Health and Nutrition Learning Paper

Surge Approach: Lessons learned from Concern Worldwide's experience in Ethiopia

Context

Ethiopia has a population of approximately 132 million people, making it the 10th most populous country in the world. The percentage of the population living below the poverty line has decreased from 30% in 2011 to 24% in 2016, indicating progress in poverty reduction[1]. However, recent issues such as the COVID-19 pandemic, the 2021 Northern conflict, and the 2023 Amhara crisis, along with the declaration of a state of emergency, have led to nationwide security concerns, displacement, unemployment, and inequality. These challenges have had a detrimental impact on the socio-economic development previously achieved.

Ethiopia continues to face persistent crises driven by protracted conflict and climate extremes, despite recent GDP growth. Insecurity in parts of Amhara, Tigray, and other regions continues to affect services and displace populations, whereas severe drought and recurrent flooding are worsening food insecurity. Ethiopia experiences regular seasonal surges in acute malnutrition and other common childhood illnesses, often linked to drought, lean seasons, flooding, population movement and disease outbreaks including cholera, measles and malaria. These predictable peaks place acute pressure on primary health services, especially in remote areas where staffing and supplies are constrained.

Overview

Ethiopia's health system is structured by three levels (tertiary, secondary and primary). The CMAM Surge pilot was implemented at the primary level in 2018, coordinated through woreda health offices and delivered through health centres and their linked health posts. Health posts are staffed by Health Extension Workers (HEWs) who serve as the frontline providers under Ethiopia's Health Extension Program (HEP). They deliver a package of essential primary health services, including disease prevention, health promotion, maternal and child health, family planning, hygiene and sanitation, and management of uncomplicated conditions such as acute malnutrition. HEWs work closely with community volunteers to extend outreach, conduct routine screenings, educate households, and facilitate access to health services, ensuring that preventive and curative care reaches both urban and rural communities.

The CMAM Surge approach was approved for pilot implementation in 2017 following a stakeholder workshop with the Ministry of Health (MoH), and the global CMAM Surge Operational Guide was adapted to the Ethiopian context. Since initiation, the approach has been introduced in 90 health facilities in Somali region and 135 in Amhara region. However, sustained support has been uneven: as of May 2024, only 25 facilities were being supported in each region, and an assessment found that 28% of supported facilities in Somali and 26% in Amhara were 'surge operational'.

This learning paper presents the key learnings from Concern Worldwide's support to the Surge Approach in Ethiopia, drawing on implementation experience in Somali and Amhara regions and a national consultative workshop held in July 2025.

[1] This information is from the World Bank's Poverty & Equity Brief (2023), and the 2015/2016 data is the most recent data available for measuring the poverty line. In addition, the Global Hunger Index, which measures malnutrition, child stunting, child underweight, and child mortality, has decreased from 53.6 points in 2000 to 27.6 points in 2022.

The Approach

The Surge Approach (previously known as 'CMAM Surge') supports primary health facilities to anticipate and respond to predictable increases in service demand, for example, acute malnutrition, without compromising routine service delivery. It uses routine data and locally agreed thresholds to trigger phased actions when there is an increased workload.

In Ethiopia, the Surge Approach is implemented through a set of practical steps and tools used by health facility teams and woreda structures to anticipate predictable increases in caseloads, identify capacity bottlenecks, and agree phased actions (facility-led actions during 'alert' and externally supported actions during 'serious' phases).

The approach was piloted in 2018 in Bati woreda of South Wollo zone, led by health post and health centre staff with strong engagement and support from Concern Worldwide. It was subsequently expanded to other woredas in the zone, and in 2020 extended further to woredas in North Gondar (Amhara region) and two woredas in Somali region.

Implementation has included adaptation of global guidance to an Ethiopia-specific guide, Training of Trainers (ToT) for zonal and woreda teams, cascade training to health facility and health post staff (including HEWs), and routine follow-up through supportive supervision and review meetings.

