

## **Standard Operating Procedures**

# **HUMANITARIAN SYSTEM-WIDE SCALE-UP ACTIVATION**

## **Protocol for the Control of Infectious Disease Events**

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April 2019

Endorsed by IASC Principals

INTER-AGENCY STANDING COMMITTEE  
REFERENCE DOCUMENT

**Humanitarian System-wide Scale-Up Activation Protocol for the  
Control of Infectious Disease Events**

*This reference document replaces the 6 December 2016 Level 3 (L3)  
Activation Procedures for Infectious Disease Events and was revised  
following the review of the L3 system and the endorsement of the new Scale-  
Up protocols*

4 April 2019

## I Definitions

In addition to major humanitarian crises triggered by natural disasters or conflicts, infectious disease events<sup>1</sup>, including outbreaks, can result in a Humanitarian System-wide Scale-Up activation<sup>2</sup> (i.e. ‘Scale-Up activation’) to ensure a more effective response.

Scale-Up activation procedures for infectious disease events build on the Inter-Agency Standing Committee (IASC) Scale-Up activation protocols, 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 (IHR) (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’<sup>3</sup> approach.

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

In summary, the designation of a Scale-Up response to an infectious disease event will be issued by the Emergency Relief Coordinator (ERC), in close collaboration with 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 a Scale-Up activation should be based on both an analysis of the IASC’s five criteria<sup>4</sup> adapted to meet International Health Regulations (2005) (IHR) criteria (see Annex 1) and WHO’s formal risk assessment of the event. In keeping with

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<sup>1</sup> 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.

<sup>2</sup> As outlined in the IASC *Protocol 1: Humanitarian System-Wide Scale-up Activation: Definition and Procedures* (November 2018).

<sup>3</sup> A multisectoral, multidisciplinary approach with expertise from public, animal and environmental health that is promoted by the WHO, the Food and Agriculture Organization (FAO), and the World Organisation for Animal Health (OIE) tripartite collaboration.

<sup>4</sup> The five criteria are: scale, urgency, complexity, capacity and risk of failure to deliver effectively and at scale to affected population.

IASC's existing procedures, the initial Scale-Up activation period should be reviewed after a minimum of 3 months and maximum of 6 months.

## **II Main Steps in the Procedure**

During the period of assessment and decision-making by the IASC Principals regarding Scale-Up 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.

### II.1 Assessing the situation

Early detection, verification and WHO Rapid Risk Assessment (RRA) are essential to preventing public health events from becoming emergencies. Under the IHR (2005), WHO works on an ongoing basis to detect and verify public health events, and to assess the associated public health risks. Close collaboration and consultation with Governments, UNICEF, members of the Global Outbreak Alert and Response Network (GOARN), FAO and the World Organisation for Animal Health (OIE) (in the context of zoonotic diseases), are central to these processes. Other relevant agencies, including NGOs, are consulted on a case-by-case basis and according to context and capacities in place.

Once a public health event is detected and WHO has verified it, WHO may decide to undertake a rapid risk assessment (RRA). The decision to conduct a full and rigorous RRA is context-specific and signals the need to document the public health risks of an event, its likely impact and recommended actions. It is conducted as soon as possible, ideally, within 24 hours of verification of the event. Nonetheless, timing may vary by type of hazard, the accessibility of the affected areas, and the rate of onset or evolution of the acute event.

The RRA documents the likelihood and the consequences of the event for human health, the potential for spread, and the available in-country capacities to control the event. A risk level related to the event (very high, high, moderate, low) is determined for country, regional and global levels.

WHO's formal RRA is an internal document that will:

- impartially and independently assess the risk posed by an infectious disease event;
- provide transparency and reproducibility regarding the WHO decision-making process, through application of a standardized methodology and reporting template;
- document and summarize all relevant public health, operational and contextual information on the event;
- inform and support WHO, UN, and IASC decision-making on how to respond to the public health event.

The initial assessment should be updated as the situation evolves and in accordance with WHO's obligations under the IHR (2005). In contexts of zoonotic diseases FAO, OIE and WHO will work together under the framework of the Joint FAO–OIE–WHO Global Early Warning System

(GLEWS) for health threats and emerging risks at the human–animal–ecosystems interface<sup>5</sup>.

For all public health events assessed as high or very high risk at regional or global levels, and/or when WHO declares an internal Grade 3 emergency, the WHO Director-General will systematically notify the United Nations Secretary-General (UN S-G) and the Emergency Relief Coordinator through a standard briefing memo.<sup>6</sup>

The memo, issued within 48 hours of completion of the RRA, will include details of the situation analysis, risk level at country/regional/global levels, initial country-level response and coordination efforts (including IASC engagement), and WHO assessment of the need to discuss the IASC Humanitarian System-Wide Scale-Up activation procedures.

