Toolkit for Health Service Continuity Planning for Healthcare Facilities managed by RCRC Societies

HEALTH SERVICE CONTINUITY PLANNING GUIDELINES

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ACKNOWLEDGMENTS

RELATED DOCUMENTS INCLUDE:

- Inception Report for the Development of a Business Continuity Planning toolkit for NS led Healthcare facilities (.pdf)
- Health Services Continuity Planning template (.doc)
- Risk assessment template spreadsheet (.xls)
- Report from the piloting of the HSCP toolkit in Cameroun and DRC

ABBREVIATIONS

|	
BCP	Business Continuity Plan/Planning
CAR	Central African Republic
CHW	Community Health Worker
CIS	Critical Incident Staff
COVID-19	Coronavirus Disease 2019
CP3	Community Epidemic and Pandemic Preparedness Programme
DRC	Democratic Republic of the Congo
DRR	Disaster Risk Reduction
FAQ	Frequently Asked Questions
FGD	Focus Group Discussion
FRC	French Red Cross
GDPC	Global Disaster Preparedness Center
HCF	Health Care Facility
HCW	Health Care Worker
HIC	High Income Countries
HIV	Human Immunodeficiency Virus
HQ	Headquarters
HSCP	Health Services Continuity Plan/Planning
ID	Inpatient Department
IFRC	International Federation of Red Cross and Red Crescent Societies
IPC	Infection Prevention and Control
IT	Information Technology
KII	Key Informant Interview
KPIs	Key Performance Indicators
LMIC	Low- and Middle-Income Countries
MW	Maternity Ward
MoH	Ministry of Health
NS	National Society
OD	Outpatient Department
OT	Operations theatre
PHC	Primary Health Care
RCRC	Red Cross Red Crescent
TB	Tuberculosis
TFMCC	Task Force for Mass Critical Care
WHO	World Health Organization

GLOSSARY

The Disaster Risk Management, Public Health and even the Business literature use different terminologies to refer to similar or related concepts. To facilitate understanding of this document, as well as recommended tools and reading materials, we have compiled the following glossary.

Business continuity plan/planning - An organizational tool to ensure that an organization's systems can continue to function during times of crisis. A good business continuity plan ensures an organization can continue to operate their essential services. The concept comes from the business world, but has been extended to other types of organizations. WHO uses "health services continuity planning or operational continuity planning" as terminology for healthcare facilities/services. The terminology "health services continuity planning" has been retained for this toolkit.

Contingency plan/planning - Contingency planning aims to prepare an organization to respond well to an emergency and its potential humanitarian impact. Contingency planning involves "anticipating a specific hazard based on specific events or known risks at local, national, regional or even global levels (e.g., earthquakes, floods or disease outbreaks), and establishing operational procedures for response, based on expected resource requirements and capacity. Developing a contingency plan involves making decisions in advance about the management of human and financial resources, coordination and communications procedures. Effective contingency planning should lead to timely and effective disaster-relief operations." (IFRC, 2012. Contingency planning guidelines).

Response plan/planning – Response planning involves "identifying, strengthening, and organising resources and capacities so as to reach a level of preparedness for timely and effective response to a potential crisis. Response planning is preliminary in nature, based on educated assumptions of risks and hazards, and does not address specific hazard scenarios". (IFRC, 2012. Contingency planning guidelines). Response plans are usually higher level, plans and can have hazard-specific contingency plans in annexes.

Figure 1. Comparison between Business Continuity, Contingency planning and Emergency management tools (Source: IFRC 2020. Explanatory note, Business Continuity Plan, Contingency Plan and Emergency plan of Action)
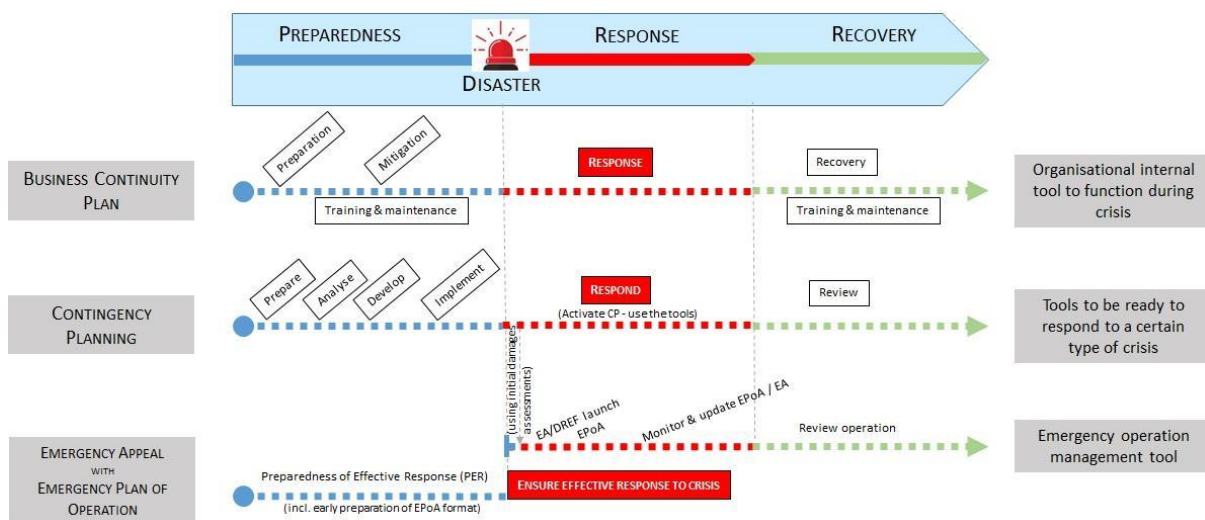
Capacity Gap Analysis. A systematic process of identifying discrepancies between the existing capacities of an organization or community and the capacities needed to effectively prepare for, respond to, and recover from disasters or crises. This analysis helps to identify areas where additional resources, training, or support may be required to enhance resilience and improve overall response capabilities.

Hazard - *"A process, phenomenon or human activity that may cause loss of life, injury or other health impacts, property damage, social and economic disruption or environmental degradation."* (WHO, 2021. Health service continuity planning for public health emergencies)

Evaluation. A systematic process of assessing the effectiveness, efficiency, relevance, and sustainability of programs or interventions. It involves gathering and analyzing data to measure outcomes against objectives, identify strengths and weaknesses, and inform decision-making for improvement and accountability.

Monitoring. "The routine collection and analysis of information to track progress against set plans and check compliance to established standards. It helps identify trends and patterns, adapt strategies and inform decisions for project/programme management." (IFRC 2021 Project/programmemonitoring and evaluation guide)

One Health – "An integrated, unifying approach to balance and optimize the health of people, animals and the environment. It is particularly important to prevent, predict, detect, and respond to global health threats".The approach mobilizes multiple sectors, disciplines, and communities at varying levels of society to work together. One Health involves the public health, veterinary, public health and environmental sectors. (WHO. 2017. What is "One Health"?)

Preparedness – "Knowledge, capacities, and resources that enable Healthcare Facilities to fulfill their mandate to meet the needs to those most affected by disasters and crises with timely and effective humanitarian assistance." (IFRC, 2023. National Society Preparedness for Effective Response leaflet)

Readiness - "The ability to quickly and appropriately respond when required." (IFRC, 2023. National Society Preparedness for Effective Response leaflet)

Recovery – "Support people's efforts to cope and self-recover by building back better and restoring services and assets in a resilient manner." (IFRC, 2023. National Society Preparedness for Effective Response leaflet)

Resilience – "The ability of individuals, communities, organizations or countries exposed to disasters, crises and underlying vulnerabilities to anticipate, prepare for, reduce the impact of, cope with and recover from the effects of shocks and stresses without compromising their long-term prospects." (IFRC, 2014. Framework for community resilience".

Response – Can be defined as the actions taken to "save lives, meet basic needs and avoid further losses. Respond to ongoing and cascading hazards and impacts." (IFRC, 2023. National Society Preparedness for Effective Response leaflet)

Figure 2. The links between different concepts in this glossary, as presented in IFRC's 2023 National Society Preparedness for Effective Response leaflet.
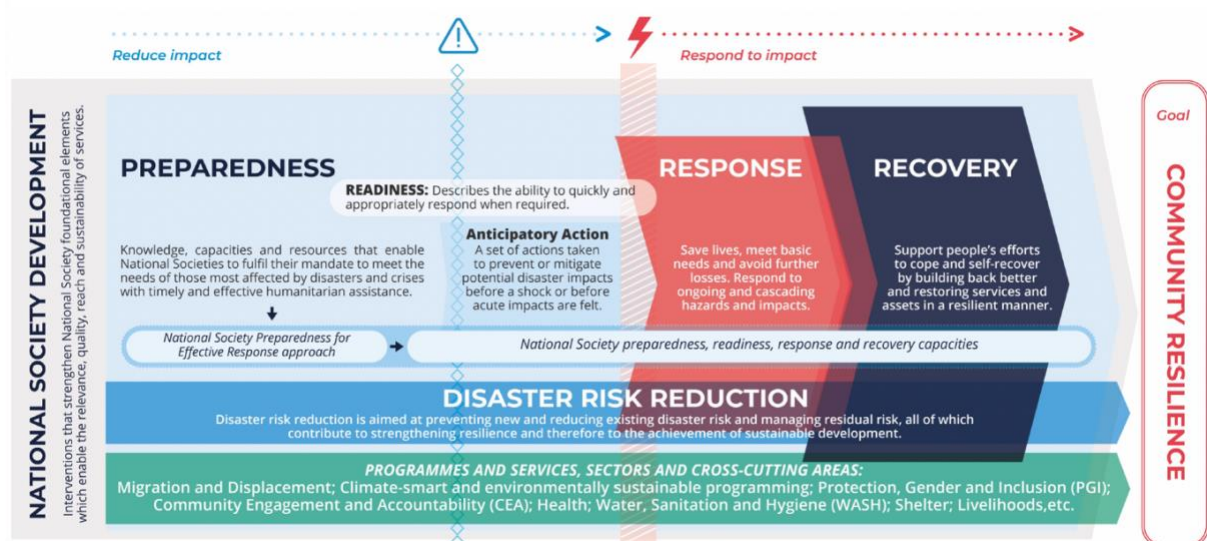
Risk - Risk is defined as "the potential loss of life, injury or destroyed or damaged assets which could occur to a

system, society or a community in a specific period. The level of risk depends on the nature and exposure to the hazard, vulnerabilities and capacities and level of preparedness and readiness to respond." (WHO, 2021. Health service continuity planning for public health emergencies)

Risk Assessment - "A methodology to determine the nature and extent of risk by analysing potential hazards and evaluating existing conditions of vulnerability that together could potentially harm exposed people, property, services, livelihoods and the environment on which they depend. Risk assessments (and associated risk mapping) include: a review of the technical characteristics of hazards such as their location, intensity, frequency and probability; the analysis of exposure and vulnerability including the physical, social, health, economic and environmental dimensions; and the evaluation of the effectiveness of prevailing and alternative coping capacities in respect to likely risk scenarios. This series of activities is sometimes known as the risk analysis process." (WHO, 2021. Health service continuity planning for public health emergencies).

