

INTER-AGENCY STANDING COMMITTEE
REFERENCE DOCUMENT

Level 3 (L3) Activation Procedures for Infectious Disease Events

This reference document has been endorsed by the IASC Principals

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I Definitions

In addition to major humanitarian crises triggered by natural disasters or conflicts, infectious disease events¹, including outbreaks, can result in an IASC *Level 3 Activation*² (i.e. 'L3 activation') to ensure a more effective response.

L3 activation procedures for infectious disease events build on the existing IASC L3 procedures, with adjustments to reflect the potential evolution of an infectious event, the roles of the World Health Organization (WHO) and its Director-General and Member States under the *International Health Regulations (2005)*, and the importance of non-IASC organizations in responding to infectious disease events. These procedures also recognize that many infectious hazards are of animal origin, with the response incorporating a 'One Health'³ approach when needed.

This paper outlines the IASC procedures for the assessment of infectious disease events, the consultation and decision making processes on L3 activation for such events, the activation and deactivation criteria and procedures, and implications for IASC members and other collaborating organizations.⁴

In summary, the designation of an L3 response to an infectious disease event will be issued by the Emergency Relief Coordinator (ERC) on the recommendation of the Director-General of WHO and in consultation with IASC Principals and, potentially, Principals of other relevant entities (see 'Invited Principals' below). For infectious disease events, the designation of an L3 response may be on the basis of an analysis of the IASC's 5 criteria (see Annex 1) *or* on the basis of the scale and urgency of a response needed to *prevent* a crisis. In keeping with the IASC's existing procedures, the initial L3 activation period should not exceed 3 months.

¹ Any event due to an infectious hazard that may have negative consequences for human health, including by exposure to infected or contaminated food, water, animals, manufactured products or environments.

² See IASC Transformative Agenda Reference Document '*Humanitarian System-Wide Emergency Activation: definition and procedures*' (April 2012).

³ A multisectoral, multidisciplinary approach with expertise from public, animal and environmental health that is promoted by the WHO, FAO, OIE tripartite collaboration.

⁴ A single, consolidated L3 activation protocol covering acute and slow-onset natural disasters, conflicts and infectious disease events, and reflecting lessons learned will be developed as part of the review of the Humanitarian Programme Cycle Reference Module.

II Main Steps in the Procedure

During the period of assessment and decision-making by the IASC Principals regarding L3 activation, the response at country level is already underway. This analysis should not in any way delay the response to the infectious disease event and implementation of outbreak control measures, and, where necessary, the provision of humanitarian assistance, as rapidly as possible.

2.1 Assessing the situation

Under the *IHR (2005)*, WHO assesses the risks associated with infectious disease events⁵ on an ongoing basis, consulting as necessary with the relevant Governments, Country Offices, Unicef and partner agencies, including FAO and the World Organization for Animal Health (OIE) in the context of zoonotic diseases and potential zoonotic events that may require a large-scale response in animals. The risk posed by a specific infectious event is assessed using a standardized approach that evaluates the potential mortality, morbidity, amplification and national/international spread associated with the underlying hazard, the potential broader secondary effects, the exposure, and the local vulnerability and capacities (e.g. hygiene and sanitation, behavioural practices, and strength of the health system including specialized capacities such as laboratories and diagnostics). All infectious disease events that WHO classifies internally as a Grade 2 or 3 emergency⁶, or that WHO assesses to be high or very high risk, are informed by the WHO Director-General to the United Nations Secretary-General and the ERC within 72 hours of detection by or reporting to WHO⁷.

WHO's initial assessment to the ERC will reflect:

- consultations with the national Ministry(ies) of Health and/or other national sources (e.g. Ministries of water/sanitation, environment and, for a zoonotic disease, agriculture and livestock) in the affected country(ies) and, if appropriate, neighbouring countries;
- consultations with relevant IASC and non-IASC entities such as national and international public health agencies and centres for disease control, the Global Outbreak Alert and Response Network (GOARN), infectious disease technical expert and laboratory networks, Global Health Cluster partners, international NGOs (e.g. MSF) academic institutions with expertise in the relevant hazard, and, in the case of zoonotic diseases, OIE;
- lessons learned and experience from previous such infectious events when available.

