# Working group 5
# Integration and longer term issues:

# 1a:

- Parallel programming is often because there is no govt – or weak – or failing
- Or because it is easier to do it ourselves
- Where govt is in place it is not right to take over – esp if govts have asked you to come in – question should be qualified  - it is too categorical
- Where there is really no govt – the parallel system is the only one possible
- Purpose of question is to define when and how to do CTC

- lessons in southern Africa have not been taken up - staff should be involved in emergency preparedness – not just response
- Integration issue – pre–emergency stage is vital too – what will this require? – more long term issue
- CTC’s have so far been implemented in secure environments – is it possible in insecure places?  It is being done unofficially & not yet reported
- Parallel community based care – in practice how would this work? – challenge is how to make it community based care an efficient and effective form of treatment

- OK to think about integration as a temporary measure – but in the long term this has not yet been thought through properly
- How to create these networks – start with the lowest level – already issue of incentives comes in
- The question is not just referring to CTC but any selective feeding programmes
- Context specific
- Change question to about CTC and not selective feeding programmes

- Can community based care be set up in a complex emergency?
- Focus is that we are trying to integrate *more* – not whether we can integrate totally
- Sometimes parallel programming is actually desirable – incompetent NGO’s – lack of govt structures etc.

# Vote(as question is worded now) agree 0

# disagree 13

- but if question is changed to:
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- where it is possible to work with local structures (i.e. existing) there should be integration – Govt and other existing service providers should be central to any emergency preparedness plans and response from the outset to ensure integration and longer term benefits
-
- Agree 13 (100%)

# 1b:

- Not just MoH – could be other actors also – Malawi example – and nature of CTC is that you use whoever is around
- How can everyone have input into training and syllabus if it is new to them – maybe at the 2nd or 3rd emergency they can input better
- But must involve them in the planning of the training it is better than having lots of people designing the project – training needs etc who may have no idea of the context

- This question is about strategy – sustainability, capacity strengthening, exit strategy etc
- CTC is about reactivation and transitions also – needs to be part of a tool for emergencies or other programmes
- If emergency programming appears to be useful can be used in “normal times”

- Need to change question as well:
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- To ensure sustainable programmes – capacity strengthening and exit/transition strategy needs to be developed in partnership with local and other partners
- Agree 13

# 1c: (look at b!!!)

- most times don’t have time in set up mode to think of phase out plans
- but plans must be thought of – even if it means that you change them completely through the life of the programme – if you put plans in place from the beginning then it forces you to think about them more
- In Malawi form the beginning they had plans – i.e. if this numbers we do this – if that numbers we do that – very good integration there for a relief programme with phase out plans in place from the beginning
- 2 fold in Malawi – emergency programme but also the chance to investigate the potential of CTC

# 1d:

Adherement with national protocols – as it is an integration issue with many aspects of treatment (not just CTC) Important element of integration – you can’t expect to work with MoH staff if you are not prepared to go along with the national protocols even if you disagree with them

- In national level it is important to get agreement with any change (or adjustment) to national protocols – often this doesn’t get down to the lower level staff in the clinics
- National protocols evolve – but it is a slow process

- Needs to be identified as a key part of the process
- Adaptation of CTC protocols needs to happen depending on what national protocols you are faced with
- i.e. in Malawi – protocols adapted as it was operational research – policy will not be changed until clear evidence happens
- CTC protocols are not set in stone yet – they are evolving with research findings & evidence – need to be monitored
- Need broader content for non-medical guidelines i.e. HR needs etc

- At present Ethiopian protocols only refer to TFC protocols – but at least a statement at the end mentions CTC as a possibility
- But protocols as it exists now appears to block the possibility of CTC – needs more flexibility as 90% go direct to phase 2 and protocol says all should go through phase 1.
- Different protocols need to be met depending on your programme i.e. operational research will have to have more different protocols than a conventional programme
- Differences should be minimised between national and operational protocols as this will make it easier to implement from the top downwards (i.e. national level to clinic workers)

- Need to maximise what is the same and minimise what is different.
- Depends on what country and context you are in whether you have the facility to change any protocols – some places will allow it while others will not
- Is this the same for refugees? (very important point for one member) i.e. will Malawi insist on the same treatment for foreign nationals? Some countries will insist on the same protocols while others will not care about refugees as much as their own – there will be exceptions

