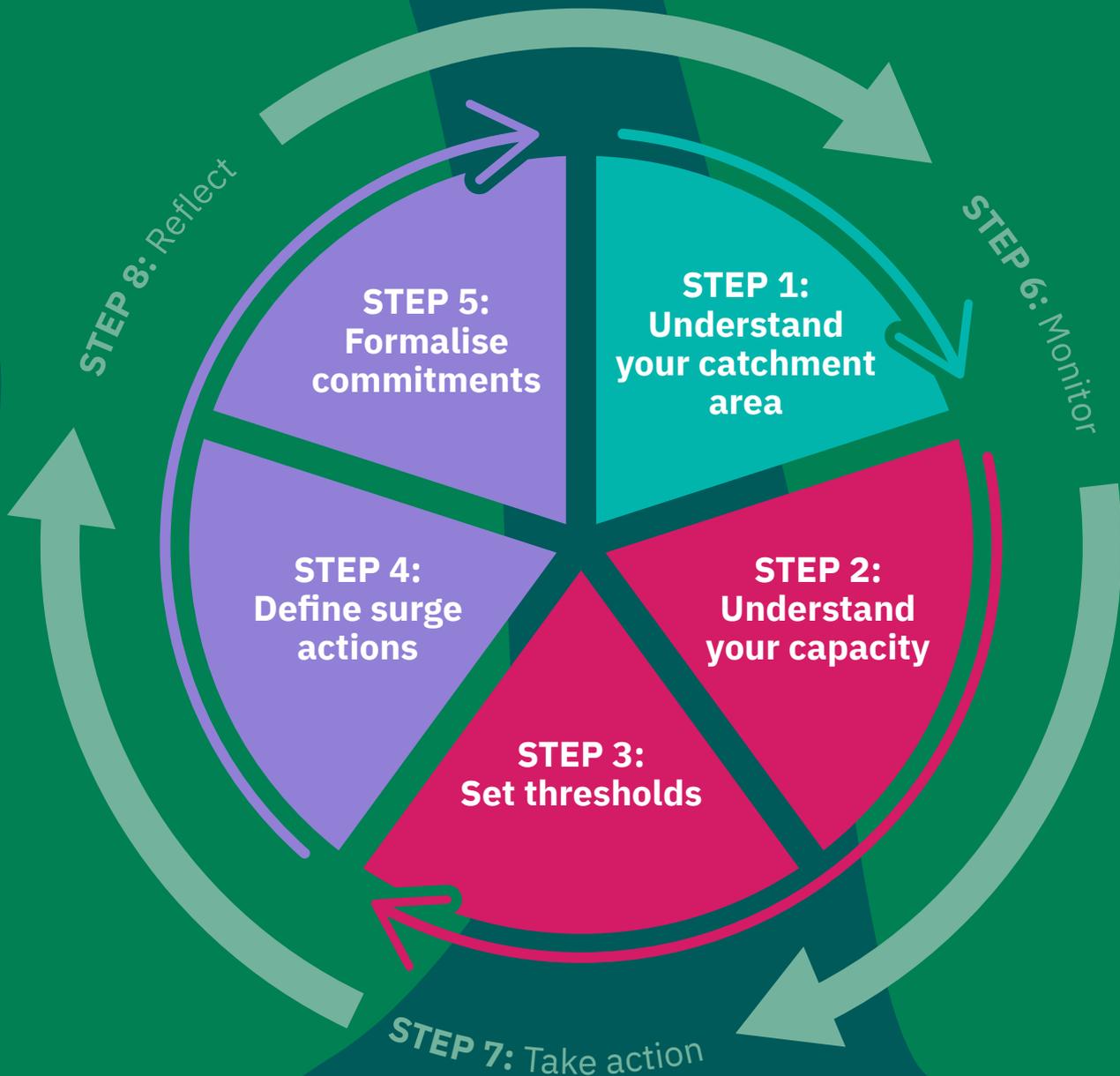


**SURGE APPROACH:
Strengthening local capacity to manage peaks
in demand at health facilities**

Orientation Guide (updated)

JUNE 2023



Acknowledgments

This updated orientation guide is based on the original CMAM Surge Operational and Facilitators guides, and was written principally by Lucy Lafferty (Concern Worldwide) with extensive inputs from Kate Golden (Senior Nutrition Advisor – Concern) and Christine Bousquet (Health Advisor – Concern). Nicola Dent supported the copy editing of the guide (consultant recruited for this purpose).

We would like to thank the Global CMAM Surge Technical Working Group for their direction and inputs during the revision process. In particular, Erin McCloskey (independent consultant) for her initial work in establishing the technical working group and elaborating the learning agenda and Amanda Yourchuck (John Snow Research and Training Institute) and Megan Pollack (Save the Children US) for their feedback on this guide.

We would also like to thank all the governments and partners who have tested, innovated and shared their experience of using the CMAM Surge Approach over the past 10 years. These invaluable contributions have shaped this updated guide. Of note, we would like to thank the West and Central Africa CMAM Surge Taskforce who have fostered a community of sharing and learning since 2017 – in particular, Diane Moyer (Concern) and Anne Sophie Desmaris (previously French Red Cross) who led this group. We would like to thank Terre des Homme (Burkina Faso) and Concern Worldwide (Niger and Kenya) for sharing practical examples to enhance this guide.

Finally, we wish to acknowledge the generous financial and technical support of the European Union's DG ECHO which provided funding to support the revision of this guide via the Enhanced Responses to Nutrition Emergencies (ERNE) programme; in particular, Marie-Sophie Whitney (Regional Nutrition Expert, ECHO Nairobi) who has been a member of the Global CMAM Surge Technical Working Group and the Field Focal Point for the ERNE programme under Concern's Pilot Programmatic Partnership (PPP) with ECHO from 2020–2023.

Preface

This Orientation Guide replaces the initial Community-based Management of Acute Malnutrition (CMAM) Surge Operational and Facilitators guides produced by Concern Worldwide in 2016.

It incorporates learning from pilots and innovations based on ongoing work from Concern Worldwide and other actors including ministries of health (MOH) and other non-governmental organisations.

A West and Central Africa CMAM Surge Taskforce and a Global CMAM Surge Technical Working Group were established in 2017 and 2020 respectively; at regional level to support sharing and harmonisation of good practices and continued contextualisation; and at global level, to ensure technical integrity and documentation. Learning generated and consolidated via these groups (now at the end of their term) has informed this revised guide. Going forward it is encouraged that, where relevant, this approach is included in other health and nutrition forums for discussion. Key changes in this guide include broadening of the approach to include common child illnesses beyond acute malnutrition/wasting; a simplification of the approach to focus on key tools that can be integrated into other existing health and nutrition interventions and trainings, and more focus on community level and national engagement.

In all situations, it is important to first consider existing national guidance and tools. For countries that have already adopted the approach, not all the steps and tools listed in this guide will be relevant and it is encouraged to maintain what has been used and shown to work in that context.

For more background information, access to learning papers and country reviews, information on the coordination platforms and a map of countries using the Surge Approach, please visit the [Surge Approach website](#).

Contents

| | |
|---|-----------|
| Acknowledgments | i |
| Preface | i |
| Introduction | 1 |
| SECTION 1: NATIONAL ENGAGEMENT – INITIAL ANALYSIS OF RELEVANCE | 6 |
| SECTION 2: HEALTH DISTRICT INVOLVEMENT | 10 |
| SECTION 3: IMPLEMENTATION AT THE HEALTH FACILITY | 16 |
| SECTION 4: COMMUNITY ENGAGEMENT | 28 |
| SECTION 5: ADDITIONAL SUPPORT MATERIALS | 30 |
| Conclusion | 32 |
| Annexes | 33 |
| References | 36 |

Introduction

What is the Surge Approach?

The “Surge Approach” is the updated name for the Community Management of Acute Malnutrition (CMAM) Surge Approach. The approach was first proposed in 2012 in Kenya to help the health system more effectively deliver services for children with acute malnutrition during periods of peak demand/high caseloadsⁱ and has since been implemented in 16 countries.ⁱ Since 2020, the same approach has been applied in several contexts to better manage peaks in other childhood illnesses and referred to as “Health Surge.”ⁱⁱ The terms “CMAM Surge” and “Health Surge” will be used if referring to specific learning related to either of these approaches; otherwise, the term “Surge Approach” will be used throughout.ⁱⁱ

The overall aim of the Surge Approach is to make the health system more resilient over time, equipping it to cope with periodic peaks in demand for essential nutrition and child health services – when the potential to save lives is often greatest – without undermining the capacity and accountability of government health actors. In this way, it can contribute to building health system shock responsiveness.³

Where is the Surge Approach most relevant?

The Surge Approach is particularly suited to contexts where there are largely predictable, seasonal fluctuations in the number of children presenting to the health facility with common child illnesses, such as acute malnutritionⁱⁱⁱ, malaria, diarrhoea or acute respiratory infection.

When should you use the Surge Approach?

Introducing the approach during the peak of an emergency is unlikely to yield the intended benefits. In these situations, other critical lifesaving activities should be prioritised. The aim is to have a **surge action plan** in place in areas at risk before a peak period to support the health facility to respond in a timely manner. It is recommended that **at least 3 months are planned** between the setting up of the Surge Approach and the first anticipated seasonal peak period.

What is in the orientation guide and toolkit?

This orientation guide consists of an introduction and **four main sections** dealing with different levels of the health system (1. national, 2. health district, 3. health facility and 4. community). Each section introduces and explains how to use the relevant tools (Table 1). A final section contains additional support materials, including training and orientation resources. All tools referenced are available to download to facilitate easy adaptation (see annexes). Contextualisation of the tools and terminology is critical to ensure **alignment** with national MOH policies and strategies (Box 1). The guide and tools have been designed to promote flexibility to choose the components of the approach that add value based on the health system set up and existing resources.

- i. CMAM Surge: Mauritania, Senegal, Mali, Burkina Faso, Niger, Nigeria, Chad, Cameroon, Sudan, South Sudan, Uganda, Burundi, Kenya, Ethiopia, Somalia and Pakistan. Health Surge: Mauritania, Mali, Burkina Faso, Niger, Chad, Kenya and Ethiopia.
- ii. Please refer to Section 1, for guidance on choosing a name which is suitable to the context.
- iii. For the purpose of this guide, acute malnutrition is considered as a common child illness. See box 1 for more details.

Table 1: Eight core tools for use at different levels

| | | NATIONAL | HEALTH DISTRICT | HEALTH FACILITY | COMMUNITY |
|----------------------------|---|----------|-----------------|-----------------|-----------|
| <i>Assessing relevance</i> | Tool 0.1: Context and stakeholder mapping | ✓ | ✓ | | |
| | Tool 0.2: Decision tree | ✓ | ✓ | | |
| <i>Surge in practice</i> | Tool 1. Seasonal and events calendar | | ✓ | ✓ | * |
| | Tool 2. Trends analysis | | ✓ | ✓ | |
| | Tool 3. Capacity review | | | ✓ | |
| | Tool 4. Threshold setting | | | ✓ | |
| | Tool 5. Surge action plan | | * | ✓ | * |
| | Tool 6. Monthly monitoring | | | ✓ | |

*involved in completing the tool at a health facility level

Who is the orientation guide and toolkit for?

The primary audience are MOH management teams at health district, regional or national level and health workers at health facility level, as they are responsible for overseeing or implementing health facility activities, respectively. It is also aimed at partner organisations (principally non-governmental organisations and United Nations agencies e.g. UNICEF, WFP, WHO),^{iv} health and nutrition clusters and, potentially, disaster response actors.

BOX 1: TERMINOLOGY USED IN THIS GUIDE

For the purpose of this guide, the following terms are used, but these should be adapted to what is used in country.

Acute malnutrition and wasting

- **Acute malnutrition, severe acute malnutrition (SAM) and moderate acute malnutrition (MAM)** will be used throughout the guide. At global level, there is a move to use the term wasting in place of acute malnutrition⁴ However, acute malnutrition, SAM and MAM are the terms commonly used by health workers, thus used throughout this guide.

Child illness

- **Common child illnesses:** These refer to malaria, diarrhoea and acute respiratory infection, as well as SAM and MAM, which are the leading illnesses for children under-five globally.
- **Priority child illness(es):** Thresholds will be set for these illnesses: SAM is assumed to always be included (unless the prevalence of SAM is very low in the target area). A second priority child illness may be identified based on an analysis of trends in monthly consultations for common illnesses in the target area. Guidance on how to identify the priority child illness(es) is provided in Section 1 and Section 2.

A common term for SAM admissions and under-five consultations

- **Consultations** will be used in the guide as a blanket term to refer to both new admissions of SAM and outpatient consultations for other common illnesses among under-fives (this will often include new and return visits by the same child, as it is often very difficult to distinguish between them).
- **New admissions are used to track SAM** (rather than, for example, total in programme or caseload) because most *CMAM Surge* experience to date has used new admissions. New admissions are the most time consuming, simpler to track on a monthly basis, and are better aligned to the one-off reporting for under-five curative consultations.

iv. Aspects of the Surge Approach can be used by partner organisations to support with their own internal planning.

