CMAM SURGE LEARNING REVIEW

SOMALIA , NOVEMBER 2021

Concern Worldwide

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1.0 INTRODUCTION

Concern Worldwide (Concern) is currently implementing a health and nutrition project as part of the European Union Civil Protection and Humanitarian Aid (ECHO) funded Caafimaad Plus consortium led by Action Contra la Faim (ACF). The consortium has two other non-governmental, international, humanitarian organization members: SOS and International Medical Corps - IMC Croatia. The humanitarian imperative determines the consortium partners continued presence in Somalia despite considerable challenges. Within this consortium, Concern is taking the lead in the pilot implementation of Community-based Management of Acute Malnutrition (CMAM) Surge approach pilot, the first of its kind in Somalia, with potential for scalability in subsequent programmatic designs supported by ECHO and/or other institutional donors as well as the Somalia Federal Ministry of Health.

The aim of the CMAM Surge approach is to support health systems to become more resilient over time by making them better able to anticipate, prepare for and deliver services during periodic peaks in demand for services to address acute malnutrition. Through reinforcing the local capacity of government and health actors, the approach aims to maintain the quality of care, and reduce lives lost during peak periods. CMAM Surge is a complement to routine CMAM services. It is a health management tool, which builds the capacity of health workers, and empowers them to use their available data and contextual information to better prepare and respond to Surges in caseloads.

CMAM Surge was initially piloted in Kenya in 2012, and following the development of the CMAM Surge Global Operational Guide in 2016, it has been implemented in 17 countries, supported by approximately 17 implementing partners in close collaboration with ministries of health at national and sub-national levels. The key lesson learnt across these countries is that contextualisation of the tools is essential for the success of Surge.

The CMAM Surge approach was designed as a set of simple and practical tools to help government teams better respond to Surges in malnutrition. The pilot in Somalia, the first to our knowledge, is intended to test that the CMAM Surge approach can be adapted to suit the functionality of the health system, and help in strengthening certain building blocks of the health system. The three key stakeholders are the community, health facility (HF) staff and the health management team. CMAM Surge focuses on improving communication between these stakeholders, while promoting decision-making at the HF level.

Global learning has informed the Somalia pilot, and lessons learnt from the implementation in Somalia will feed into the revision of the Global CMAM Surge Operational Guidance planned in 2022.

2.0 CMAM SURGE PILOT IN SOMALIA

To ensure the quality implementation of the CMAM Surge pilot, Concern contextualised the Global CMAM Surge Toolkit (CMAM Surge Operational Guide 2016) with some adaptations based on the experiences and tools from other countries. This was followed by training of 23 trainers (Caafimaad consortium staff and MoH representatives) and subsequently the training was cascaded to the staff of the two pilot facilities (Obosibo Halane and Liqliqato). The delivery of CMAM services in both HFs are directly supported by NGOs (table 1). To date, the two facilities have set up CMAM Surge and are monitoring the nutrition situation guided by the Surge approach. As part of the planned evaluation of the pilot, Concern conducted a review of the CMAM Surge set up and its functionality.

Table 1: Profile of the two facilities

Facility	Obosibo Halane	Liqliqato
Target population	35,796	75,217
Under 5 population	7,515	15,796
How long has the facility been implementing CMAM services	2011	2008
Average SAM admissions/month	125 new cases per month	157 new cases per month
When CMAM Surge was started	Jul-21	Aug-21
No. of staff trained on Surge	41 (Health workers, District Health Management Team members (DHMT) and community representatives)	15 (Health workers, DHMT and community representatives)

2.1 Rationale of the Review

The main aim of the review was to assess the progress of implementation during the Pilot phase, identify challenges lessons learnt and best practices, and the potentiality of scaling-up of the approach in Somalia.

2.2 Objectives of the Review

1. Review CMAM Surge implementation status in the two HFs, best practices, innovations and bottlenecks.
2. Identify technical gaps in the Global CMAM Surge toolkit in the implementation of the Surge approach in a fragile context, where the delivery of CMAM services are directly support by technical and implementing partners (e.g. NGOs).
3. Develop a road map for scale-up in Somalia (based on implementation review outcomes).

