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Annual report
Health

MAA00001
03/MAY/2012

This report covers the period 01/Jan/2011 to 31/Dec/2011.

Hygiene promotion project in schools and communities that contributed to the improved health of 600 people in six target communities.
Vanuatu, Weest Ambrym, 2011

In brief

Programme outcome
To reduce the number of deaths, illnesses and impact from diseases and public health emergencies, and to help communities increase their capacity to deal with diseases and public health emergencies.

Programme(s) summary
Over the past years, secretariat health staff have continued to support National Societies based on a global strategic direction, on NSs' expressed needs, strengths, and capacities, in order to allow them to address more effectively the needs of beneficiaries (as well as according to available resources).

Secretariat Health department provided guidance and leadership by supporting NSs technically through guidelines and manuals, tools, and materials. The secretariat health department invested as well actively in capacity building of NSs in the field of health through workshops and trainings and through active knowledge sharing. It supported NSs financially, allowing them to increase their capacity and deliver programmes to beneficiaries. In this process, the secretariat health team ensured programme technical quality and financial accountability.

Internally, during the reporting period, main achievements include success in pulling together a global health team, including Geneva staff, zonal health coordinators, and representatives from various IFRC reference centres, ensuring an organization wide concept of resilience and contributing to the cost effectiveness of the organization. This was achieved through setting strategic

directions, and formalizing them in a Strategic Operational Framework (SOF) for health that started to be rolled-out through advocacy and alignment of the different technical files. In this SOF, resilience was taken beyond the pure DRR context (linked with the disaster context) and focused on community level, allowing health and other development programmes to be resilience based.

In addition, the health department, together with the global health team, have launched in the last year a global advocacy campaign on inequitable access to health reaching different audiences at various high level meetings of the UN, the International Conference of the Red Cross and Red Crescent, as well as internal discussion fora. Notable results from the campaign include the launching of a strongly worded advocacy report around health inequities (Eliminating health inequities) bringing together human rights and public health aspects, along with the adoption of a related resolution during the 31st International Conference of the Red Cross and Red Crescent (Resolution 6: Health inequities: reducing burden on women and children).

At programme level, main achievements of 2011 include:

- **TB:** Over 200,000 TB patients were supported by RCRC programmes on a daily basis ensuring 90% of treatment completion.
- **Harm Reduction:** IFRC and RCRC Societies remain among the few organisations providing prevention, treatment and care services for drug users: Harm Reduction Projects demonstrate encouraging results in addressing the specific problem of drug use. Over one year period, National Societies with the Federation's support reached in average 40,000 drug users with regular support and care, trained over 500 peer educators and reached around 2 mln community members.
- **CBHFA:** 2011 mapping showed that 85 NSs are using the CBHFA approach with 2,737 facilitators and 23,434 volunteers reaching 2,308,065 beneficiaries.
- **NCDs:** A RCRC framework to address NCDs at the community level was developed, focusing on five key areas: prevention, innovation & research, monitoring & evaluation, and partnership & advocacy.
- **VNRBD:** in 2011, the RCRC International Club 25 project was implemented in 13 countries.
- WatSan: A mid term review of the Global Water and Sanitation Initiative was concluded and showed that the initial ten year target of five million beneficiaries have been surpassed.
- **Emergency health:** the team supported during the reporting period almost all 27 emergency appeals and 87 DREF operations.
- Influenza: influenza online modules were made available in additional languages and now exist in English, French, Spanish, and Russian.
- **HIV/AIDS**: In 2011, a total of 11,047,748 beneficiaries were reached with prevention messages and 115,980 PLHIV and orphans received care and psycho-social support. Services were delivered by a total of 56,402 volunteers.
- **Malaria:** in 2011, more than 18,900 RCRC volunteers reached more than 8.1 million people with malaria messaging through household visits and net distribution activities.
- **MNCH/Immunization:** During the year funds from the Global Measles & Polio Initiative were provided to 9 National Societies for polio and measles campaigns, mobilizing over 7,300 volunteers to reach over 1 million households with vaccination messages.

