WHO’S EMERGENCY RESPONSE FRAMEWORK: A CASE STUDY FOR HEALTH EMERGENCY GOVERNANCE ARCHITECTURE

By: Catherine A. H. Smallwood, Ihor Perehinets, J. Sam Meyer and Dorit Nitzan

Summary: During COVID-19, attention was drawn to a lack of functional governance frameworks for health emergencies. Routine governance structures were neither agile, nor flexible enough to operate with the speed required for urgent and coordinated action within complex and far-reaching responses. WHO’s Emergency Response Framework has significantly contributed to a stronger WHO response capacity in the European Region by providing accountabilities, responsibilities, delegation of authority, and rapid access to resources for response, while also allowing for participating members to be held accountable for their actions. We argue that now is the time to move health emergency management forwards by supporting States in strengthening their emergency governance architectures.

Keywords: Health Governance, Emergencies, Emergency Response Framework, WHO, COVID-19

Background
The importance of ensuring clarity in roles, relationships and coordination mechanisms within the health sector and across government before, during, and after health emergencies is highlighted within the International Health Regulations (IHR 2005) and models to address this need have evolved over time. During the course of the COVID-19 pandemic response, broader governance and accountability frameworks for emergencies have been deemed insufficient at both international and national levels. The three independent reviews that recently submitted their reports on the preparedness for and response to COVID-19 to the 74th World Health Assembly, point to the inadequacy of ‘just-in-time’ planning during emergencies and to the need for strong governance architectures for emergencies established from global to national and community levels. Such
architectures need clear direction, coordination, planning, target setting, policy, norms, technical guidance and technical support, as well as procedures that promote agile, timely, and adequate response with solidarity.

Up to now, emergency management has seldomly been mentioned in the health governance literature. Rather, the field of health governance has focused on strengthening governance as a health systems function, and even this has shifted over the past decade. This shift, as described by Meesen (2020), has been towards an understanding of governance as the organisation of collective action. Collective action is precisely what is required during the response phase of health emergencies, where timing and coordinated interventions are critical to save the lives and livelihoods of affected populations. Meesen proposes thinking of health governance around four key variables: (i) the set of collective action problems to solve; (ii) the group of individuals facing the problems; (iii) the set of possible actions that members can take in time; and (iv) the conditions determining the problems.

The field of health emergency management is dynamic and often described using the four phases of the emergency cycle. This article starts by explaining how all stakeholders need to be involved in health governance and must be mobilised during the response phase to health emergencies. We then make the case for countries to use the Emergency Response Framework as a tool during the response phase. Finally, we discuss the gaps in the governance of health emergencies and suggest taking a more holistic approach that could be applied to all phases of the emergency cycle.

COVID-19 has revealed critical gaps in the governance architecture

COVID-19 has revealed that if emergency management systems, processes and capacities are not in place upstream to an emergency, they have the potential to ultimately cripple the efficiency of the response over time. Over the past decade, the response mechanisms and infrastructure through the Incident Management Systems (IMS) and the establishment of a Public Health Emergency Operations Centre (PHEOC) that creates strong coordination and command systems for acute responses has been the main governing function for health emergencies and was also able to contribute to all other aspects of the emergency cycle.

Though a critical function of emergency management, we find that the IMS and associated Incident Management Support Team (IMST) must be supported by a robust governance system, that includes command-control and coordination systems, and embedded within national legal frameworks which feed into community action with clear accountability and capacities. Whilst emergencies are unpredictable, and often the specific actions and resources associated with them are difficult to plan for as part of routine health planning cycles there must be advance planning. In order to be prepared and functional at the very start of an emergency, the architecture that governs the health emergency cycle needs to be established in advance, and well understood and accepted by those who will eventually come to rely on it.

The governance of all actors during a large-scale health emergency extends beyond the health sector need

WHO identifies key stakeholders in health governance as the State (government organisations and agencies at central and sub-national level); health service providers (public and private, non-clinical health service providers, professional

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Figure 1: The emergency cycle

![Figure 1](source_image)
COVID-19 responses in Europe – towards better governance

During emergencies, particularly during large-scale emergencies that have far-reaching and non-health consequences, these stakeholders expand to include humanitarian actors, and those in non-health sectors. Within the global humanitarian landscape, these include water, sanitation and hygiene (WASH), protection, shelter, education, social protection and logistics. The broader governance of these actors is facilitated by the ‘cluster approach’ established to enhance predictability, accountability, and partnership. In the wake of several humanitarian failures, the cluster system was established to bring together the humanitarian actors (UN agencies, international NGOs and others) involved across sectors and designated by the Interagency Standing Committee (IASC) and coordinate their collective interventions.

WHO’s Emergency Response Framework helps clarify roles, responsibilities and actions

With the creation of the WHO’s Health Emergencies Programme (WHE) in 2016, the WHO’s Emergency Response Framework (ERF) was updated and revised with the adoption of new protocols for both acute and protracted emergencies. The ERF clarifies WHO’s roles and responsibilities during emergency responses and brings WHO’s response to all types of hazards into a single approach. Ultimately, the ERF requires WHO to act with urgency and predictability, and serve and be accountable to populations affected by emergencies. It provides shared accountability, roles and responsibilities, delegation of authorities, standard operating procedures, and reporting lines. The first variable of governance is the set of collective action problems and the ERF lays out WHO’s commitments during health emergencies (see Box 1).