2.3 Methodology of the Review

The review was conducted in Mogadishu in two separate physical workshops, which brought together key stakeholders involved in CMAM Surge implementation and future scale up. These included: MoH at Regional and District level, health facility staff and Caafimaad Plus partners. Efforts were made to engage other key stakeholders as well (e.g. donors, UN agencies). The review was structured as follows:

a) The <u>first review workshop</u>: This workshop involved the key stakeholders of the facilities implementing CMAM Surge (DHMT members, facility staff, community representatives and NGO partner staff). Fourteen participants from the two facilities attended the workshop. The team met at a central location for one day and had a group discussion guided by reflective questions (Annex 1). The information generated from this group discussion, combined with information from the monthly review meetings, was utilised to generate the presentation for the second high-level forum of partners and other key stakeholders.

This workshop primarily aimed to address the first and second objectives outlined above.

b) The <u>second review workshop:</u> This workshop was a high-level forum involving, the Banadir Regional Administration (Regional MoH), consortium technical working group and Project Steering Committee (PSC) members of the consortium, among other stakeholders. In this forum, a presentation guided by outcomes from the first review workshop was delivered. This was followed by an experience sharing session (breakaway and plenary) guided by the following questions:
- How practical is Surge implementation in the Somalia context?
- How do we address challenges encountered and what opportunities exist for the Surge?
- What should be the criteria for scale up in the context of Somalia?
- What do we do next to make CMAM Surge more sustainable?
- Who else needs to be brought on board to make CMAM Surge a success?

The second workshop's aim was to contribute to the second and third objectives outlined above.

3.0 LEARNINGS FROM THE REVIEW WORKSHOP

3.1 Setting up the Surge at Facility Level

Both facilities trained all the key stakeholders including all the HF staff, Community Health Workers (CHWs), community representatives, and DHMTs for a period of three days. The trained trainers facilitated the cascade training. The training(s) in both facilities was carried out at the facility level and this was more advantageous in that:
- No cost was incurred in booking venues,
- Easily accessible to community representatives,
- Training sessions were held in the afternoon when the facilities were not busy, hence no interference with day-to-day activities,
- All the facility staff were able to attend,
- All the data and information required was readily available.

Key Lesson Learnt:
- As the community is one of the key pillars in this approach, it would have been preferable if parts of the toolkit were translated into Somali language for easier understanding.
- Global learning has highlighted that staff turnover and poor community engagement is a barrier to the sustained implementation of CMAM Surge. Completing the training at the HF allowed all key stakeholders to be involved and trained on the approach.

3.2 Trends and Situation Analysis (Step 1)

Step 1 focuses on analysing historical malnutrition and other morbidity caseload trends within a HF and then identifying factors that influence health care seeking behaviours, drivers of caseload

fluctuations or demand for services. This information is then used to look forward to anticipate how these factors are likely to evolve and may influence malnutrition caseloads in the months ahead.
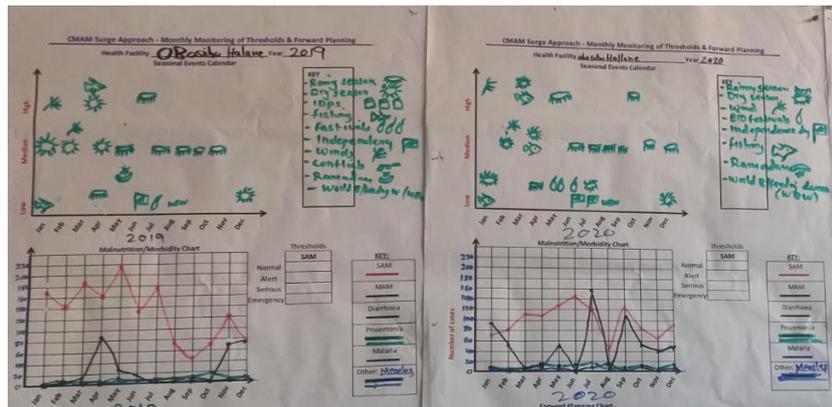

Figure 1: Obosibo Halane CMAM surge historical trends and situation analysis charts

Both facilities identified diarrhea, pneumonia and measles as key morbidities to monitor as they may influence SAM caseloads. Other contextual factors identified were: festivals, rainfall/flooding, dry seasons, population movement and conflict among others. From the data analysis of three years, Liqliqato identified May, August and Sept as the months with spikes of malnutrition caseloads while Obosibo Halane identified March, May, June and September.