Financial situation
The total 2011 budget is CHF 6,945,681, of which CHF 7,521,075 (108 per cent) covered during the reporting period (including opening balance). Overall expenditure during the reporting period was CHF 5,153,803 (74 per cent) of the budget.

Click here to go directly to the financial report.

No. of people we have reached
During 2011, at least 30 million people benefited directly from secretariat-supported health programme interventions through vaccination campaigns, household visits, and preventives messages, among others. Details can be available by programme area.

Our partners
Primary partners of the IFRC are National Societies. Additionally, the IFRC works in coordination with United Nations agencies, humanitarian organizations, non-governmental organizations, as well as the private sector.

Context

Overall, the period has seen a significant increase in recurring cholera/AWD outbreaks both in expected locations but elsewhere confirming IFRC concerns for some years (and recent studies by WHO) that have indicated the problem may be 6 times as great as previously thought. The importance of ensuring communities have improved resilience against cholera is paramount. An increase in cholera cases demonstrates the importance of preparing communities for repeated outbreaks linked to the rainy season cycles. Interventions are needed to further increase cholera awareness, and the importance of hygiene, safe water and adequate sanitation.

For example, the Haitian Red Cross with support from the International Federation of Red Cross and Red Crescent Societies (IFRC), the International Committee of the Red Cross (ICRC) and Partner National Societies (PNS) in the country continued to reach the affected and vulnerable with cholera prevention and control activities including: managing Cholera Treatment Centres (CTC), Cholera Treatment Units (CTU), maintaining Oral Rehydration Sachet (ORS) points, hygiene promotion, disinfections and distribution of cholera prevention and treatment materials.

The story of the ‘Arab spring’ is another emergency that have required involvement from the health department with countries in the region going through different, but connected, changes. The Libyan conflict for instance led to ongoing violence affecting individuals and communities, along with displacement of Libyan citizens and third-country nationals across land borders as well as by sea. Health activities were varied and included partnering with local authorities for the referral of patients in need of emergency or advanced care. Services provided also focused on safe water supply, sanitation and hygiene promotion activities, crucial to maintaining or improving the health status of those affected, as well as essential medicines and equipment, non-food items (NFIs), and other health and hygiene materials.

Difficulties continue in addressing ‘chronic’ food security needs that regularly become ‘acute’ such as the Horn of Africa & Sahel drought crises. In both cases exacerbated by war and civil unrest. Emergency Health and Water & Sanitation needs are often not prioritised as much as need be,

especially in relation to nutritional surveillance and reducing the incidence or threat of water and sanitation related disease.

On the global level, within a global economic crisis context continuing in 2011, aid budgets are increasingly under pressure, and resource mobilization for health is increasingly challenging. Nowadays, it has become extremely important for the IFRC and its member National Societies to demonstrate its aid effectiveness through evidence-based results that have a positive impact on public health. Better planning, monitoring, and reporting of RC/RC health interventions is required to provide donors and the public with good value for money.

While 2011 was the year where the global HIV & AIDS response had recorded higher numbers of people on antiretroviral treatment and fewer new infections, the announcement by the Global Fund to Fight AIDS, TB and Malaria, cancelling its next funding round up to 2014 casted a shadow over any celebrations and highlighted the precarious nature of HIV funding while straining funding for TB and Malaria. Malaria is in fact a primary cause of poverty and puts additional burdens on health systems and families. Over 90 per cent of the deaths[1] and 85 per cent of malaria cases occur in the Africa region[2], costing Africa at least USD 12 billion annually in lost productivity[3].

Today, the Federation is confronted with a clear choice: maintain current efforts and/or invest smartly, as to attract resources, building upon the foundation laid out by our various programmes, and our comparative advantages, working together to reach the Millenium Development Goals, and achieve the vision of an AIDS free generation adopted by the UN High Level Meeting by Head of States and Governments in June 2011.