Summary of the Surge Approach

The approach is structured around **eight-steps**, introducing **simple tools** that enable health workers and district health teams to identify risk factors for, and patterns of, common child illnesses in their community (Figure 1). It enables health workers to better understand their capacity to manage increased caseloads and to put in place a practical health facility level action plan, which can be triggered when their capacity is overwhelmed. The aim is to protect the quality and continuity of health services. The action plan can be divided broadly into two types of actions 1) making *internal* changes to improve immediate capacity to respond to increased service demands (alert phase) and 2) requesting additional *external support*, from the district health management team (DHMT) or actors in the area, if peaks are beyond health facility capacity (serious phase).

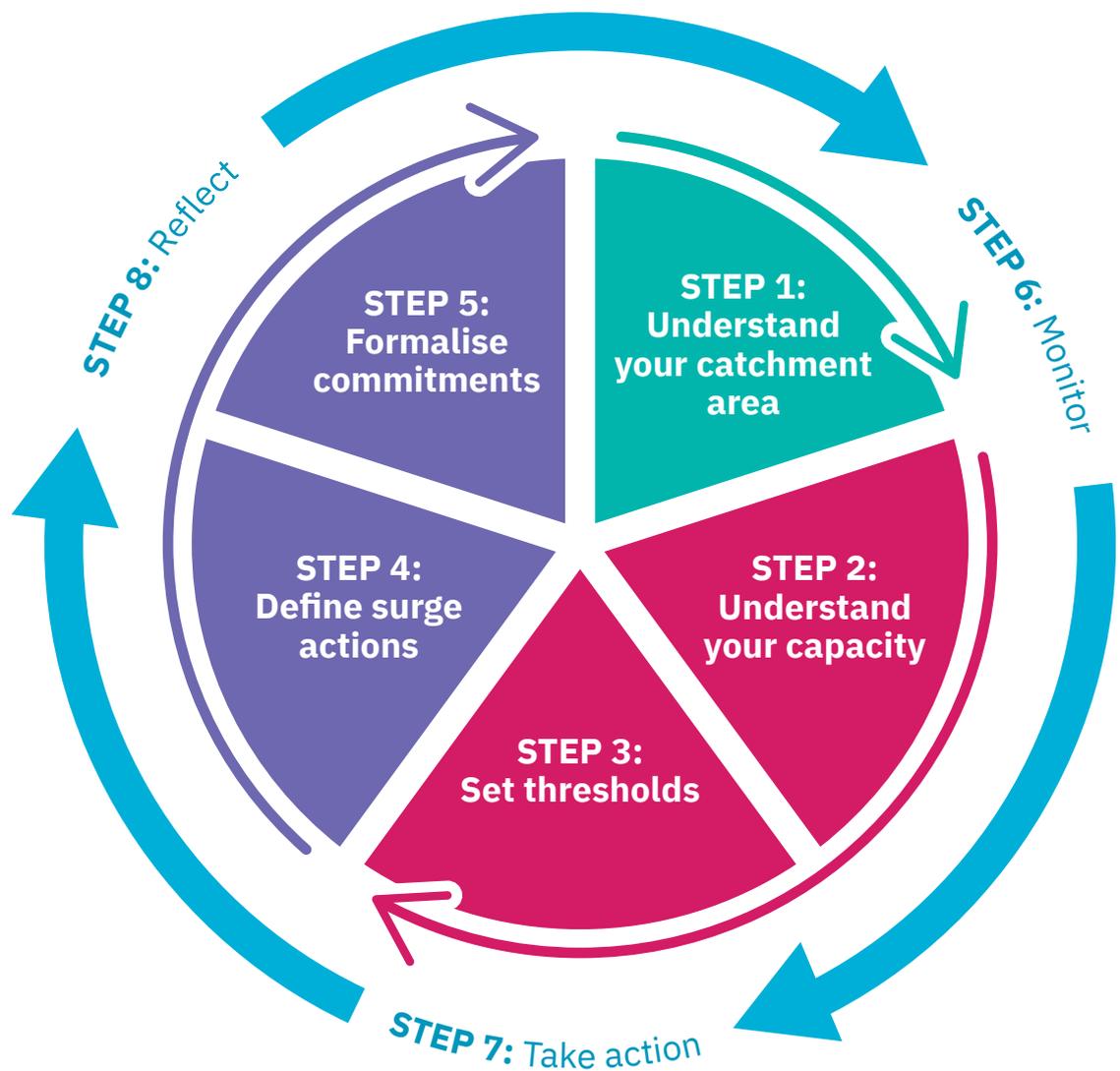


Figure 1: The eight steps of the Surge Approach (updated)

Table 2: Summary of the eight steps**STEP 1: UNDERSTAND YOUR CATCHMENT AREA**

The health facility team* create a seasonal and events calendar and analyse historical trends in common child illnesses (including acute malnutrition) using wall charts. This information is used to identify potential risk factors that drive peak periods in service demand of the **priority child illness(es)** in that community. (Priority child illness(es) will usually be defined by the DHMT and in most cases will be SAM and one other common child illness).

STEP 2: UNDERSTAND YOUR CAPACITY

The health facility team reviews their capacity to manage essential child health and nutrition services during normal times and peak periods and identifies capacity gaps to be addressed. They then agree on the **number of consultations** for the priority child illness(es), which they **consider to be ‘manageable’ each month** with existing capacity.

STEP 3: SET THRESHOLDS

The health facility team then agrees on thresholds or ‘cut off point’s defined as the **number of consultations of the priority child illness(es)** that would push the health workers into the **alert** and the **serious phases**. When the **alert threshold** is crossed, the health facility will need to take **internal actions**, making small adaptations to maintain the quality of service delivery. When the **serious threshold** is crossed, the health facility team would require **external support** to ensure delivery of quality services to all patients.

STEP 4: DEFINE SURGE ACTIONS

The health facility team, in discussion with key stakeholders from the community and the DHMT, outlines a **surge action plan**. The action plan includes: actions to help **prepare for expected peaks** in service demand during normal times; **internal adaptations** for the alert phase (e.g. community health workers help with anthropometric measurements) and **external support needs** for the serious phase (e.g. additional medical supplies, nutrition commodities or staff). Actions which have a cost implication are noted so commitments from stakeholders to resource the actions can be agreed in Step 5.

STEP 5: FORMALISE COMMITMENTS

The health facility team, other community stakeholders and the DHMT **agree how the actions in the surge action plan (Step 4) will be resourced and who will be responsible** to ensure they are delivered swiftly when thresholds are passed. The DHMT may make further agreements with regional stakeholders and non-government actors to support them to deliver the support to health facilities.

STEP 6: MONITOR

The health facility team monitors the **seasonal and events calendar** noting any deviations from what was expected (e.g. delayed rains, sudden population movement, mass screening campaign). The actual **number of consultations for the priority child illness(es)** each month are plotted and **compared against the set thresholds**. Trends in other common child illnesses are also monitored.

STEP 7: TAKE ACTION

The health facility team **triggers preparedness actions** if the monthly review of the situation indicates consultation numbers may increase soon. If the alert threshold is crossed, health workers will **trigger their agreed internal actions** from the surge action plan (which may include support from community health workers). If the serious threshold is crossed, they will **communicate directly with the DHMT (and community)** to trigger the support agreed as soon as possible. Once the situation stabilises the adaptations/actions can be stopped or scaled down.

STEP 8: REFLECT

Ongoing **review and reflection are critical**. The health facility team, ideally joined by a DHMT representative and community member/s, must regularly review their capacity, thresholds and surge action plan and adapt as needed (at a minimum once a year). In addition, the health facility team is encouraged to complete a simple ‘post-surge’ evaluation to review the impact and efficiency of any surge response.

* The health facility team consists of health workers at the health facility level (e.g. health facility in-charge, clinical officers, nurses, nutritionists, or other staff delivering health services) and community health workers (i.e. health care provider who lives in the community they serve and may provide a range of services, including basic clinical services e.g. at a health post).

Evolution of the approach

Since the early pilots in 2012, significant expansion, innovation, and learning around the Surge Approach has taken place, especially across the Sahel and East Africa regions where there are distinct seasonal patterns of common child illnesses. This learning has been incorporated into this guide and associated tools.^{5,6} Key changes include:

» *Moving to a more holistic ‘Surge Approach’*

Reviews of **Health Surge** found that applying the CMAM Surge steps to support the management of other child illnesses is relevant and addressed the needs of health workers by supporting them to better manage increases in consultation numbers, especially during peak periods. Using the Surge Approach in a broader sense was a logical expansion as described by a District Medical Director in Niger “...it is not only malnutrition that is the biggest burden of the work, it is malaria.”⁷

» *Promoting better integration into health systems*

A section dedicated to **national level engagement** provides guidance and tools to assess if/how the Surge Approach is relevant to a country or regions: “*Securing government ownership in each country of implementation needs to be a priority to avoid it being regarded as an external intervention. In this respect, governments should adapt the approach to fit their health system and specific needs*”.⁸

The national section guides users on how to identify key stakeholders and potential entry points in the health system and provides some tips on adapting the approach to each country context. Two ‘pre-step’ tools (Tools 0.1 and 0.2) aim to support a smoother integration of the Surge Approach into existing health system functions, including, existing trainings e.g. for the management of acute malnutrition and/or the integrated management of childhood illness.

» *Increased focus on community engagement*

A section dedicated to **community engagement** focuses on improved sharing of information and leveraging community resources to prepare and respond to peak periods. The important role of the community in managing peak periods was highlighted by a Deputy Mayor in Niger: “*It is the mayor’s office that is accountable to the population and it is important that we are involved...[in supporting surge action plans], for example, financing of a temporary labourer in a health facility, essential rehabilitations, fuel assistance for patient referrals, and sourcing an ambulance...*”⁹

» *Improved preparedness*

Within the guide, more focus has been placed **on using routine monitoring information to anticipate and prepare** for rises in under-five consultations, rather than waiting for thresholds to be crossed e.g. increasing community acute malnutrition screening or repositioning nutrition commodities or essential medicines when a change in the situation is noted on the seasonal and events calendar. Understanding and using information from any early warning systems¹⁰ that are established in the country is important because they are likely to help predict events and thus trigger earlier action at a health facility level.

» *Improved guidance on financing surge actions*

More emphasis is placed on **identifying and leveraging funding at a health district level for surge responses**, either through integration into annual planning/budgeting or by establishing links with regional or national rapid response or contingency funds. Mapping out how support (additional funds, staff and supplies) can be accessed by high-risk health districts so it can be quickly channelled to health facilities when they cross thresholds is included.

SECTION 1: NATIONAL ENGAGEMENT – INITIAL ANALYSIS OF RELEVANCE

The involvement of national and regional stakeholders from the beginning of the process is critical to determine if the Surge Approach is relevant for the country or specific areas within the country. Early engagement with national actors will also influence the subsequent success of the Surge Approach if it is taken forward and reduce it being regarded as an external intervention. Deciding whether the approach is **appropriate and feasible** must be based on a thorough understanding of the country context, its health system, and how the approach can be contextualised.¹¹

How to engage national stakeholders?

A meeting or workshop is the ideal way to engage key stakeholders at national or regional level to orient them on the basics of the Surge Approach and jointly decide if the approach is a good fit for the country or part of the country, and if yes, how to take it forward. The **context and stakeholder mapping tool (Tool 0.1)** can be used to guide this process. There are three main parts in the tool, each with guiding questions.

The aim of this tool is to determine:

- If the country or specific areas experience peaks in consultations of common child illnesses;
- How the health system functions and potential entry points for the Surge Approach;
- Who should be engaged and involved.

Before the meeting/workshop some of the basic information should be gathered and analysed (desk review) to plan the content and guide the discussion:

- List of key stakeholders (who to invite to the initial meeting/workshop);
- Key health and nutrition policies and strategies which will inform this process, as well as any national profiling or mapping exercises that have been previously completed;
- Trend analysis of common child illnesses (by region/ sub-national area): collating monthly consultation data from the health information management system (HMIS).

Additional support materials, such as an introduction presentation, are provided in [Annex 3](#), and can be adapted and used as needed.

1.1 Trends and Location: WHERE could the Surge Approach add value?

A review of regional (sub-national) level trends in common child illnesses, by month, will provide an understanding of how consultation numbers fluctuate throughout the year. It should also highlight any **marked geographical differences between regions** – identifying areas that are more likely to experience peaks in the number of consultations during certain times of the year. Tool 0.1 (component on *trends and location*) can help organise some of this data and includes questions to ask when reviewing the data. The HMIS should be used where available, but be mindful of the completeness of HMIS data when interpreting trends.

The Surge Approach **is most appropriate where there are fluctuations or peaks in consultations for child illnesses during certain months of the year** and where these peaks can be **anticipated to some degree**. If no fluctuations are seen initially, and there are expected fluctuations based on local knowledge of the regions consider reviewing the data of certain health districts within regions (see Section 2).