Lessons Learnt

- Facility staff were able to understand the community aspects much better; for instance, how the seasons and events of the year have an impact on malnutrition.
- Community participation during this step was key since they have broad knowledge on the happenings in their community – events and seasons.
- The facility staff requested the chart sizes (seasonal and forward planning chart) to be increased to capture more information.
- One facility suggested including MAM services as part of the indicators to monitor since MAM services were running at the same time.

3.3 Capacity Review (Step 2)

This step guides the health facility staff to undertake a self-assessment of their capacity, generally with an emphasis on CMAM services (this is guided by the WHO Building Blocks). The review is done to identify factors that affect appropriate service delivery during normal times with the lens that weaknesses identified will become more important in the event that SAM caseloads increase. Health facilities should review this step every time the capacity of the facility changes.

All the facility stakeholders in both facilities were involved in this step. It was the first time the facilities were undertaking a self-assessment. The tool was useful in identifying key capacity strengths and weaknesses in the facility under each of the WHO Building Blocks and subsequently in developing action plans to address the gaps. Some key gaps identified were: weak community health committees (CHC), incomplete DHMTs, lack of height boards and some drugs suffering stock-outs.

Lessons Learnt:

- This tool could be used across other facilities, not only those implementing Surge to help the facilities identify and address weaknesses in service delivery.
- The step takes time but is key in setting thresholds.

- The tool gives an opportunity to health managers to compare the capacity of HFs (using the score from the capacity review) and hence prioritise which HFs require more attention/resources.

3.4 Threshold Setting (Step 3)

Threshold setting is a process whereby the Surge stakeholders at each HF bring together the information gathered from the trends and situation analysis (Step 1) as well as their self-assessed capacity (Step 2) to handle the workload of patients that they have and consider when they may need help to respond to any increase in demand for CMAM services. At a minimum, thresholds should be reviewed on an annual basis and adjusted as needed. In addition, thresholds should be reviewed whenever there is a change in staffing or when the HF feels that there has been a significant change in its capacity.

In both facilities piloting CMAM Surge, lived experience of past admission caseloads/peaks and the capacity of the facility including workload of the facility were the key factors considered in setting thresholds. At this early date none of the facilities has re-reviewed their thresholds.

Lessons Learnt
- Patience is key for the program team supporting facilities to set thresholds because it not an easy process.
- Some HF staff reported that it was easier to review workload on a daily basis rather than looking at past years and months (lived experience-reflecting back on capacities). This was because some of the staffs could not recall or they were not working in the facility then.

Figure 2: Agreed thresholds for Obosibo Halane and Liqliqato

3.5 Defining and Costing Surge Actions and Formalizing Agreement (Step 4 & Step 5)

Step 4 is a process to define what actions should be undertaken to ensure that the HF has the capacity to respond to the caseload of acute malnutrition at all times, whether during a normal situation or when thresholds are passed into the alert, serious or emergency phases. The actions are then formalised (Step 5) by ensuring there is confirmed commitment of a stakeholder and that, if there are cost implications the action is both budgeted and funded.

In the two facilities, most of the actions with cost implications were funded by the supporting agencies, with the HF and community taking leadership for a few actions with minimal or no cost implications - for instance active case finding and mass screening.

Key addition: To support with this step and triggering actions (Step 7), a Surge Committee was established, which is chaired by a DHMT member, with the facility in-charge as the secretary and community representative and NGO partner staff as members.