- Change proposition again:

- Any differences between operational protocols and national protocols need to be discussed and agreed in advance with the view for harmonisation later
-
- Agree 11
- Abstain 2

# 2a:

- Refer to sphere guidelines – gives explicit guidelines for NGO's working in emergency situations.
- In Malawi – adding functions and workload to existing staff – should that be rewarded – even if incentive comes in form of bicycle or raincoat etc
- Problems with incentives and sustainability issues are not specific to CTC – EPI programmes – polio etc face the same problems
- For donors this is a big problem – strict rules on per diems etc

- In emergency situations – need to have an explicit plan at start up
- Improvise or be explicit in planning? How much more the NGO is paying than the govt is the issue
- Language needs to be revised in accordance with Sphere guidelines (no-one can quote them accurately here!)
- CTC is no different than anyone else to its responsibility to go along with Sphere
- But is Sphere relevant when we are looking at longer-term issues? Which is how CTC is different – it is not just looking at emergency issues but with a longer-term focus

- Idea of CTC is to eventually use volunteers as mobilisers etc even during the emergency programme – will this be practical? Even if you have mobilisers to begin with will they continue throughout the life of the programme or will they get tired/fed up? Due consideration needs to be given to this Need auditing & monitoring of situation and adapt as you go along

- Not democratic to strike proposition (as some have suggested) – so keep proposition in but change to:
- 
- In the short-term adhere to Sphere standards – in the longer-term incentives and salaries must consider impact on motivation and commitment of local staff
- Agree 8
- Abstain 5

- 2 b: When defining staffing requirements if utilising govt staff and local service delivery, consideration should be given to the impact of additional work load/demands on existing duties and quality of service
- agree 11
- abstain 4

# 3:

- transition or exit strategy should look at donor funded programmes
- 2 different issues – children who fail to respond and children who are left in the prog at the end.
- Main issue is what to do in the transition period – practical phase out stuff
- Why make provisions for those who fail to respond when we are sending them home to die in reality?

- Protocols has to be clear about non-responders –
- Here we are trying to talk about those who are left in the end of the programme – which is beneficiaries left – not failure to respond
- Issue is whether you are stopping admissions

- Change proposition to :
- No, say proposition is redundant
- Agree 12
- Abstain 1

# 4a:

adequate access to food should be advocated/prioritised in support of effective feeding programmes

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- SFP has to be in place for CTC to be implemented? Mostly yes – but maybe some context (Niger?) it can work without the SFP
- Not only food – but good water/sanitation etc
- Disagree with whether the progression from GFD – SFP – OTP is correct
- From medical viewpoint because there is no food that is not a reason to not give medicines

- Issue with food security lobbying to the WFP
- Where possible address the underlying causes
- if thinking about health aspects want not just to concentrate on the food aspects – what about water, sanitation etc
- food insecurity as only one aspect – have to think of all the other options as well
- principal underlying cause could be HIV in some settings –not just inaccessibility to food

- Change proposition to:
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- where possible, therapeutic feeing programmes should be integrated with complementary activities that address the underlying causes of malnutrition
-
- agree 13

- **4b;**
- ran out of time & kind of included with 4a

# Integration and Long Term

- 1a.where it is possible to work with local structures (i.e. existing) there should be integration – Govt and other existing service providers should be central to any emergency preparedness plans and response from the outset to ensure integration and longer term benefits

- 1b.To ensure sustainable programmes – capacity strengthening and exit/transition strategy needs to be developed in partnership with local and other partners

- 1d. •Any differences between operational protocols and national protocols need to be discussed and agreed in advance with the view for harmonisation later
- 2a.In the short-term adhere to Sphere standards – in the longer-term incentives and salaries must consider impact on motivation and commitment of local staff
- •2 b: When defining staffing requirements if utilising govt staff and local service delivery, consideration should be given to the impact of additional work load/demands on existing duties and quality of service

- 3. Strike
- 4.where possible, therapeutic feeing programmes should be integrated with complementary activities that address the underlying causes of malnutrition