*Extracted from the* ***Surge Approach Orientation Guide (pages 19-27)*** *for easy adaptation and contextualisation. A worked example of each tool has been include for illustrative purposes. It is encourage to adapt this resource before using it to support health workers set up the Surge Approach.*

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| STEP 1: UNDERSTAND YOUR CATCHMENT AREA |

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

**Using** **Tool 1 - Seasonal and events calendar:**

* Reflect on key events and seasonality over the last year, noting whether this was a ‘typical’ year or not, and if so, how it differed.
* Consider and discuss the factors that may have increased and/or decreased the number of consultations at the health facility, 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 to the health facility (e.g. conflict, road condition, population movement, festivals).

Factors that directly referred children to the health facility such as mass MUAC screenings 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.

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

**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 (side-line) accordingly e.g. number of consultations.
* 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 a lower range on the axis on the left side and those with a higher range on the right side, to ensure that 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 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).

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| ***Step 1:*** | **Worked example** |
| ***Tool 1,*** *seasonal and events calendar.*  *Note: Monthly review is not completed during this step.* |  |
| ***Tool 2,*** *trends analysis.*  *Note: Threshold box is not used for this step. In this example, both axis are used to allow trends to be more clearly visualised.* |  |

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| STEP 2: UNDERSTANDING CAPACITY |

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

**Using Tool 3 - Capacity review:**

* **Gather and review any recently completed MOH capacity assessments**. If none have been completed, is there an existing MOH template available? Decide if it is appropriate to use it.
* Use the **probing questions** 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 if there is not 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 there were peaks. 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 new 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?

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| **Step 3** | **Worked example** |
| ***Tool 3,*** *capacity review.* |  |

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| STEP 3: THRESHOLD SETTING |

**Aim:** To define thresholds (cut-offs) for the number of consultations for SAM and/or the other priority child illness. ***[‘looking back’ to help response]***

* **Alert threshold** indicates the point at which health facility staff will have to make some internal adaptations to avoid being overstretched and compromising the quality of care.
* **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.

**Using Tool 4 - Threshold setting:**

* Agree **how many consultations each month would** **be manageable** for the priority child illness(es) with the existing resources and ensuring good quality services.[[1]](#footnote-1) Use the information gathered through the capacity review to inform this.
* Discuss with key stakeholders broadly what internal actions and/or 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. Consider the number of trained staff, time per consultation, opening hours etc.
* Decide on the **threshold (cut-off) number** of consultations for the priority child illness(es), that would trigger the health facility to take internal action **(enter alert phase)** and subsequently the threshold (cut-off) number of consultations which would trigger the facility to request external support **(enter serious phase)**. The cut-off number which will trigger action can be recorded in the columns in Tool 4.

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| **Step 4** | **Worked example** |
| ***Tool 4,*** *threshold setting.*  *Note: if only one priority child illness has been identified only one column is used.* |  |

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| 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’]***

**Using Tool 5 - Surge action plan:**

* At a health facility level, organise a meeting with key stakeholders to define and agree on 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 that they are practical so that they can be easily actioned **(Table 4).** There is also a catalogue of suggested surge actions which can be referred to if needed (Annex 2).

**Table 4**: Overview of preparedness and surge response actions

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| **Preparedness actions**: | **Surge response actions (two types)**: |
| * + - Actions to prepare for ‘typical’ peak periods can be at least **partially planned** for according to the situation analysis - seasonal and events calendar and historical trends analysis (Step 1) e.g. prepositioning supplies or screening campaign.     - Events may arise that were not anticipated, 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. | * + - **Alert actions** - those that do not require external support and can be arranged by the health facility are appropriate for alert phase e.g. suspending annual leave, extending working hours temporarily, simplification of procedures, task shifting etc. |
| * + - **Serious actions** that do require resource mobilisation and external support are more appropriate for serious phase e.g. additional staff, supplies, or increasing outreach services to more remote communities (e.g. mobile teams). |

* Preparedness actions, for anticipated seasonal peak periods, can be **‘planned for’** and noted accordingly in Tool 5.
* Ensure any gaps in basic capacity identified during the capacity review are 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. Can the action be managed by the health facility with their existing resources, or does it require support from an external partner (e.g. health district)?

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| **Step 4** | **Worked example** |
| ***Tool 5,*** *Surge action plan.*  *Note: this tool is started during step 4 however not all columns will be completed (see Step 5).* |  |

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| 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 on 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. Any external partner (health district, community actor, non-governmental organisation) should ensure they have available resources before committing to supporting the actions.
* Mark when you **plan to carry out preparedness actions for seasonal peaks**. 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.

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| **Step 5** | **Worked example** |
| ***Tool 5****: Surge action plan.*  *Note: Continue to elaborate on the surge action plan during Step 5. Certain actions may be adapted based on the available resources of the key stakeholders.* |  |

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| 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****. These steps are cyclical, and are dependent on steps 1 to 5 being integrated in a health facility.* *Monitoring and evaluating (reflection) using the surge tools should be integrated with routine facility level monitoring.*

**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.

**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.
* 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 illnesses** (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 that is being monitored against thresholds has its own wall chart so that the trends can be easily visualised. E.g., the number of SAM cases is often much less than diarrhoea, if they are tracked on the same chart it can be difficult to see the SAM changes month to month. Mark the thresholds (cut-offs) in the ‘threshold box’ (Figure 2).
* ***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.
* Thresholds should be reviewed regularly (for example, 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).

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| **Step 6** | **Worked example:** |
| ***Tool 6,*** *monthly monitoring.*  *Note: For the purpose of the example, it is taken the health facility is completing the review for the month of May. Each month questions are answered based on the review of the ‘monitoring’ graphs below.* |  |
| ***Tool 1,*** *seasonal and events calendar.*  *Note: the seasonal and events calendar – completed in Step 1 is updated. If the situation is different than expected the event can be added to the calendar.* |  |
| ***Tool 2,*** *trends analysis.*  *Note: Using a new version of tool 2 monitor the non-priority child illnesses. Compare the trends with the historical trends completed in Step 1. The threshold monitoring box is not used here.* *The table under the graph is used to record the monthly numbers.* |  |
| ***Tool 2****, trends analysis.*  *Note: using two new versions of Tool 2 monitor each priority child illnesses against the pre-defined thresholds (set in Step 3) – in this case SAM and Malaria. The table under the graph is used to monitor the weekly consultations here (optional if this data is routinely collected).* |  |

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| STEP 7: TAKE ACTION |

**Aim:** To take preparedness actions or surge response actions based on triggers recorded during routine monitoring.

**Taking action – preparedness and surge response:**

* If a threshold is crossed or a trigger is noted, 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 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.

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| **Step 7** | **Worked example:** |
| ***Tool 5,*** *surge action plan****.***  *Note: In the example (Step 6), the SAM ’alert’ thresholds was crossed in the month of May. The agreed surge action plan is reviewed, and actions taken. The health facility marks the actions which were taken.* |  |

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| 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. It is encouraged that a post surge review is complete (**Annex 2**). Review Tool 4 to see which actions were taken.
* Other reflection around surge implementation should be integrated into monthly reviews, supervision or annual meetings.

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| **Step 8** |  |
| **No core tool.**  Option to complete *Resource 5* (Post surge review) |  |

1. There is an additional tool to support this reflection if needed – see **Annex 2**. [↑](#footnote-ref-1)