Within countries, there may be **distinct livelihood or ecological zones**, with different climate and seasonal factors **influencing the profile of common child illnesses and the timing of peaks**. These seasonal fluctuations are often, but not exclusively, driven by the occurrence of the annual lean season/hunger gap; rainfall patterns (particularly for malaria or diarrhoea peaks); and seasonal migration or increases in workload, particularly for women as primary caretakers. Unfortunately, climate change is making ‘normal’ seasonal patterns more difficult to predict, but it is still important to leverage knowledge of these factors as much as is possible to improve planning. Analysis of these seasonal factors and events alongside the child illness trends is explained further in Section 2.

While the Surge Approach is focused on improving the quality of services at a health facility level, it is **important to consider if the number of under-five consultations reflects the true situation at a community level**. Therefore, reviewing any available information on the prevalence of common child illnesses, and the coverage of treatment services in the likely target areas will help decide its relevance (e.g., low coverage of health and nutrition services, efforts to increase coverage such as community level screening or outreach services may need to be prioritised before or alongside the Surge Approach).

NIGER – HEALTH SYSTEM MAPPING EXERCISE (CONCERN WORLDWIDE)

In Niger, the transition from CMAM Surge to Health Surge highlighted the diverse systems that the Surge Approach could and should engage with. A mapping exercise was conducted at the start of the Health Surge pilot to identify key stakeholders within the health system that needed to be involved. Beyond the MOH, important functions and relevant opportunities were identified within the Ministry of Humanitarian Action and Disaster Management (notably the rapid response mechanism) and the National Food Crisis Prevention and Management System: Early Warning System. The mapping exercise also highlighted how Health Surge was contributing to health system strengthening. (See [Annex 3](#) for an example of the Niger mapping.)

1.2 Health System Mapping: HOW does the health system function and what are potential entry points?

It is important that the Surge Approach aligns with national priorities. The *health systems mapping* component of Tool 0.1 aims to compile information on how the health system is set up and existing resources, helping **to guide decision makers on the relevance of the Surge Approach**, and how **links could be established, synergies promoted, and duplication avoided**. It can help identify ways in which the Surge Approach can address gaps under specific health system building blocks (see [Annex 4](#)).

Tool 0.1 (*health systems mapping* component) includes a set of key questions exploring different aspects of the health system and emergency response mechanisms at national, regional and district levels. These include understanding the nutrition and medical supply systems, HMIS, integrated disease surveillance and response systems, funding mechanisms, early warning systems^v and other early action mechanisms. It also suggests how the information gathered can be presented visually.

1.3 Stakeholder mapping: WHO should be involved?

The key stakeholders who will be **directly involved in implementation or have influence over the Surge Approach at each level** – national, regional, district, health facility and community – should be identified early on. This is likely to include people from key MOH departments, health and nutrition cluster/ coordination body members and non-governmental organisations, at a minimum. Use the health system map to help **brainstorm a list of actors** (see **Tool 0.1** component on *stakeholder mapping*).

Beyond health and nutrition, it may be relevant to establish links with national early warning systems or rapid response mechanisms or actions to share relevant information, at a minimum, and to explore opportunities to access and pool resources for wider response if and when health facilities are overstretched.

v. An early warning system is an integrated system of hazard monitoring, forecasting and prediction, disaster risk assessment, communication and preparedness activities systems and processes that enables individuals, communities, governments, businesses and others to take timely action to reduce disaster risks in advance of hazardous events (*Sendai Definition – Risked Informed Early Action Partnership, 2022 Edition*)

For all actors it is important to have a clear understanding of their **role and responsibilities** within the health or related system.

Relevance and feasibility:

Deciding if the Surge Approach adds value and if yes, where?

Once an understanding of the context has been established, the decision makers (MOH and other relevant partners) should **decide if it makes sense to introduce tools from the Surge Approach** at a health district and health facility level. Key questions to ask, include:

- On balance, will the Surge Approach be useful in this country?
- Is it relevant to the whole country or specific areas within it? If specific, where?
- Are there other activities that should be prioritised first or alongside integrating the Surge Approach (e.g. improving access to services)?
- Who are the key stakeholders to work or discuss with further?

A **decision tree (Tool 0.2)** is available with a list of questions linked to the information gathered during the context and stakeholder mapping. Following the questions in the decision tree, you will arrive at **one of three options**:

YES: take the Surge Approach forward and consider how to best adapt and use tools. Refer to **considerations for contextualisation** below and **Section 2: Health District Involvement**.

MAYBE: the Surge Approach appears relevant. However, there are certain activities that should be completed before starting (e.g. improve screening and referral of cases) and/or it might be preferable to start with a small pilot to get buy in from stakeholders.

NO/NOT YET: Consider reading through the guide anyway and think about it for the future.

Contextualisation: What to consider?

Once a decision has been made to integrate the Surge Approach, it is important to use the information gathered using Tool 0.1, to contextualise the approach and tools **to ensure they make sense to health workers in that context and to further explore any potential entry points** to integrate with and reinforce the national health system.

NIGER – NAMING OF THE SURGE APPROACH (CONCERN WORLDWIDE)

An evaluation completed in 2022 proposed the word “*hanguie*” (haoussa) which means “*to see ahead and what is coming*” and “*dogoney*” (zarma) which means “*overcoming or needing support*”. As the Surge Approach had, at that time, already been implemented for over seven years a new name was not adopted, but these terms are being used when supporting health workers to implement the approach. Other countries should generate possible names for discussion as the approach is introduced.

Identifying a local name that reflects the Surge Approach objective, will be understood by health workers and does not create confusion with other related approaches should be considered during the initial analysis or workshop. Evaluations have shown that “CMAM Surge” or “Surge Approach” are sometimes not well understood by health workers, and this impacts the ownership of the approach.¹²

Adapting the standard terminology and definitions in this guide to align with national health and nutrition guidelines and protocols is important at the outset. Countries should use their own administrative divisions (e.g. district, state, locality, county, commune, etc.) and substitute their own terms for the body responsible for managing health service delivery (e.g. District Health Office, County Health Management Team) or for health facility types (e.g. health centre, primary health care unit) or health worker titles, including at the community level (Box 2).

BOX 2: TERMINOLOGY USED IN THIS GUIDE – HEALTH SYSTEM LEVELS

National: Anything happening at the federal or policymaking level of the health system.

Health district: Including DHMT for the first level of management above the health facility, (note some countries also have regional health management or zonal teams between the health district and national level).

Health facility: Any location where healthcare is provided: hospital, health centre, health post.

Health worker: Health facility staff including health facility in-charge, clinical officers, nurses, nutritionists, or other staff delivering health services.

Community health worker: Health care provider who lives in the community they serve and may provide a range of services, including basic clinical services e.g. at a health post.

Volunteer: Individual freely giving time for community services (e.g. community nutrition volunteers, community health volunteers, 'lead' mothers).

Further points related to contextualising Tools 1–6 is discussed in Section 2. For example, it will be important to consider the frequency of reporting for health and nutrition information or how annual health facility plans are elaborated and funded.

SECTION 2: HEALTH DISTRICT INVOLVEMENT

This section describes the **involvement of the health district in supporting** health facilities to integrate the Surge Approach into their routine health service delivery activities.^{vi} It is crucial that the DHMT leads the process and are involved in developing **surge action plans** at the health facility level, as budgets and resource reallocation, particularly for staff and supplies, are likely to come from the health district in the event of any *serious* thresholds being passed.

The initial analysis of the relevance of the Surge Approach (Section 1) completed at a national (or regional) level should be made available to the DHMT. In addition, the **DHMT should be familiar with the detailed guidance** for health facility staff in **Section 3**.

INVOLVEMENT AND ROLE OF THE HEALTH DISTRICT

2.1 Expand on the context and stakeholder mapping (Tool 0.1)

This will help the DHMT to decide if all health facilities in the health district can be covered, and if not, which to prioritise. It will also help determine which child illnesses are putting the greatest stress on the workload of health facilities (i.e. priority child illnesses). It is important to do this first, before moving to health facility level.

Health facilities:

- Map or list all the health facilities in the health district and note:
 - » The different types of health facilities (e.g. health post, health centre, hospital);
 - » The services offered in each type;
 - » The links between health facilities (e.g. number of health posts linked to a health centre);
 - » Who manages them (e.g. DHMT or private entity or non-governmental or faith-based group).

Key stakeholders:

- Highlight who will be directly involved in implementing or have influence over the Surge Approach. This will include health facility staff, community actors, and partners working in the health district, among others.

Situation and trends analysis:

- Complete a basic **seasonal and situational events calendar** for the health district (see [Tool 1](#)).
 - » Consider what might influence the fluctuations in consultation numbers of common child illnesses and whether there are distinct differences across the health district.
 - » Refer to any health district level early warning system data to get more precise weather/ climate information to inform the seasonal calendar.
- Analyse the trends in common child illnesses across the health district for at least the last year. Use the HMIS to create trend graphs, or download the data/gather from another database and use [Tool 2](#).
 - » If possible, review the monthly consultation data **by health facility** and note which health facilities have **the highest number of consultations** and **in which months** (they are more likely to require additional support).
- Compare the trends analysis with the seasonal and events calendar for the health district. Note **factors that tend to drive up the number of consultations** at different times of the year.
 - » Is it what you expected and what you see most years?
 - » Are there any seasonal factors or events driving these trends in consultations?

vi. Note: differing from the old guidance, it is not advised to 'set up' the Surge Approach, following the eight-step process, at a health district level.

Identify which common child illnesses have **distinct seasonal fluctuations and impact the workload of health facilities most significantly**. These child illnesses will be the **priority child illness(es)** for which health facilities will set thresholds (Box 1). Guidance may have been provided by the national or regional level, if so confirm that the chosen priority child illness(es) are reflective of the trends and situation analysis completed at a health district level. Consider that there may be variations within the health district.

BOX 3: NOTE ON MODERATE ACUTE MALNUTRITION

- MAM consultations can be plotted as a common child illness as part of the trends analysis as they will affect workload and service quality in the health facility.
- It is however important to remember when reviewing trends, that trends in MAM are strongly affected by availability of the supplementary feeding service and the pipeline of supplementary foods.
- The best way to understand and predict MAM new admissions is often by knowing when the food pipeline is expected to continue or stop. It is not advised to choose MAM as a priority child illness for this reason
- It might be more useful for health facility staff to record events that may increase or decrease MAM admissions (e.g. supply breakages of ready to use supplementary food, screening campaign) on their seasonal and events calendar to help anticipate surges in workload.

Understand the disease surveillance and response mechanism in country:

- Integrated Disease Surveillance and Response (IDSR) mechanisms focus on prevention and control of priority communicable diseases facilitating timely and targeted response to outbreaks and other public health emergencies (from a national level).^{vii} Note, they may go by another name.
- Priority communicable diseases are identified and trends monitored through the IDSR mechanism. This mechanism may be linked to the national HMIS but is sometimes managed separately with more frequent reporting (e.g. weekly basis).
- It is important to consider how the Surge Approach can complement (and not duplicate) this mechanism. The Surge Approach sets capacity-based thresholds, defining when the normal workload of health workers would be surpassed. It intends to protect the quality of service delivery at a health facility level with local responses. This differs from alert or epidemic thresholds set by IDSR mechanisms, which are intended to detect disease outbreaks, with responses managed at a national level.

Finally, decide which health facilities should integrate the Surge Approach:

- When planning to introduce the Surge Approach, ideally **all health facilities in the health district** should be targeted for ease and consistency in managing and monitoring thresholds and response.
- If it is not possible to support the entire health district, **prioritise the health facilities that more often experience significant fluctuations in consultations due to local factors**, as they should benefit the most. This may be a specific type of health facility, for example, health centre rather than health post, or health facilities in a particular livelihood zone.
- It is helpful to have the **same priority child illnesses selected for an entire health administrative area** (such as a health district) for efficiency in supervision, monitoring thresholds and supporting response across a health district.

vii. Definition (source: OpenWHO.org): Integrated Disease Surveillance and Response is a strategy adopted by countries in the WHO African Region for implementing comprehensive public health surveillance and response systems for priority diseases, conditions and events at all levels of health systems.

2.2 Support the integration of the Surge Approach at health facilities

The DHMT has an important role to play in supporting health facilities to understand their capacity limits and building surge capacity for peak periods. **They should be familiar with the steps and tools laid out in Section 3.** There are additional support materials in Section 5, which might be useful for orientating staff on the approach.

Capacity review:

- **Each health facility** will complete an **individual capacity review**, reflecting on how they have managed previous peak periods, as well as their capacity in normal times.
- Recent supervision reports or other assessments, if they exist, can be used when completing this exercise. Having a member of the DHMT present during this process is helpful to guide the health facility staff.

Threshold setting:

- The DHMT should provide clear guidance to health facilities on **threshold setting** for the **priority child illness(es)**.
- In general, thresholds will be set **for SAM and one other priority child illness** that demonstrates significant peaks and impacts the workload of health workers e.g. contexts with seasonally driven diarrhoea or malaria will often have seasonal peaks in acute malnutrition as a result.
- **Case definitions** should align with the national HMIS and clinical guidelines, to ensure that monitoring of thresholds reinforces routine and timely reporting.
- In most health facilities, reporting is monthly, **therefore thresholds will also be set in terms of consultations per month**. The process of setting thresholds is outlined in Section 3.