Routine health services - These are "all health services provided routinely or during normal times; they include but are not limited to those identified in essential health service packages. They are considered distinct from the additional health services demands brought about by public health emergencies." (WHO, 2021. Health service continuity planning for public health emergencies)

Simulations. Structured exercises that replicate real-life scenarios to test and improve disaster response capabilities. They involve role-playing and scenario-based training to enhance preparedness, coordination, and decision-making among responders. Simulations help identify strengths and weaknesses in systems and procedures, fostering learning and improvement.

Vulnerability - "This refers to the conditions determined by physical, social, economic and environmental factors or processes which increase the susceptibility of an individual, a community, assets or systems to the impacts of hazards". (WHO, 2021. Health service continuity planning for public health emergencies)

THE HEALTH SERVICE CONTINUITY PLANNING TOOLKIT

What is Health Service Continuity Planning?

Business Continuity Planning (BCP) is a crucial tool aiming at ensuring the continuity of services in adverse conditions, for example during and after a disaster, conflict, but also an epidemic outbreak. It can be applied to different structures and organizations, including healthcare facilities (HCFs). **WHO uses the term Health Services Continuity Planning instead of Business Continuity Planning, and many healthcare facilities may identify more with this terminology, which is why the term has been retained for this toolkit.**

Planning for crises takes different names in different sectors. Contingency planning, disaster preparedness, and response plans for example are key Disaster Risk Reduction tools, whereas (Emergency) Healthcare facilities may talk about scenario planning, plans for continuity of services, and community health teams talk about epidemic preparedness and response plans (see the Glossary section for definitions of these and related terms). A related concept is health systems resilience, defined as "the capacity of a health system to absorb internal or external shocks (for example prevent or contain disease outbreaks and maintain functional health institutions) while sustaining achievements". (Ammar W, et al).

BCP is defined as a tool to ensure the continuity of services in adverse conditions and thus includes different crises such as natural or man-made hazards, conflicts, and epidemic outbreaks. Structures and organizations providing services, whether public, private, or not-for-profit, can benefit from BCP. The GDPC has developed, for example, Business Continuity Plans for Red Cross Red Crescent (RCRC) National Societies (NS), as in their auxiliary role to the government, they are usually key actors during emergencies and need to ensure their own continuity of services.

The concept of BCP can also be applied to healthcare facilities. In many cases, the terminology used is operational plans for continuity of health services, or **Health Services Continuity Planning (HSCP)**. Some healthcare facilities around the world have begun applying lessons learned from COVID-19 and developing HSCPs. Ideally, a HSCP for healthcare facilities would help build health systems resilience, especially in contexts that are exposed to multiple hazards and risks.

Why this Health Service Continuity Plan toolkit?

In many countries around the world, the **RCRC NS manage healthcare facilities as part of their auxiliary status to national governments**. Health Service Continuity Plans are needed for these RCRC-managed HCFs to assure continuity of services during outbreaks and disasters, facilitate reacting to changing needs and mobilise across multiple fronts to address the healthcare needs of a population. Health Service Continuity Plans for healthcare facilities contribute to efforts aiming at health system resilience, especially in contexts that are exposed to multiple hazards, such as the combination of new potential future outbreaks and disasters.

Surveys conducted by WHO on disruptions to essential health services during the COVID-19 pandemic showed that disruptions in essential services were found to be widespread across the globe, with 90% of countries responding reporting some disruption in August 2020, and greater disruptions being reported in LMICs than in HICs. Disruptions persisted into the last quarter of 2022 when the surveys started showing some recovery. This long perturbance of services occurred even though many countries had developed some national policy for continuity of services, suggesting challenges may have been playing out at the local or HCF level.

Supply-side factors for disruptions included cancellation of elective services, staff redeployment to provide COVID-19 relief or insufficient staff to provide services, insufficient personal protective equipment available, closures of services or health facilities (e.g. screening services, disease-specific outpatient clinics), and interruptions in the supply of medical equipment and health products. Demand side factors also played a role (lower demand, lockdowns, financial difficulties)

Many countries also reported requiring "guidance and support in adapting strategies to maintain essential health services, assuring essential supplies, strengthening the health workforce, strengthening adequate

infection prevention and control capacities, providing risk communication, monitoring and implementing telemedicine".

This toolkit was developed to support **RCRC-managed healthcare facilities to minimize disruption, be able to maintain essential services, and ultimately increase the resilience of health services** during public health emergencies, disasters, and other crises. Figure 3 shows the logical framework for the Health Service Continuity Planning toolkit. The toolkit is the input, leading to the development of the Health Service Continuity Plans in HCFs (output). When a crisis strikes, the plan is then implemented (outcome), leading to decreased or minimized disruption of healthcare services (impact level desired change).

Figure 3. Logical framework for the Health Service Continuity Planning Toolkit

The toolkit provides step by step guidance for developing service continuity plans in the context of specific local threats by outlining the procedures and key elements to be considered for planning including a planning template.

Scope of the toolkit

The Health Service Continuity Plan toolkit is designed for small to medium-sized HCF, including various common types supported by NS such as primary HCF (community health centres, health posts) and referral hospitals. While larger-size HCF may still benefit from using this toolkit, they will likely need to adapt some components and develop a more elaborated plan.

To ensure the toolkit is easy to use by this range of HCFs, we have included the minimum components in the main body of the HSCP template and added the rest (which may be required by larger HCFs, as annexes).
The toolkit is focused on HCF supported by NS, however, it will also be applicable in most cases to other healthcare facilities of similar size (government, NGO, or private led).

To ensure the development of a HSCP plan is a worthwhile investment, it is important to consider is some key elements are in place, for example:
- A commitment by a partner to accompany the NS with the development of an advocacy/fundraising plan to ensure implementation of the plan is feasible; interest
- A commitment from both the HCF leadership and the NS supporting the HCF, to ensure there will be follow-up after the development of the plan, with adequate testing, training, monitoring and maintenance.

Who is this toolkit for? (audience)

The audience for the toolkit is health facility managers and key staff who can participate in the development of the toolkit. It is also important to include in the HSCP development process the following stakeholders:
- NS staff including health and DRM coordinators, and management as relevant.
- Health authorities at the national, district or local level, as relevant.
- Community representatives
- Representatives of other health facilities in the area (at the same, higher or lower levels of care), as relevant.
- Private sector partners with experience in continuity planning, as relevant.
The audience for the plan developed by the HCF includes all staff, as everyone will need to be involved in the preparedness activities and activation of the plan in an emergency. The plan can also be shared with the stakeholders listed above.

The toolkit can help RCRC-managed healthcare facilities to:

1 Develop service continuity plans if there are none for their health facilities.

2 Review and update their existing service continuity plans and other arrangements for health services continuity.

3 Enhance awareness of the necessity of service continuity planning.

Components of the toolkit

- Health Service Continuity Planning Guideline (this document)
- Risk Assessment Matrix (as a fillable spreadsheet)
- Health Service Continuity Planning Template, with the following sections
  - Part 1. Management commitment: signature of management after approval of plan.
  - Part 2. Prepare to develop your Health Service Continuity Plan
  - Part 3. Asses capacities and risks
    - i. HCF Diagnostic (staff, materials and equipment, financial)
    - ii. Assessment of essential healthcare services
    - iii. Risk assessment and prioritization (use Risk assessment matrix)
  - Part 4. Continuity planning (staff, materials and equipment, financial)
    - i. Objectives and operational priorities
    - ii. Continued activities during response phase
    - iii. Staff planning for emergencies
      - Critical incident staff matrix
      - Delegation of tasks and responsibilities
    - iv. Internal and external communication
    - v. Financial needs assessment and funding sources
  - Part 5. Activating and deactivating the plan
  - Part 6. Preparedness and mitigation
    - i. Training and simulations
    - ii. Preparedness and mitigation activities
  - Part 7. Monitoring and evaluation
  - Part 8. Maintenance and Sustainability
  - Part 9. Recovery Strategy
  - Checklist
  - Annexes
    - Annex 1. List of potential services/operations of a health facility
    - Annex 2. Incident Management Structure
    - Annex 3. Surge staff and responsibilities
    - Annex 4. Stakeholders and contact details
    - Annex 5. Example of an activation plan
    - Annex 6. Simulations per hazard
    - Annex 7. Examples of monitoring and evaluation indicators
    - Annex 8. All hazards approach and examples of preparedness and mitigation activities per hazard.

Basis of this toolkit

This toolkit is based primarily on three documents: the IFRC's contingency planning guidelines, the IFRCs Business Continuity planning toolkit for National Societies, and WHO's Handbook Health Service Continuity Planning for public health emergencies. The first two come from the Disaster Risk Management sector and the latter from the Public Health sector. This toolkit aims to combine guidance and best practices from both sectors to best serve NS-managed HCF. It also incorporates good practices and lessons learned that have been published in the literature (see the Inception report for this toolkit).

The north star for this toolkit has been the three questions posed by the IFRC's contingency planning guidelines:

• *What is going to happen? →Assess*
• *What are we going to do about it? → Develop a Health Service Continuity Plan*
• *What can we do ahead of time to prepare? → Preparedness and mitigation*

What is going to happen?

What are we going to do about it?

What can we do ahead of time to prepare?

Design principles of the toolkit

Simple and easy to use: Based on the concerns that a heavy, complex Health Service Continuity Plan development approach might not be taken up by HCF already overburdened with tasks and facing many challenges, this toolkit is focused on the minimum standards needed, without adding complexity, it has a user friendly format and language and can be completed by a small core team of key clinical and management staff in 3-5 days of (facilitated) effort.

