absence of a country-level response (a multi-country event involving, for example, scattered cases of a severe unknown respiratory illness, or where a country does not have a WCO). Such a response may involve the repurposing of staff in relevant

regional offices and headquarters, event assessment and information management, deployment of staff, development of international control strategies, provision of technical assistance, promotion of international standards, and issuance of reports and communications. In such a situation, these relevant Performance Standards would apply at the international level, on any graded emergency.

3.3 Reporting on Performance Standards

- 3.3.1 WHO is committed to reporting annually against its Performance Standards.
- 3.3.2 Internally, the relevant regional office tracks and reports on the implementation of the Performance Standards in each graded emergency, and explains any case where a specific performance standard was deemed unnecessary for a particular emergency.
- 3.3.3 For an IASC Level 3 emergency, WHO is committed to reporting to the Humanitarian Coordinator on its achievements against these Performance Standards, upon request.

4

WHO's four critical functions in emergency response

To deliver on its core commitments and Performance Standards, WHO must fulfil four critical functions in emergency response: leadership, information, technical expertise and core services.

4.1 The four critical functions

4.1.1 The four critical functions are listed below.

- **Leadership:** provide leadership and coordination of the health sector/cluster response in support of the national and local health authorities.
- **Information:** coordinate the collection, analysis and dissemination/communication of essential information on health risks, needs, health sector response, gaps and performance.
- **Technical expertise:** provide technical assistance appropriate to the health needs of the emergency (including the provision of health policy and strategy advice, promotion of expert technical guidelines, standards and protocols, best practices, and implementation/strengthening of disease surveillance and disease early warning systems); WHO will always work to ensure the provision of health services through partners and, as a last resort, will take measures to cover the critical gaps, for example through mobile clinics or other interventions.
- **Core services:** ensure logistics, office establishment, surge and human resources management, procurement and supply management, administration, finance and grant management.

4.2 Delivering on the four critical functions

4.2.1 Where a country-level response is required, the WHO country office is responsible for fulfilling these four critical functions, bringing in additional internal and external resources as required.

4.2.2 The country-level team that delivers the four critical functions is called the Emergency Response Team (ERT).

4.2.3 Depending on the situation, one or more staff or even teams may be required against each of the four critical functions, both in the WCO and in sub-offices.

4.2.4 The ERT is normally led by the HWCO. However in Grade 3 emergencies, and sometimes in Grade 2 emergencies, an experienced and pre-qualified Health Emergency Leader is deployed to run the ERT, in support of the HWCO (see the Health Emergency Leader policy in 6.2).

4.2.5 The ERT is composed of repurposed WCO staff and, if required, additional deployed experts from stand-by surge teams with expertise in the four critical functions.

4.3 Support to the four critical functions from the international level in emergencies

4.3.1 At the international level, for Grade 2 and 3 emergencies, WHO establishes an Emergency Support Team (EST) to back-stop the ERT in performing the four critical functions.

4.3.2 Where an international response is required in the absence of a WCO, the EST itself delivers on WHO's four critical functions (see 3.2.5).

4.3.3 The EST (1) provides technical support for the four critical functions; (2) mobilizes and deploys emergency experts; (3) leads international communications with partners, donors and media; (4) leads international resource mobilization efforts; and (5) manages grants that come through the regional office or HQ.

4.3.4 The EST is led by a senior Emergency Support Team Leader (ESTL) who will be physically based at the regional office in a single-region emergency and at HQ in a multi-region emergency.

4.3.5 The ESTL is supported by an Emergency Support Team Coordinator (ESTC) who manages the day-to-day workings and communication flow of the EST.

4.3.6 In a Grade 3 that affects only one region, where the EST is at the regional office, the EST members who are based at HQ are similarly coordinated by an ESTC at HQ level.

4.3.7 In a Grade 3 that affects multiple regions, where the EST is at HQ, the EST members who are based at the regional offices are similarly coordinated by an ESTC at regional office level.

5.1 The purpose and composition of the GEMT

- 5.1.1 The Global Emergency Management Team was established in late 2011 to lead the planning, management, implementation, monitoring and evaluation of WHO's emergency work including national preparedness, institutional readiness and emergency response for any hazard with public health consequences.
- 5.1.2 The GEMT is composed of the relevant headquarters and regional office Directors (or their delegates) responsible for all-hazards emergency risk management, including preparedness, surveillance, alert and response, as well as any Directors overseeing hazard-specific work on epidemic-prone diseases, natural disasters and conflict, zoonoses, food safety, and chemical and radio nuclear hazards. Other relevant headquarters, regional and country office representatives may be invited to join the discussion of the GEMT, as required.
- 5.1.3 The expertise of the GEMT is all-hazards emergency risk management. The GEMT also has expertise in Health Cluster leadership and in the specific hazards mentioned above. For technical expertise on other specific areas, the GEMT seeks the advice of the Global Emergency Network (GEN). The GEN is comprised of Directors (or delegates) of departments and programmes with a role in the emergency work of the Organization, e.g. reproductive health, maternal, newborn, child and adolescent health, communicable diseases, non-communicable diseases, water and sanitation, environmental health, mental health, health systems, pharmaceuticals, etc.