1. **Situation analysis (seasonal variations and events):** Facility teams map key seasonal patterns and shock events; lean season, drought, flooding, disease outbreaks, population movement, and plot historical trends in severe-acute malnutrition (SAM) admissions and selected childhood illnesses like diarrhoea, malaria and pneumonia to understand when and why workload rises.

2. **Capacity assessment:** Health Facility Teams assess their specific facility routine services capacity and likely constraints during peak periods including staffing, opening days, patient flow, essential commodity management (ready-to-use therapeutic food (RUTF) and essential drugs), outreach and screening, referral and transport and reporting. This helps identify which constraints can be addressed locally and which require woreda or partner support.

3. **Threshold setting:** Using their specific health facility routine data, each facility defines locally appropriate workload thresholds for priority conditions (at minimum SAM; in some settings other morbidities such as diarrhoea, malaria and pneumonia may also be included). Thresholds are typically set for 'normal', 'alert' and 'serious' phases to reflect increasing pressure on service delivery.

4. **Surge action planning:** Facilities agree a simple, phased action plan linked to the thresholds.

    - 'Alert' phase actions are primarily facility-led (task sharing, reorganising patient flow and clinic days, accelerating orders and requesting redistribution of supplies).

    - 'Serious' phase actions require external support (surge staffing, emergency transport for supplies, additional RUTF or commodities and intensified supervision). Where feasible, agreed actions are linked to woreda planning and budgeting processes to support sustainability.

5. **Formalise commitments:** The health facility team, relevant community stakeholders, and the District Health Management Team (DHMT) collaboratively determine how actions in the surge plan (Step 4) will be resourced and who will be responsible for ensuring timely implementation once thresholds are exceeded.

6. **Real-time monitoring, act and reflect:** Each month (and more frequently where feasible), facilities update monitoring charts or dashboards to compare admissions against thresholds, document actions are taken, and the next steps agreed upon. Woreda teams use this information for supportive supervision and to

coordinate external support when thresholds are crossed; as caseloads reduce, actions are scaled down and routine systems are restored.

Implementation is strengthened when roles and responsibilities are clear across levels: health posts and health centres lead data use and first-line actions; woreda health offices enable supervision, problem-solving and resource mobilisation; both regional and national structures provide technical oversight and harmonisation. Evaluations from the Ethiopia pilot highlighted that using their own data can empower health workers, support evidence-based decisions (for example ordering supplies based on analysis), and improve communication across levels (the surge approach dashboard alerting woreda health offices to spikes in selected morbidities). As part of regular reporting, the surge approach dashboard is shared with woreda health offices, where authorities monitor each health facility individually and provide timely support whenever admissions exceed the established threshold.

Salahad woreda SAM Admission from January 2022 to December 2022

No	Health Facility	Setted Threshold				Month												Total
		Normal	Alert	Serious	Emergency	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sept-22	Oct-22	Nov-22	Dec-22	
1	Salahad HC	0-18	19-36	37-54	≥55	6	26	19	30	16	15	17	0	35	1			165
2	Wangey HP	0-10	11--20	21--30	≥31	5	7	4	7	3	5	2	0	2	0			35
3	Magalo ad HP	0-10	11--20	21--30	≥31	3	14	10	6	3	4	3	0	1	0			44
4	Haro-ogaden HP	0-8	9--16	17--24	≥25	4	7	11	9	4	5	4	0	7	0			51
5	Bali-ade HP	0-11	12--22	23--33	≥34	2	3	10	5	3	7	7	0	5	0			42
6	Haroledi HP	0-7	8--14	15--22	≥23	0	3	7	6	2	5	3	0	4	0			30
7	Galile HP	0-9	10--18	19--27	≥18	3	10	6	6	4	7	2	0	4	0			42
8	Barni arte HP	0--5	6--10	11--15	≥16	5	4	11	5	3	7	1	0	4	0			40
9	Kaldisa HP	0-6	7--12	13--18	≥19	3	5	10	5	5	9	1	0	7	0			45
10	Afwayne HP	0--8	9--16	17--24	≥25	4	8	3	9	3	5	6	0	6	0			44
11	Dargudud HP	0--5	6--10	11--15	≥16	4	2	3	7	4	4	5	0	5	0			34
Total						39	89	94	95	50	73	51	0	80	0	0	0	572

Strengthening linkages with routine reporting systems (for example the District Health Information System (DHIS2)) and Public Health Emergency Management (PHEM) is critical to avoid parallel systems and to embed thresholds, dashboards and surge actions within government mechanisms.