BOX 4: DEFINITION OF A THRESHOLD AND TRIGGER

A **threshold** is a recognised point at which a response is required.

In the Surge Approach, thresholds are a cut-off point, defined as the number of monthly consultations that a health facility team feel is beyond their capacity to manage well.

A **trigger** represents a change that causes an event or situation to happen or exist, indicating the need for a decision.

In the Surge Approach a trigger is used to refer to a change in the situation (e.g. seasonal or situational event) which may prompt action.

Surge action plan:

- Each health facility will elaborate a **surge action plan** based on their capacity and how they have managed peak periods in the past.
- If they have not participated in the elaboration of the surge action plans, the DHMT should **review the anticipated support needs** of each health facility.
- It is critical that the DHMT **supports the costing of the actions**. At a health facility level, they will usually have only noted if there was or was not a cost implication for each action.

2.3 Forecast needs and identify resources

Once the Surge Approach has been introduced at a health facility level, the DHMT should reflect on the overall support needs and their capacity to support health facilities if thresholds are crossed.

First, the DHMT can rank health facilities according to their capacity, referencing the capacity reviews completed by health facilities (Table 3). This can help identify gaps in service delivery that need to be addressed and provides an overview of where capacity varies so that support can be prioritised during peak periods.

Table 3: Prioritisation of health facilities (suggestion for categorisation)

| # CONSULTATIONS | CAPACITY | | |
|-----------------|------------|------------|------------|
| | | LOW | HIGH |
| | Low | Priority 2 | Priority 4 |
| High | Priority 1 | Priority 3 | |

Second, the DHMT can reflect on their own capacity to support health facilities when thresholds are crossed. What resources could they access if needed (e.g. from partner or regional level)? What could they manage themselves? It might be useful to consider past peaks:

- *What resources were available within the health district (e.g. staff, supplies, funds)?*
- *Was a rapid response mechanism triggered?*
- *Were there any resources that the health district could not access or were insufficient?*

Third, the DHMT should think through different scenarios of health facilities requiring support. There may be certain times of the year when many health facilities have passed their thresholds and require support at the same time. It is essential to plan for this and ensure the health district has the resources to support them.^{viii} Table 4 outlines three different scenarios that may help to guide the discussion.

Table 4: Health district scenario support planning

| NORMAL | TYPICAL SEASONAL PEAK PERIOD | EXCEPTIONAL PEAK PERIOD |
|--|---|---|
| What does this scenario look like? (will vary by context) | | |
| <p>One or two health facilities may be in alert phase but are managing the situation without any support from the DHMT. No health facilities have passed their serious threshold.</p> <p>Preparedness actions may be triggered based on knowledge of seasonal trends or changes in the situation.</p> | <p>Several health facilities may be in alert phase and a few in serious phase requiring additional external support.</p> <p>Health facilities in <i>alert</i> phase should manage the situation internally. Health facilities in <i>serious</i> phase will require additional support from the DHMT (e.g. temporary secondment of health worker from one health facility).</p> | <p>A significant number of health facilities in the health district pass their serious thresholds at the same time.</p> <p>The DHMT cannot manage the situation without support from external partners or from a higher level of the health system. Strategies such as temporary secondment of staff is not possible because too many health facilities are in need.</p> |
| How does the health district fund the support needs in this scenario? | | |
| <p>The DHMT should use their annual health budget to fill gaps in basic capacity as normal, and support health facilities to carry out basic preparedness actions if peaks are expected.</p> <p>They should plan where they will secure funds from if/when thresholds are crossed.</p> | <p>The DHMT should be able to manage the situation with their own resources within their annual health budget. For example via a flexible surge support line in their annual budget.</p> | <p>The DHMT is likely accessing additional sources of funding that were previously identified for the exceptional peak period e.g. from the Regional Health Office, National MOH or Emergency Fund.</p> <p>Access to these additional funds may be on a rolling basis and may require declaring a heightened state of need for the funds to be made available.</p> |

viii. It is not recommended to set thresholds at a health district level, but to rather monitor the situation across the health facilities in the health district, and then respond based on the capacity of the health district at that time.

Fourth, the DHMT should consider the funding sources that could be accessed under the different scenarios above to ensure effective response considering peak periods in the past. The DHMT should gather and consolidate the surge action plans and estimate the potential funding needed to deliver the actions when some or many health facilities pass their thresholds.

The context and stakeholder mapping exercise (Tool 0.1) outlines key considerations that can now be further elaborated on. For example:

- **Health district annual review and budgeting:** When does the process start? What activities can be financed? Could a flexible ‘surge’ support line be included?
- **Contingency/emergency funding:** What additional funding sources are available to the health district or could be accessed if further support was required? Is there a national rapid response mechanism that could be activated in response to population displacement/conflict or other emergencies? Is there an integrated disease surveillance and response mechanism that may trigger a response, and if so how?

ESTABLISHING LINKS WITH MOBILE CLINICS (RAPID RESPONSE MECHANISMS)

Rapid response mechanisms generally trigger a response when a shock occurs, such as rapid population displacement, and local capacity to respond is overwhelmed. Two key time points have been identified where links could be strengthened between the Surge Approach and rapid response mechanisms, these are being explored future in Niger.

Firstly, if the ‘serious/emergency’ surge threshold in a health facility is breached – and adequate external support cannot be provided by the health district – rapid response mechanisms could be activated to support the health district.

Secondly, post a rapid response mechanism intervention – the surge action plan could support resumption of routine activities increasing the capacity of the health facilities in that catchment area.

The DHMT should aim to include a ‘surge support’ line in the annual health district budget if possible – this may require some advocacy. They should also explore **formalising agreements with regional actors or implementing partners** for situations when they are not able to resource their own commitments or for ‘exceptional peak periods’. For each funding source, it is essential that the DHMT understand how support could be triggered and what the DHMT would need to do to facilitate that and access funds quickly.

Once the funding sources have been confirmed, the DHMT can **formalise their commitments with the health facilities** for actions where they have secured funding.

Formalising commitments is important to ensure roles and responsibilities are clear and thoroughly understood and will vary depending on the context. It could be in the form of a signed letter, memorandum of understanding or minutes from a meeting.

2.4 Monthly monitoring and supporting surge responses

Any aspect (i.e. step or tool) of the Surge Approach which has been integrated in to routine health activities should be **regularly monitored**. Support to health facilities **should be provided as agreed in their surge action plan**.

Routine monitoring and supervision:

- At a health district level, it is important that **monitoring surge preparedness is integrated into routine supervision** and is not a separate, stand-alone activity (which can be costly and inefficient). This includes reviewing and confirming set thresholds and surge action plans in each health facility. If a standard health and nutrition supervision grid or checklist exists, questions linked to the functionality of the Surge Approach could be included (see [Annex 3](#) for suggested questions).

Health facilities will monitor three main components on a monthly basis if implementing the Surge Approach 1) seasonal and events situation 2) common child illness trends and 3) number of consultations of the priority child illness(es) against the pre-agreed thresholds. More details in Section 3.

BURKINA FASO – DIGITAL TECHNOLOGY AND THE SURGE APPROACH (TERRE DES HOMME)¹³

In Burkina Faso, Terre des Homme have been using digital solutions to strengthen health and nutrition service delivery, working closely with the MOH since 2014. Together, they developed the electronic diagnostic approach to improve access to equitable and comprehensive health care in hard-to-reach areas. The approach consists of four pillars –

1) electronic consultation register, 2) data management, 3) quality improvement and supervision and 4) online learning. In several regions, Terre des Homme integrated the Surge Approach, allowing health workers and district health teams to receive an alert by phone when the number of consultations crossed the capacity threshold. This digitalisation allowed early warning alerts to be shared in real time, and actions to be taken in a timely manner.

KENYA – COUNTY LEVEL MONITORING USING DASHBOARDS (CONCERN WORLDWIDE)¹⁴

In Kenya, County Health Management Teams have been using Surge dashboards to monitor which health facilities across the County have passed their threshold each month and to gauge the level of ‘stress’ on the County health services. County Health Management Teams enter monthly SAM and MAM admissions into the excel dashboard, using the numbers reported by facilities via the HMIS. The thresholds for each facility are entered into the dashboard at the start of the year (and updated if they are changed). Cells in the dashboard turn orange or red when a health facility crosses their alert or serious threshold. Health facilities also call the County team when a threshold is passed. County and Sub-county health managers have reported the dashboards help them plan and trigger Surge support but also to prioritise facilities when resources are limited.

- It is not essential that the DHMT maintains oversight of the exact threshold cut-offs because they are dynamic and likely to change. It is important, however, that the DHMT advises the health facility in-charge to alert them immediately if any threshold is crossed (via phone/text etc.), especially at the higher level of “*serious*”, and that this is noted. In some contexts, the DHMT may decide to visit the health facility to verify the situation.
 - » The health district should continue to **monitor the monthly situation via the HMIS**. Any significant increases in child illness consultations or any changes in seasonal and routine events should be noted.
 - » Any changes observed allows the **health district to prompt or support health facilities to take early action to better prepare for a peak period** (e.g. pre-positioning stock) or activate preventative actions to reduce potential rises in consultations (e.g. activate a screening campaign or mosquito net distribution). Some preparedness actions such as pre-positioning stock will depend on the health district’s available budget and/or resources.

Supporting a surge response if requested:

- Depending on the district-wide situation, **resources may be reallocated from a neighbouring health facility or budget mobilised from the health district ‘surge support’** line to respond to a *serious* threshold being crossed. However, if the capacity of the health district is already overstretched, the DHMT may have to request support from a regional level or implementing partner, arrangements for which should be confirmed previously. It is essential that communication is clear and happens promptly so that resources are mobilised efficiently and the quality of services are not compromised.
- After each surge response, a **‘post-surge’ review** should be completed by the health facility. The DHMT should support this, and encourage the health facility to revise their capacity review and adapt thresholds and/or surge action plans accordingly.

SECTION 3: IMPLEMENTATION AT THE HEALTH FACILITY

This section introduces a set of tools to integrate the Surge Approach at a health facility. The tools are designed to be used by health workers, engaging key stakeholders from the community and health district as

needed. Within the eight steps, there are **six core tools**. In Figure 2, click on the step to see the associated tools, click on the title of each tool to access a full size version.

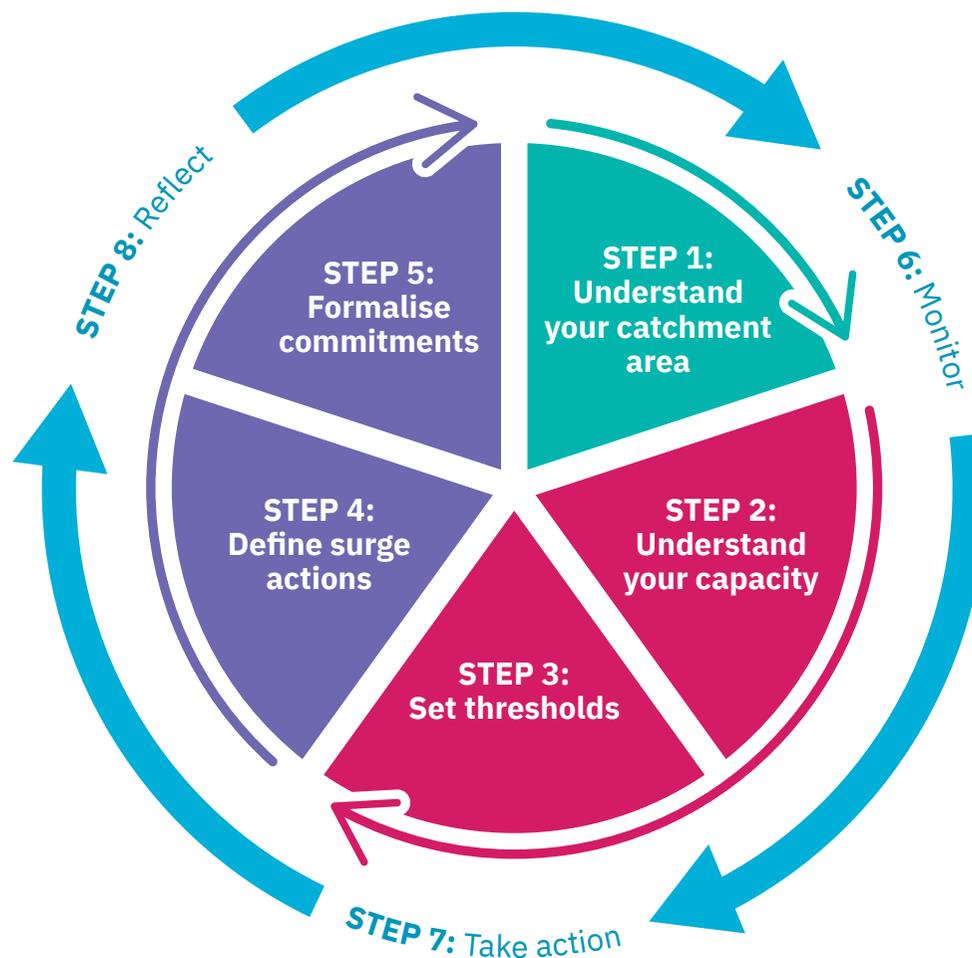


Figure 2: Overview of the Surge Approach and the associated tools

3.1 Orientation and training

It is strongly encouraged that health workers are trained on site rather than attending a classroom style training so that as many staff and community based health workers/volunteers can attend. Additional orientation and training resources are explained in Section 5. The **one-page summary diagram** provides an overview

of the main components of each step and how the steps are interlinked ([Annex 2](#)). These resources can be used when introducing the approach to health workers e.g. use the diagram with eight blank boxes and draw in the key components as the facilitator explains the approach (Figure 3).

