**Regional Community Safety and Resilience Forum Meeting**

**REPORTING TEMPLATE**

**Date: 17/09/2014 Session title: Health session**

**Chair: Dr Sok Long**

**Note taker: Rose Fenton**

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| **Key discussion point** | **Main recommendations** | **Specific action points** |
| * Ryan Chair for HTWG from Philippines was unable to attend and sends his apologies.
* May thanks to Dr Sok Long for taking the chair at short notice

*Overview of the CSR – Dr Sok Long** Regional CSR in Cambodia Feb 2014 where leadership will discuss and approve/not approve recommendations from the forum
* Outputs of meetings
	+ Finalise the agenda for Pandemic preparedness
	+ Reviewing and updating the road map
	+ Mapping capacity and interest mapping
	+ Recommendations to CSR

*Community-based health development -Cambodia Red Cross Dr Sok Long** Last five years have been implementing CBHFA, evaluation and recommended split FA and Community based health
* Community Based Health development Programme Framework 2011. Utilized a consultant to assist with development.
* Localized to local context
* Integrate all aspects of community base health, harmonize regional initiatives,
* CBHD Framework is practical reference, guideline with components chosen relevant to the local need. Establish minimum standards for CBH programming
* Basic design 3 components: WatSan, MCH community development ( improve livelihood).
* Integrates healthy messages
* Implement in association with OD
* Sustainability (Projects) – Uses the approach where the Program with diversified partners, more ownership for NS, Program driven, many opportunity, big or small scale still maintain the project
* CSR is dependent on good collaboration/integration at different levels

QuestionsHow to make program sustainable?* Integrate health topics into existing project e.g. HIV make cross cutting,
* Have diverse donors
* Community ownership of programs who will be able to mobilize their own resources. Communities even if they are vulnerable they have capacities
* Attach with DM if no specific funding for health
* Also to mobilize to local funding – within country
* Utilise National Society funding to core activities

Are you conducting health assessment or multi-sectoral assessment? Answer: CRS in the process of developing CRS approach between health and DM previously. * Abhishek: Multisecotral Assessment: Risk Reduction Field Assessment: Review the secondary data, problem tree and go to the community with some issues – multisectoral assessment booklet, - step by step process, joint assessment, and planning and come back together at different times during project. Finalise by end of next year
* Case study on field sessions – will be end of this year
* Training of community volunteers so that they will be able to own the project
* Myanmar Use First Aid as entry point before conducting VCA .

*Pandemic Preparedness – Abhishek** In SEA PP is not a new thing as there has been a range of activities for SARS, H1N1 and engaged with pandemic agencies. Initially there was pandemic preparedness focus for national societies and then H1N1 so the focus changed to H1N1 response
* Tools have been developed to support Pandemic Preparedness
* In reality, community bears the burden esp as the health sector may be overwhelmed
* Community Preparedness considered least invested in global preparedness
* Focus has been on clinical care not primary prevention
* Aim to shift from relief to more risk reduction mode
* Developing concept note, regional coordination and non-pharmcalogical interventions
* Concept not will include developing a regional standard operating procedures
* 1st step Pandemic Preparedness workshop 17th-20 November 2014,
* Review the current status, enhance knowledge and develop POA
* Focus is on “One health” – Animal health, environment and public health
* Focus on pandemic preparedness but include other issues emerging diseases and seasonal epidemics

Discussion* Myanmar have volunteers who are at the airport and do not have Personal protection equipment or training need to determine govt and RC responsibility to ensure safety of volunteers
* Leadership meeting – the focus on pandemic not on epidemics. Leaders see the key added value is the access at community, want an answer to what NS can do using their community network during pandemics
* Will invite ASEAN representative to be part of Pandemic Preparedness, Regional lobbying to secure a place in next year Pandemic Preparedness meeting.
* Also invite WHO, FAO

*Health Updates - Jim** Consultations with NS to split the CBHFA into CBH and FA and rename CBH
* Movement to strengthen the science of FA fuelled by the creation of the global health center
* Clear definition between health and DM nutrition components. Asia pacific not high acute malnutrition but prevalence of chronic nutrition
* Mobile health (using mobile phones) IFRC can support with the development of this with consultants training etc
* IFRC has an increased focus on First Aid – mapping to match capacities and needs
* International FA certificate
* No FA forum in AP , FA E bulletin 3 times a year, but are discussing with Global reference centre as they are wanting to also produce E bulletin
* May evolve into a health bulletin to share activities
* Working with AP Fundraising Network – on business development and management training of health mangers and utlise peer support mechanism
* First Aid App; Myanmar and Philippines – takes minimum two months from start to launch
* Will setup working groups NCD in emergencies, nutrition in emergencies
* Will track and engage health staff/volunteers trained in emergency health and determine if still available
* Blood: build up youth engagement – utilize the yes strategy
* Continue VNRDB workshops
* Engagement with GAP on blood services
* Psychosocial support – SEA are interested in supporting work with links to PS Centre. As no delegate in area how can we continue to provide support to NS
* Global health mapping; Thank-you for completing, Geneva are now complying and analyzing
* Global health is developing a learning strategy
* Advocacy report has been prepared on health and equality
* Ethical commission implementation as we are wanting to conduct research and there is no ethics committee

*Medical response in sudden-onset emergencies - Jim** Local to Global Response Tools – many tools
* ERU providers in region. Australian RC and Hong Kong RC provide HR, HK are in process of developing full ERU in future. Japan complete ERU
* Recipients have been China RC, Indonesia, Pakistan, Philippines and Sir Lanka
* Some NS interest in medical response to regional disasters Malaysia, Republic of Korea, Singapore, Thailand and some middle east countries outside the ERU system
* IFRC role is in coordination
* Establising ERU is a long-term commitment that requires people, equipment, systems procedures and coordination
* Yearly ERU technical working group meeting to included new developments e.g. Psychosocial support

Questions:* How can NS request the ERU and is there is a linkage with DREF?