Lessons learnt

- As per the CMAM Surge Guidelines, MoH involvement in Surge implementation is key; implementing partners should work hand in hand with existing government structures for sustainability.
- The Surge committee has been useful in supporting the flow of information – from the facility to the community, to the DHMT and vice versa.
- Enhanced DHMTs participation in program activities helps promoting ownership and sustainability.

3.6 Real Time Monitoring (Step 6)

This step is the heart of the Surge approach. It involves monitoring the demand for services in real time and paying attention to whether thresholds that have been set are crossed.

In both HFs, the Surge charts (Figure 3) were updated on monthly basis by the facility in-charge with support from other staff. On a daily basis, the staff delivering nutrition services were monitoring the admissions in the registers and compiling weekly reports, and comparing them against the monthly threshold. In one of the facilities (Obosibo Halane) they crossed a threshold mid-month and were able to call for support (see case study for more details). Also on a monthly basis, the HFs were able carry out forward planning, looking back on what happened previously and predicting what may happen in the coming months and developing action plans to prepare for Surges or prevention actions.
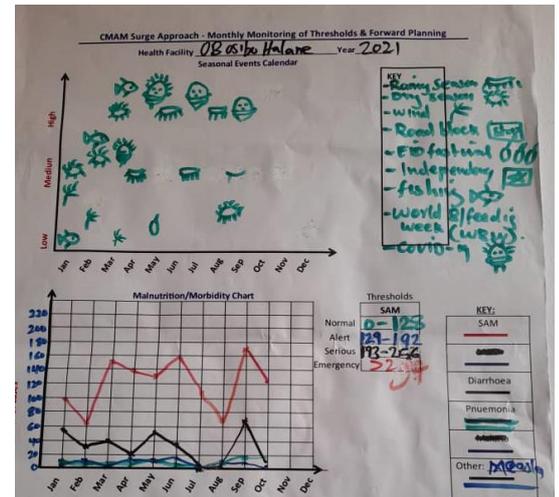

Figure 3: Obosibo Halane CMAM surge monthly monitoring.

Lessons learnt
- Prior to setting up CMAM Surge, the facility staff focus was on higher level programmatic quantitative outcomes i.e. achievements of targets against indicators; while CMAM Surge presents the opportunity to review qualitative programmatic impacts, in particular the quality of care patients receive during peak periods.
- Experience with the CMAM Surge toolkit so far shows that it is an effective programme management tool as well as acting as an early warning mechanism to trigger early actions, i.e. real time caseload monitoring, context specific attributing factors as well as evidence-based context specific corrective actions.

3.7 Scale Up and Scaling Down (Step 7)

This step encompasses the process to activate and scale up the package of Surge actions when admissions for SAM exceed thresholds, as well as deactivating and scaling down the package when the situation normalises.

Since setting up CMAM Surge, one facility surpassed a threshold: Obosibo Halane moved from normal to the alert phase in September 2021 (see case study for more details). The key Surge actions activated were:

OBH moved from Normal to alert . Facility incharge holds a meeting with facility staff

Facility incharge contacted the focal person supporting the facility . Surge committe met at the facility

Infomation was shared with different stakeholders inclduing community members

Within 1 week the surge support package was activated and implemented

- Enhanced screening in the community by CHWs.
- Ensuring prompt referral between the OTP/TSFP & inpatient for complicated cases.
- Staff reorganization at the facility - recalling staff from leave/cancellation of staff leave.
- Enhanced health education by CHWs on good hygiene practices.
- Request for additional drugs for the treatment of Diarrhea.
- Request for additional OTP commodities to cater for the increased numbers.
- Advocacy to MoH to carry out a measles campaign due to increase suspected cases of measles As of November 2021, the facility had not yet returned to 'normal' and thus have not scaled down the Surge actions.
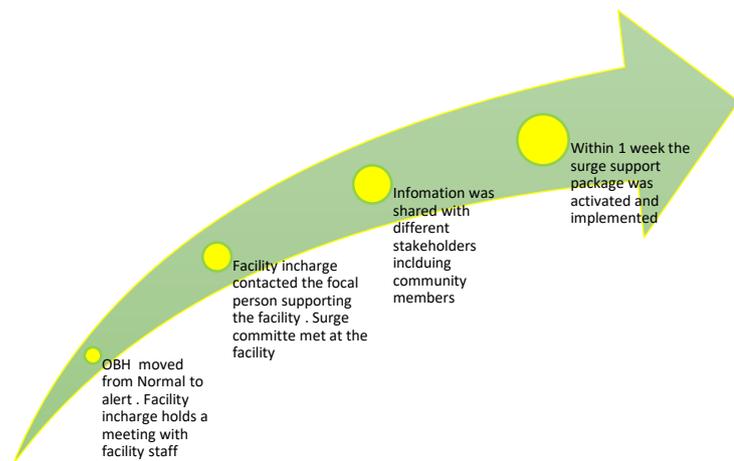
3.8 Reflection, Adaptation and Review (Step 8)