## II.2 Statement of public health strategic priorities and proposed response structure

When WHO indicates the need to discuss IASC Scale-Up activation, within 24 hours of having informed the UN S-G about the event, WHO will provide to the UN S-G and to the ERC a draft statement of public health strategic priorities, proposed response structure and the major activities required to control the infectious event. This initial recommendation will be the basis for guiding further HCT, EDG, and Principals level discussions and decisions.

As soon as possible, but no later than 12 hours after its reception, the ERC will share the draft statement of public health strategic priorities and proposed response structure with:

- 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). The HCT with the support of OCHA will, in turn, provide more details on the potential scale and humanitarian impact of the event, the capacities of national authorities and communities and of humanitarian actors already present, access and security constraints, population movements and displacements, conflict and gender dynamics, protection challenges, and on how IASC and other partners can best support the response. This will include implications for any wider humanitarian response in the area.
- IASC partners at headquarters (EDG, IASC Focal Points) and regional levels (regional hubs), to obtain their assessment of the situation to inform an EDG discussion. This will include whether IASC member organisations are recommending activation of their respective corporate emergency procedures. For NGOs, consultation may be done through a pre-established role of the consortia as appropriate.

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<sup>5</sup> <http://www.glews.net/>;

[http://www.who.int/foodsafety/zoonoses/final\\_concept\\_note\\_Hanoi.pdf?ua=1](http://www.who.int/foodsafety/zoonoses/final_concept_note_Hanoi.pdf?ua=1)

<sup>6</sup> IASC Principals will receive the communication to the ERC from the IASC secretariat and UNOCC will be copied on the communication to the UN S-G.

This analysis will serve as additional background for the EDG discussion and complement, in a separate document, WHO's draft statement of public health strategic priorities and proposed response structure.

### II.3 Consultation and decision-making

Following these initial discussions, the ERC and the Director-General of WHO, supported by the RC/HC, will jointly contact national authorities at the highest possible level to inform them about measures being considered to bolster operational capacities.

The IASC Emergency Directors Group (EDG) will be convened, within 48 hours of the WHO notification to the ERC, to discuss the event, the risk of national and international spread, potential humanitarian consequences, the context, response capacities at country, regional and global levels, and the assessed need for an IASC Scale-Up activation. The latter should be informed by the five IASC criteria adapted to conform with the assessment criteria of IHR (2005) (Annex 1).

WHO will provide technical input to the EDG deliberations, supported by the IASC Secretariat and OCHA. The EDG will prepare immediately a set of recommendations for the consideration of the IASC Principals, including on the activation of an IASC Scale-Up.

Within 24 hours of receiving the EDG recommendations, the ERC will convene and chair the IASC Principals to jointly review the consolidated assessment and the EDG recommendations<sup>7</sup>.

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 international NGOs 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.

At the Principals' meeting, WHO will provide an overview of the situation analysis, the results of the RRA, and the statement of public health strategic priorities and proposed response structure. The ERC will present the recommendations from the IASC EDG on a "no objections" basis.

The ERC will make a final decision on the system-wide Scale-Up activation based on the recommendations of the Director-General of WHO and the IASC EDG, in consultation with the IASC Principals, and Invited Principals of relevant non-IASC entities. Every effort will be made to reach consensus; however, the ERC will have the final decision. The decision will be communicated no later than 24 hours after conclusion of the IASC Principals' meeting.

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<sup>7</sup> Any of the IASC Principals may also request to the ERC that such a meeting be convened.

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 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;
- (c) the clusters or cluster-like mechanisms to be activated at national and subnational levels<sup>8</sup>, reflecting the specific infectious hazard and its necessary control measures<sup>9</sup>, as well as humanitarian needs;
- (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 Scale-Up activation should be in place (up to six months)<sup>10</sup> and assigned responsibility for defining and implementing an exit strategy;
- (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 event, including appropriate staff safety, security, protective measures, medical assistance and 'in extremis' medical evacuation, including of responders.

#### II.4 Activation

The ERC will officially announce the humanitarian system-wide scale-up activation Protocol for the Control of Infectious Disease Events to the UN S-G,- the Chair of the UN Sustainable Development Group (UNSDG), and the UN Operations and Crisis Centre (UNOCC). The ERC will also 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, including support to national and in situ capacity. This shall depend on the context and should be discussed among the IASC Principals when they meet on the proposed

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<sup>8</sup> If the outbreak was in a context with refugee coordination mechanisms in place, they will also be used.

<sup>9</sup> Depending on the event and its control strategy, a system-wide Scale-Up 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

<sup>10</sup> The Scale-Up activation can be extended for three additional months.

activation. In the case of a zoonotic disease, the Director General of FAO will also play a role, in consultation with the OIE Director-General<sup>11</sup>.

All messages should state the geographic coverage and duration of the Scale-Up 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 Scale-Up activation and response.