5.2 The role of the GEMT in emergency response

- 5.2.1 During an emergency, a subset of the GEMT, known as the GEMT-Response (GEMT-R), comes together to grade and manage the response to a specific emergency.
- 5.2.2 The GEMT-R is composed of the relevant HQ and regional office Directors (or delegates), and the HWCO and/or Health Emergency Leader, if applicable.
- 5.2.3 For Grade 2 or 3 emergencies, based on on-going monitoring, the GEMT-R is responsible for making recommendations to executive management related to the

required **repurposing** of staff and resources at the country, regional and headquarters levels, to ensure that WHO has the most appropriate emergency managers and technical experts at the site of an emergency in the Emergency Response Team, and in the international Emergency Support Team.

5.2.4 The GEMT-R is responsible for making recommendations to executive management on the **best use of WHO resources**, taking into account the extent, duration and complexity of the support required and any other events that draw on the same limited Organization-wide resources.

5.2.5 The GEMT-R is responsible for ensuring the **application** of the following standards, procedures and policies:

- WHO's Performance Standards in emergency response (see part 3);
- the emergency Standard Operating Procedures (SOPs);
- the policies of surge, Health Emergency Leader, and no-regrets (see part 6);
- the Emergency Response Procedures (ERPs) (see part 7); and
- expedited clearance and dissemination of internal and external communications.

5.2.6 The GEMT-R is responsible for ensuring that **communications** are fast, reliable and unencumbered by extended clearance procedures. Where there is the potential for substantial risk to public health, the GEMT-R ensures available information is rapidly shared both internally and externally, and that on-going and regular communication occurs as new information becomes available.

5.2.7 The broader GEMT is also responsible for continuous **tracking** of all global events and the Organization-wide use of internal and external resources in all emergencies.

5.2.8 The GEMT produces an **annual report** on all graded emergencies. The report describes each grading process, the justification for each grade, performance against standards, and the application of the Emergency Response Procedures and Standard Operating Procedures in each graded emergency.

6

Essential policies for optimizing WHO's emergency response

The application of three policies is essential to optimize WHO's response to Grade 2 and 3 emergencies by ensuring the rapid deployment of appropriate staff and resources with the full support of the Organization.

6.1 Surge policy

6.1.1 WHO mobilizes and rapidly deploys (surges) experienced professionals to join the WCO as part of the Emergency Response Team (ERT) to perform WHO's four critical functions in emergency response, as required. This is accomplished using an Organization-wide, interregional surge mechanism consisting of qualified staff from throughout WHO's programmes worldwide as well as from partner organizations.

6.1.2 Recognizing the challenges of meeting surge requirements, WHO follows a two-phased human resources surge process over three months. Prior to this surge, the WCO first repurposes existing WCO staff to form the initial ERT, and then identifies any remaining surge needs to complete the ERT. After the three months of surge, the WCO and regional office ensure longer term staffing, as required.

6.1.3 In phase 1 (start-up: Surge Team 1), within 72 hours of grading, WHO surges pre-identified, trained and experienced professionals primarily from across the Organization on a no-regrets basis.

6.1.4 Surge Team 1 (ST1) members complement or replace existing WCO staff members who were repurposed for the response, both in the capital city, and in any WHO sub-office at the site of the emergency. Both ST1 and the repurposed WCO staff make up the ERT that works to deliver on WHO's four critical functions in emergency response. ST1 members are expected to work in the WCO for a minimum of three weeks and a maximum of four weeks. In Grade 3, and potentially in Grade 2 emergencies, a Health Emergency Leader (HL) is deployed to run the ERT (see 6.2 below). The HL is expected to work in the WCO for a minimum of eight weeks. Key positions for possible deployment in ST1 include a Health Emergency Leader (HL), a WHO Response Coordinator (WRC), a Health Sector/Cluster Coordinator (HCC), a Public Health Adviser, an Information Officer, an Epidemiologist, a Data Manager, a Communications Officer and a Logistician.

6.1.5 In phase 2 (reinforcement/replacement: Surge Team 2), within two weeks from grading, WHO provides additional surge staff, from within WHO, the Global Outbreak Alert and Response Network (GOARN), or Global Health Cluster partners or other entities holding pre-signed Letters of Understanding or Stand-By Agreements, to strengthen

or replace the existing ERT in the WCO and on-site sub-offices. Surge Team 2 (ST2) members are expected to work for a minimum of six weeks and a maximum of eight weeks, including a one week overlap if replacing any outgoing members of the ERT. Depending on the duration of these assignments, this phase may require progressive deployments to ensure full coverage of the four critical functions for the initial 12 weeks after grading.