This step describes several opportunities to step back and reflect on how the Surge approach is going generally in order to make adjustments that will help make sure that the HF is better able to predict, prepare for and respond to fluctuations in demand for services.

During the pilot period, none of the facilities reviewed their thresholds since there was no change in capacity in either facility. Once Obosibo Halane has scaled down their Surge actions, they will carry out a post Surge review to assess the quality and effectiveness of the response. Recommendations will be made to improve the quality of Surge responses in the future. In addition, the learning review for the two facilities that was held in November 2021 allowed key facility stakeholders to reflect and share lessons learned and identify areas for improvement.

4.0 CASE STUDY: OBOSIBO HALANE SURGE RESPONSE

Overview: Obosibo Halane Health Centre (HC), is situated in Wadajir District in Banadir Region. It is approximately 5km away from the Banadir hospital, referral site for inpatient care for complicated SAM cases. The facility has; 4 nurses, 2 nutritionist and 30 CHWs at the community level. The health centre delivers primary care services, including nutrition services.

Figure 1: Nutrition screener taking weight of child at screening area at Obosibo Halane HF.

Caseload management prior to CMAM Surge set up: The HF staff reported that the HC has experienced both high and low numbers of SAM admissions. On a monthly basis, they track SAM admissions against the target (expected caseload). However, many a times the staff were more focused on providing services to the beneficiaries without questioning and digging deeper to understand the cause of the high or low numbers. Sometimes they would experience high workload and work for extended hours.
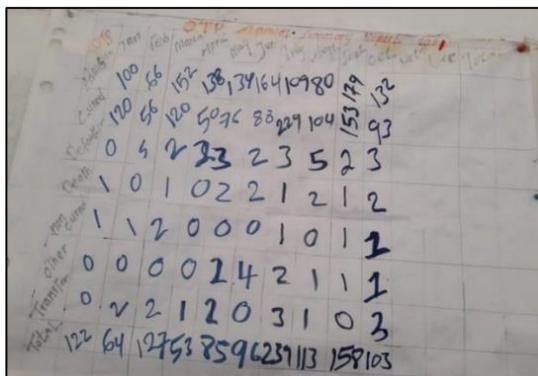
Figure 2: Chart used in recording admissions before Surge approach

CMAM Surge was set-up at the HC in July 2021. This allowed the health facility staff to conduct real time monitoring of their caseloads, comparing them against the pre-defined thresholds.

CMAM Surge response triggered: In the month of September, the health facility staff noticed an increase in the number of OTP new admissions. By the third week of September, the admissions had gone up to 114 and by 26th of the month, the facility had admitted 130 new cases moving from normal to alert (normal thresholds 0-128).

> Bihi, HF in charge: "*I immediately contacted a staff from Concern who is in charge of the facility. He immediately visited the facility and we planned for a meeting with surge committee. However, before the meeting I had chat with the facility staff and the CHWs on the situation and probable reason why the numbers had gone high.*"

On 28 September 2021, the health facility staff had the meeting with the CMAM Surge Committee, discussed the probable cause of the surge, and agreed on an action plan.