As soon as possible, but no longer than within 18 hours of receiving WHO's assessment and in keeping with current L3 practice, OCHA will complement the WHO assessment with:

- perspectives of the Humanitarian Country Team (HCT) or, where the Humanitarian Coordinator (HC) function is not activated, the UN Country Team (UNCT) via the Resident Coordinator (RC), on the potential scale and impact of the event, including the risks of wider, secondary impact(s) and further national and international spread;

⁵ The *IHR* define an event as 'a manifestation of disease or an occurrence that creates a potential for disease'.

⁶ WHO grades emergencies based on the 5 IASC criteria. A WHO Grade 2 event has moderate to high public health consequences, requiring substantive support from WHO and partners; a WHO Grade 3 event has high to very consequences, requiring organization-wide mobilization and support from WHO and partners.

⁷ Consistent with the Annex 2 of the *IHR (2005)*, and/or the World Bank's Pandemic Emergency Financing Facility (PEF), events which may trigger immediate notification to the SG and ERC include human influenza caused by a new subtype, certain coronaviruses (e.g. SARS), certain filoviruses (e.g. Ebola), smallpox, and poliomyelitis due to wild-type poliovirus.

- consultations with IASC partners at headquarters and regional levels, including on the current and potential activation of their respective corporate emergency procedures (for NGOs, consultation may be done through a pre-established role of the consortia);
- if appropriate, direct consultations with the National Disaster Management Agency and/or other national sources; and
- an analysis of the current and potential humanitarian consequences of the event, including the needs for protection and assistance, the general economic, social, political and security context, the capacities of national authorities, communities and other entities (e.g. the private sector) to respond, population movements and displacements, access constraints, disruptions to basic services, and, to the extent possible, the views of affected populations, particularly with respect to the impact on their livelihoods, welfare, and food and water security, gender equality and safety.

Any IASC member organization can request WHO to conduct a rapid assessment of an infectious hazard or event, and WHO and FAO in the case of zoonotic events⁸. These assessments will have a multisectoral dimension when appropriate to cover relevant areas such as WASH, communications and community engagement. The initial assessment can and should be updated as a situation evolves and in keeping with WHO's obligations under the *IHR (2005)*.

2.2 Consultation and decision-making

Following discussion of the initial situation assessment, the ERC and the Director-General of WHO, supported by the RC/HC, will jointly contact national authorities at the highest possible level to explore their views about a possible L3 activation.

The Inter-Agency Emergency Directors Group (EDG) will be convened, within 24 hours of the WHO notification to the ERC, to discuss the specific infectious disease event, the risk of national and international spread, the response required for its control, potential humanitarian consequences, context and capacity at country, regional and global levels, gap analysis, lessons learnt from past outbreaks, and advocacy priorities. The EDG will also consider the scale and urgency of the response needed to *prevent* the evolution of a risk into a full-blown crisis.

WHO will provide technical input for the EDG deliberations, supported by OCHA. The EDG will prepare a set of recommendations for the consideration of the IASC Principals, including on the activation of an L3 response.

Within hours of receiving the EDG proposals, and no later than 48 hours after notification of the event by WHO, the ERC will convene and chair the IASC Principals to jointly review the initial consolidated assessment and the EDG recommendations.⁹

On the recommendation of the Director-General of WHO, the ERC may invite Principals of other relevant non-IASC entities to participate in the meeting (i.e. 'Invited Principals'), such as the Chair of the GOARN Steering Committee, non-IASC INGOs such as the appropriate MSF lead, heads of national and/or inter-country Centres for Disease Control, and, in the case of a zoonotic disease, the Director-General of OIE.