Low threshold for implementation: One concern is institutional memory due to the high turnover of staff. A low activation threshold for the plan can ensure that it is activated (or at least parts of it) often enough (in the range of once a year) that a large part of the staff becomes familiar with it.

Fun/playful/entertaining: Colourful materials for the toolkit, as well as a gamified approach to it may help ensure the development of a Health Service Continuity Plan becomes an engaging task instead of a dreary responsibility for busy HCF staff, ensuring motivation and strengthening ownership.

Evidence-based: The toolkit incorporate lessons learned and best practices from the literature.

Linked to other processes: Where possible, we have added recommendations of how can the development of the plan and/or the plan per se be linked to other processes (e.g. planning algorithms, IPC implementation plans), to ensure its continuity as a living document that can be tapped into when needed as it is well known by all key staff, independent of staff turnover

Promoting ownership of the plan: The HSCP toolkit proposes an approach to HSCP development that strengthens ownership and engagement from operational and management staff at the HCF. This includes, for example, initial participatory priming sessions where participants discuss challenges and disruptions faced during a crisis and solutions they have implemented; participatory approach to the development of the HSCP, flexible templates and tools that people can tweak to their contexts, and a specific section to collect signatures from management for commitment and ownership.

All hazards approach. The revised version of the International Health Regulations (2005), as well as the Sendai Framework for Disaster Risk Reduction 2015–2030, promote an "all-hazards" approach in emergency preparedness. This is an integrated approach to emergency management and planning focusing on critical capacities for a full spectrum of emergencies recognizing that there are common elements, and common capacities required, in the management of these risks. The all-hazards approach allows for a unified plan with the flexibility to adapt to specific hazards and remove the need for multiple, often siloed, plans.

How to use this toolkit?

Follow the instructions in the Health Service Continuity Plan development section below to put together a team and develop a Health Service Continuity Plan for your health facility. The guidelines will walk you through how to fill out the Health Service Continuity Planning template, based on the steps that you can see in Figure 3. Steps to develop a HSCP. A ribbon with these steps has been added to the bottom of the guidelines and the template to easily identify the steps of the process.

You will find throughout the Guidelines and Template the following boxes:

- **IN ADDITION**. These boxes suggest other items that the team may want to consider while building their Health Service Continuity Plan. Many of these will be more relevant for larger healthcare facilities.

- **TIPS.** These boxes contain good rules of thumb, tips and tricks from available evidence or from previous experiences for building a HSCP.

- **CONSIDER.** These boxes contain important reminders, or things to consider and discuss while building your HSCP.

CONSIDER. Pilots show that participants from HCF with constrained resources have a difficult time developing an HSCP as they already face huge needs and gaps on a daily basis are great, and planning on what resources may be needed for an emergency may seem counterintuitive.
These types of HCF may benefit from conducting a two-step approach. The first step can focus on capacities, needs and gaps analysis, and the development of a budget and a funding advocacy plan for daily operations. With this out of the way, the focus can now turn, in the second step, to developing a HSCP. These two steps could be carried out as separate trainings or as a two-week continuous one. "

Depending on your starting point you may want to skip some sections, for example:

- If a comprehensive Risk assessment has already been carried out in the past or if a diagnostic of the healthcare facilities services, staff, materials, equipment, drugs and funding has already been conducted in recent times.
- If you have already developed a health service continuity plan, for example for COVID-19, you may want to add a risk assessment for other hazards and specific considerations for other hazards.

- If you already have an all-hazards health service continuity plan that you are satisfied with, you may want to skip to the section on preparation and training or use the monitoring and evaluation section to analyse how well your current plan is working.

Figure 3. Steps in the development of a HSCP. Consider that smaller healthcare facilities may only require going through some of the key steps (2, 3 and 5) while larger ones may benefit from carrying out all the steps

1. Prepare
1.1 Set up a collaborative planning team
1.2 Plan the BCP development workshop
1.3 Establish trust and raise awareness

2. Assess
2.1 HCF diagnostic
2.2 Risk Assessment and Prioritization

3. Continuity Planning
3.1 Overall Objectives and Priorities
3.2 Continued Activities
3.3 Staff Planning
3.4 Financial Needs and Budget
3.5 Communication Plans

4. Activation/Deactivation
4.1 Activate the Plan
4.2 Deactivate the Plan

5. Preparedness and Mitigation
5.1 Train and Test
5.2 Other Preparedness and Mitigation measures

6. Monitoring and Mitigation
6.1 Routine Monitoring
6.2 Evaluation
6.3 M&E Communication

7. Maintenance and Sustainability

8. Recovery Strategy

Optional

Optional

HEALTH SERVICE CONTINUITY PLAN DEVELOPMENT

1. Prepare to develop your Health Service Continuity Plan

1.1 Set up a collaborative, multidisciplinary HSCP development team

Developing and implementing a Health Service Continuity Plan requires a multidisciplinary HSCP development team.

Who **assembles** the HSCP development team?	The HSCP development team can be assembled by the head of the health facility or even its board, if it has one, or by the person responsible for the HCF at the NS, depending on the set up of the HCF. Alternatively, if there is a focal point for continuity or contingency planning, or for emergency preparedness, either at the HCF or the NS, this person can set up the HSCP development team and lead the process.
Who **facilitates** the Health Service Continuity Plan development exercise for the team?	Based on the pilot experiences, it is strongly recommended **to have a facilitator team to guide the HSCP development team through the process**. Consider requesting a facilitator from the IFRC, the National Society or partners experienced in HSCP. Alternatively, HSCP development team members can be appointed to facilitate and lead different stages of the development of the HSCP or a team leader can be assigned that facilitates the entire process. The team leader can be someone from the HCF or the NS. Co-facilitation with experts from the MoH can also be considered.
Who should **be on the HSCP development team**?	The HSCP development team benefits from being **multidisciplinary** and including people who would take on important roles in case of an emergency. **Internal participants**: It can include Heads of Wards, Head doctor, Head nurse, people in management, logistics, finance, and administration. You may also want to include a relevant focal point from the NS (e.g, someone from the health and finance departments) External stakeholders: inviting a range of external stakeholders either as team members or as observers and advisors is key to ensuring a successful and realistic plan. These stakeholders may include: o local/regional/national health and public health authorities, o community representatives, o representatives of other health facilities (at the same, higher or lower levels of care), o WHO and other health partners and donors/potential donors o Private sector partners or stakeholders, particularly if they have experience with continuity planning.
How many people should be on the HSCP development team	It is recommended that the HSCP development team **does not include more than 5 key stakeholders from the HCF** with relevant knowledge and decision-making powers
How to **ensure** people in **the HSCP development team participate actively**?	It is strongly recommended to **conduct the workshop for HSCP development off-site and residential** to facilitate participants' focus. Ensure there is a strong commitment from leadership to allow staff members to participate by giving them the time and means, and ensuring they do not have competing responsibilities during the development of the planning workshop. To ensure good coordination, collaboration, and participation, set up roles and responsibilities (moderator, note-taker, etc), communicate them clearly to all participants and external stakeholders.

Do small healthcare centers and health posts need a Health Care Services Continuity Plan?

Smaller healthcare facilities also benefit from having clarity on what they would do during an emergency. If your healthcare facility has less than 5-10 staff members, you may not need to go through a full development of a Health Service Continuity Plan. However, you may want to sit with management and staff to discuss what are the most likely hazards the facility may face, and how you would respond in each case.

Guide the discussion using the following questions:
- What is going to happen/What might happen?
- What are we going to do about it?
- What can we do ahead of time to prepare?

It might be that the answer is to shut down services until the emergency is over. In this case, you may want to plan ahead to know how you will communicate this to health authorities and to patients and the community.

It might be that you have the possibility of continuing to provide certain basic services, or reconvert your services to contribute to the larger overall emergency response (e.g. becoming a vaccination point if there is an epidemic, or providing outpatient services to people with chronic diseases if larger healthcare facilities are overwhelmed, etc).

You can discuss and write down your plan in just a few hours, without having to fill out the full HCSP template. Ensure you communicate this plan internally and to external stakeholders such as health authorities and referral healthcare facilities.

1.2 Carry out pre-workshop data collection for the HCF diagnosis and the risk assessment

To facilitate and speed up the development of the HSCP during the workshop, one or two members of the HSCP development team, and/or the workshop's facilitators can carry out previous to the workshop:

a) a short desk review,

b) a structured visit to the HCF (see *Annex IV* for a checklist).

This allows to gather information needed for the diagnostic of the HCF and the risk assessment. This information may include:

Data to collect for the HCF diagnostic	Data to collect for the Risk assessment
• Descriptions of HCF services • HMIS data on patient load, dissagregated per service if possible • Organizational chart • Data on nearby HCFs and referral centers. Note: A structured visit to the HCF previous to the HSCP development workshop is recommended (see Annex IV for a checklist to guide this visit)	• Meteorogical and climatic data available for the locality from the previous year/years • Records from recent natural hazards such as floods, earthquakes, hurricanes, tornadoes, etc. • Any lessons learned or after action reviews or reports from previous emergencies faced by the HCF.

The subteam in charge of the desk review can analyze and organize this data to be ready to present it and discuss it during the workshop. Data collected and analysed can be presented in any format, however, to ensure the most efficient process during the workshop, it is recommended that:

- The HCF diagnostic section (section 2) is pre-filled in the HSCP template with this information, for presentation and discussion during the workshop.
- A full risk assessment is carried out previous to the workshop using the Risk Assessment Matrix in the HSCP toolkit (spreadsheet). In this case, during the workshop, the risk assessment can be presented and discussed, and only the prioritizations of the risks need to be carried out during the workshop.