Probable causes of spike in malnutrition:

- Shortage of OTP commodities in two Health Facilities within the district thus these beneficiaries moved to Obosibo Halane ;
- Increased number of suspected measles cases in the catchment area (10, 12 and 8 cases for June, July and August respectively)
- Increased Acute Watery Diarrhoea (AWD) (from 22 cases in August to 75 cases in September) and Pneumonia cases (from 6 cases in August to 18 cases in September).
- CHWs had increased MUAC screening and referral during the normal phase as there was an observed decrease in admissions in August (from 71 SAM referral in August to 131 SAM referrals in September); and CHWs were able to reach new area in the catchment location which previously, could not be able to reach due security.

HF In-Charge (also secretary of the surge committee) together with the committee **activated the pre agree surge actions**;

- Reorganization of staff within the facilities including recalling staff from leave ;
- Enhanced screening by CHWs at the community ;
- Ensuring prompt referral from OTP to TSFP;
- Requested additional commodities RUTF and diarrhoea essential drugs;
- Enhanced health education at the facility and community by CHWs.

The facility is currently reviewing their workload with a view to scaling down the Surge actions.

Initial review of Surge Response: With the timely identification of the surge and proper implementation of the planned surge actions, the staff were able to manage their workload and ensure the quality of service delivery.

Despite the fact that the facility had the highest admissions in September compared to other months of the year, the performance indicators remained the best at 99% cure rate for SAM compared to a monthly average of 96% an indication that the quality of services was not compromised during the Surge. Looking back at previous years when the facility had experienced spikes of similar magnitude, the cure rates are relatively lower compared to those of September 2021.

The changes seen so far:

- The HF staff now have a better understanding of the seasonal and situational events that happen within their community. Using a graph to visualise the SAM and other key morbidities improves interpretation of this data.
- The HF staff are now carrying out monthly meetings consistently with a focus on data and risk analysis, understanding fluctuation of caseloads and forward planning rather than before when they were focusing on achievement in numbers and challenges
- The HF staff are now more engaged with the DHMTs and community than before and this was possible due to formation of Surge committee. This has improved the flow of information – from the facility to the community and to the government and vice versa

Fatima, OBH OPD nurse:

> "..*this approach is not only useful for CMAM services but also can be applied to other areas of service delivery especially to manage outpatient department caseloads. For instance we are now experiencing increased caseloads in the OPD due to supply gap of nearby facilities and we have tried to apply some surge actions like revising staff leaves, requesting additional supplies that are related to spikes of some communicable disease e.g. ARI and Skin disease drugs- Its working for us*"

5.0 CHANGES OBSERVED OVER THE PERIOD OF IMPLEMENTATION

1. The CMAM Surge approach promotes **data utilization for decision-making** and corrective actions, i.e. charts provide clear data visualization and monitoring of trends allows for early action (Figure 4).
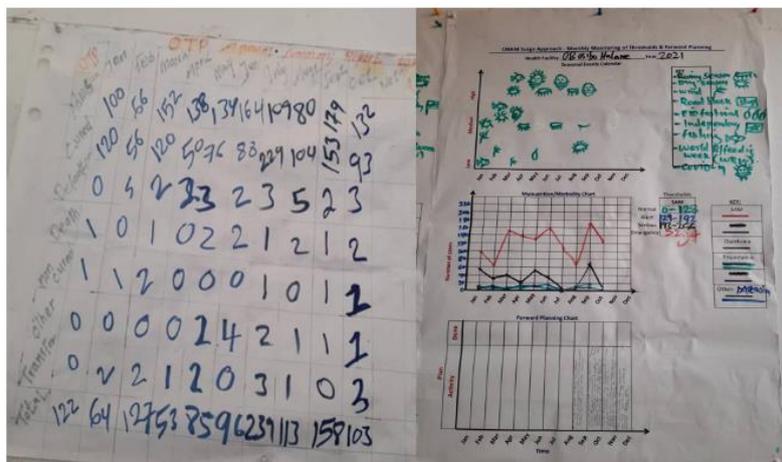

Figure 4: Old monthly monitoring of SAM admissions compared with CMAM Surge charts visualising data trends.