The individuals charged with these actions are the relevant WHO personnel at the country, regional and global levels. As
an outward facing framework, the ERF is also consistent with and reflects the WHO Secretariat’s engagement with a range of stakeholders engaged in emergencies. This includes Member States, the global humanitarian system and Inter-Agency Standing Committee (IASC), partners (UN agencies, the International Red Cross and Red Crescent Movement, the Global Outbreak Alert and Response Network (GOARN), Emergency Medical Teams (EMTs)), donors, and the public.

The set of possible actions that members take in time is set out by a framework based on procedures for decision making and systematic actions which extend from before an event is detected, to assessing and grading events so that the response, as well as the resources provided to it, can be scaled up and down as necessary (see Figure 2). All actions are based on a key planning assumption in emergencies, the ‘no regrets’ policy.

The conditions determining the choice of action are defined during the activation of an emergency response (pre-grading), during the internal grading process, and during the management of the emergency (including its scale down and recovery). During the course of the emergency, it is assessed against the five international humanitarian criteria of: scale, urgency, complexity, capacity, and reputational risk. Based on these five criteria, and the extent of the needed WHO response to an emergency, the resources, the responsibilities, and the accountabilities associated with WHO’s response are defined within the grade assigned to it.

Following the grading process, the incident management system and emergency Standard Operating Procedures (SOPs) are immediately activated. These SOPs allow for faster administrative approvals, delegation of authority, and rapid access to financial resources for Incident Managers and the WHO Representatives through the Contingency Fund for Emergencies (CFE)*.

During the lifetime of the IMST, there are several conditions assessed to determine the actions required:

- Changes to the international humanitarian criteria and to the Grade assigned: this determines the operational responsibilities and accountabilities within WHO, allowing a response to be scaled up or down and accountabilities to be adjusted.
- Critical response functions needed for the specific emergency: this determines the form and function of the IMST based on the actual needs of the event. The functions need to be adapted to the specific hazard (e.g. respiratory virus, chemical hazard, natural disaster, conflict) and applied to all levels of the response (global, regional and country level).

Fundamental to this system is its key features of scalability and predictability, with each level of the organisation adopting the same shadow structure enabling rapid horizontal communication and coordination, as well as a single line of authority for command and control to ensure responsibility, transparency and accountibility.

This structure is illustrated for COVID-19 based on the critical response functions identified for COVID-19 as part of WHO’s 2021 Strategic Preparedness and Response Plan, and with the translation of these critical response functions into a

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* The CFE is included in WHO’s constitution which states in Article 29 that: “A special fund to be used at the discretion of the Board shall be established to meet emergencies and unforeseen contingencies”.

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**Figure 3:** WHO’s country, regional and global critical functions (top) and WHO/Europe’s Incident Management Support Team structure (bottom) for COVID-19 during 2021
Box 2: Governing the health emergency cycle: Towards a holistic and adaptable governance framework and practice

Dealing with serious health emergency requires additional conceptual governance frameworks that facilitate better governance practices. The health emergency cycle as described in Figure 1, is composed of four stages including prevention, preparedness, response and recovery. Each of the stages are very different. They include different actions, stakeholders and organisations. Adequate governance will therefore vary from stage to stage. This makes the health emergency cycle very dynamic and a ‘moving target’ for governance.

There are existing governance principles and capacity measurement tools to build on. Most importantly the international health regulations (IHR) and related tools like, e.g. the Intra Action Review (IAR), the annual reports of the State Parties to the IHR (SPARs) or the Joint External Evaluations. These principles and tools, though they establish a solid understanding of the governance mechanisms and capacities of the health emergency cycle, are neither ‘holistic’ enough to cover sufficiently all stages nor sufficiently adaptable to address the variations in actions, stakeholders and organisations.

This governance shortcoming, however, can be remedied. One way to do so is by adapting the more ‘holistic’ existing health system governance framework. Key dimensions of this framework include accountability and transparency, capacity, organisational adequacy and intelligence. All of those are embedded in the human rights framework.
How can we transfer service and policy innovations between health systems?

By: E Nolte, P Groenewegen

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Learning from other countries is a key tool for helping health systems to improve. However, with each system organized, governed and financed differently, what works in one place will not work identically in another. We therefore need special methods to analyse how care has been organized well in one place; to disentangle the innovation and its local context; and then to transfer that innovation to a new, different context elsewhere.

This new policy brief looks at how health systems can learn from each other. The authors set out what we mean by innovative solutions in health services and policies and outline why we need research on ‘service and policy innovation’ in health systems. A synthesis of the available evidence on what we know, and what we do not know, about the conditions for what works in one place and for determinants of successes and failures in the transfer (and possible scale-up) of service and policy innovations between regions and countries is also presented. In doing so, the brief helps to generate much-needed evidence to inform the further development of resilient, effective, equitable, accessible, sustainable and comprehensive health services and systems in Europe and elsewhere.

The policy brief is one of two that sets out key findings from the TO-REACH project funded by the European Union’s Horizon 2020 programme, which explored what the key priority areas are where European health systems can learn from each other and how we can improve their ability to do so.

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namely, by engaging all those that need to be involved and generating the support that will be required at all levels (from the field level, to the highest levels of the State), and to agree on clear accountability frameworks.

A third step will be for WHO to develop the tools, guidelines, and support necessary for countries to put such architectures in place.

An opportunity exists now, amidst the COVID-19 pandemic, to demonstrate and build momentum around what is needed, from the very local levels to the highest levels of the State. Only when these architectures feed into a functioning global governance system for health emergencies will we have made true progress in mitigating the risks of future pandemics.