1.3 Plan the Health Service Continuity Plan development workshop

Aspect	Description	Comments
Objective of the HSCP development workshop	To develop a full Health Service Continuity Plan for the HCF.	The HSCP development team will work during the workshop on filling out the HSCP template that is a part of this HSCP toolkit.
Potential outcomes of the workshop	• A strong first draft that can be presented to management, reviewed by other colleagues at HCF or externally, as necessary, and finalized at a later date. • A finalized and approved plan. In this case, the worshop can include a presentation to management and a review, finalization and approval process.	The outcome will depend on time considerations, on the size of the HCF (and thus on additional staff and management that would need to review the plan), as well as on who would need to review and approve the plan
Timing and schedule considerations	• Option 1. Compress the training into a few full days, which might be easier for some healthcare staff to do. • Option 2. Half a day or 2- 3 hours sessions over several days (potentially	Consider conducting the workshop off site to avoid transportation times and potential delays and help participants focus on the subject at hand. Consider different formats for the

	afternoons if less hectic) • Option 3. If no external facilitators are needed, the HSCP development team could also meet once a week over several weeks to develop the plan.	workshop to ensure that it has the least impact possible on other HCF activities.
Creating subteams.	While clinical staff and management are key members of the HSCP development team, specific expertise might be needed, in particular for larger HCFs to fill out certain sections of the HSCP template (e.g. financial sections, communication sections).	The facilitator can agree with HCF management in advance on potential subteams that can be organized to support the development of sections that require specific expertise. It can also be suggested to assign roles to participants (moderator, note-taker, etc) to ensure everyone participates.

Example of workshop agenda. An example of a workshop agenda can be found in *Annex V*. This example agenda can be tailored to the needs of the HSCP development team, the size of the HCF, the time available, who will be facilitating, etc.

Techniques for facilitating comprehension
To support participants who might not be very familiar with the terms, exercises, and reflections used for this workshop, facilitators can consider using one or more of the following techniques: ● Provide participants with summaries at the beginning and the end of the day. ● Provide a one-page overview of the process as a large printout and add a pin to the section that is being tackled then, so participants have an easier time following. ● Provide printouts of the template and guidelines, one per participant to facilitate following, and ensure enough projects are available if participants are split into teams. ● Use an adapted scenario (such as those used for ERU training) or a specific case study to help participants walk through the exercise using a clear example. ● Develop or use existing simple tools for visual and discussion exercises, such as sorting out images about the root causes and consequences of a disaster, and health service continuity measures that can be taken. These exercises could be similar to the cards used for One Health training.

1.3 Establish trust, raise awareness and strengthen ownership of the process and plan.

Establish trust: To ensure a well-functioning multidisciplinary HSCP development team, where everyone feels empowered to contribute, the leaders or facilitators of the Health Service Continuity Plan can carry out exercises such as a short team-building activity and a participatory exercise to establish the norms and rules of the team at the start of the workshop.

To **raise awareness** of the importance of the Health Service Continuity Plan, the facilitator can start the workshop by guiding the team through a short reflection on the impact of a recent event (a natural hazard, a conflict, or an epidemic) on the services provided by the HCF (including impact on patients, the community and HCF staff, as well as financial resources for the HCF), followed by a short discussion of what could help prevent these disruptions.

TIPS

Pilots have shown that participants are mostly unfamiliar with concepts introduced by this toolkit, such as HSCP, risk analysis and M&E. The facilitation team may benefit from creating and sending a short 3–5-minute video to previous to the start of the workshop and at key points during the workshop.

Strengthen ownership: To ensure the HSCP development team sees the process and the resulting plan as their own, facilitators can:
- Ask participants to present their plan to facilitators (and potentially other HCF facility members) at the end of the workshop, and provide guidance on what they can inlcude in the presentation so participants can work throughout the workshop towards this end.
- Include daily check ins at the start and end of each workshop day, where participants take turns to reflect on key learnings from the current or previous days and/or share something that went well, and one challenge.

2. Assess capacities and risks

From this point on, **the guidelines are aligned with the Health Service Continuity Plan template** and the instructions here will allow the HSCP development team to fill out the different sections of the template.
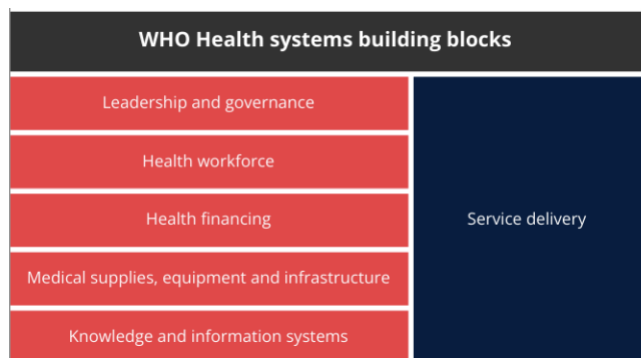
2.1 Conduct or complete the HCF diagnostic

CONSIDER. *The data for this section may have been collected and filled out in the risk assessment spreadsheet previous to the HSCP development workshop. If that is the case, instead of the steps below, the team will discuss the findings and provide any necessary corrections and additions.*

The team will carry out a diagnostic of the HCF by filling out the different tables in the Health Service Continuity Plan template.

2.1.1 The first step is for the team to conduct a rapid diagnostic of the **current capacities of the HCF**, focusing on some of the key building blocks as suggested by WHO:
- Clinical staff and bed capacity, as well as non-clinical staff (health workforce)
- Medicines, supplies, equipment (and potentially infrastructure)
- Funding and financial resources
- Leadership and governance (optional, based on on HCF size)
- Knowledge and information systems (optional, based on on HCF size)

WHO Health systems building blocks
- Leadership and governance
- Health workforce
- Health financing
- Medical supplies, equipment and infrastructure
- Knowledge and information systems
- Service delivery

For this, the HSCP development team can be divided into sub teams, based on their current positions, that can rapidly *fill out each of the tables in the template* (e.g. head doctor or nurse can fill out the clinical staff and bed capacity table, pharmacy and log staff can fill out the medicines and supplies table, and the finance and admin team can do the financial resources section).
Ensure that after filling out the separate sections, the full team reconvenes and briefs each other on the status of each section.

IN ADDITION
Some larger HFC teams may also want to assess the status of two other key pillars of a health system: the leadership and governance of the HCF and the health management information systems, and make sure to include them in the Health Service Continuity Plan.

2.1.2 The next step in the diagnostic is to **map the neighbouring health facilities** with whom your HCF will likely partner or collaborate in case of an emergency or a crisis. This can be brainstormed by the whole team. NOTE:

This may not be needed or feasible in all HCF. In some settings, neighbouring HCF don't necessarily collaborate and a mission order or other official documentation may be needed to obtain information from these centres.

2.1.3 Finally, the **HCF's organizational chart** needs to be copied in. If the HCF does not have one, now it is a good time to put it on paper. Participants from HCF where no organizational charts exist may find this exercise more difficult, but it will be more rewarding and provide additional value.

IN ADDITION

Pilots have shown that participants had a hard time imagining a hypothetical emergency situation and planning activities to prepare for it. It is thus critical that facilitators come prepared with examples or made up scenarios, (which could be based on the observations from the HCF visit or previous recent outbreaks in the country)

2.2. Conduct risk assessment and prioritize risks

To ensure a realistic and evidence-based plan, as well as to develop a plan that works for different hazards, it is important to conduct a risk assessment and prioritize those risks, so that the plan can focus only on the ones that are considered to have a potential high-impact to the health facility and the community it serves.

The risk assessment and prioritization allow tailoring of response actions in accordance with the identified risks.

2.2.1 Risk assessment. Using the Risk assessment spreadsheet, the facilitator guides the team through these steps:

1. **List all hazards.** Make a list of all the hazards or threats that could potentially affect the health care facility and threaten the continuity of services and the health and wellbeing of the staff and the population the HCF serves. Consider hazards that are linked to animal and environmental health as well, following a One Health approach. Threats can be external, but internal threats can also be considered, if appropriate (e.g. strikes among the staff).

Some hazards can be influenced at least partially, while others are outside of the HCF control. This can be further discussed in the Preparedness and Mitigation section.

2. **Establish the likelihood of occurrence.** The team discusses and agrees on the **likelihood of occurrence** (low, sporadic, probable, frequent/imminent) for each threat, based on as much evidence as possible that has been collected previous to the workshop, as well as knowledge and expertise from the team and invited stakeholders.

3. **Agree on potential impact.** The team discusses and agrees on the level of **potential impact** to the staff, HCF premises, health services and the consequences for the population (minor, moderate, severe and critical).

4. **Risk level.** The spreadsheet will automatically establish the risk rating based on the assigned likelihood and impact, classifying them as normal, emergency, disaster or catastrophic (See table Risk assessment below).

TIPS

Pilots have shown that participants may have a difficult time understanding what the different levels of impact and probability mean. Facilitators can ask questions and offer explanations to help with this exercise (e.g. Impact: How many people would be affected, what would the severity of damages be? Probability: How likely is that this event happens in the near future?)

If the team is having trouble identifying threats/hazards and potential impacts, they can use the examples on the second tab of the spreadsheet as a starting point for discussions.

Table 1. Risk assessment

Impact		Minor	Moderate	Severe	Critical
Likelihood	Frequent/Imminent	Disaster	Disaster	Catastrophic	Catastrophic
	Probable	Emergency	Disaster	Disaster	Catastrophic
	Sporadic	Emergency	Emergency	Disaster	Disaster
	Low	Normal	Emergency	Emergency	Disaster

2.2.2 Risk prioritization

Once the highest-level threats have been identified based on the risk assessment, the team can copy these (classified as catastrophic or disaster) back into the template (Table 7 of the Health Service Continuity Plan template).

Now the team will discuss in detail the consequences of each prioritized hazard to the staff, infrastructure, medicines and supplies (including supply chain), information systems and services, community, governance, and coordination. The team may have already discussed this during the risk assessment part, here it is about detailing them and capturing them in writing.

TIPS

There is no limit to the number of hazards the team might want to include in the HSCP. However, the higher the number, the longer the plan will take to develop and implement. We recommend focusing on the 2-3 hazards that are highest on the risk assessment and grouping hazards that have similar consequences (e.g. floods and mudslides)

CONSIDER. In the risk prioritization it is also important to take into account the role that the health facility has agreed to play to respond to various types of emergencies if that has been discussed with local or national authorities or MoH, e.g. based on the capacity of the health facility and the type of risks the area is facing.