2. This approach has given the health facility **staff a sense of ownership**. Before CMAM Surge facility staff were more focussed on day-to-day service delivery and assessing their performance against the set targets, with the new approach facility staff are now able to analyse data, plan actions and have discussions with stakeholders on the risk/contextual factors, improving preparedness and responses.

3. CMAM Surge has enhanced the **engagement of DHMT and community representatives** via the Surge Committee and monthly meetings, meaning that there is more and a better flow of information at all levels.

4. All the stakeholders have become **more cautious and alert** to what is happening around them – CHWs are reporting all of the happenings in the community, more so than before.

5. The facilities are **applying some of the Surge actions** to manage spikes in **other morbidity** caseloads – as seen in Obosibo Halane which is responding to a spike in OPD cases using lessons learnt from the CMAM Surge approach

6.0 CHALLENGES OBSERVED OVER THE PERIOD OF IMPLEMENTATION

1. It would have been good to have a proactive and motivated representative of community health committee (CHCs) as part of the Surge committee. There is a need to improve CHCs engagement and enhance their capacity and role in service delivery.
2. In the first month after training, facility staff were struggling to update the charts. Consistent monitoring and on the job training in the first months of implementation is important to support staff during this set up phase.
3. The relocation of one of the HF from its original site to a temporary site was a noticeable challenge that affected overall program implementation as well as CMAM Surge progress.
4. The limited number of pilot facilities in an urban only context means that learning from rural context was not obtained.
5. The seasonal experiences from January to May were missed hence the learnings are only limited to the latter half of the year

7.0 GENERAL LESSONS LEARNT

1. At the start of the implementation of CMAM Surge, there has to be consistent support and monitoring of the facilities to increase ownership and clarify contentious issues.
2. Health facilities when given the opportunity and support can use contextual information to trigger Surge actions in a timely manner and adapt service delivery as per identified needs. The CMAM Surge response in one of the pilot facilities illustrates that CMAM Surge can support quality, timely and evidence based programming that is responsive to the needs of the beneficiaries.
3. Starting CMAM Surge implementation in two facilities was a reasonable approach where the approach could be tested before including more facilities.
4. The Surge approach can support project managers and other stakeholders to rationalize resources.

8.0 DISCUSSIONS POINTS FROM THE LEARNING WORKSHOP:

- **How practical** is Surge implementation in the Somalia context?

Yes it is practical because:

- There are seasonal trends in caseloads
- During the spikes in caseloads there are often gaps in service delivery (e.g. HR, supplies, etc.)
- Guidelines are already available plus successfully implemented within the region
- Enabling structures – Community , DHMTs
- Stakeholders have a lot of interest in the approach
- Provides a way to proactively use data
- Availability of local resources and capacity.

But with some key points to consider:

- Short period of implementation and only in an urban context
- Need to establish what CMAM Surge looks like in other partner modalities (e.g. MoH run facility, local partner run facility).
- May not be practical in all areas due to challenges in access, lack of fixed health facilities, or lack of established DHMTs.

- How do we address **challenges** encountered and what opportunities exist for the Surge?
  - Sometimes low CHC pro-activity and involvement – need to reinforce their capacity and encourage their engagement (in line with MoH guidelines) – The question of sustainability of incentives arises
  - Regular monitoring and supervision is essential especially during the first few months post set up (HR intensive from this perspective)
  - Need to analyse further the health system/processes of Somalia – to ensure that CMAM Surge in contributing to strengthening them and not creating parallel systems
  - Partners to only construct facilities in government owned land to avoid evictions.

- What **should be the criteria** for scale up in the context of Somalia?
  - Need to consider challenges before scale
  - Scaling up quickly may lead to failure
  - Clear road map required for stakeholders.

- What do we do next to make Surge **more sustainable**?
  - Align with other health system processes
  - Refresher ToT
  - Pilot in MoH run facility
  - Review how it can be linked with Disaster Risk Reduction/Early Warning, Early Action (DRR/EWEA)
  - Establish a more developed evidence base for CMAM Surge.

- Who else needs **to be brought on board** to make Surge a success?
  - Stakeholder mapping – roles and responsibilities
  - UN agencies
  - SUN Network – targeting the learning event in the 3rd week of December
  - MOH
  - NGOs
  - Clusters.