The ERC will present to the Principals the recommendations from the Emergency Directors on a 'no objections' basis. WHO will provide technical support to the Principals discussion as to

⁸ FAO would assess animal events with a potential impact on food security, food safety, trade and/or social stability, and events with intervention strategies at the zoonotic source.

⁹ Any of the IASC Principals may also request to the ERC that such a meeting be convened.

whether the health aspects of the situation response warrants L3 activation. Every effort will be made to reach consensus but the ERC will have the final decision, in consultation with the Director-General of WHO.

At this meeting, the Principals will also decide on:

- (a) the most appropriate leadership model at the country, regional and HQ levels to support national authorities, taking into consideration pre-established resources (e.g. Humanitarian Coordinator Pool; WHO Incident Managers roster);
- (b) the clusters or cluster-like mechanisms to be activated at national and subnational levels, reflecting the specific infectious hazard and its necessary control measures¹⁰, as well as humanitarian needs;
- (c) the overall in-country mechanism to ensure coordination and linkages across the humanitarian system and the technical aspects of the infectious disease response, in alignment with national structures and processes and reflecting the roles and responsibilities of each agency at the country, regional and global levels;
- (d) the composition of the surge capacity to be deployed (based on the nature of the infectious hazard, the response required, and existing capacity at country level) and its interface with the national coordination structure;
- (e) the period during which the measures triggered by the L3 activation should be in place (up to 3 months) and assigned responsibility for defining and implementing an exit strategy;¹¹
- (f) resource and scale-up requirements;
- (g) common advocacy priorities and messages, including on risk communications, that will be at the core of the ERC's communication strategy with regards to the emergency situation;
- (h) contingency planning for international spread; and
- (i) other specific arrangements, as applicable, for the particular infectious disease event, including appropriate staff safety, security, protective measures, medical assistance and 'in extremis' medical evacuation, including of responders.

2.3 Activation

The ERC will make a final decision on the L3 activation based on the IASC criteria and the recommendation of the Director-General of WHO, in consultation with the IASC Principals and Invited Principals of relevant non-IASC entities. While consensus should be the norm, it is not a requirement. This decision will be taken as soon as possible after the event is verified and no later than within 48 hours of notification of the event by WHO¹².

¹⁰ Depending on the infectious disease event and its control strategy, an L3 activation may require rapid activation of health, WASH, logistics, food security/security and/or protection Clusters and sub-clusters, as well as cluster-like mechanisms for specific disease control activities such as contact tracing and social mobilization.

¹¹ During the meeting, a date will be set within 7-10 days for the Principals to meet again and review the application of the procedure.

¹² As infectious events may evolve over time, a high or very high risk infectious hazard that is not initially declared an L3 crisis may require rapid reassessment, even within days, by the EDG and IASC Principals.

The ERC will inform the UN Secretary-General (SG) and the lead UN Department (Department of Peace-Keeping Operations or Department of Political Affairs as applicable),¹³ as well as the chair of the UN Development Group (UNDG) of the L3 activation. The ERC will announce the activation via e-mail to all IASC Principals and Invited Principals and issue a note to the HCT via the HC (or UNCT via the RC, if an HC/HCT is not in place).

The ERC and WHO Director-General will contact the national authorities at the highest level to explain the decision and its implications. The exact way to go about this, including the role of the in-country UN leadership, will depend on the context and will be a point for the IASC Principals when they discuss the proposed activation. In the case of a zoonotic disease, the Director General of FAO will also play a role, in consultation with the OIE Director-General¹⁴.

All messages should state the geographic coverage and duration of the L3 activation, and leadership and coordination arrangements. Communications should focus on the prioritized disease control measures and humanitarian response, strengthened coordination mechanisms, enhanced response capacity, engagement with communities, and advanced preparedness actions, particularly in neighbouring at-risk countries. The exact messaging will depend on the infectious disease event and context and as discussed among the IASC Principals. The ERC will systematically update the IASC Principals on all ongoing advocacy initiatives relating to the L3 activation and response.