- 6.1.6 By the end of the twelfth week from grading, the regional office ensures the longer term replacement, as required, of surge team members (WCO staffing-up). All surge team members are removed and all WCO repurposed staff revert to previous activities by the end of the third month, unless special arrangements are made by the RO. Longer-term staff are expected to have a one week overlap with outgoing surge staff or reverting WCO staff.
- 6.1.7 Surged individuals are fully supported by the WCO and RO to work, to be mobile, to communicate and to be safely housed. They are further supported by the Emergency Response Procedures, the emergency Standard Operating Procedures and pre-agreed job descriptions. Before deployment, they are provided with training and basic equipment.
- 6.1.8 WHO provides incentives for staff to volunteer to be part of surge. All WHO staff across the Organization and across the technical programmes with relevant expertise are expected to be part of an on-call surge team at least once a biennium.

6.2 Health Emergency Leader policy

- 6.2.1 In Grade 1 and most Grade 2 emergencies, the Emergency Response Team (ERT) is led by the HWCO (see 4.2.4). In Grade 3 emergencies, and sometimes in Grade 2 emergencies, an experienced and pre-qualified Health Emergency Leader (HL) is deployed within 72 hours on a no-regrets basis to run the ERT, in support of the HWCO.
- 6.2.2 The HL is directly responsible for all staff involved in the emergency, including existing WCO staff who are repurposed to work on the emergency as well as those deployed to the WCO through surge. The HL supervises both the Health Sector/Cluster Coordinator (HCC) and the WHO Response Coordinator (WRC), who run the day-to-day work of the ERT to fulfil WHO's Performance Standards.

- 6.2.3 The HL is drawn from a pool of pre-qualified and experienced individuals from country offices, regional offices and headquarters who have successfully performed leadership and management functions as described in the Emergency Response Procedures (see part 7) during major emergencies (as evaluated by both WHO and the relevant Humanitarian Coordinators), have undertaken refresher training on best practices in emergencies, know WHO's ERF and the IHR (2005), and understand IASC approaches and processes, including the Cluster Approach and Transformative Agenda.
- 6.2.4 As head of the ERT, the HL is accountable to the RD through the HWCO, and in the case of an IASC Level 3 humanitarian emergency, the HL is also accountable to the empowered Humanitarian Coordinator. The HL represents WHO and the Health Cluster on the Humanitarian Country Team (HCT) while the HWCO continues to represent WHO on the UN Country Team (UNCT).
- 6.2.5 The HL has delegation of authority and approval level for all expenditures of Outbreak and Crisis Response (OCR) funding related to the emergency, and any other funding made available by the WCO.
- 6.2.6 Before deployment, the HL has the pre-agreed support of his/her supervisor to be absent from his/her regular post for the minimum eight week deployment period.
- 6.2.7 In very unique or exceptional circumstances,¹² the DG and RD may decide to designate the HL to serve as the HWCO in place of the incumbent HWCO. In these cases, a communication to the corresponding national authorities, including the CV of the selected person, will be issued.

6.3 No-regrets policy

- 6.3.1 At the onset of all emergencies, WHO ensures that predictable levels of staff and funds are made available to the WCO, 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 the critical functions rather than risk failure by under-resourcing.

¹² These include: a sudden and profound disruption of in-country operations, serious health issues, personal security concerns, and/or a clear absence of expertise, placing WHO's life-saving operations at serious risk.

6.3.2 In terms of human resources, this policy facilitates the successful implementation of the surge policy and the Health Emergency Leader policy.

6.3.3 In terms of financial resources, this policy provides the Health Emergency Leader with the authority to spend up to US\$500 000 without having to obtain the normal WHO programmatic approvals in advance of expenditure. The financial procedures for accountability and documentation remain in place, as per the emergency Standard Operating Procedures. The US\$500 000 is drawn from either the regional office's rapid response accounts or headquarters' rapid response account, and is replenished as OCR funds are raised for the emergency. This no-regrets policy applies to any expenditure incurred during the first three months of the response.

7

WHO's Emergency Response Procedures

WHO's Emergency Response Procedures are described in the following tables. They define expected outputs from each level of the Organization, by WHO's four critical functions, with concrete deliverables and timelines.