#### II.4 Deactivation

The initial duration of the Scale-Up activation will be defined by the Principals during their first meeting, but should not exceed six months. That could be exceptionally extended by three additional months, as the primary purpose is to support the surge necessary for an effective response.

As per standard IASC procedures, a transition plan will be drawn up by the Country Team, in consultation with the Emergency Directors Group, in the 3 weeks following activation<sup>12</sup> and should include at minimum:

- i) a statement of how the chosen leadership model will evolve at the end of the 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 Scale-Up activation; and
- iii) an agreement on how reporting lines, roles and responsibilities will evolve at the time of Scale-Up deactivation.

The Principals will convene at the end of the activation period to review the situation and formally deactivate the Scale-Up or, if deemed appropriate, extend it.

### III Implications of Humanitarian System-Wide Scale-Up Activation

Scale-up activation commits IASC members to the procedures as laid out below. It does not however prejudge or affect the ability of IASC member organizations to decide on activation of their respective major emergency mechanisms and procedures, nor the manner in which they would be applied.

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<sup>11</sup> For example, when an animal sector response is required and/or FAO's Emergency Management Centre for Animal Health (EMC-AH) is engaged to provide expert support to national veterinary services or embedded within the WHO/GOARN mechanism.

<sup>12</sup> With an infectious disease event, the timing for formulating an exit strategy will need to be adapted to the evolution of the outbreak and may be later than 3 weeks.

The activation commits IASC member organizations to ensure that they put in place the most appropriate systems and dedicate the required capacities and resources in a timely manner to contribute to the effectiveness of the response as per their mandated areas, Cluster Lead Agency responsibilities, and commitments made in the “Statement of Key Strategic Priorities” (see below).

In addition, it automatically triggers the following actions:

**1. Immediately:**

- **Activation of the “empowered leadership” model.**<sup>13</sup>
- **Establishment of the HCT**, if not already active, with the current RC re-hatted as HC a.i.<sup>14</sup>, and, if appropriate, the WHO Representative or another senior WHO official appointed as Deputy HC a.i. pending decision on the most appropriate leadership model;
- **Deployment of supplies and logistics**, ideally sufficient for the activation 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; Mechanism’s should include space for NGOs/Civil Society (national and international) involvement.
- **Deployment of surge capacity** by all relevant IASC member organizations on a ‘no regrets’ basis<sup>15</sup>, and other context-specific capacities such as the WHO Incident Management System and GOARN partners, including the FAO Emergency Management Centre for Animal Health (EMC-AH) as one of the 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.

**2. Within five days of activation:**

- **Designation of a Senior Emergency Humanitarian Coordinator** within 48 hours of the IASC decision to lead the overall system response in support of national authorities for the activation period<sup>16</sup>, and of a **WHO Incident Manager** to assist by directing the technical aspects of the event related to

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<sup>13</sup> For details see IASC Protocol 2. ‘Empowered Leadership’ in a Humanitarian System-Wide Scale-Up Activation.

<sup>14</sup> The ERC discusses IASC decisions and proposals on leadership models with the Chair of the UNDG.

<sup>15</sup> Meaning that agencies commit to deploying senior and experienced staff immediately without waiting for more precise details on exact needs and response plans and withdraw them later should they not be required.

<sup>16</sup> 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.

human health<sup>17</sup>. The ERC will consult as appropriate on IASC proposals to confirm the RC as the Senior Emergency HC or to deploy a HC for that purpose.

- The Senior Emergency HC will have experience in management of public health emergencies at senior level, and 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 the WHO Representative in situ to serve as deputy HC ad interim;
- **Development of a “Statement of Key Strategic Priorities” (SSP)** by the HC/HCT within four days of the Scale-Up activation, with the technical direction of WHO<sup>18</sup> and in accordance with the IASC template. The SSP will lay out priorities and a common strategic approach for controlling the infectious disease event, including community engagement strategies to build trust with affected communities, managing humanitarian consequences and, where appropriate, implementing preparedness measures. It will serve as a basis for the Flash Appeal and for the performance monitoring benchmarks;
- **Immediate announcement of Central Emergency Response Fund (CERF) and Country-Based Pooled Fund (CBPF)** (if available in-country) funds. Allocations for the humanitarian response, to be issued by the ERC (by HC for CBPFs) on a ‘no regrets’ basis within 72 hours of activation<sup>19</sup> and under the leadership of the HC or IASC-designated country-level leader, in consultation with health partners and according to the priorities identified in the SSP and subsequently the Strategic/Humanitarian Response Plan and Flash Appeal<sup>20</sup>; and
- **A Flash Appeal** will be launched within 5 days of activation.