2.4 Deactivation

The initial duration of the L3 activation will be defined by the Principals during their first meeting, but in principle should not exceed 3 months as the primary purpose is to support the surge necessary for an effective response. As per standard L3 procedures, an exit strategy will be drawn up by the Country Team, in consultation with the Emergency Directors Group, in the 3 weeks following activation¹⁵ and should include at minimum:

- i) a statement of how the chosen leadership model will evolve at the end of the L3 activation and how the transition would be managed;
- ii) a strategy to mobilize and deploy the required capacity to take over from the initial surge support for core functions required past the initial period of L3 activation; and
- iii) an agreement on how reporting lines, roles and responsibilities will evolve at the time of L3 deactivation.

The Principals will meet at the end of the 3-month period to review the situation and formally deactivate the L3 response or, if deemed appropriate, extend it.

III Implications of Humanitarian System-Wide Activation

L3 activation commits IASC members to the procedures as laid out below; it does not however prejudice or affect the ability of IASC member organizations to decide on activation of their

¹³ If there is a PKO or SPM in the country in question, responsibility for informing the SRSRG that this is under consideration would rest both on the HC and/or RC/DSRSG as applicable, as well as with WHO and the Lead Department at Headquarters.

¹⁴ For example, when an animal sector response is envisaged or required and/or the FAO-OIE Crisis Management Center is deployed to provide expert support to national veterinary services or embedded within the WHO/GOARN mechanism.

¹⁵ in an evolving infectious disease event, the time for development of an exit strategy may need to be extended.

respective major emergency mechanisms and procedures, nor the manner in which they would be applied.

The activation commits IASC member organizations to ensure that they put in place the right systems and mobilize resources to contribute to the response as per their mandate areas, Cluster Lead Agency responsibilities, and commitments made in the strategic statement (see below).

In addition, it automatically triggers the following immediate actions:

- Establishment of the HCT, if not already active, with the current RC re-hatted as HC a.i.¹⁶, and, if appropriate, the WHO Representative or another senior WHO manager/incident manager appointed as Deputy HC a.i. pending decision on the most appropriate leadership model;
- Designation of a Senior Emergency Humanitarian Coordinator within 72 hours of the IASC decision to lead the overall system response in support of national authorities for up to 3 months¹⁷, and of a WHO Incident Manager to assist by directing the technical aspects of the infectious disease event response related to human health¹⁸. The ERC will consult with the Chair of the UN Development Group (UNDG) on IASC proposals to confirm the RC as the Senior Emergency HC or to deploy an HC for that purpose. The Senior Emergency HC will have overall leadership of the IASC contribution, supported by the WHO Incident Manager for the infectious disease response and, when required, by a Deputy HC for the humanitarian aspects of the response. Alternatives could be considered such as the naming of a Special Envoy or the deployment of a Special Representative, especially for an event that involves multiple countries or regions, or at country level the nomination of a Head of Agency *in situ* to serve as deputy HC *ad interim*;
- Deployment of surge capacity by all relevant IASC member organizations on a ‘no regrets’ basis¹⁹, and other context-specific capacities such as the WHO Incident Management System and GOARN partners, for the response to the specific infectious disease event as recommended by the Director-General of WHO and decided by the IASC Principals;
- Establishment by WHO of a common, interagency epidemiology and response Situation Report to be updated at least weekly to guide the international response and planning;
- Implementation of a multi sectoral rapid assessment (e.g. Joint Needs Assessment and Analysis), particularly the Situation Analysis;
- Elaboration of a statement of strategic priorities by the HC/HCT with the technical direction of the WHO Representative/senior manager²⁰ and in accordance with the

¹⁶ The ERC discusses IASC decisions and proposals on leadership models with the Chair of the UNDG.

¹⁷ All costs related to the initial 3-month deployment of the Emergency Humanitarian Coordinator will be borne by OCHA. This will include the salary costs (and related entitlements), travel costs to/from the location of the assignment as well as other support costs related to the deployment.