LEADERSHIP

WHO's Emergency Response Procedures

Includes WCO positions: Health Emergency Leader, Health Cluster/Sector Coordinator, WHO Response Coordinator, External/Donor Relations Officer

Performance Standards (timeline as of grading)	Organizational support	
WHO Country Office	Regional Office	Headquarters
Within 12 hours		
PS 1: Designate the WHO emergency focal point and share contact details with relevant staff throughout the Organization.	Identify the RO focal point and share contact details throughout the Organization.	Identify HQ focal point and share contact details throughout the Organization (Grade 2 and 3).
PS 2: Repurpose the WHO country office and/or other relevant offices, mobilizing existing staff to form the Emergency Response Team (ERT) to initially perform WHO's four critical functions in emergency response and to deliver on the first Performance Standards, until the emergency grade is removed, or until the staff are replaced by newly arriving (deployed) staff.	For Grades 2 and 3, repurpose the RO to establish the inter-departmental Emergency Support Team, and identify its leader and coordinator. Provide WCO with a standard organizational chart for ERT and guidance for WCO repurposing.	For Grades 2 and 3, repurpose HQ as required to ensure expert technical back-up support to the EST on the four critical functions; identify the HQ ESTC to lead coordinated HQ support to the EST; mobilize and deploy HQ staff to RO to reinforce EST as required; activate the SHOC room, as required.
Based on the standard organizational chart for the ERT, request that the RO deploy needed members of the on-call surge team to reinforce the ERT.	Respond to WCO requests for support; liaise with HQ for back-up support. Begin administrative and travel arrangements to deploy surge team members.	Respond to RO requests for support. Prepare for possible deployment of HQ staff to RO as part of EST. Prepare for possible deployment of HQ surge team members to WCO as part of ERT.
Within 48 hours		
PS 3: Ensure continuous WHO presence at the site of the emergency and make initial contact with local authorities and partners.	Monitor the situation, the overall health sector response and the WHO response (using information from WCO, media reports, inputs from other regional institutions and sources, and other intelligence-gathering techniques).	Back-up support. Monitoring of global response with information from global institutions, agencies, partners and media.
PS 4: Negotiate access and clearances with government, where relevant, on behalf of health sector partners. HWCO has initial meeting with UNCT/HCT to contribute to decision-making and priority setting, including whether Cluster Approach is activated.	Back-up advocacy with relevant regional bodies or institutions.	Back-up advocacy with relevant global bodies, institutions, embassies. Represent WHO and Health Cluster at the meeting of IASC principles to determine emergency level.

LEADERSHIP

WHO's Emergency Response Procedures

Performance Standards (timeline as of grading)	Organizational support	
WHO Country Office	Regional Office	Headquarters
Within 72 hours		
<p>PS 7: Ensure the arrival in-country of a team of experienced professionals to reinforce or replace the repurposed WCO staff to fulfil WHO's four critical functions as part of the ERT.</p>	<p>Ensure the arrival in-country of a team of experienced professionals to reinforce or replace the ERT.</p> <p>In a Grade 3, and in some Grade 2, ensure the arrival in-country of a Health Emergency Leader to lead the ERT.</p>	<p>Back-up support.</p>
<p>PS 9: Establish health sector/cluster leadership and coordination; conduct a health sector/cluster meeting; and plan next steps.</p>	<p>For Grade 2 and 3, lead teleconference with global health partners (including GHC).</p> <p>Provide ERT with copies of the Health Cluster Guide and other relevant guidance.</p>	<p>For Grade 2 and 3, organize teleconference with global health partners (including GHC).</p>
<p>PS 10: Represent WHO and the health sector/cluster at meetings of the UN Country Team, Humanitarian Country Team, inter-sector/cluster coordination and other relevant sectors/clusters, e.g. water/sanitation/hygiene, logistics and nutrition.</p> <p>Present urgent health sector budget to Humanitarian Coordinator for initial CERF funding.</p>	<p>Provide technical support on IASC and GHC policy and guidance.</p> <p>Support with analysis, priority setting and technical advice.</p>	<p>Back-up support.</p>
Within 5 days		
<p>PS 13: Coordinate overall development of a flexible, short-term health sector response strategy and action plan, in collaboration with the MoH and partners, that addresses health needs, risks and capacities, with appropriate preventive and control interventions, for the first three months (and then review and update as required).</p>	<p>Support with logical framework, technical input, writing, editing, budgeting; ensure conformity with WHO rules and regulations,</p>	<p>Back-up support.</p>
Within 7 days		
<p>PS 14: Coordinate overall development of a funding appeal, if required, in collaboration with the MoH and partners.</p> <p>Conduct resource mobilization and advocacy; keep donors informed of health concerns through inter-agency and bilateral meetings; actively seek opportunities for local fund raising; ensure full implementation and reporting on funds received.</p>	<p>Ensure conformity with WHO rules and regulations and with donor specifications.</p> <p>Actively seek opportunities for regional fund raising; for Grades 2 and 3, conduct regional donor meeting to present the strategy, action plan and appeal.</p>	<p>Back-up support; final edits to related appeals and proposals to ensure global donor specifications are addressed</p> <p>Actively seek opportunities for global fund raising; for Grades 2 and 3, produce and disseminate donor brief and advocacy materials; for Grade 3, hold global donor meeting to present strategy, action plan and appeal; negotiate contribution agreements.</p>
<p>PS 20: Monitor the response of the health sector and address gaps in implementation of prevention and control measures, service delivery and cluster leadership (then weekly).</p>	<p>Provide monitoring tools, technical support and analysis as required.</p>	<p>Back-up support.</p>