The approach is particularly relevant in Ethiopia where consultation loads follow seasonal patterns and can be anticipated, for example peaks in acute malnutrition during lean seasons or drought, and increases in malaria, diarrhoea and acute respiratory infection during specific periods, allowing facilities to prepare early and request support before quality of care is affected.

In July 2025, a National Consultative Workshop convened the Ethiopian Public Health Institute, Regional Health Bureaus and partners to discuss how to sustain and scale the Surge Approach within government systems. Immediately following the workshop, the Acute Malnutrition Prevention and Management Desk, under the Nutrition Coordination Lead Executive Office of the Federal MoH (Ethiopia), agreed to integrate the Surge Approach into its annual planning, while emphasising the need to document the approach's strengths and limitations to inform potential inclusion in the National IMA Guidelines. Concern Worldwide was requested to develop a learning document and to serve as the Surge Approach Focal Point under the CMAM Technical Working Group, consolidating lessons learned and coordinating partner inputs.

Results

The Surge Approach has strengthened the health system's ability to manage seasonal increases in caseloads through practical, facility-level adaptations and improved local coordination. Health facilities implemented measures such as task sharing among staff, planning for workload peaks, cancelling leave, redeploying staff from nearby facilities, and initiating early stock requests within the pull-based supply system. Localised health promotion activities also helped prevent disease outbreaks. Regular woreda-level review meetings improved coordination, enabling joint

problem-solving and low-cost, data-driven decision-making. This led to better facility-level planning and management, including the development of costed surge plans for operational support.

In addition, the programme generated important evidence through endline surveys that assessed implementation performance and informed future improvements. Findings from the Enhanced Response to Nutrition Emergencies (ERNE)[2] Programme endline survey showed that health facilities were able to maintain quality of care even during peak periods of increased demand.

Table 7. Total health facilities maintained Surge standards for performance (% exits cured/defaulted/ died) during peak period.

		Midline (Nov 2021)		Endline (Feb 2023)		
	Total HFs assessed	Maintained performance standards during peak (3 months)		Total HFs assessed	Maintained performance standards during peak (3 months)	
Woreda		#	%		#	%
Beyeda	16	7	44%	24	24	100
Janamora	20	7	35%	37	34	92%
Total	36	14	39%	61	58	95%

Challenges

Start–stop implementation due to short project cycles. One-year funding periods and moving between woredas limited continuity and prevented the approach from becoming routine.

Limited ownership at multiple levels. Weak engagement of Regional Health Bureaus and woreda offices, and at times limited internal ownership within Concern teams, reduced accountability for follow-up.

High staff turnover. Trained government and partner staff leaving posts undermined retention of skills and facility-level continuity.

Training model created dependency. Training a single facility representative through classroom sessions reduced wider team uptake and made implementation vulnerable when focal staff were absent.

Too many facilities for effective monitoring. Wide coverage without sufficient supervision capacity reduced the proportion of facilities completing all core steps and becoming ‘surge operational’.

Insufficient national-level advocacy and standardisation. Limited sustained advocacy and inconsistent partner approaches slowed progress towards harmonised tools, joint review and integration into national systems.

Lessons Learned

Ownership is decisive. Active engagement of government counterparts (woreda and regional levels) and facility leadership strengthens acceptance and functionality during implementation, but experience shows the Surge Approach often remains operational only while projects are present. This is largely because it is not yet systematically integrated into routine Primary Health Care systems; national guidelines, supportive supervision mechanisms, or annual planning and budgeting, so it can be perceived as a project-driven model rather than a routine health system

[2] https://www.concern.net/knowledge-hub/ERNE

function. Health workers tend to apply surge processes when supported by project supervision and follow-up but revert to usual practices once external support ends. In addition, key tools (threshold monitoring, preparedness actions and regular review mechanisms) are rarely embedded in standard systems, and staff turnover further weakens continuity. These lessons demonstrate that, beyond ownership, institutionalisation within government systems is essential for the Surge Approach to be sustained beyond project cycles.