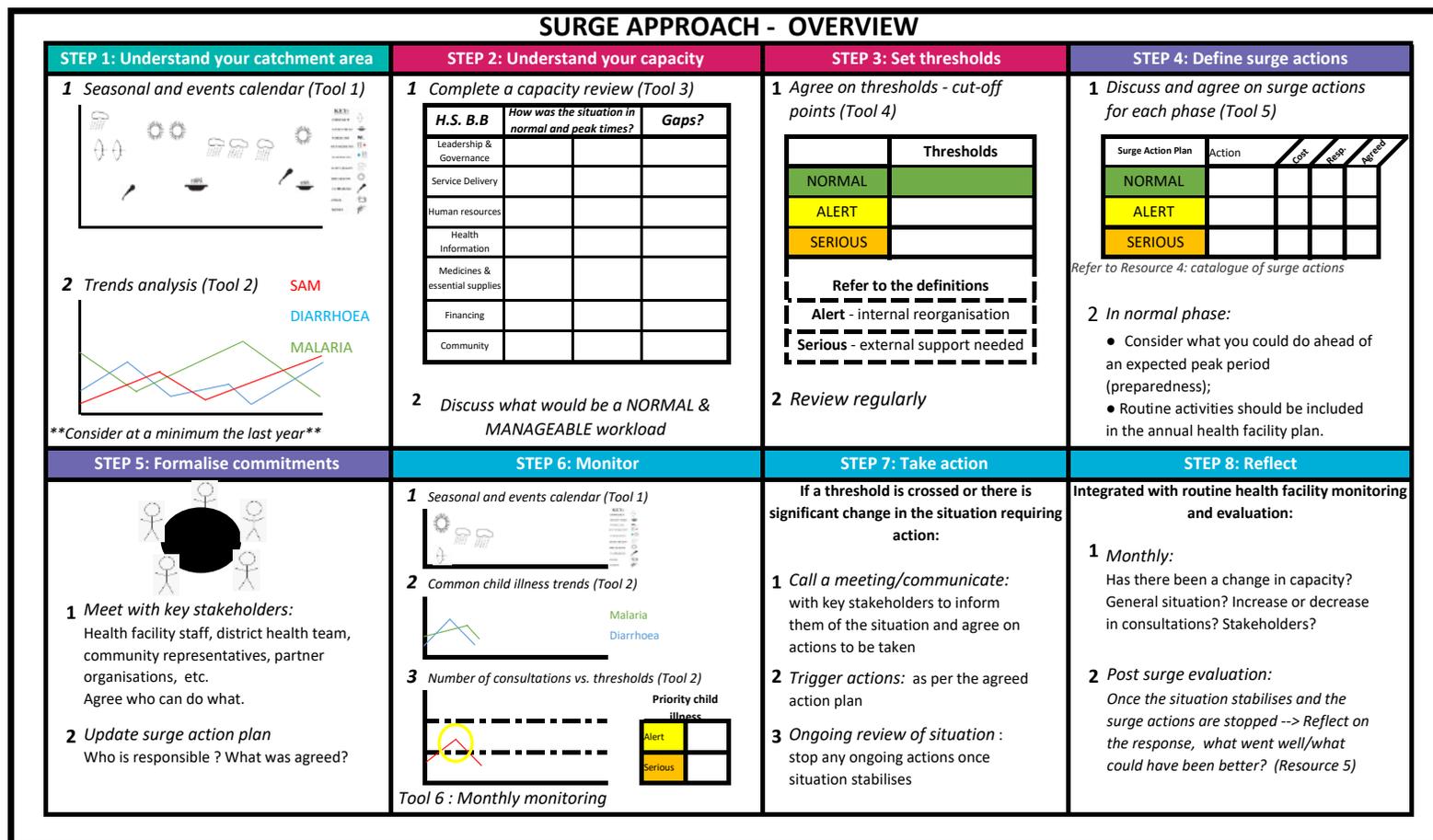


Figure 3: Practical example (left) of using the one-page summary diagram (right) as a training resource.

BOX 5: KEY POINTS TO COVER WHEN BRIEFING HEALTH WORKERS ON SURGE APPROACH

- **Consultations** is the term used in the tools to refer to **outpatient visits for under five common child illnesses** (including SAM, see Box 1). For acute malnutrition only new admissions will be counted as consultations. For other common child illnesses (i.e. diarrhoea, malaria, and acute respiratory infection) both new and return visits will be counted as consultations (as it is often difficult to distinguish between them).
 - ~ New admissions are used for acute malnutrition because although caseloads or total registered in programme may give a better indication of the cumulative workload, new admissions are more sensitive to detect immediate changes and are what experience to date in CMAM Surge is based on.
 - ~ Case definitions for common child illnesses must be aligned with those reported in national HMIS and health workers must be clear what they are plotting on wall charts.
- **Priority child illness(es) should have been agreed already by the DHMT** based on an analysis of trends in consultations across the health district (Section 2). Priority child illnesses will generally be SAM plus one other common child illness that has fluctuations during the year and impacts the workload of health workers. This should be communicated clearly to the health facility teams.
 - ~ The DHMT may identify different priority child illnesses for different areas of the district, but be aware setting thresholds for different priority illnesses across the district may make monitoring complex.
 - ~ If the DHMT has not set the priority child illness(es), health workers can decide as they complete Step 1.
- **Thresholds are only set for the priority child illness(es)**. However, health workers will also monitor other common child illnesses to help anticipate peaks in workload and know when preparedness actions should be triggered.
 - ~ Setting thresholds for **no more than two priority child illnesses** is advised. The priority child illness(es) may be adjusted over time, as appropriate.
- **Wall charts should be hung in a visible location** in the health facility, if possible. Being able to see the seasonal and events calendar and monthly monitoring of the priority child illness(es) against thresholds is important to engage staff and inform service users.

How to use the tools:

- **Contextualise the tools and guidance** in this section before sharing with health workers (see Sections 1 and 2).
- The **six core tools** are in [Annex 1](#) in a version that can be downloaded and edited.
- The **Step Guide** below, describing how to move through each of the eight steps and use the relevant tools, can also be found in [Annex 2](#) in word format (including worked examples). This can be printed as a job aids and used during any training.^{ix}
- Remember **several tools will be used more than once**. When a tool is introduced in Steps 1–5, a new, blank version may be used later or it may be built upon and referred to during Step 6 (monitor) and Step 7 (take action).
- The terms **‘looking back’** and **‘planning forward’** are used in each step to help health workers understand if they are focused on analysing past trends and experiences, or planning for the future.
- **Step 1 (understanding your catchment area)**, can be a useful exercise to support planning, even if no distinct peaks in the number of consultations were observed at the health facility. For example, a health post may have low consultation numbers or limited fluctuations from month to month so setting thresholds may not be useful. However, the seasonal and events calendar could still help support planning of community-based activities and improve quality of reporting by encouraging staff to interrogate and use their own data.

Who should be involved?

- Health workers (health facility in-charge, nurse, nutritionist etc.)
- Community actors (community health workers, chief of village/religious leader etc.)
- DHMT representative (especially for Step 4–5 defining and agreeing on the surge action plan)

ix. Complementary notes on implementation from experiences in different contexts are also available in [Annex 2](#).

3.2 Surge Approach: Step Guide

STEP 1: UNDERSTAND YOUR CATCHMENT AREA
(seasonality, events, child illness trends)

Aim: To understand the external factors that affect demand for services at the health facility by reviewing seasonal, situational, and child illness trends; and to identify high risk time points/months and events which may trigger early action to prepare for a surge in consultations. *['looking back']*

Figure 4: Tool 1 – Seasonal and events calendar

[\(Access online here\)](#)

| SEASONAL AND EVENTS CALENDAR | | | | | | | | | | | | |
|---|--|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| | | | | | | | | | | | | |
| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
| MONTHLY REVIEW <small>(For use in monthly monitoring)</small> | Were there any unexpected events or activities that might increase or decrease consultations? | | | | | | | | | | | |
| | If YES, add/mark on the calendar. | | | | | | | | | | | |

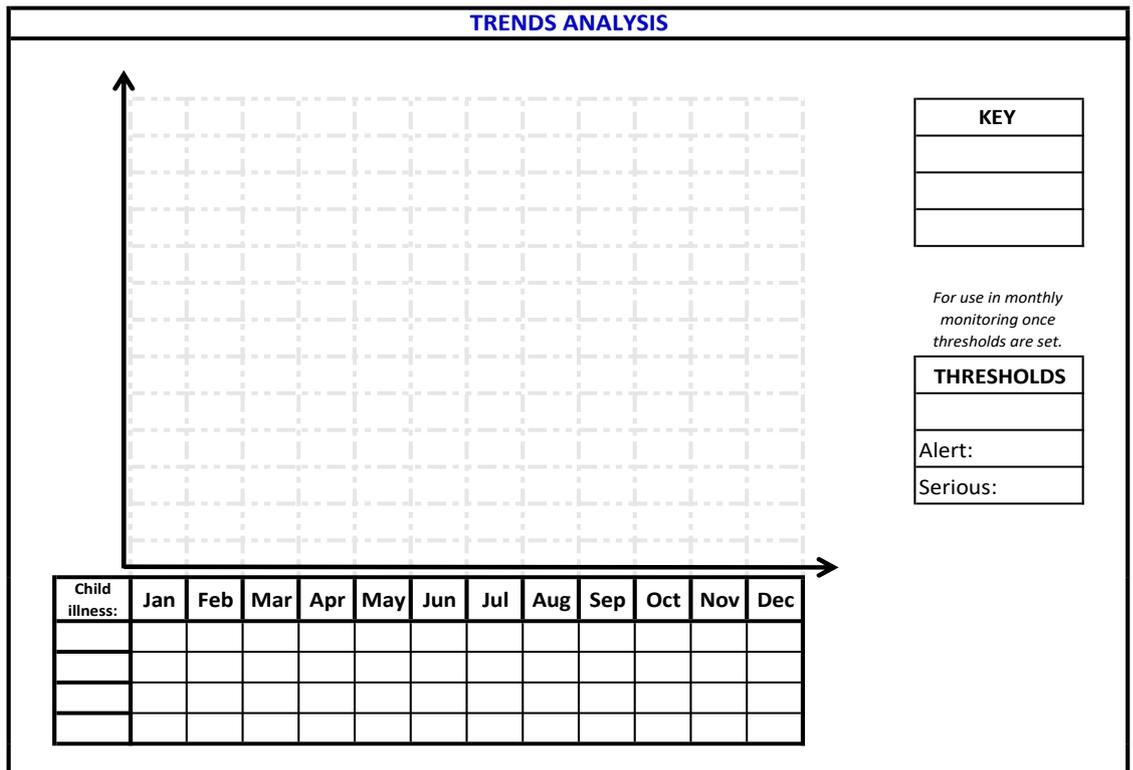
KEY

Using Tool 1 – Seasonal and events calendar:

- Reflect on key events and seasonality in the health facility catchment area over the last year, noting whether this was a ‘typical’ year or not, and if not, how it differed.
- Consider and discuss the factors that may have increased or decreased the number of consultations at the health facility each month, e.g.:
 - » Factors that caused more children to become sick or malnourished (e.g. food availability, flooding, drought).
 - » Factors that affected caretakers’ ability or decision to bring their child for treatment (e.g. conflict, road condition, population movement, festivals).
 - » Factors that increased referral of children to the health facility such as mass screenings for malnutrition or health campaigns.
- Pick a symbol for each factor, label it in the key and mark on the timeline the month in which it generally happens.

Note: the ‘monthly review’ box at bottom is for when this same tool is used in Step 6.

Figure 5: Tool 2 – Trends analysis
([Access online here](#))



Using Tool 2 – Trends analysis:

- Complete a historical trends analysis. Gather consultation data for the last year for common child illnesses (use outpatient registers or data from the HMIS) and plot on the chart.
 - » A single line should represent each common child illness (different colours or line styles should be used to distinguish between them, note this in the key). Label the Y-axis (vertical line) with the number of consultations (e.g. 10, 20, 30...).
 - » Consider how wide the range is between the maximum and minimum number of consultations for each of the common child illnesses. You may want to plot those with fewer consultations on the axis on the left side and those with a higher number of consultations on the right side, to ensure the trends are easily visible.
- The table underneath the graph can be used to note the monthly figures if not displayed elsewhere in the health facility. Write the name of the common child illness in the first column.
 - » More than one year of past data can be reviewed if available, and may help to provide a clear idea of trends/fluctuations, but on separate charts.