LEADERSHIP

WHO's Emergency Response Procedures

Performance Standards (timeline as of grading)	Organizational support	
WHO Country Office	Regional Office	Headquarters
Within 60 days		
Prepare for arrival of Surge Team 2 members; arrange for their in-country transport, communications, housing and office space; within 21 days.	Ensure the arrival in-country of Surge Team 2 members to reinforce or replace Surge Team 1 team members.	Back-up support.
Revise, in collaboration with MoH and partners, the funding appeal, within 30 days and as necessary thereafter.	Support, as required.	Back-up support.
Prepare for arrival of longer term staff, as required.	Finalize longer term staffing, as required.	
PS 23: Coordinate overall development of a health sector transition strategy from response to recovery, in collaboration with MoH and partners.	Support with logical framework, technical input, writing, editing and budgeting.	Back-up support.
After removal of grade		
Advise HCT and Health Cluster of consequent changes to WCO staffing and activities.	Conduct evaluation mission.	Support evaluation mission.

INFORMATION

WHO's Emergency Response Procedures

Includes WCO positions: Assessment Officer, Data Analyst (Epidemiologist), Information Officer, Writer/Editor, Communication/Media Officer

Performance Standards (timeline as of grading)	Organizational support	
WHO Country Office	Regional Office	Headquarters
Within 24 hours		
Ensure that relevant information is shared with the international community for appropriate action.	Establish and lead all communications between WCO, RO and HQ; establish mechanism for information sharing; web sites, share point, e-mail and contact lists; provide meeting summaries and action points of all internal meetings (on-going). Expedite clearance and dissemination processes of all internal and external communications (on-going).	For Grade 3, the WHO Department of Communications (DCO) conducts all media relations and all external communications and briefings, unless delegated otherwise.
Within 48 hours		
Hold first media interview at the site of the emergency and be visible (on-going).		
Enter any new information into WHO's Event Management System (EMS) (on-going).		
PS 5: Make widely available the preliminary health sector analysis based on the most recent event risk assessment.	Support, as required.	Back-up support.
PS 6: Compile and produce the first situation report (using a standard format), media brief and other communications and advocacy products relevant to the emergency.	Quality control and editing; disseminate information to regional partners and relevant RO staff.	Back-up support; disseminate information to global donors, partners, media, relevant HQ staff, including wwDGO.
Within 72 hours		
PS 9: Update the 4W matrix (a database of who does what, where and when).	Provide the tool and technical support.	Back-up support.
PS 12: Engage health sector partners to participate in a joint health assessment as part of a multisectoral process (also see PS 21).	Technical support; disseminate results to regional partners and relevant RO staff.	Disseminate results to global donors, partners and relevant HQ staff, including DGO.

INFORMATION

WHO's Emergency Response Procedures

Performance Standards (timeline as of grading)	Organizational support	
	WHO Country Office	Regional Office
Within 7 days		
PS 18: Compile and produce a second situation report, media brief and other communications and advocacy products relevant to the emergency (and then at least twice per week).	Quality control and editing; disseminate information to regional partners and relevant RO staff.	Back-up support; disseminate information to global donors, partners, media, relevant HQ staff, including DGO.
PS 19: Monitor and share relevant information for decision-making on health indicators, using appropriate parameters of measurement.		
Within 15 days		
PS 21: Make widely available the results of the joint health assessment (also see PS 12).	Disseminate regionally.	Disseminate globally.
Within 60 days		
PS 22: Lead the health sector/cluster in conducting an in-depth health-specific assessment (after day 15 and before day 60).	Provide methodologies, tools and technical support.	Back-up support.

TECHNICAL EXPERTISE

WHO's Emergency Response Procedures

Includes WCO positions: Public Health Officer for Strategic Planning in Emergency Settings, Surveillance Officer, other technical experts as relevant (infection control, laboratory, clinical, vector control, behavioural/social interventions, water and sanitation, specific diseases experts, specialized logistics experts for implementation of infection control and bio-hazard management, cold chain, vaccination, etc.)