3. Develop the Healthcare Service Continuity Plan

The facilitator can now guide the team through the development of the health service continuity plan. All the sections below require the Health Service Continuity Plan template. While working on the plan, remind the HSCP development team of the following:

- WHO recommends that "health service continuity plan development should be aligned as much as possible with national or subnational emergency management plans to ensure streamlining of processes and provision of resources and capacities at the operational level".
- Especially for larger HCF where there are many stakeholders, the first draft of the HSCP developed by the HSCP team may require revision and feedback from additional stakeholders who were not present during the HSCP development workshop to ensure ownership and buy-in. In this case, the HSCP development team may need to incorporate feedback from key stakeholders into the HSCP after the HSCP development workshop.
- The final plan should be:
  - Easy to read, with simple, clear, and plain language, no jargon, and minimal use of acronyms. Use short sentences and an active voice.
  - Well structured and formatted so users can quickly find the information they need
  - Summarise important information using checklists and visual aids.
  - Provide enough detail to convey the message accurately, but use as few words as possible.
  - As far as possible, consistent and coordinated with other related plans, e.g. those developed for emergency preparedness and response

3.1 Determine overall objectives and operational priorities

The first step is to determine what are **the objectives that the HCF wants to achieve in terms of continuity of essential healthcare services** when confronted with each hazard. Being clear on what the objectives are will allow the HCF to prioritize activities and services and plan accordingly (e.g. determine the operational priorities).
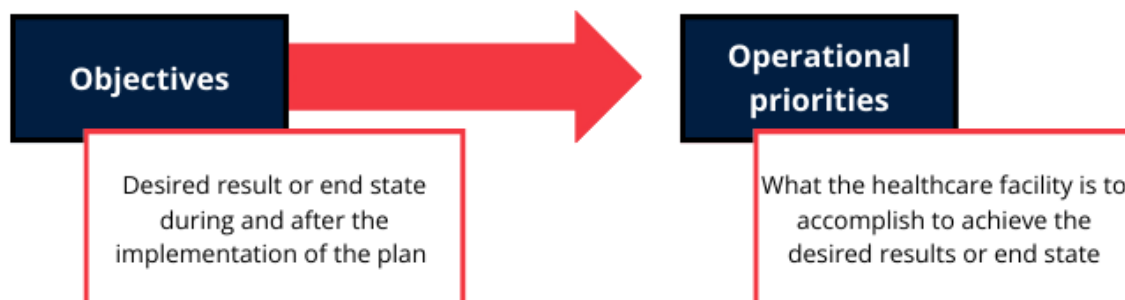
This also ensures unity and consistency among all stakeholders. Because in an emergency, different key objectives can be distributed among various HCF, it is important to have external stakeholders present at this stage (local health authorities, other nearby HCF).

Note that objectives may be similar or identical for several hazards, in which case, a single list of objectives and priorities may suffice.

Examples of Objectives

- Routine health services are reprioritized to maintain the most essential or urgent services during public health emergencies
- Develop/activate alternative platforms for certain services (e.g. community- or home-based care or telemedicine)

TIPS

A useful approach to health service continuity planning is to focus on 4 potential scenarios that may happen simultaneoulsy:

unavailability of human resources ;
unavailability of the site or equipment;
unavailability of the suppliers;
unavailability of information

The table in the Health Service Continuity Plan template also provides space to fill out secondary objectives. These may be things the HCF sees as second in priority but would

still like to consider in the plan.

CONSIDER. HCF participants in resources-constrained settings may find it difficult to distinguish needs and objectives for the day to day operation of the HCF as opposed to the objectives for continuity of services in an emergency or outbreak. This distinction needs to be raised early and reminded often during the workshop, while not disregarding the resources needs of participants and potentially suggesting sources of funding or support.

3.2 Continued activities during the response phase

3.2.1 Decide on the status of each service during an emergency. Once there is agreement on the objectives, the team moves on to the key task of deciding, based on the established objectives and operational priorities, which services will be maintained, reduced, temporarily suspended or modified, and note their decisions in *Table 9 in the Health Service Continuity Plan template*.

Constraints in resources may mean that not everything that the team would like to do is likely to be feasible or realistic. Adopting a mitigation approach (i.e. thinking of how the impact on the population served can be minimized) can be useful.

The facilitator must consider that these discussions can be hard on staff, as the decisions might apply to their own services. Keeping the objectives and priorities front and centre can help with difficult decisions.

3.2.2 Identify gaps in clinical and non clinical (support) resources and how to fill them. Next, the team will continue to fill out **Table** *9 (clinical) and Table 10 (non clinical, support services) in the Health Service Continuity Plan template* to:

- Map the estimated capacity required for each maintained or reduced service during an emergency.
- Identify existing resources, based on the HCF diagnostic done previously and any reorganization (repurposing/reallocation) of services that might liberate resources, and match them to the estimated resources needed.
- Detect gaps and shortfalls in resources needed for maintaining essential healthcare services during an emergency.
- Establish action points to fill those gaps in an emergency.

> **TIPS**
> One challenge in many HCFs is the high turnover of staff and the many unfilled positions. It is thus recommended to use the names of the positions instead of names of current staff in those positions, when filling out the HSCP template.

The HSCP development team can discuss with external stakeholders what central national resources may become available in an emergency, what additional resources may be obtained through the community, through aid agreements and partners. It is also important during this exercise to consider potential disruptions in transportation, communication, and supply chains that might affect resources (both human and material).

Categories of health service resources

Staff. Health workers (including rapid response teams and community health

Equipment and supplies. Infrastructure, bed capacity, medicines

Funding. Normal funding and emergency funds to cover the other

Information and information technology. External and HCF based data;

| workers, if applicable to the HCF), Non clinical support staff (administrative, finance, cleaning, management, etc) | medical and cleaning supplies and equipment | categories | data collection, analysis, reporting and sharing, IT tools and systems. |

3.3 Staff planning for emergency response

Once the HSCP development team has clarity on the services that will be maintained or reduced and an overall vision of the existing human resources and additional resources that would need to be obtained, the team can proceed to map how the staff will be reorganized during an emergency. Clarity on new communication and management lines, as well as new roles and responsibilities during an emergency, will be key for staff to quickly jump into action once the plan is activated.

3.3.1 Outline the emergency management structure. The HSCP development team will use the current organizational chart (established in the HCF diagnostic) and the list of maintained or reduced services to map out the temporary emergency management structure.

A good way to carry out this exercise is to use sticky notes in different colours, representing different levels or services, and move them around on a board or wall as the HSCP development team brainstorms the best structure.

Annex I has information on establishing an Incident Management Structure and explains the benefits this can provide. Think about:

- *Who will be in charge of leading the operational continuity plan?*
- *Who is responsible for which department?*
- *Will current managers in services that are closed take on a supporting role in other departments?*
- *Will teams be split up or merged?*

3.3.2 Critical incident staff matrix. Not all staff may be needed at the HCF during an emergency or crisis, especially if many services are temporarily suspended. In addition, in some situations, like epidemics, it might be best to ensure as many people as possible stay home.

The critical incident staff matrix was originally developed to apply to clinical staff, but it can be expanded to include all staff (administrative, management, logistics, cleaning, etc). Using critical incident staff matrix allows the HSCP development team to pre-determine, for each hazard, which staff will be considered:

CONSIDER. In many resource-constrained settings, people may not get a salary if they are sent home, so this matrix may cause concern. In addition, many HCF may be understaffed and having staff stay at home may be considered unrealistic.

	Critical incident staff (CIS). P*eople who are responsible for carrying out a critical function. These people are the critical incident staff and are expected to maintain their regular work at the HCF throughout the emergency.*
	Back up to critical incident staff: They do *not come to the HCF, but are expected to be able to replace the critical incident staff in case they become unavailable and during planned breaks. They can also support the CIS remotely. They should therefore maintain contact with the CIS to stay up-to-date on working knowledge.*
	Non critical incident staff. *This staff will remain at home during the emergency. They should be available in case they are needed and be prepared to return to work as soon as the emergency is declared over. They may have a role supporting activities remotely (e.g. administrative or logistical staff), if relevant.*

3.3.3 Key management roles and responsibilities. To ensure an unambiguous implementation of the emergency management structure, it is important to clearly assign responsibilities to the new roles and have people designated to fill them (although consider turnover rates). Contact details for these key managers should also be provided. The HSCP development team will use this section in the template to map out the responsibilities of the new roles, who will be assigned to them, and the contact details of this person. Full terms of reference for these new positions can also be drafted separately. If turnover rate is high, this is one of the sections that needs to be updated regularly and at the moment where the plan is activated.

3.3.4 Surge staff. Any surge staff considered to be required during an emergency should also be mapped out along with their job description and responsibilities. In this manner, if and when the surge staff can be obtained, they can start working immediately, and no precious time needs to be wasted in creating job descriptions.

3.3.5 Key external stakeholders. In this section, the HCF will link its emergency response to the broader emergency response at the local, district, or national level. While neighboring HCF were already mapped out during the HCF diagnostic, here the HSCP development team can consult with external stakeholders to map critical **individuals or positions** in external organizations for collaboration and communication (health authorities, collaborating facilities, schools, community leaders, etc), and have clarity on their potential roles during an emergency and contact details, if available.

CONSIDER. Can the HCF use task-shifting strategies that have been shown to work to support staffing challenges during emergencies? CHWs and/or RCRC volunteers can be trained in certain routine healthcare tasks, such as screening of signs and symptoms for diseases like COVID-19, administering routine childhood vaccinations, conducting home visits, etc. The CHWs can then step in to perform tasks that would normally be conducted by more extensively trained professionals. IFRC. World Disaster Report .2022.

3.4 Define financial needs, budget and funding sources

Due to a shift in activities and personnel during the emergency, the regular budget will be altered and potentially additional sources of funding will be needed.

A small group of participants including key decision makers and financial and admin participants in the HSCP development team can spend time developing an emergency budget and brainstorming with external stakeholders on potential sources of funding likely to become available during an emergency. Having a pre-established budget and a list of potential sources of funding can expedite obtaining emergency funds, as the needs are clearly established and can be transmitted quickly to known partners and donors.

3.4.1 Create a budget for the emergency based on the resources estimated to be needed for maintaining essential and reduced services, including staff, medicines, supplies, and equipment. The budget will be based on the current budget of the healthcare facility (and current sources of funding mapped in section *2.2 HCF Diagnostic*) and *Table 9 from section 3.2 Continued activities during the response phase* in the HSCP template. Brainstorm about additional services that could be needed to provide continuity of care during an emergency and provide information on them in the table, to account for additional materials and optional staff positions.