Compare the seasonal and events calendar and the historical trends analysis:

- Do you see peaks for common child illnesses at certain times of the year? Which child illnesses and when?
- Is it what you expected and what you see in most years?
- Are there any seasonal factors or events driving these peaks?
- Are there key events (that may not be seasonal) that increase consultations?

Note: Both the seasonal and events calendar and the trend analysis chart(s) can be hung on the wall or notice board to support routine planning of activities and referred to each month to better anticipate any changes in the situation (see Step 6 for more details). **Remember changes in the context may cause peaks to occur sooner or later than the seasonal calendar suggested** and the timing of activities should be adapted accordingly (the box at the bottom of Tool 1 will prompt you to consider this during monthly monitoring). A fresh, blank version of Tool 2 will also be used to monitor the number of monthly consultations of each priority child illness against thresholds (Step 6).

STEP 2: UNDERSTANDING CAPACITY

Aim: To understand the capacity of the health facility to manage essential child health services, in particular for SAM and/or another priority child illness, and identify gaps that need to be addressed. *['looking back']*

Note on Step 2 and 3. *Step 2 (Understanding capacity) and Step 3 (Threshold setting) are complementary to each other and should be completed together. Understanding capacity, what support is needed both before and during a significant increase in consultations, is critical to establishing how many consultations per month can be managed and where thresholds should be set. Reviewing the capacity of health facility teams should be part of routine quality assurance measures within the health service, regardless of whether the Surge Approach is being introduced. However, if a detailed assessment of each health facility’s capacity has not been recently undertaken, a self-assessment can be done as part of the Surge Approach.*

Figure 6: Tool 3 – Capacity review
(Access Tool 3 online here)

| CAPACITY REVIEW | | |
|--|---|---|
| Is there a MOH tool to assess the capacity of health facility teams to deliver the essential health package? If there is, use it as a starting point instead. | | |
| Date of last review/completion: _____ | | |
| Health System Building Block | Guiding questions (consider normal times and past peaks) | Are there any gaps that need to be addressed? |
| Leadership and governance | <ul style="list-style-type: none"> How often does the district health office supervisor usually visit your health facility? Is there appropriate communication and involvement of key stakeholders? Is there a health facility management committee that meets regularly? | |
| Equipment and infrastructure | <ul style="list-style-type: none"> Are all the key infrastructure elements and equipment functioning – examination room, storage, water and sanitation? Is the waiting area sufficiently shaded for large crowds (covered for rain/sun)? Are there sufficient handwashing stations, latrines, etc. | |
| Medicines and essential nutrition supplies | <ul style="list-style-type: none"> Are essential medicines (ex. antibiotics), supplies (ex. RDts) and nutrition commodities (ex. RUTF) sufficient and delivered on time, even during peak periods? Has the health facility had any period when essential medicines were out of stock? If so, for how long? What are the main reasons? | |
| Service delivery | <ul style="list-style-type: none"> What services are included in the basic health service package at this facility? Is treatment of SAM included? Are they all currently being delivered for under-fives? If not, why not? What are the facility opening hours? Which days or times of the day are most busy? How is the linkage between inpatient and outpatient and community? For example how are children transferred from OTP to inpatient? Does the health worker feel confident about the quality of services provided? | |
| Human resources | <ul style="list-style-type: none"> According to health policy, how many staff should there be in this facility by grade/type? How many of those mandated positions are filled with a qualified staff actually in place and working? What are the key gaps? Do all the staff have the same capacity? Or do certain staff have specific training (e.g. CMAM, IMCI)? During peak periods are there sufficient staff? Can additional staff be mobilised? From where? How? | |
| Health information | <ul style="list-style-type: none"> How are monthly reports/caseloads reported to the district health team? (By paper, phone, computer?) What are the main reasons for late reports (and therefore late response to requests e.g. for more supplies)? Do you compile and review monthly data for the health facility as a team? Who participates and what is the outcome? Do you put any health or nutrition information into charts or tables monthly so staff can see trends (ex. consultations, vaccinations, SAM admissions)? | |
| Financing | <ul style="list-style-type: none"> Does the health facility have a budget and funds to spend? If so, where do these funds come from? What can they be spent on? If not, how do you get the support and goods you require to run the health facility? Who makes decisions about how to spend money/invest in resources? If the facility suddenly requires a repair or other goods or services, how would you pay for it? | |
| Community | <ul style="list-style-type: none"> Are there recognised community health workers or volunteers? Do they cover all the villages in the catchment area? How many villages does each usually cover? Are they paid or any incentive provided? How does the health facility staff interact/communicate with them? Is there any village health committee system? Are you able to mobilise community members to volunteer time or resources if needed (via village health committees or other groups)? | |

Using Tool 3 – Capacity review:

- **Gather and review any recently completed MOH capacity assessments.** If no up to date assessments are available, check if there is an MOH template or guide available. Decide if the MOH tool is detailed enough to use.
- Use the **guiding questions in Tool 3** to complement the information already available **or** to complete a self-assessment of the health facility capacity, considering each of the health system building blocks. **Tool 3** can be used to document key points from the discussions (even if using or partially using an existing MOH template).
- **Reflect on how the health facility managed the situation during past peaks.** Refer to the child illness trends analysis (Step 1) to jog your memory of when these peaks occurred. It is important to consider especially staffing and supplies for the priority child illness(es):
 - » In the month with the maximum number of consultations, how was the workload for the staff?
 - » What would be considered a ‘normal’ month in terms of consultations? In this month, how is the workload for the staff? Is it manageable? Are staff overstretched?
 - » During a ‘normal’ month, does the health facility team have the capacity to see a few more patients or are they at their limit? Do they have sufficient supplies? Have they time to attend a training, or for some staff to take annual leave?

STEP 3: THRESHOLD SETTING^x

Aim: To define thresholds (cut-offs) marking the number of monthly consultations for SAM and/or the other priority child illness that will require a change in how services are managed. *['looking back' to help response]*

- The **alert threshold** indicates the point at which health facility staff will have to make some internal adaptations to avoid being overstretched and to protect the quality of care.
- The **serious threshold** indicates the point at which the health facility staff, despite making internal adaptations, will require external support to protect the quality of care.

Figure 7: Tool 4 – Threshold setting
([Access online here](#))

| THRESHOLD SETTING | | | |
|--|---|---|--------------------------|
| Date of last review: _____ | | THRESHOLDS # of consultations per month that will trigger actions to help manage the increasing workload. | |
| PHASE | SITUATION IN THE HEALTH FACILITY | PRIORITY CHILD ILLNESS 1 | PRIORITY CHILD ILLNESS 2 |
| NORMAL | <ul style="list-style-type: none"> • The health facility is managing the number of consultations comfortably with the staff and supplies they have. Routine activities are ongoing (including staff trainings and annual leave). • If indicated, preparedness actions can be activated in anticipation of an increase in the number of consultations. | | |
| ALERT | <ul style="list-style-type: none"> • The health facility is no longer able to comfortably deal with the number of consultations. Waiting times may be increasing, staff might be taking shorter breaks which may impact the quality of service delivery. • Internal simple actions are needed to manage the situation, and deal with the increased number of consultations. For example, slight simplification of procedures, task shifting, suspending unessential training or annual leave, asking community actors for additional support. • The ALERT threshold indicates when these internal actions should be triggered. | ALERT THRESHOLD: | ALERT THRESHOLD: |
| SERIOUS | <ul style="list-style-type: none"> • The health facility can no longer manage the number of consultations even after taking internal ALERT actions. Waiting times are increased, the quality of service delivery is compromised, some patients may be turned away, and significant stock outs may occur. • External support is needed to manage the situation and deal with the increasing number of consultations. For example additional staff, supplies or transportation. • The SERIOUS threshold indicates when this external support from the health district and/or partner should be triggered. | SERIOUS THRESHOLD: | SERIOUS THRESHOLD: |
| EACH MONTH: Do you need to review the thresholds? Has there been a change in capacity or consultation trends? Are the thresholds still appropriate? | | | |

Using Tool 4 – Threshold setting:^{xi}

- Agree **how many consultations each month would be manageable** for each of the priority child illness(es) with existing resources, ensuring continuity and quality of services.^{xii} Use the information gathered through the capacity review to inform this.
- Discuss with key stakeholders what internal actions and/or external support would be needed in order to protect the quality of services with increasing number of consultations. Tool 4 can be used to guide the discussion, which can be broad at this stage (specific actions will be identified in Step 4). Consider the number of trained staff, time per consultation, opening hours, etc.
- Decide the **threshold (cut-off) in terms of the number** of consultations for the priority child illness(es) that would trigger the health facility to take internal action (**enter alert phase**). Subsequently decide the threshold (cut-off) in terms of the number of consultations that would trigger the facility to request external support (**enter serious phase**).^{xiii} Record the threshold (cut-off) number for each in the columns in Tool 4.

x. Guidance should be provided by the health district as to whether SAM and/or another child illness should be targeted (i.e. have thresholds set). If not, it should be based on the health facility’s assessment of their catchment area (Step 1), identifying which common child illness(es) is putting the greatest pressure on the workload of health facility staff.

xi. Thresholds are set based on number of consultations per month, unless otherwise indicated by the health district.

xii. There is an additional tool to support this reflection if needed – see [Annex 2](#)

xiii. The CMAM Surge Operational Guide recommended three phases, reviews of learning suggested simplifying to two as the actions in *emergency* phase were generally the same as *serious* phase.

STEP 4: DEFINE SURGE ACTIONS

Aim: To define actions to be completed during normal periods (in preparation of a peak period) or in response to a peak period (i.e. alert and serious phases) aiming to protect the quality of essential child health and nutrition services during periods of increased demand. **['planning forward']**

Note on Step 4 and Step 5: Step 4 (Defining surge actions) and Step 5 (Formalising commitments) are complementary and should be completed together. The template for documenting the surge action plan should be adapted to suit the context, and efforts made to facilitate integration of certain surge actions into contingency planning at a health district level. This may require the health facility to integrate surge actions into their annual plan (e.g. via a micro-plan).

Figure 8: Tool 5 – Surge action plan
([Access online here](#))

| SURGE ACTION PLAN | | | | | | |
|----------------------------|--------|-------------|---------------------------|-----------------|---------------------|-----------------------|
| Date of last review: _____ | | | | | | |
| Phase | Action | Responsible | Cost Implication (Yes/No) | Agreed (Yes/No) | Planned for (Month) | Completed/ Activated? |
| Normal (PREPAREDNESS) | | | | | | |
| | | | | | | |
| | | | | | | |
| Alert (INTERNAL) | | | | | | |
| | | | | | | |
| | | | | | | |
| Serious (EXTERNAL) | | | | | | |
| | | | | | | |
| | | | | | | |

Using Tool 5 – Surge action plan:

- At a health facility level, organise a meeting with key stakeholders **to define and agree** who will complete the actions, if triggered.
 - » List the actions for each phase in **Tool 5**: normal (preparedness), alert and serious.
- Use the capacity review, and consider how past peak periods were managed. Define actions clearly and ensure they are practical so that they can be easily actioned (**Table 4**). There is a catalogue of suggested surge actions which can be used if needed ([Annex 2](#)).

Table 4: Overview of preparedness and surge response actions

| PREPAREDNESS ACTIONS: | SURGE RESPONSE ACTIONS (TWO TYPES): |
|---|--|
| <p>Actions to prepare for ‘typical’ peak periods can be at least partially planned for based on the situation analysis (seasonal and events calendar and historical trends analysis) completed in Step 1, e.g. prepositioning supplies or screening campaign.</p> <p>Events may arise that were not anticipated thus triggering planned actions sooner e.g. an influx of displaced persons from the neighbouring region or changes in climate patterns (missed rainy season), or may require alternative preparedness actions.</p> | <p>Alert actions – those that do not require external support and can be arranged by the health facility are appropriate for <i>alert</i> phase e.g. suspending annual leave, extending working hours temporarily, simplification of procedures, task shifting etc.</p> <p>Serious actions that do require resource mobilisation and external support are more appropriate for <i>serious</i> phase e.g. additional staff, supplies, or increasing outreach services to more remote communities (e.g. mobile teams).</p> |

- Preparedness actions, for anticipated seasonal peak periods, can be **‘planned for’** and the month noted in Tool 5. These dates may change as the situation evolves, but it is useful to indicate when preparedness actions will likely be needed based on what is known from Step 1.
- Any gaps in basic capacity identified during the capacity review should be noted and plans to address them included in the annual work plan of the health district and health facility as per standard MOH processes. They can be included in this Tool 5 if there is no work plan but it is preferable if this focuses more on **preparedness and surge actions**.
 - » Addressing these basic gaps before any peaks occur is important to ensure that the health facility is ready to respond when consultations increase e.g., routine training on essential health and nutrition protocols, improving water, sanitation and hygiene infrastructure and strengthening reporting systems. These routine activities are different from preparedness or surge response actions, which are triggered in anticipation of, or in response to, an increase in the number of consultations.
- Record who will be **‘responsible’** for each action.
- Note if there is an expected **‘cost implication’** with the action. It is not necessary to complete a detailed budgeting exercise. However, consider if the action be managed by the health facility with their existing resources, or whether it requires support from an external partner (e.g. health district).