9.0 RECOMMENDATIONS

General:

1. Further pre-analysis of national health systems structures and processes to ensure that CMAM Surge can align and integrate where feasible (e.g. health committee, CHCs etc.)
2. Mapping of current and future stakeholders involved in the CMAM Surge approach, including their roles and responsibilities.
3. Advocacy and awareness building of key stakeholders on the Surge approach (e.g. present CMAM Surge pilot at the upcoming SUN meeting).

Caafimaad Plus consortium:

4. CMAM Surge refresher and ToT training for other consortium members (IMC and SOS).
5. Gradually expand the CMAM Surge approach to similar HFs within the Caafimaad consortium.
6. Trail CMAM Surge approach in other HFs with alternative partnership modalities/levels service provision/location. E.g., Stabilisation Centre – Banadir Hospital, MoH led health facility, rural location.
7. Ensure engagement of CHCs in the set up and implementation of the CMAM Surge approach.

8. Ensure that sufficient technical resources are available to support with regular monitoring of HFs, especially within the first three months post training.

9. Establish clear learning outcomes to support the validation of the approach within the context of Somalia (e.g. improvements in shock responsiveness of health facilities, improvement in the quality of care during peak periods).

10. Considering that these learnings are limited to the last six months of the year, the next phase of scale-up should ensure facilities establish Surge earlier in the year to allow learnings across the year

Longer term:

11. Dependant on the learning outcomes advocate with MoH for the validation of Somalia specific CMAM Surge guidelines, and/or integration of the CMAM Surge approach in CMAM or Essential Package of Health Services (EPHS) guidelines.

ANNEX 1: QUESTIONS FOR GROUP DISCUSSION IN THE IMPLEMENTERS' WORKSHOP.

Questions to the health facility stakeholders - 2 facilitated group discussions based, divided by the two HFs

Background information

- Name of the health facility
- The under 5 (U5) target population
- Length of time the facility has been offering SAM services
- The average number of SAM cases per month
- When was the CMAM Surge started in the facility?
- Number of staff who were trained

Setting up of Surge at the facility

- Which approach was used to roll out Surge to the facility? What do you think were the advantages and disadvantages? Do you think it was the best approach? What else could have been done to make it better?

Trends and risk analysis (Step 1)

- Were all the suggested indicators in the trends and risk analysis applicable? If not, which ones were not/should be removed?
- How do you find the monitoring charts, scales, sizes, and their ease of use?
- Which months of the year does the facility have spikes in admission?
- What are the lessons learnt and new approaches developed for the step?

Capacity assessment (Step 2)

- What was the experience?
- What else do you think should have been included?
- Any challenges, lessons learnt with the process?

Thresholds setting (Step 3)

- How were the thresholds set?
- What was your experience in the process of setting thresholds, have you revised them, if yes when and why?
- Any challenges, lessons learnt with the process?

Surge support and formalizing agreement (Step 4 & Step 5)

- How were you involved in the development of the Surge support?
- What are the key resources proposed for the support, how helpful do you think they are? Do they reflect your gaps?
- What were the challenges and lessons learnt in this step?
- Whom have the actions been formalised with?

Real-time monitoring (Step 6)

- Is it normally practical to do real-time monitoring for new admission in the nutrition program? Who does the monitoring? (When do you tack the monthly admissions on the wall chart? /who does this?)
- Have you been completing/updating a seasonal calendar on a monthly basis? If yes, do you compare it with the previous months?
- Have you had a chance to request support mid-month?
- What lessons have you learnt from the monthly meetings?
- What are the challenges and lessons learnt for this step?

Scale-up and scale down (Step 7)

- How many times have you surpassed your thresholds since set up?
- What was your experience, how and who did you communicate with, how long did support take to come, what support came, was it adequate?
- Was the support helpful? Could it have been improved?
- Any challenges, lessons learnt?

General issues

- What challenges have you faced since the inception of the CMAM Surge?
- What changes have you seen since you started the implementation of the CMAM Surge?
- What lessons can you share?