Performance Standards (timeline as of grading)	Organizational support	
WHO Country Office	Regional Office	Headquarters
Within 72 hours		
PS 11: Use preliminary health sector analysis (see PS 5) to identify major health risks and health sector objectives and priorities for the first three months, including potential downstream public health consequences.	Provide coordinated technical input from relevant departments (and in Grade 2 or 3, provide through the EST).	Provide coordinated technical input from relevant departments (and in Grade 2 or 3, provide through the EST).
Within 5 days		
PS 13: Develop a flexible, short-term health sector response strategy and action plan, in collaboration with the MoH and partners, that addresses health needs and risks and capacities, with appropriate preventive and control interventions, for the first three months.	Provide coordinated technical input from relevant departments (and in Grade 2 or 3, provide through the EST).	Provide coordinated technical input from relevant departments (and in Grade 2 or 3, provide through the EST).
Within 7 days		
PS 15: Provide coordinated, specialized, international technical assistance as required, including logistics for implementation of prevention and control interventions (then on-going)	Provide coordinated technical input from relevant departments (and in Grade 2 or 3, provide through the EST).	Provide coordinated technical input from relevant departments (and in Grade 2 or 3, provide through the EST).
PS 16: Adapt/strengthen surveillance and early warning systems for diseases and other health consequences in the affected area (or ensure its establishment within 14 days), and produce first weekly epidemiological bulletin.	Provide coordinated technical input from relevant departments (and in Grade 2 or 3, provide through the EST).	Provide coordinated technical input from relevant departments (and in Grade 2 or 3, provide through the EST).
PS 17: Promote and monitor the application of national, and where applicable international, protocols, health standards, methodologies, and tools and best practices (e.g. IHR, other WHO, GHC, IASC, SPHERE).	Provide coordinated technical input from relevant departments (and in Grade 2 or 3, provide through the EST).	Provide coordinated technical input from relevant departments (and in Grade 2 or 3, provide through the EST).
Within 60 days		
PS 23: Develop a health sector transition strategy from response to recovery, in collaboration with MoH and partners.	Provide coordinated technical input from relevant departments (and in Grade 2 or 3, provide through the EST).	Provide coordinated technical input from relevant departments (and in Grade 2 or 3, provide through the EST).