NOTE: The HSCP development team may need support from facilitators during the budgeting process to focus on the necessary items related to the continuity of services during the crisis, as opposed to needs for daily operation. This exercise is difficult because some of those items may overlap, for example, PPE.

3.4.2 Map potential funding sources. Discussing with external stakeholders present in the workshop, the HSCP development team can map out potential sources of funding that are likely to become available in an emergency (be aware that sources may vary by type of hazard).

3.5 Define internal and external communication plans

Clear and regular communication, which is critical in an emergency, requires not only clear messages but also well-established communication channels. In this section, the HSCP development team will establish the internal and external communication channels and frequency of communication in an emergency. These can be modified as the emergency unfolds, but they will be useful reminders at the start of the emergency when people are extremely busy.

3.5.1 Internal communication plan. The HSCP development team brainstorms needed communication channels (meetings, information boards, email or SMS blasts, posters, etc), as well as roles and responsibilities, frequency of communications, and position responsible for it. The plan can include a visual showing the interactions and direction of communication between the various parties.

It is important to ensure regular and clear communication not only with the staff (both staff working at HCF and staff remaining at home), but also with patients, family members and the wider community served by the HCF.

3.5.2 External communication plan. External communication can become even more chaotic than internal communication during an emergency. Overburdening others with too much communication, or not sharing enough needed information, as well as crossed or unclear channels, are all common challenges.

Being able to determine where to obtain certain information, and understanding who the players are can be a game changer to ensure continuity of services. It is also important for the HCF to contribute to the wider effort to ensure strong communication and thus collaboration at the local, district, national or regional level.

The HSCP development team here has an opportunity to determine in advance who the HCF needs to contact when confronted with different hazards, with what purpose and which information needs to be shared.

Case studies: How continuity plans and preparedness allowed RCRC National Societies to better respond during the COVID-19 pandemic

During the COVID-19 pandemic, the IFRC documented best practices and successful case studies from RCRC National Societies related to preparedness for an effective response. Some examples from these case studies include:

Lebanese Red Cross. Their multihazard scenario planning allowed the NS to respond to the double burden of needs caused by the COVID-19 pandemic and chemical explosions in Beirut affecting over 300,000 people.

Indonesian Red Crescent. The simulations and trainings -carried out t the Bogor Hospital before COVID-19 cases started, and the effective scale up of their Infection prevention and Control capacity resulted in the hospital being designated a COVID-19 specific care center at the onset of the pandemic due to its capacity to handle a disease outbreak. The case study also highlights the importance of the psychosocial support provided to hospital staff, and the ability of the hospital to adapt and adjust in the moment, changing procedures and increasing capacity to better support the response.

Colombia Red Cross. The Sectional Emergency Medical Services in Cundinamarca and Bogotá served as an example of how low complexity outpatient emergency care services can prepare and adapt to emergencies. The case study highlights how the services created different care routes for patients with and without COVID-19, and transformed non specialized medical services into critical care units.

Uganda Red Cross and **Botswana Red Cross** quickly developed Business Continuity Plans for their National Societies, focusing on protecting staff and volunteers. Their lessons learned include the importance of having guidance and templates for the continuity plans, of providing psychosocial support and of responding quickly based on pre-established plans.

Read the full case studies here to inform the development of the HSCP.

4. Activating and deactivating the plan

- When should the continuity plan be activated?
- When does the HCF switch to the emergency management structure and shut down or reduce certain services while maintaining others?

While an ongoing assessment of the situation in any emergency will be carried out by the HCF management, having pre-established triggers for activation (either for the whole plan or for different activities) can facilitate decision-making and provide clarity in a difficult situation.

The HSCP development team will spend time mapping out in *the HSCP template* the activation triggers for different hazards, as well as what triggers can be used to decide if it is time to go (partially or totally) back to normal.

4.1 Establish activation triggers for the plan

CONSIDER. To ensure institutional memory and readiness, one suggestion is to choose low activation thresholds for (some) hazards. This ensures that the plan may be activated every 1 to 2 years. However, the resources this takes are also considerable. Alternatively, to preserve resources, consider:

- Regular simulations to raise awareness and train new staff (See Test and Train section).
- Multilevel activation thresholds where some part of the plan gets activated over lower thresholds with activities that do not consume a lot of resources (training, coordination meetings, etc). And higher activation thresholds are chosen for resource consuming activities (such as hiring more staff, infrastructure work, etc)
- Coordinating with local, district or national health authorities to participate in simulations set up by local authorities or the National Society

During crises or emergencies, the plan is activated by the responsible stakeholders according to predetermined triggers and breaking points. This is done in close communication with relevant local, district or national health authorities, other partners (e.g. neighboring HCF), and stakeholders, in order to maintain high-quality essential health services for those in need. The whole or parts of the plan may be activated, as established. Triggers for activation are based on the risk assessment and possible scenarios.

In this section of the *HSCP template*, the HSCP development team can discuss and map out the triggers for activation for the prioritized hazards. Triggers for activation are based on the risk assessment and possible scenarios. Breaking points can also be agreed upon.

Triggers, planned activities and breaking points. *Modified from WHO. 2021. Health service continuity planning for public health emergencies*

Triggers for activation. Examples of triggers may unclude the number of patients or the nature of the emergency, e.g. a local 20-bed emergency department being alerted to a disaster that may send 40+ patients requiring care to their facility.

Planned activities. These are the identified actions or interventions in the plan to absorb the shock of an emergency and maintain high quality essential health services, which are mapped out in the HSCP. These activities need to be clearly communicated in simple

Breaking points. The point at which the planned actions are no longer able to meet the demands of the emergency and ensure the continuity of essential services. E.g. a facility loses its ability to manage patients within its current physical structure. When

terms to those concerned and implemented in a coordinated manner.

a plan fails, a basic framework needs to be in place to allow activities to remain organized until patients can be transferred elsewhere or more aid arrives.

4.2 Define deactivation triggers for the plan -optional step

Although the activation of the operational continuity plan might happen overnight, the 'back to normal' will probably happen more slowly.

With certain emergencies (such as a local fire causing a short-lived doubling of patients), the HCF could revert to the 'status quo' described in the first section of this template in a short time period. In other situations, (e.g., an epidemic) the HCF might scale down the alert status and make step-by-step changes in the organization by reintroducing health services and having staff regain their previous tasks in a stepwise manner.

Yet in other scenarios, the return to normal will require a recovery process (e.g. if a flood destroyed parts of the infrastructure) that needs its own plan (see Section 8. Recovery strategy). This recovery process could require corrective actions in which communication throughout all levels of the organization will be key.

In this section of the *HSCP template*, the HSCP development team has the opportunity to think ahead to potential triggers to deactivate the plan, as well as the necessary steps (if any) to take the HCF back to normal, and who will be in charge. Recovery strategies are mapped in a later section.

5. Preparedness and Mitigation

Preparedness touches upon the third question guiding the exercise: **'What can we do ahead of time to prepare?'**. Mitigation is a linked concept that explores what can be done in advance of a disaster or a crisis to mitigate its negative impacts on lives and livelihoods, as well as what can be done after to palliate the impact. Mitigation measures can reduce hazards and/or vulnerability and exposure to hazards, and increase the HCF's coping capacities.

Developing this Healthcare Services Continuity Plan, testing it and training HCF staff on it are preparedness measures. Other preparedness and mitigation measures can also be mapped out in this section of the *HSCP template*.

CONSIDER. In constrained resources settings, it may be difficult to consider implementing preparedness and mitigation measures due to lack of funding. Facilitators can encourage HCF participants to consider what training or awareness-raising sessions could happen without additional budget.

5.1 Test and train

To ensure that a HCF continuity plan will work, testing it and training the HCF staff on it is key.

This section of the *HSCP template* can be filled out by individuals in the HSCP development team who are more familiar with the development of training and simulations. This section of the template guides the team through the development of simulations for priority hazards (section 5.1.1), and mapping out the training activities for different staff (section 5.1.2).

While testing and training can be planned as separate activities, it is usually more effective to combine them. In this way, HCF staff can become familiar with the plan and practice activating it, while at the same time the HSCP

development team can observe what works and what does not work and modify the plan accordingly.

SIMULATIONS

Simulations are the usual exercise of choice to test an emergency plan, and can also be used for HSCPs. They allow for training and testing at the same time. Simulations are also great for training the staff as they:

- ▪ Allow critical staff to practise the procedures and become familiar with the new structures, roles and activities.
- ▪ Ensure that stakeholders know each other and have an opportunity to work with each other under tough but safe conditions, to enable effective collaboration and communication during the real emergency.
- ▪ Create necessary awareness of what may happen in a crisis and update the *knowledge and skills of health workers and other staff responsible for implementing the plan, including staff working in non-critical- areas.*

While simulations are a great training tool, training may involve not only simulations but also information sessions, workshops or other approaches.

Testing of plans allows the HCF to evaluate key components of the plan well in advance of an emergency and carry out any needed amendments to the plan. WHO states that "Successful execution of service continuity plans relies on frequent testing and monitoring and evaluation of the plan". While plans can and should be tested without any hazard on the horizon, a regional or global threat (such as an epidemic in a neighboring region) can also be a good prompt to carry out a simulation.

Key components to test may include: activation procedures, critical activities and networks and communication pathways, including having clarity on who is the person responsible for activating the plan. After the plan is tested, it is important to make changes in the plan as needed and to address any gaps or obstacles identified during testing.

5.2 Other preparedness and mitigation measures

The HSCP development team can brainstorm additional preparedness and mitigation measures for each hazard (see *Annex II.* All hazards approach) and add them into the *HSCP template*. Many preparedness and mitigation measures will require additional funds. To ensure these can be implemented, budgets for these activities and measures can be developed and discussions with partners and donors started on the basis of this HSCP.

CONSIDER. Can the training and testing be linked to other processes? For example, a simulation or training for an infectious disease outbreak could be linked to an Infection and Prevention Control (IPC) training. In a similar fashion, it may also be possible to include IPC or other training components into a HSCP training or testing. IPC elements are particularly relevant as they are key in normal situations and emergencies, especially epidemic outbreaks.

6. Monitoring and Evaluation – Optional step

Monitoring. Once the plan is activated, it is important to have measures in place for continuous monitoring, to ensure proper implementation and to determine if and when there is a need for adjustment, or changes, based on the situation.