STEP 5: FORMALISE COMMITMENTS

Aim: To agree who will contribute to supporting the actions in the surge action plan, and to secure commitments to mobilise funds for the actions that have a cost implication. [**‘planning forward’**]

Note on Step 5: *Each context will have to decide what level of documentation or verbal agreement is considered enough to be considered ‘formalised.’ It may be an iterative process with an initial agreement, but then once financing sources are confirmed a stronger commitment is made.*

- Mark **‘agreed’** next to each action once the commitment has been made by the stakeholder (**Tool 4**). This will allow the health facility in-charge to follow up on any outstanding actions that were perhaps not made during the meeting. Any external partner (health district, community actor, non-governmental organisation) should ensure they have available resources before committing to supporting the actions.

STEP 6: MONITOR

Aim: To identify changes in seasonality, situational and child illness trends so that preparedness actions can be anticipated and triggered in a timely manner ahead of peak periods; and to monitor the number of consultations for SAM and/or the priority child illness against the set thresholds so that a surge response can be triggered in a timely manner.

Note on Step 6, Step 7 and Step 8” Step 6 (Monitor), Step 7 (Take action) and Step 8 (Reflect) are cyclical, and are dependent on steps 1 to 5 being integrated at the health facility. Monitoring and evaluating (reflection) using the surge tools should be integrated with routine facility level monitoring.

Figure 9: Tool 6: Monthly monitoring
([Access online here](#))

| MONTHLY MONITORING | | | | | | | | | | | | | |
|---|---|---|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| Review questions at the end of each month | | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
| | | Review the seasonal and events calendar and trends analysis when responding to these questions | | | | | | | | | | | |
| TUATION/ CONTEXT | Were there any unexpected events or activities that might increase or decrease consultations? | | | | | | | | | | | | |
| | Was any mass screening for malnutrition done? | | | | | | | | | | | | |
| | Is there an increasing trend for any common child illness? | | | | | | | | | | | | |
| | | Review the number of consultations vs. set thresholds when responding to these questions | | | | | | | | | | | |
| THRESHOLD | Was a threshold crossed? | | | | | | | | | | | | |
| | Is it anticipated that a threshold might be crossed next month? | | | | | | | | | | | | |
| | | If you answered yes, to any question above --> Review your surge plan (preparedness & response actions) | | | | | | | | | | | |
| ACTION | Have the necessary preparedness actions be taken? Should any others be done? | | | | | | | | | | | | |
| | Should any surge response actions be triggered? | | | | | | | | | | | | |

Using Tool 6 – Monthly monitoring:

Review each month **the situation/context, thresholds and actions** taken or that should be taken. This could be completed as part of a monthly health facility meeting (or last weekly meeting of the month) if organised.

Situation/context monitoring:

- Review the actual situation – were there any **unexpected events or activities that might increase or decrease consultations?**
 - » Use the typical seasonal and events calendar (**Tool 1**), to compare the actual situation against what was expected. Mark any unexpected events or activities on the calendar.

Example: Last week, a mass acute malnutrition screening campaign was organised by the local health district with the support of UNICEF, following a second failed rainy season in the health district. Both ‘events’ are noted on the seasonal and events calendar during the monthly review. The mass screening will likely increase the number of children presenting at the health facility over the next week. Based on this information the health facility can now anticipate a rise in consultations and take early actions such as reviewing available stock, requesting that a staff member return from annual leave etc.

- It is suggested to record the number of consultations each month for the non-priority child illnesses on a new chart (**Tool 2**) to see if there **is an increasing trend in any common child illness**.
 - » These are the child illnesses that thresholds were not set for (the priority child illness(es) will be charted separately see below – threshold monitoring).
 - » There will now be two graphs – one with the historical trends, and one for the current year, which is updated monthly. Compare the charts to see if the situation is as expected.
 - » This is particularly important if SAM is one of the priority child illnesses, as an increase in another common child illness such as diarrhoea may allow you to anticipate an increase in SAM consultations.

Threshold monitoring:

- Plot the number of **new consultations that month for the priority child illness(es)** (usually SAM and/or one other child illness) on separate wall charts (use another copy of **Tool 2**).
 - » It is important that each priority child illness has its own wall chart so that the trends can be easily visualised, and compared against the set thresholds e.g., the number of SAM consultations is often much less than diarrhoea, if they are tracked on the same chart it can be difficult to see the fluctuations in cases from month to month.
 - » Mark the thresholds (cut-offs) in the ‘threshold box’ (see Figure 5).
- Optional: If weekly reports are compiled, the grid under the graph can be used to note weekly figures (cross out child illness and replace with week 1, 2, 3, 4). This prompts more regular comparison (cumulatively) against the monthly threshold, allowing surge actions to be triggered mid-month if the threshold is crossed before the end of the month.
- Threshold cut-offs should be reviewed regularly (for e.g. during the monthly health facility meeting).
 - » Part of this will be to review any changes to capacity. It is only through regular review, and discussion with DHMT, that you can confirm thresholds have been properly set and that they remain relevant. Threshold setting is a dynamic process.
 - » The following points can be considered at each monthly review:
 - Was there a change in the health facility’s capacity this month (e.g. change in staffing, supplies)?
 - Did the staff feel stressed/overworked even though a threshold was not crossed? (if yes, consider if the thresholds are set too high).
 - Did the health facility pass a threshold but the staff felt that they did not need to implement the surge actions? (if yes, then consider if the thresholds are set too low).

Example: SAM and malaria have been identified as the two priority child illnesses. During the monthly review, the total number of monthly consultations for each are plotted on their respective charts (Tool 2) and compared against the thresholds. This month, it is noted that the number of malaria consultations has passed the alert threshold, while the number of SAM consultations remains within the normal phase. This triggers internal action to better manage the malaria caseload, and also prompts the health facility staff to review their capacity to manage their acute malnutrition services, considering that there might be an increase in consultations in the coming month.

STEP 7: TAKE ACTION

Aim: To take preparedness actions or surge response actions based on triggers noted or thresholds crossed.

Taking action – preparedness and surge response:

- If a trigger is noted or a threshold is crossed the situation should be discussed during the routine monthly meeting or an *ad-hoc* meeting arranged immediately.
 - » Confirm the actions to be taken.
 - » Contact the persons responsible, as outlined in the surge action plan, as soon as possible to ensure the actions are completed in a timely manner.
- Inform the DHMT of all thresholds crossed, regardless of whether their support is required, so that they maintain oversight of the situation in their health district.
- Use **Tool 4**, to record when certain actions are taken (**‘completed/activated’**) – add more columns as needed if the actions are completed more than twice in the year.

Scaling down:

- Once the number of consultations has decreased, and returned to beneath the normal threshold, consider scaling down the surge actions and recommencing routine activities (if they were temporarily suspended).
 - » In some situations, the surge actions may have a set time frame (e.g. secondment of staff for three months) which is not directly tied to when the threshold returns to normal.
 - » If the health facility was in *serious* phase and moves to *alert* phase as the situation stabilises, continue with the alert actions until the situation return to normal and the capacity of the health workers is not stretched.

STEP 8: REFLECT

Aim: To review the efficiency and effectiveness of a surge response, and make necessary improvement and adaptations to improve future surge responses; and to adapt and improve specific surge steps based on observations made during routine monitoring (e.g. capacity changes).

Note on Step 8: *There is more information on monitoring and evaluation at a health district level in Section 2 and resources in Section 5.*

Reflect:

- Once the situation has stabilised, it is important to review and document the efficiency of the response. Review Tool 4 to see which actions were taken and complete a ‘post-surge’ review ([Annex 2](#)).
- Other reflections around surge implementation should be integrated into monthly reviews, supervision or annual meetings.

SECTION 4: COMMUNITY ENGAGEMENT

Community involvement in the Surge Approach is crucial if the health facility is to anticipate, prevent, prepare and respond to a peak in the number of consultations of the priority child illness(es). Evaluations and reviews have frequently cited poor engagement of community stakeholders as a bottleneck to the sustained implementation and impact of the approach (in particular in terms of a timely response). An improved understanding of the health facilities' catchment area is reliant on engaging community actors to access better information and understand local resources. Directly implicating community actors can sometimes help reduce the scale of a peaks because they can see health warning signs in their communities in advance of this information reaching health facilities. It is however important to note that the role of the community is still being explored and each country should contextualise community involvement to suit their need. Refer to the stakeholder mapping (**Tool 0.1**) to identify key stakeholders who should be involved. This can include:

- Community health workers or volunteers;
- Members of community health committees;
- Representatives of Mayors Office;
- Members of village level community structures or sentinel sites for vulnerability monitoring or early warning systems;
- Local non-governmental organisations, civil society or religious groups;
- Groups in charge of community mobilisation.

It is important that community stakeholders are orientated on the objectives of the approach especially if they will be **directly involved** or **have influence**. Where possible, they should participate during the set up process, especially if they are likely to be called upon to support surge actions.

Considerations when engaging community actors in the Surge Approach

4.1 Understanding the health facilities' catchment area and capacity

The health facility seasonal and events calendar (**Tool 1**) is a tool which can be enriched by community actors, who often have a more detailed understanding on what has or is happening at a village level. Their involvement may help to identify months or events that allow the health facility to anticipate peak periods and trigger early action. Equally they may be able to explain why consultations are lower than expected for that time of the year. During monthly monitoring, community actors could share an update on the current situation to help answer the question in Tool 1: *“Were there any unexpected events or activities that might increase or decrease consultations?”*

KENYA – SCREENING SURGE (CONCERN WORLDWIDE)

In Kenya, health workers integrated a 'screening surge' component to trigger increased community screening when SAM or MAM admissions were lower than expected (referred to as a 'false normal' in admissions). It was reported that this action engaged community health volunteers to review admission data alongside community health agents and health facility staff. It was also report that it helped volunteers better focus their screening activities and improved motivation.

The community is a key pillar to the health system, and the functionality of community networks and the activities they complete will influence the number of consultations at a health facility level. It is important to consider this when completing the health facility capacity review (**Tool 2**). Engaging certain community members during this reflection can help to identify gaps in community services, enrich reflections on what may have influenced past peaks and how they were managed.

Remember that activities led by community actors can increase demand for, and access to, quality health services. Promoting better communication and collaborative efforts between health workers and community actors can be mutually beneficially.

4.2 Preparing and responding to surges

Community actors have an important role to play when defining surge actions and should be engaged when the health facility is elaborating their surge action plan (**Tool 4**).

Community health workers and volunteers are an important resource in preparing for and during peak periods e.g. increasing acute malnutrition screening, targeted community awareness campaigns or supporting activities at a health facility level. If consultation trends are lower than expected for that point in the year, community actors play an important role addressing the challenges and promoting positive health-seeking behaviour.

Local community health structures or government offices often have annual budgets. Integrating surge actions in community planning processes can help ensure that there are resources available if the health facility crosses a threshold. These commitments can be outlined in Tool 4.

NIGER – USING WHATSAPP TO ENGAGE COMMUNITY STAKEHOLDERS (CONCERN WORLDWIDE)

In Tahoua (Niger) WhatsApp groups were created with key community and health district level stakeholders. Once elaborated, health facilities shared their surge action plans requesting support for peak periods. Through this, agreements were made; commitments were followed up on and the stakeholders congratulated when their support was mobilised during peak periods.

Consider using existing multi-stakeholder forums (e.g. meetings) to hold different actors accountable to the actions they have committed to. This could include communication platforms such as **WhatsApp or Telegram**. These forums can be used to share surge action plans and updates on actions that have been agreed or require financing. Equally they can be used to share updates on the situation between the community and health facility (e.g. threshold crossed at a health facility, contaminated water point in a village etc.).

SECTION 5: ADDITIONAL SUPPORT MATERIALS

5.1 Orientation and trainings

Orientations and trainings must be tailored to suit the audience, their capacity and work schedules. To date, various training methods have been trialled and there is no one size fits all or standard approach recommended. Trainings were initially more intense given the ‘piloting’ and research nature of the approach. It is now strongly recommended, wherever possible, to **integrate/align training on the Surge Approach with other health and nutrition trainings at health facility level or orientations at health district or regional level** and to make trainings practical and context based. This is also more time and cost efficient.

High rotation of staff has regularly been cited as a challenge for the sustained functionality of the approach. Evaluations have shown that the **quality of training** is an important determinant of the functionality of the Surge Approach. Thus, the **format, duration and location** of any training should be adapted to limit the disruption to essential services. It can be useful for the DHMT to maintain oversight on which health workers have been orientated or trained on the approach, if they are aiming to integrate the approach across their health district.

[Annex 3](#) gives an overview of available resources, many of which can be downloaded and adapted to suit the context and audience – national, health district, health facility and/or community. There is a series of **audio-visual training videos which can be accessed here**^{xiv}. In addition, it is strongly encouraged to refer to any learning papers or case studies from the country or a similar context. Many of these documents can be accessed on the [Surge Approach website](#) and can be valuable as they give the history of the approach and practical examples of adaptations.