CORE SERVICES

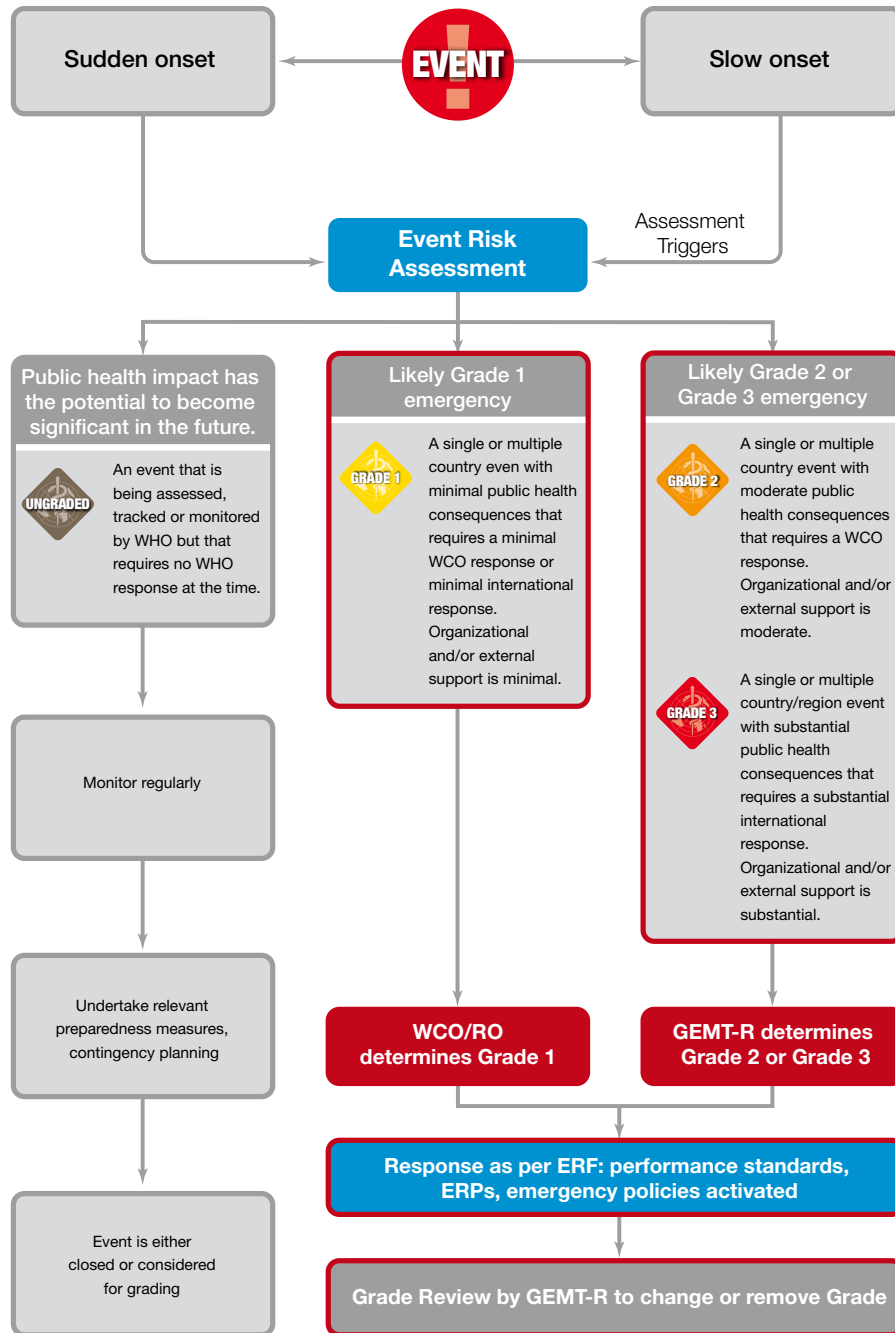
WHO's Emergency Response Procedures

Includes WCO positions: Administrative Officer, Human Resources in Emergencies Officer, Senior Logistics Officer for Emergency Settings, Finance and Grant Management Officer for Emergency Settings, IT Officer, Security Officer

Performance Standards (timeline as of grading)	Organizational support	
WHO Country Office	Regional Office	Headquarters
Within 72 hours		
PS 7: Provide all administrative support to ensure the arrival in-country of a team of experienced professionals to reinforce or replace the repurposed WCO staff to fulfill WHO's four critical functions as part of the ERT.	Administrative support for contracts/travel.	Back-up administrative support for deployments from HQ and global partners/consultants.
PS 8: Establish and deliver emergency administrative, human resources, grant management and logistics services.	Deployment of surge team.	Back-up surge support with global partners/consultants.
	Deployment of supplies from regional stockpiles, if provision of supplies is identified as a priority intervention.	Back-up deployment of global stockpiles.
	Deployment of regional emergency funds and/or advice on reprogramming of existing WCO funds.	Back-up deployment of HQ emergency funds.
	Technical support on implementation of SOPs.	Back-up support on SOPs.
	Manage grants that pass through RO, and ensure timely reporting.	Manage grants that pass through HQ, and ensure timely reporting.
	EST members negotiate contribution agreements; initiate awards; negotiate details of award including no-cost extensions, reallocation of funds, waivers of rules; track pledges and funds received; oversee the management and reporting on awards to donors; produce financial reports, and deliver reports to donors on time.	Back-up support.
Authorize Health Emergency Leader (HL) to approve expenditures up to US\$500 000 for immediate costs related to the response, to extent required, supported by the SOP delegation of authority.	Approve allocation of the US\$500 000 to HL from the RO rapid response account.	If required as back-up to RO, approve allocation of the US\$500 000 to HL from the HQ rapid response account.

ANNEX 1

ERF grading flowchart



ANNEX 2

Country-level timeline for response

WHO performance standards (PS)		IASC processes			
Day 1	PS 1: Designate the WHO emergency focal point and share contact details. PS 2: Repurpose the WHO Country Office and/or relevant offices.	Decision on cluster activation	Initial sector analysis and preliminary scenario definition (PSD)		
Day 2	PS 3: Ensure a continuous presence at the site of the emergency and make initial contact with local authorities and partners. PS 4: Negotiate access and clearances with government, where relevant, on behalf of health sector partners. PS 5: Make widely available the preliminary health sector analysis based on the most recent event risk assessment. PS 6: Compile and produce the first situation report, media brief and other communications and advocacy products.				
Day 3	PS 7: Ensure the arrival in-country of a team of experienced professionals to reinforce or replace the repurposed WCO staff. PS 8: Establish and deliver emergency administrative, human resources, finance, grant management and logistics services. PS 9: Establish health sector/cluster leadership and coordination; conduct a health sector/cluster meeting; update the 4W matrix. PS 10: Represent WHO and the health sector/cluster at meetings of the UN Country Team (UNCT), Humanitarian Country Team (HCT), inter-sector/cluster coordination and other relevant sectors/clusters. PS 11: Use preliminary health sector analysis to identify major health risks and health sector objectives and priorities. PS 12: Engage health sector partners to participate in a joint health assessment as part of a multisectoral process.	Inter-agency rapid assessment	Initial strategic plan	Initial CERF allocation	
Day 5	PS 13: Develop a flexible, short-term health sector response strategy and action plan.				
Day 7	PS 14: Develop a funding appeal. PS 15: Provide technical assistance. PS 16: Adapt/strengthen a surveillance and early warning system and produce the first weekly epidemiological bulletin. PS 17: Promote and monitor the application of protocols, health standards, methodologies, tools and best practices. PS 18: Compile and produce a second situation report, media brief and other communications and advocacy products. PS 19: Monitor and share relevant information for decision-making on health indicators, using appropriate parameters or measurement. PS 20: Monitor the response of the health sector and address gaps.				
Day 15	PS 21: Make widely available the results of the joint health assessment.	Assessment report			
Day 20			Revised Strategic plan		
Day 30					
Day 60	PS 22: Lead the health sector/cluster in conducting an in-depth health specific assessment. PS 23: Develop a health sector transition strategy from response recovery.	In-depth sectoral assessment	Health sector transition strategy	2nd CERF and revised Flash Appeal	
Day 90					