Evaluation. The HSCP can be evaluated after a simulation, after an emergency once the plan is deactivated, or after critical periods during the emergency. Adjustments and improvements of the plan can be made based on the lessons learned from these evaluations.

This section will guide the HSCP development team in the development of a monitoring and evaluation framework based on the objectives of the plan that can be added to the *HSCP template*. Monitoring and evaluation activities can and should draw on existing data and health information systems.

Because participants in some HCFs may be new to these concepts, facilitators can take a moment to briefly explain M&E and its importance, and to understand what information is being monitored in the HCF. Provide active support when filling the table or creating a new table based on what the HCF is currently using to monitor.

6.1 Key indicators for routine monitoring and evaluation

Monitoring will help the HCF verify if it is achieving the objectives of the HSCP. Monitoring indicators must thus be aligned with the objectives of the plan. For example, if the chosen objective for an epidemic is to maintain chosen essential services to 100% and protect healthcare workers, indicators to measure this should be selected. Indicators can be developed at all levels:

- For outputs that are relevant to ensure the success of HSCP implementation, such as training and simulations; or activities within the preparedness and mitigation section
- For outcomes that can be measured during the implementation of the plan, such as maintaining bed capacity or protecting healthcare workers
- For impacts that can be measured after the emergency (usually during evaluations) and pertain to the highest levels of the objectives set for the HSCP (e.g. reducing morbidity and mortality or ensuring continuity of basic healthcare services)

The HSCP development team will select a small set of key indicators to monitor the continuity of services and the implementation of the plan, at the Output, Outcomes and Impact level, based on the objectives established in the plan and fill them out on the table available in the *HSCP template*.

Annex III in these guidelines contains examples of potential indicators at each level that can serve as a discussion point. Key indicators need to be adapted to the hazard and the HCF's own Health Service Continuity Plan.

6.2 Evaluation

The Health Service Continuity plan can benefit from evaluations carried out during or after its implementation, to improve service continuity planning and better prepare for and respond to future emergencies. These lessons must be documented and shared as part of the learning and improvement process, both internally and externally. Whether the implementation of the continuity plan was successful or there were failures in execution, sharing what was learned (without placing blame) is the only way to ensure continuous improvement for this HCF and others.

This section allows the HSCP development team to think ahead and determine how and when the implementation of the plan will be evaluated, who will participate in the evaluation, and who will lead it, by filling out the table in the *HSCP template*.

6.3 M&E Communication

Monitoring findings should be communicated regularly during the emergency, both internally and externally, as appropriate, and via the pre-established channels mapped out in this plan, and should serve as a basis for analysis, decision making, and action. Evaluation findings also need to be communicated to the appropriate stakeholders internally and externally as part of a learning and improvement process.

The HSCP development team can use this section to map: What will be communicated, how it will be communicated, to Whom and When.

7. Maintenance – Optional step

In this section of the *HSCP template*, the HSCP development team will brainstorm and write down strategies to be implemented to ensure the maintenance of the service continuity plan.

To ensure the plan is maintained and up to date, it is key to review the HSCP after training or a simulation, or after an evaluation if the plan has been implemented during an emergency. In addition to these revisions, regular points of revision to the plan should be scheduled to ensure the plan never becomes outdated, even if training or simulations are not taking place.

Natural points of change may be good moments to revise the plan. Consider that the hazards faced by the HCF may change, or need reprioritizations. More funding may become available, etc. The diagnostic of the HCF may need revisiting after an increase in staff or infrastructure, etc. These changes may prompt a revision of the assessment and the plan per se.

One challenge faced by healthcare facilities is keeping these plans up to date and ensuring there is an institutional memory of their existence, so they can be used in an emergency. Strategies to strengthen institutional memory of the plan and its maintenance include:

- Having a low threshold for activation of the plan, so it can be partially or wholly activated once every 1 to 2 years. This might be because at least one of the hazards selected occurs frequently and/or because the triggers for activation (e.g. number of patients requesting services) are not very high.
- Having regularly scheduled points of revision that are linked to other activities that tend to always take place (such as donor reporting, staff allocation meetings, end-of-year reviews, etc)
- Establishing a tradition of a yearly emergency simulation day at a time of the year when the HCF is usually not overly busy. Donors, external partners, and communities can be invited to participate.
- Ensuring there is a budget for revision and update of the plan, yearly simulations, and training refreshers.

> TIPS
>
> One potential source of funding may be to include a 3 to 5 year budget for these activities in an emergency response plan or a recovery plan. This takes advantage of the funding cycles, where there is usually large amounts of money during or immediately after an emergency or crisis hits.

8. Recovery strategy – Optional step

Once the emergency has passed, and based on triggers, at some point the plan will be deactivated. In some cases, the local or national health authorities' green light may be needed to move out of the emergency phase. In any case, this will be done in a coordinated manner with partners.

Depending on the type of hazard, the level and the length of disruption, in some cases, a recovery strategy may be needed to get 'back to normal'. Some examples of challenges that the HCF may face after deactivation of the plan include:

- Having lost staff that had to stay at home, and who could not be paid, or staff lots for other reasons
- Destruction of infrastructure or equipment
- Depletion of supplies
- Drying up of funds that became available during the emergency
- Need to scale down (or up) the number of healthcare staff

This section allows the HSCP development team to map out in the *HSCP template* the potential challenges that the HCF may face after a crisis, and brainstorm potential recovery strategies and action steps, thinking through how this recovery process may look like, and keeping in mind the concept of 'Build back better'.

Some guiding questions may include:

- What corrective actions need to be taken?
- What investigations on damage assessments might need to be carried out?

- How will you communicate changes to internal stakeholders (e.g. staff) and external stakeholders (e.g. reinstalling all healthcare services for patients)?

ENSURING USE OF THE HEALTH SERVICE CONTINUITY PLAN

A HSCP is one useful if it is present in people's minds and the HCF remembers to activate it when needed. To reinforce the plan's potential use, the HSCP development team could create some materials and a simple strategy for Information Education and Communication purposes. Items could include:

- A poster that can be pasted on the walls of the HCF to remind staff of the importance of knowing and updating their HSCP.
- Develop a short video explaining the purposes and key features of the HSCP that can be used for on onboarding of new staff.
- Assign a HSCP focal point from one of the HSCP development team members, to act as the champion of the plan, and ensure uptake.

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ANNEXES
Annex I. Incident Management Structure

An Incident Management Structure (IMS) provides a framework for coordinating and organizing resources, personnel, communication and services during an incident. It ensures a coordinated and efficient response, allowing healthcare facilities to effectively handle emergencies[1]. An IMS has several key concepts and principles:

1. **Standardized emergency functions**. There are several key management structures that need to be undertaken in any emergency. For the WHO, these include for example Leadership, Partner coordination, Information and planning, Health operations and technical expertise, Operations support and logistics, and Finance and administration. Another article on emergency preparedness (Christian, 2005) divides these essential functions into Operations, Planning, Logistics and Finance.
2. **Standardized terminology**. The use of common terms allows stakeholders from different levels to collaborate and understand each other.
3. **Flexibility, adaptability, and scalability**. The IMS can be used for all types of emergencies. Subsections can be added or removed based on the changes in needs during an emergency. Moreover, the number of staff assigned to each function is flexible.
4. **Unity of command.** There is a clearly defined chain of command, in which every staff member reports to a single appointed person.
5. **Unified command structure**. Every incident has to be coordinated by a single incident commander.
6. **Incident Action Plans (IAPs)**. For every incident, a brief written plan has to be developed by the incident commander. IAPs describe the incident objectives, response strategies and available resources.
7. **Resource Management**: Implement a system for tracking and managing resources, including medical supplies, personnel, equipment, and other assets needed during the emergency.
8. **Action sheets.** These are short job descriptions of functions that need to be filled during an emergency. The objective of action sheets is to allow multiple people to fill in a specific role if someone becomes unavailable.

Examples can be found at:

WHO (2017). Emergency Response Framework. Second edition. Chapter 3. https://www.who.int/publications/i/item/9789241512299

Christian, M. D., Kollek, D., & Schwartz, B. (2005). Emergency preparedness: what every health care worker needs to know. Canadian Journal of Emergency Medicine, 7(05), 330–337. https://doi.org/10.1017/s1481803500014548

Example of IMS structure by the WHO (WHO, 2017).

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[1] Depending on the context and the HCF's rules and regulations, the IMS may need to be previously approved by internal or external stakeholders, or may require other legal measures to be considered to be effective. These should be taken into account in the HSCP.

WHE Incident Management System (IMS) structure

□ IMS critical functions
□ IMS sub-functions
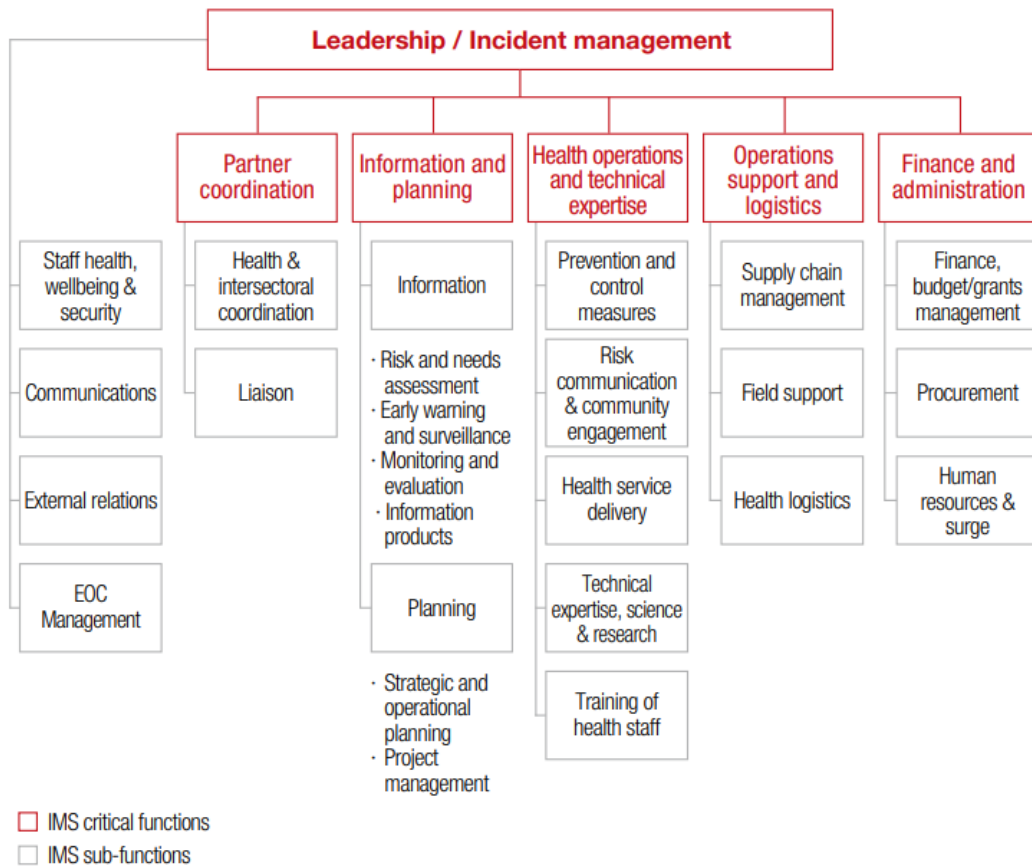
Annex II. All hazards approach and considerations for specific hazards