5.2 Planning and budgeting

The cost and duration of setting up the Surge Approach will vary depending on the context and the accessibility of health facilities. The most significant budget implications are in relation to financing the actions in the surge action plans which is outlined in the sections above.

When initiated as a pilot, it is likely to involve more costs (e.g. more intensive monitoring required). As mentioned above, it is now strongly encouraged that the Surge Approach is integrated into other health and nutrition trainings, thus there should be few additional costs incurred. If the approach is being piloted with the support of a non-governmental organisation, there is an example of a work plan with budget considerations ([Annex 3](#)).

5.3 Monitoring and evaluation

Monitoring and evaluation are integral aspects of the Surge Approach and are integrated within the eight steps of the approach when implemented at a health facility level. In addition, it is recommended that the DHMT considers monitoring aspects of the Surge Approach as part of routine monitoring of child health and nutrition services (Section 2). Key questions, linked to the functionality of the approach, can be integrated into a supervision grid or checklist to assess the anticipation capacity and preparedness of the health facility for a peak period (see resources in [Annex 3](#)).

If the Surge Approach is introduced as a pilot, it may be useful to complete some additional external evaluation. The main aim should be to assess whether the health facility staff capacity has increased and/or enabled them to manage peaks in consultations more efficiently. Considering the nature of the Surge Approach, both qualitative and quantitative components should be considered. There are additional resources in [Annex 3](#) to support this reflection.

xiv. Currently only available in French. Note the tools referenced in the series are specific to the context of Niger.

5.4 Coordination

Since the development of *CMAM Surge*, in addition to global and regional groups, several national CMAM Surge Taskforces/Technical Working Groups have been established to support coordination, and the development and harmonisation of tools and resources.

Going forward, it is encouraged that the Surge Approach is integrated into general health and nutrition coordination mechanisms (e.g. clusters) and considered in other coordination groups (e.g. rapid response mechanism or early warning systems). At a health district or regional level, it is important that the Surge Approach is discussed at coordination meetings, ensuring that information is shared (e.g. several health facilities in a health district crossing their *serious* threshold simultaneously) and other actors supporting health service delivery engaged (e.g. to support with response).

If a dedicated group is deemed necessary, it is important that links are established with existing national coordination mechanisms. It might be useful to refer to the mapping exercise in Section 1.

Conclusion

The Surge Approach has now been implemented in 16 countries supported by MOH and international non-governmental organisations. The most critical learning has been the importance of adapting the tools and approach to suit the context. Concern Worldwide welcomes feedback on the updated guide and comments can be sent to thesurgeapproach@concern.net. To continue to promote a community of learning, please let us know if you have any evaluations, learning papers, or resources which can be shared on the Surge Approach website. It is anticipated that any updates or revision to tools referenced in this guide will also be uploaded here.

“I really appreciate this approach, it has woken us up, it allowed us especially to see that you must anticipate in advance solutions once you know the problems. If there is a problem identified – how are you going to manage it. That is for me the objective of the approach.”

Mr. Abdoulaye Djibril Alhousseine, General Secretary of Tajaé Commune, Tahoua, Niger. Full interview available [here](#).

“During the recent years of drought and the related nutrition emergency, the IMAM Surge Approach has provided an important foundation, where health facility teams analyse facility data, identify critical support that is needed and make small adjustments at health facility level to better manage workload when consultations numbers peak. Moreover, the approach proved critical in the management of acute malnutrition during the COVID 19 pandemic. Specifically, the IMAM Surge Approach served as an early warning tool for escalating malnutrition cases and guiding the response during the pandemic, when routine assessments and supervisory activities could not be implemented as informed COVID 19 infection prevention and mitigation measures. The IMAM surge approach is currently implemented in 63 per cent (750) of health facilities in ASAL counties. The Government of Kenya will continue implementation of IMAM Surge as an integral part of managing acute malnutrition in high risk areas of the country”.

Ms. Veronica Kirogo, Head, Division of Nutrition and Dietetics, Ministry of Health, Kenya.

Annexes

Annex 1, 2, and 3 contain several documents within folders as outlined in the tables below. Download the folder to access the documents. The documents may be updated from time to time, so please check the Surge Approach webpage for the most up to date versions.

Annex 1: Surge Approach Tools

Tool 0.1: Surge Approach – Context and stakeholder mapping

Tool 0.2: Surge Approach – Decision tree

Tools 1–6: Surge Approach – Core tools

Annex 2: Additional Resources (implementation at the health facility)

Resource 1: Surge Approach – Step guide including worked example (*job aid*)

Resource 2: Surge Approach – Summary diagram (*job aid*)

Resource 3: Surge Approach – Support when calculating normal and manageable workload (Step 3)

Resource 4: Surge Approach – Catalogue of surge actions

Resource 5: Surge Approach – Post-surge review template

Resource 6: Surge Approach – Frequently asked questions

Annex 3: Additional Support Materials (training and orientation)

Support 1: Surge Approach – Light orientation (PowerPoint presentation)

Support 2: Surge Approach – Example of health system mapping exercise (Niger)

Support 3: Surge Approach – Training videos and other online training resources

Support 4: Surge Approach – Training presentation and mock dataset

Support 5: Surge Approach – Example of on-job training schedule

Support 6: Surge Approach – Example of a work plan for setting up a pilot

Support 7: Surge Approach – Reviewing the quality of implementation

Annex 4: What the Surge Approach can contribute to Health System Strengthening

This table is adapted from Deconinck & Hendrix Surge Review (November 2021): Exploring the current and potential role of the CMAM and Health Surge Approaches in creating shock responsive health systems: setting the scene for collaborative learning

| WHO HEALTH SYSTEM BUILDING BLOCK | WHAT TO CONSIDER WHEN INTEGRATING SURGE? |
|---|--|
| Health Workforce | <p>Staff availability and capacity must be considered when setting thresholds. Especially in remote areas, staff can sometimes be pulled away for extended periods of time (or moved and not replaced quickly) and that affects the capacity of the facility to respond to peaks.</p> <p>Consider national staffing standards for health facilities.</p> <p>Integrate into routine health facility management support and training/ refresher training.</p> <p>How it involves and motivates health workers, increases empowerment and encourages ownership.</p> |
| Health Financing | <p>Include a contingency fund in district annual plans to support surge actions during peak periods.</p> <p>Use the surge action plan as a framework to guide support from community actors.</p> |
| Medical Supply | <p>Understand the source and supply chain of nutrition commodities, essential drugs and other supplies.</p> <p>Align any surge action supporting additional essential drugs and other supplies during peak periods with the national essential medicines list and therapeutic protocols.</p> <p>Give attention to improving accuracy of forecasting, ordering timely supplies, stock management and monitoring.</p> |
| Health Management Information Systems (HMIS) | <p>Use national MOH HMIS case definitions for monitoring and threshold setting.</p> <p>Align frequency of monitoring new admissions/consultations against thresholds with HMIS reporting schedules.</p> <p>Ensure comparison of current data with historical data trends and local events and seasonality is prompted</p> |
| Service Delivery | <p>Implement in consideration of routine acute malnutrition and child health services and how best to protect service delivery during peak periods.</p> <p>Facilitate improvement of disease-specific quality by a more rational use of resources, planning and operational organisation.</p> <p>Consider ways to ensure the continuity and quality of services throughout the year – especially during seasonally-driven periods of high demand.</p> |
| Leadership and governance | <p>Map out key stakeholders at national, regional and district level and engage from the beginning.</p> <p>Encourage that DHMTs view the surge approach as a component of routine monitoring of wasting and child health service delivery.</p> <p>Encourage health workers to stand back from routine work to diagnose and conceptualise problems and share solutions, taking own initiatives on managing surges.</p> <p>Identify resilience conscious-local solutions to local problems.</p> |
| Community | <p>Include key community figures in all steps of planning and response.</p> <p>Use information from the community for earlier detection of surges.</p> |

Annex 5: Terminology and acronyms

| | |
|--|---|
| Acute malnutrition | Acute malnutrition is a nutritional deficiency resulting from either inadequate energy or protein intake or underlying disease/infection – includes both severe acute malnutrition (SAM) and moderate acute malnutrition (MAM) . |
| Wasting | Wasting is defined as low weight-for-height. It often indicates recent and severe weight loss, although it can also persist for a long time. |
| National | Anything happening at the federal or policymaking level of the health system – Ministry of Health (MOH) . |
| Health district, including District Health Management Team (DHMT) | For the first level of management above the health facility (note some countries also have Regional Health Management Teams or Zonal teams) |
| Health Management Information System (HMIS) | Collects, stores, analyses, and evaluates health-related data from health facility to district, regional and national administrative levels. It provides analytical reports and visualisations that facilitate decision making at all these levels. |
| Health facility | Any location where healthcare is provided: hospital, health centre, health post. |
| Health worker | Health facility staff including health facility in-charge, clinical officers, nurses or other staff delivering health services |
| Integrated Disease Surveillance and Response (IDSR) | A mechanism or strategy to prevent and control priority communicable diseases facilitating timely and targeted response to outbreaks and other public health emergencies. |
| Volunteer | Individual freely giving time for community services (e.g. Community Nutrition Volunteers, Community Health Volunteer, ‘Lead’ Mothers) |
| Community health worker | Health care provider who live in the community they serve and may provide a range of services, including basic clinical services e.g. at a health post. |
| Consultation | Refers to under-five outpatient consultations for common illnesses, e.g. acute malnutrition, diarrhoea, malaria or acute respiratory infection. |
| Admission | Refers to new cases of acute malnutrition enrolled into a therapeutic programme. |
| Caseload | Refers to the total number of acutely malnourished children enrolled in a therapeutic programme. |
| Threshold | A threshold is an internationally recognised point at which a response is required e.g. IPC Phase 4, or 15% Global Acute Malnutrition |
| Common child illness | Refers to acute malnutrition, malaria, diarrhoea and ARI. |
| Priority child illness | Will be used when referring to a child illness, which has been identified as having significant caseload fluctuations, often impacting the workload of health workers. Thresholds are set for priority child illnesses. |

References

1. Concern Worldwide. An Introduction to the CMAM Surge Approach. January 2022.
2. Concern Worldwide. Health Surge Learning Paper #1: An Introduction to the Health Surge Approach. November 2021.
3. Maintains. What is a Shock-Responsive Health System? Working Paper – Version 2. March 2021
4. World Health Organisation. Note on Terminology of “Wasting” and “Acute malnutrition”. February 2023.
5. Global CMAM Surge Technical Working Group: Learning Agenda. January 2021 – January 2023.
6. Key documents informing this revision are available on the Surge Approach website.
7. Concern Worldwide. Health Surge Learning Paper #2: Practical learning from a year of implementation. December 2022 [Quote from District Medical Director, Niger].
8. Deconinck & Hendrix. Exploring the current and potential role of the CMAM and Health Surge Approaches in creating shock responsive health systems: setting the scene for collaborative learning. November 2021
9. Concern Worldwide. Health Surge Learning Paper #2: Practical learning from a year of implementation. December 2022 [Quote from Deputy Mayor, Niger]
10. Paul Knox Clarke and REAP Secretariat. Glossary of Early Action Terms: 2022 Edition. October 2022 [For a definition on Early Warning System]
11. Fortnam, M., Hailey, P., Balfour, N., Sheen, K., Lea, R. ‘Innovation history of the CMAM Surge approach’, Maintains Working Paper, Centre for Humanitarian Change and Oxford Policy Management, Oxford. 2021
12. Lasdel. Le CMAM Surge au Niger – une capitalisation « par le bas » note de synthese. 2021
13. Scaling up Nutrition. Case Study – Digital solutions for health and nutrition: Burkina Faso.
14. Weldon Ngetich, Grace Gichohi, Francis Wambua, Tewoldeberhan Daniel, Yacob Yishak and Patrick Codjia. Implementing the IMAM Surge approach – experiences from Kenya. Field Exchange 64, January 2021. p22.



Enhanced Responses to Nutrition Emergencies

JUNE 2020 – MAY 2023

-  52–55 Lower Camden St, Dublin 2
-  00 353 1 417 77 00
-  www.concern.net
-  [@concernworldwide](https://www.instagram.com/concernworldwide)
-  [Twitter.com/concern](https://twitter.com/concern)
-  [Facebook.com/concernworldwide](https://www.facebook.com/concernworldwide)
-  [Youtube.com/concernworldwide](https://www.youtube.com/concernworldwide)

Disclaimer: Funded by the European Union. Views and opinions expressed are however those of Concern only and do not necessarily reflect those of the EU or the EU's Civil Protection and Humanitarian Aid Operations department (ECHO), or other implementing partners referenced in the paper. Neither the EU, ECHO, nor other implementing partners referenced can be held responsible for them. This paper is published as part of Concern's Enhanced Responses to Nutrition Emergencies programme, funded under a Pilot Programmatic Partnership between Concern and ECHO.

CONCERN
worldwide

ENDING
EXTREME POVERTY
WHATEVER
IT TAKES



Funded by
the European Union

PILOT PROGRAMMATIC PARTNERSHIP