Train the whole facility team. Classroom training of a single staff member per facility created dependency and undermined continuity when trained staff moved. On-the-job training and mentoring using facility in-charges as focal points better support institutionalisation. Training should reach all clinical staff at health centre level and all Health Extension Workers (HEWs), using approaches that minimise time away from duties, so that all staff understand the Surge Approach and implementation is less vulnerable to staff turnover.

Focus instead of scale. Introducing the approach to too many facilities at once reduced the quality and consistency of follow-up. Health workers needed regular coaching to apply surge thresholds correctly, keep monitoring tools updated and take timely actions when caseloads increased, but this was difficult to sustain when the number of facilities exceeded what woreda teams could realistically supervise. Starting with a smaller, manageable number of facilities per woreda enabled routine supportive supervision, step-by-step verification, on-site mentoring and early correction of mistakes. This phased approach improved adherence to the methodology, strengthened staff confidence and produced more reliable results before expansion.

Monthly monitoring and practical tools make the approach usable. Simple, field-friendly tools; seasonal/event calendars, trend analysis, threshold setting, action planning and monthly reviews, support routine decision-making, especially when adapted to local formats and kept concise. However, introducing too many tools at once can overwhelm Health Extension Workers (HEWs), reduce consistency of use and compromise data quality. Prioritising a limited set of essential, easy-to-use tools supports better adoption, accurate monitoring and more effective facility-level response.

Advocacy platforms enable sustainability. National and regional technical working groups and review meetings help keep the Surge Approach on the agenda and align government and partners around common standards. Consistently sharing lessons and implementation updates through these forums builds awareness and support and helps drive harmonisation and integration.

Linking Surge to annual planning increases sustainability. The National Consultative Workshop, held in July 2025, reinforced the need to integrate the Surge Approach into MoH annual planning and to progressively build the evidence base for potential future inclusion in national guidelines. While full policy inclusion may take time and require continued advocacy, integrating the approach into the annual work plan of the Nutrition Unit within the MoH, can raise visibility, support implementation continuity and strengthen future engagement with decision-makers.

Recommendations

- Institutionalise the Surge Approach within MoH and Emergency Nutrition Coordination Unit (ENCU) frameworks and align partner implementation through the CMAM Technical Working Group (TWG).
- Use on-the-job training and mentoring for all facility staff; appoint facility in-charges as Surge focal points to strengthen ownership and continuity.
- Prioritise quality by limiting the number of supported facilities per woreda and ensuring monthly supportive supervision until facilities are consistently ‘surge operational’
- Integrate Surge into multi-year funding and routine workplans to avoid start–stop implementation and allow time for institutionalisation.

- Conduct periodic refresher and ToT at federal and regional levels (including MoH, ENCU, PHEM and partners) and cascade to regions and woredas with a clear follow-up plan.

- Strengthen national and regional advocacy by producing and sharing learning resources and case studies; progressively build evidence to support future inclusion in national guidance.

- Standardise and contextualise tools (formats, language, reporting) with government counterparts to make them practical at facility level and consistent across implementing partners.

Conclusion

Concern Worldwide's experience in Ethiopia demonstrates that the Surge Approach can strengthen health facility readiness for predictable spikes in acute malnutrition and other priority health conditions, but its sustainability depends on moving from project support to routine health system practice.

The most consistent gains occurred where woreda, regional and facility leaders owned the process, whole teams were trained and mentored on the job, and implementation focused on a manageable number of facilities with regular supportive supervision. Keeping tools simple and embedding monthly monitoring and reviews helped ensure surge decisions were practical, while national and regional platforms enabled alignment and advocacy.

Ultimately, sustaining the impact of the Surge Approach will require institutionalising surge processes within Primary Health Care systems through supervision structures, routine reporting, and MoH annual planning and budgeting, and progressively documenting evidence to support inclusion within national guidance.