The revised version of the International Health Regulations (2005), as well as the Sendai Framework for Disaster Risk Reduction 2015–2030, promote an "all-hazards" approach in emergency preparedness. This is an integrated approach to emergency management and planning focusing on critical capacities for a full spectrum of emergencies recognizing that there are common elements, and common capacities required, in the management of these risks The all-hazards approach allows for a unified plan with the flexibility to adapt to specific hazards and remove the need for multiple, often siloed, plans.

However, hazard-specific guidance can be factored into the integrated approach. For instance, accidents involving hazardous materials require an understanding of toxicology to minimise damage and protect lives; radiological accidents require special measures for decontamination; infectious disease outbreaks require extra attention to infection prevention and control.

It is important to note that the all-hazards approach does not imply that authorities or organizations should prepare for all hazards; rather, it focuses on common needs that emerge from various types of emergencies. The all-hazards approach may also have the benefit of cost-effectiveness and enhance the efficiency of planning and operations.

Although the all-hazards planning approach can provide a basic framework, service continuity planners should prioritize preparedness for hazards that pose a higher risk for the facility and services based on local, dynamic risk assessment.

Hazard	Examples of Specific Requirement for Healthcare Facilities
Fire	Installation of fire alarms and smoke detectors
	Regular fire drills and staff training on evacuation procedures
	Adequate fire extinguishers and fire suppression systems
	Proper storage and handling of flammable materials
	Fire-resistant construction materials and building design
Infectious disease outbreaks	Implementation of strict infection control protocols
	Regular cleaning and disinfection of surfaces and equipment
	Availability of hand sanitizers and personal protective equipment
	Isolation rooms for infectious patients
	Employee vaccination policies and monitoring
Disasters	Design and construction to withstand earthquakes and hurricanes
	Emergency response and evacuation plans for various disasters
	Adequate stock of emergency supplies (food, water, medical)
	Backup power generators to ensure continuous operation
	Secure medical records and data backups
Chemical Spills	Proper storage and handling of hazardous chemicals
	Availability of spill response kits and personal protective gear
	Training staff on chemical spill protocols and clean-up procedures
	Ventilation systems to prevent exposure to airborne chemicals
	Regular inspections and maintenance of chemical storage areas
Radiological Accidents	Availability of personal protective gear
	Training of healthcare staff in radiation safety and handling patients affected by radiological accidents
	Decontamination protocols for affected individuals and materials
Power Outages	Backup power sources (generators, batteries, etc.)
	Emergency lighting for critical areas
	Temperature-sensitive equipment storage solutions
	Prioritized patient care during power interruptions
	Contingency plans for extended power outages
Cybersecurity	Regular data backups and secure data storage
	Cybersecurity training for staff to identify and respond to threats
	Incident response and recovery plans for cyber attacks

Annex III. Examples of Key Performance Indicators

Note that indicators need to be adapted to specific priority hazards, HSCP objectives and operational priorities. These are just examples provided as a starting point for discussion.

Objective	Indicator name	Indicator Definition	Data Source
Patient outcomes	*Patient mortality rates*	*Number of deaths in patient population in HCF during emergency vs normal situation*	*HCF health information system*
	Patient morbidity rates	*Incidence of specific disease in patient population during emergency vs normal situation*	
	Case Fatality Rate in HCF (if an epidemic)		
Recovery	*Disruption duration*	*Average time taken to restore full services after an emergency.*	
	Recovery quality	*Quality of provided services after full recovery compared to normal situation*	
Adapt rapidly to the situation	*Activation time*	*Time it takes to activate the continuity plan and mobilise required resources*	
Maintain key in patient services open (detail which ones)	*Bed Capacity*	*#beds actually available for essential services*	
	Bed Occupation	*#beds occupied for essential services*	
	% Patients Receiving Care	*#patients receiving care / baseline (pre-emergency) (increase or decrease)*	
	Patient satisfaction with services	*% of patients declaring they are satisfied with the services / baseline (pre-emergency)*	
Provide essential services to the majority of the patients seeking care	*% Patients declined care*	*#patients who were declined care due to suspended or reduced services / baseline (pre-emergency(*	
	% Patients referred	*#patients who were referred to other hospital during emergency /baseline (pre-emergency)*	
Ensure health and well-being of healthcare staff during emergency	*% of staff negatively affected by the emergency or crises (directly or indirectly)*	*# of staff affected by the emergency / total staff*	

	% of staff satisfied with HCF response	*# of staff declaring themselves satisfied with the response / total staff*	
	% of staff who became infected during an outbreak	*# of staff who became infected /total staff*	
Ensure adequate staffing to maintain essential health services	*% of planned personnel*	*#Staff working at HCF / # of staff in continuity plan*	
	Ratio staff to patient	*#patients per medical professional*	
	% planned staff available	*#Staff working at HCF (vs forecasted in continuity plan)*	
Ensure adequate financial resources to maintain essential health services	*% of HR budget available*	*#HR budget (vs forecasted in continuity plan)*	
	% of materials and equipment budget available	*#Materials & Equipment budget (vs forecasted in continuity plan)*	
All resources	*% of all resources available*	*Percentage of essential resources (medical supplies, personnel, equipment) available during an emergency compared to normal operations.*	
Ensure adequate training	*Training*	*#trainings per year staff members receive*	
		number of staff trained and oriented to use the health service continuity plan	
		number of simulation exercises conducted to test the plan within a specified period (e.g. one year);	

Annex IV. HCF diagnostic visit checklist

☐ Provide a short description of the HCF structure

☐ Does the healthcare facility have potable water? Describe

☐ Does the healthcare facility have a steady power supply electricity? Describe

☐ Does the healthcare facility have toilets or latrines? Describe

☐ Note potential environmental risks to the HCF (e.g. flood zone, earthquake-prone zone, etc)

☐ Note any risks for spreading in the case of an infectious disease outbreak. Consider airborne, droplet, fecal oral and contact routes. (e.g. triage area, ventilation, hand-washing stations, availability of PPE for HCW, etc.)

☐ How many people work at the HCF? Describe by category (e.g. doctor, nurse, admin, etc)

☐ List number of services/wards

☐ For each service, list the number of personnel that works in it (mark part time/full time)

☐ Which seem to be the most used services? Describe

☐ Describe any additional strengths and challenges you observe.

Annex V. Example of HSCP workshop agenda

EXAMPLE OF WORKSHOP AGENDA			
WARNING: This is NOT a definitive agenda. It needs to be further developed and tailored to the size of the HCF, the needs of the HSCP development team, the time available, etc			
Date and time	**Activity**	**Linked section**	**Time required**
Day 1. Prepare and Assess	Welcome and Introduction		10 min
	Conduct a team building activity	1.3.	10 min
	Conduct an awareness raising activity	1.3.	10 min
	Discuss data collected pre-workshop about the HCF and complete the HCF diagnostic section in the HSCP template	2.1.	2 hr
	Discuss data collected pre-workshop for the risk assessment and complete the risk assessment section in the HSCP template and Risk assessment Matrix spreadsheet	2.2.1	1 hr
	Discuss risk assessment and agree on risk prioritisation, complete the risk prioritisation section in the HSCP template	2.2.2	1 hr
Day 2. Develop your HSCP	Develop your HSCP.Determine overall objectives for the plan and complete the objectives section in the HSCP template	3.1	1 hr
	Develop your HSCP. Agree on continued activities during response and complete the section in the HSCP template	3.2	2 hours
	Develop your HSCP. Discuss and complete sections on staff planning for emergencies.	3.3	2 hours
Day 3. Develop your HSCP, activation and deactivation triggers and preparedness and mitigation plan	Develop your HSCP. Break into teams based on areas of work and skills to discuss and complete the template section on Financial assessment (subteam 1), and the section on Communication plan (subteam 2).	3.4 & 3.5	2 hours
	Activation and deactivation plan. Discuss and agree on triggers for activation and deactivation of the plan and complete the corresponding section in the HSCP template	4.1 & 4.2	1 hour
	Preparedness and Mitigation plan. Break into teams based on areas of work and skills to discuss and complete the template section on Training and testing (subteam 1), and the section on Preparedness and Mitigation measures and activities (subteam 2).	5.1 & 5.2	2 hours
Day 4. Develop M&E, maintenance plan and recovery strategy	Monitoring and evaluation plan. Discuss and complete the sections on key perfomance indicators, evaluation plans, and communication of findings.	6.1, 6.2 & 6.3	2 hours
	Maintenance. Discuss and agree when and by whom will the HSCP be revised, as well as any strategies for maintenance of institutional memory of the plan, and complete the section in the HSCP template	7	30 minutes
	Recovery strategy. Discuss and agree on the recovery strategy for the HCF in the face of different hazards, and complete the section in the HSCP template	8	1.5 hours
Day 5. Present the finalized	Participants present their finalized plans to other participants in the workshop, to facilitations and to others HCF personnel as appropriate as	5.1	4 hrs

| plan and/or Conduct a simulation exercise (Optional) | an exercise to consolidate learnings and findings and receive feedback for improvement of the plan.

Run a simulation exercise with the members of the HSCP development team, simulating the activation of the BCP, to look for potential gaps and misalignments. Change the HSCP based on the findings of the simulation. | | |