Answers: * IFRC tools are deployed at request of National Society and ERU deployed part of EA
* WHO standard for field hospital deployment is 24 hours
* Usually ERU functioning within 1 week

*Foreign Medical Teams (FMT) – Jim*Global health cluster developed for sudden onset disasters e.g. earthquakes* Groups of Health Professional and supporting staff outside their country of origin, aiming to provide health care to disaster affected populations
* Provide basic advanced healthcare based on international classification and minimum standards
* During a limited period of times
* In existing or temporary structures with or without field hospitals
* System developed by health cluster is being developed to coordinate FMT as appear without invitation, lack of coordination and communication, lack of professional standards of care, data collection and accountability, unclear exit strategies, late arrivals
* Operationalizing FMT guidelines development can access online
* There are three classification looks at UN, IFRC and govt systems
	+ Type 1: Out outpatient emergency
	+ Type 2: In patient, surgical, emergency
	+ Type 3: Inpatient referral care
* Standards based on ethical practice, sphere standards and humanitarian standards
* MOH is the lead agency and need to report to MOH when present in-country and they will assign them to location
* Records are handed over to MOH at the end of mission
* Professional guidelines all staff registered in country of staff expertise. First deployment must have experience in emergency
* Decision of deployment is on the request by the MOH.
* WHO is working with each MOH to support them in the implementation of the international standards on FMT
* Secretariat will continue to coordinate FMT
* Next steps – Engage governance on emergency response preparedness Dec 2014
* Organize zone FMT meeting Q 1 2015 for those in recipients and providers esp involved in Hayian, and those that are looking at NS with potential FMT capacities, agree on: internal arrangements to meet standards requirements and coordination mechanisms

*Suggested Recommendations** Advocate to leadership to understand and support CSR
* Recognition and sensitization of CSR forum to board members
* More funding to implement CSR
* More support from leadership for regional capacity building trainings
* To develop integration policy and monitoring mechanism to understand CSR
* To support and participate health person in regional TWG meetings
* Provide the necessary resource to support the road map
* Sharing information across technical groups across working groups
* Advocate to leadership to understand and support CSR
* Have clear focal person for CSR
* Develop policy to support integrated approach
* Support Resource Mobilization to CSR
* Collaboration with MOH and local authorities on pandemic preparedness
* Capacity Buildings to health thematic under frame work

*ART Network – Dr Sok Long** ART network started in early 1993 and endorsed by SG’s ART member reports directly to SG
* Three objective contribute to HIV, to develop HIV health practitioners and sharing experience
* Discussion on the need for the future of the ART network
* Chairman is outside the SEA region
* ART management report, the chair remains to China but want to shift the financial mechanism to Thailand Red Cross due to the financial constraints within china e.g.
* ART membership fee 1000 per year. It should go to country where secretariat is attached to chairman
* Limited follow-up on any action plans developed at meetings
* Quarterly newsletter or email has stopped
* ICCAP – last year was very active, no presence in 2014
* Secretary Generals are asking what is the benefit for the ART membership costing $1000
* what is the added value on the ART network to NS programming esp when the HIV programs are very small or are include within other programs
* Briefing on the ART meeting and invite chairman to present at the Leadership meeting
* IFRC will support technically but not financially, held in Beijing
* Next ART meeting 26-27 November
* Recommend that the leadership consider the future of the ART Netowrk
* Chair Health TWG raises concerns ART network attach minutes and ask for response from chair
 | * Recommend that revise CSR structure to simply by CSR team
* Road map should have more health content
* Strengthen information sharing among technical working group
* Support Capacity strengthening of the NSs on CSR approach and its implementation
* Sensitize leadership on the evolving Resilience concept
* Suggest include a session the stakeholders assessment is included and who can support the National Societies technically and protective equipment.
* Identify the areas and what support the National Societies will require
* Add session what the information sharing mechanism among NS
* Abhishek will share concept note and agenda. Invitation will be sent next week
* National Societies to share their review of community health program
* NS encouraged to reflect on their role in chronic nutrition

*Recommendations for Leadership*Advocacy: * Leadership Support CSR approach

Policy* Develop integration policy aiming for mutual understanding and better humanitarian actions.
* Endorse Road map and support its implementation as per country context
* Promotion of long term health funding with donors
* Promote more collaboration with MoH and other relevant stakeholders
* Very clear message – it is not structural integration
* ART future discussed in upcoming leadership meeting
 | Dr Sok Long Will upload on Cambodian website the CBHD frameworkChair Health TWG raises concerns ART network attach minutes and ask for response from chair |