¹⁸ For zoonotic diseases requiring large-scale animal interventions, an incident manager for animal health would also be required.

¹⁹ Meaning that agencies commit to deploying senior and experienced staff to fulfil the agreed core coordination functions and, for infectious diseases key technical roles, immediately, without waiting for more precise details on exact needs and response plans, and decide at a later date to withdraw surplus staff as relevant.

²⁰ In the case of zoonotic diseases requiring a substantive animal sector response, technical input on the strategic priorities will also be provided by the FAO Representative.

IASC template, which will lay out priorities and a common strategic approach for controlling the infectious disease event, managing its humanitarian consequences and, where appropriate, implementing preparedness measures. This will serve as a basis for performance monitoring and will also guide the initial joint response and operational plan, Flash Appeal (to be developed within 3-5 days) and individual cluster response plans;

- Deployment of supplies and logistics, ideally sufficient for a 3 month period, as needed to complement national capacity for the immediate implementation of preventive, diagnostic, case management and other relevant disease control measures, as appropriate to the pathogen;
- Establishment of sub-national hubs/coordination mechanisms as required, with sufficient logistics and communications capacity to reach the affected populations;
- Immediate initial CERF allocation of between US\$10-20 million, to be issued by the ERC within 72 hours of the IASC decision on a ‘no regrets’ basis and to be allocated by the HC or IASC-designated country-level leader in support of priorities identified in the strategic statement²¹; and
- Activation of the “empowered leadership” model.²²

IV Other measures

- Based on WHO’s ongoing assessment of the risk of international spread of the infectious disease pathogen, at-risk countries should be identified, prioritized and supported for immediate, targeted preparedness planning and action, informed by social determinants of health and ensuring the integration of human rights norms.²³
- In the event of a multi-country, regional or global infectious disease event or emergency (e.g. a ‘pandemic’), these measures, including in particular the leadership model, inter-agency/inter-country coordination arrangements and CERF allocation, will be adapted, expanded and strengthened as appropriate. These adaptations should be consistent with and reflect such activities as contingency and preparedness planning for pandemics.
- 7-10 days after the decision to activate, IASC Principals and Invited Principals will be reconvened by the ERC to review the effective functioning of the leadership and coordination arrangements to ensure that they are fit for purpose²⁴. They will also meet at any time as required during the activation period to resolve any coordination, strategic and operational issues.
- The L3 activation automatically triggers an Operational Peer Review (OPR) which is to be conducted within the initial 3-month period and used to inform the Principals’ meeting at the end of the 3-month activation period.

²¹ When an L3 activation concerns an infectious hazard which also triggers the World Bank’s Pandemic Emergency Financing Facility (PEF) OCHA will work with the Bank to optimize the alignment of financing streams at national and international levels.

²² For details see IASC concept paper on empowered leadership.

²³ Including how to address discrimination in access to health care to ensure availability, accessibility, acceptability and quality of services.

²⁴ If it has not already been confirmed electronically following the usual procedures, the Principals will also use this meeting to formalize decisions about cluster arrangements, based on the proposals outlined to the ERC by the Director-General of WHO, the HC and HCT.

- IASC Principals will meet at the end of the 3-month activation period to review the activation and recommend the way forward (deactivation or continuation).

ANNEX A – Definition of the 5 criteria

- Scale (either size of affected areas, number of affected/potentially affected, number of countries affected);
- Urgency (importance of population displacement, intensity of armed conflict, crude mortality rates)
- Complexity (multi-layered emergency, multiple affected countries, presence of a multitude of actors, lack of humanitarian access, high security risks to staff, etc.);
- Capacity (low national response capacity, weak/fragile state, needs outweigh the capacity of CO and RO to respond). (Note that HIGH National or international Capacity may offset / balance the other criteria)
- Reputational Risk (media and public attention and visibility, expectations on the humanitarian system by donors, the public, national stakeholders and partners)