### 3. Later steps:

- **Completion of a Multi-Cluster Initial Rapid Assessment (MIRA) or alternative rapid assessment methodology** within 14 days of the activation;
- **A full Strategic/Humanitarian Response Plan** will be required within 21 days of the activation and will be launched simultaneously with a revised Appeal;

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<sup>17</sup> For zoonotic diseases requiring large-scale animal interventions, an incident manager for animal health would also be required, using the established FAO EMC-AH mechanisms and in close coordination with WHO GOARN and Strategic Health Operations Centre, and OIE.

<sup>18</sup> 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 or Chief Veterinary Officer.

<sup>19</sup> This does not apply if CERF allocation was provided prior to Scale-Up activation; instead additional CERF funding may be provided upon request of the ERC once key priorities are identified and proposed for further CERF funding.

<sup>20</sup> When a Scale-up activation concerns an infectious hazard which also triggers the World Bank’s Pandemic Emergency Financing Facility (PEF) efforts will be made to optimize the alignment of financing streams at national and international levels.

- **An Operational Peer Review (OPR)** will be conducted within the initial three to six -month period and used to inform the Principals' meeting at the end of activation period.
- **An Inter-Agency Humanitarian Evaluation (IAHE)** will be conducted, if deemed necessary, according to the Terms of Reference of IAHE and within 9-12 months of a Scale-Up activation. The IAHE should take into consideration the findings of the OPR.

#### IV Other measures

- Based on WHO's ongoing assessment of the risk of international spread of the disease pathogen, at-risk provinces and 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.<sup>21</sup>
- In the event of a multi-country, regional or global infectious disease event (e.g. a 'pandemic'), response measures, including in particular the leadership model and inter-agency/inter-country coordination arrangements and CERF allocation, will be adapted, expanded and strengthened as appropriate.
- In addition, a leadership and coordination model for contingency and preparedness planning for multi-country, regional or global infectious disease events pandemic should be established.
- 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 purpose<sup>22</sup>. They will also meet at any time as required during the activation period to resolve any coordination, strategic and operational issues.
- IASC Principals will meet at the end of the activation period to review the activation and recommend the way forward (deactivation or continuation)

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<sup>21</sup> Including how to address discrimination in access to health care to ensure availability, accessibility, acceptability and quality of services.

<sup>22</sup> 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.

ANNEX 1 – Definition of the IASC 5 criteria  
(adapted for infectious disease event)

**1. Scale**

- Large number of cases/deaths in given place and time for the type of event
- Number of affected areas/countries

**2. Urgency**

- Serious public health impact
- Significant risk of international spread
- Significant risk of international travel and trade restrictions

**3. Complexity**

- Event unusual or unexpected (unknown agent, unknown mode of transmission, etc.)
- Multi-layered emergency, presence of a multitude of actors, lack of humanitarian access, high security risks to staff

**4. Capacity**

- External assistance needed to investigate, respond and control event

**5. Risk of failure to deliver effectively and at scale to affected population.**

- Media and public attention and visibility, expectations on UN system by donors, the public, national stakeholders and partners

## ANNEX 2: TIMELINES FOR IASC INFECTIOUS EVENTS PROTOCOL

- Day 0: Event detection
- By day 3: Event verification
- By day 4: WHO Rapid Risk Assessment (RRA)<sup>23</sup>
- By day 6 (RA +2): Memo to SG / ERC with indication of recommendation by WHO to activate IASC protocol
- By day 7 (RA + 3): WHO's statement of public health strategic priorities and proposed outbreak response structure and OCHA's analysis of current and potential humanitarian consequences
- By day 7 (RA +3): ERC shares WHO statement of public health strategic priorities and proposed response structure with HC/HCT and IASC Principals.
- By day 8 (RRA + 4): EDG meeting
- By day 9 (RRA + 5): Principals meeting
- By day 10 (RRA + 6): Decision on activation.  
ERC informs UNSG, DPA/DPKO, UNDG Chair, UNOCC, IASC and invited Principals.  
WHO DG and ERC inform national authorities.  
HCT established
- By day 12 (RRA + 8): Appointment of Senior HC and WHO incident manager
- By day 13 (RRA + 9): Announcement of CERF funds
- By day 14 (RRA + 10): Statement of key Strategic Priorities (SSP)
- By day 15 (RRA + 11): Flash Appeal
- By day 20 (RRA + 16): IASC Principals meeting to review response
- By day 24 (RRA +20): Multi sectoral rapid assessment
- By day 25 (RRA + 21): Transition strategy
- By day 30 (RRRA + 26): Strategic Response Plan (SRP) and Revised Appeal
- By day 100 (RRA + 3 months)<sup>24</sup> : Operational Peer Review and Principals meeting to review status of activation

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<sup>23</sup> The timing of the RRA is ideally within 24h of the verification but may vary by hazard, accessibility of the affected areas, and the rate of onset or evolution of the event.

<sup>24</sup> If initial activation for three months. The initial activation can be for three to six months.