ANNEX 3

WHO's obligations under an IASC Level 3 emergency

The designation of an IASC Level 3 (L3) emergency, in consultation with the IASC Principals, is issued by the Emergency Relief Coordinator (ERC), on the basis of an analysis of five criteria: scale, complexity, urgency, capacity, and reputational risk.

An IASC L3 activation implies:

- a. establishment of the Humanitarian Country Team, with the current Resident Coordinator (RC) assigned as Humanitarian Coordinator (HC) ad interim, pending a decision on the most appropriate leadership model;
- b. deployment of a senior/emergency HC within 72 hours, if required, to support existing leadership at country level;
- c. activation of 'empowered leadership', where the HC has increased authority over the allocation of resources, planning and priority setting, activation of clusters, and advocacy;
- d. deployment by each agency of a core team of pre-identified and experienced staff on a no-regrets basis to ensure cluster leadership, coordination, assessment, strategic planning and other context-specific capacities, with the following time-bound deliverables: multisector initial rapid assessment, particularly the Preliminary Scenario Definition within 72 hours; elaboration of a strategic statement on which basis the initial Central Emergency Response Fund (CERF) is allocated by the ERC within 72 hours; elaboration of a strategic plan within five days to guide a funding appeal and individual cluster response and monitoring; and
- e. that IASC member organizations put in place appropriate systems and mobilize sufficient resources to fulfil these requirements and to fulfil their responsibilities as cluster lead agencies and cluster partners in alignment with the country level strategic statement.

An IASC L3 does not affect:

- a. the ability of IASC member organizations to decide on activation of their respective major emergency mechanisms and procedures, nor the manner in which those would be applied.

As per the ERF, following the activation of an IASC L3, WHO will:

- a. deploy a Surge Team (ST1) on a no-regrets basis to ensure that dedicated cluster coordination, assessment, information management, strategic planning, and other context-specific technical capacities are fulfilled;
- b. participate in the HCT;
- c. report to the HC against pre-agreed Performance Standards upon request;
- d. participate in multisectoral initial rapid assessment and contribute to the intersectoral preliminary scenario definition (PSD) within 72 hours;
- e. develop the health sector component of the strategic statement within 72 hours, laying out health sector priorities and a common strategic approach for the initial CERF allocation;
- f. develop the health sector component of the initial strategic plan within five days;
- g. develop the health sector component of the appeal within 7–10 days; and
- h. lead and coordinate the Health Cluster and facilitate and monitor the Health Cluster response within the framework of the strategic plan.

ANNEX 4

WHO's Performance Standards in protracted emergencies

In countries with protracted emergencies, where mortality rates appear to have stabilized, to increase access to basic needs and predictable service delivery to reduce mortality and morbidity, WHO will:

- a. provide policy advice and technical expertise to health authorities and partners to establish and implement a programme of work to respond to the emergency that links to appropriate development mechanisms (e.g. United Nations Development Assistance Framework – UNDAF), continually;
- b. produce the health component of a common humanitarian action plan and funding appeal, annually;
- c. compile and produce situation reports, media briefs and other communications products relevant to the emergency, quarterly;
- d. promote and monitor the application of national and, where necessary, international, protocols, health standards, methodologies, tools and best practices, continually;
- e. monitor and share relevant information for decision-making on health indicators, the response of the health sector, cluster leadership performance and health response funding, and formally assess and find solutions to gaps in the implementation of activities, service delivery and cluster leadership, at least annually;
- f. integrate a programme of work for emergency response into its Country Cooperation Strategy (CCS), every 5 years; and
- g. advocate for health as a priority sector for the response, continually.

ANNEX 5

WHO's commitment to institutional readiness

WHO is committed to implementing a programme of institutional readiness across the Organization based on the Emergency Response Framework, its commitments, Performance Standards, response procedures and four critical functions, and to ensure that WHO country offices are fit to respond to acute and protracted emergencies with public health consequences.

ANNEX 6

WHO's commitment to emergency risk management

In all countries throughout the world (focusing on those with the highest risk and lowest capacities), WHO is committed to providing technical cooperation to strengthen national and sub-national health emergency risk management programmes and capacities.



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