Many reports show that the international target to halve the number of people who do not have access to safe drinking water will be met (March 2012), and many of the Millennium Development Goals (MDGs) aimed at improving the health of women, children, and the poor will be closely achieved. However, these global achievements disguise what remains a reality of inequitable access to basic health services for many. Many low and middle-income communities don't seem to be on track to achieve the MDGs.

Another source of health inequities are noncommunicable diseases (NCDs). Indeed, the impact of noncommunicable disease is larger in low and middle income communities where premature deaths caused by NCDs are an increasing yet underestimated threat. Disadvantaged populations suffer more from this risk due to unhealthy lifestyles and unfavourable environments.

As a community of health practitioners and humanitarians we must seek to do all we can to improve the conditions of daily living through resilience-based and community-based health programming. We will continue to partner with national governments and key health actors in tackling today's and tomorrow's health issues and eliminating health inequities by scaling-up the response to reach out to more vulnerable populations and marginalized groups.

[1] Roll Back Malaria – press release. September 2011
[2] WHO. World Malaria Report 2010. Geneva. 2010
[3] Roll Back Malaria – press release. September 2011

Progress towards outcomes

First Aid, Community Based Health and First Aid, and NCDs

First aid reduces deaths, injuries and impact during disasters and daily emergencies. It provides an immediate response to an emergency, taking life saving measures until professional help arrives. National Societies provide high quality first aid education and skills to its volunteers, meeting approved standards set by different national authorities.

Community-Based Health and First Aid (CBHFA) is Red Cross Red Crescent approach empowering communities and their volunteers to take charge of their health through mobilizing them to address priority health needs by using simple tools adapted to local contexts. The CBHFA approach seeks to create healthy, resilient communities worldwide thus playing a vital part in Federation Strategy 2020, the Strategic Operational Framework (SOF) for Health 2012-2015 and contributing to Millennium Development Goals 4, 5, 6 and 7.

A noncommunicable disease (NCD) is defined as a disease which is not infectious. Such diseases may result from genetic or lifestyle factors. Current evidence indicates that four types of NCDs make up the largest contribution to mortality in the majority of low- and middle-income countries and worldwide. These are: cardiovascular diseases, cancers, diabetes and chronic respiratory diseases. NCDs are a leading threat to health and development. Yet, these diseases are preventable by eliminating shared risk factors such as tobacco use, unhealthy diet, physical inactivity and the harmful use of alcohol. Several NSs are active in NCDs prevention and control.

Outcomes

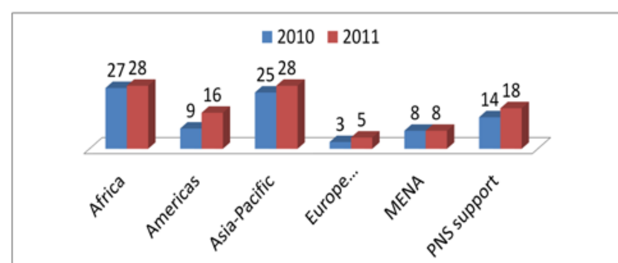
- Outcome 1: National Societies are supported to effectively implement the CBHFA approach in order to reduce morbidity and mortality caused by injuries and health priorities through an integrated community based approach to disease prevention and health promotion.
- Outcome 2: National Societies are supported to effectively scale up and make quality first aid education and activities accessible to all in order to reduce morbidity and mortality caused by injuries and diseases.

Achievements

Reduce vulnerabilities related to injuries and diseases and build resilient communities

Around 400 master facilitators from more than 100 NSs were trained on CBHFA tools in regional and zonal trainings during 2007-2011. Those trainings highly contributed to rolling out CBHFA materials and supporting project implementation. Following master facilitators training, NSs started to train their own facilitators and volunteers at all levels. During the last few years there was

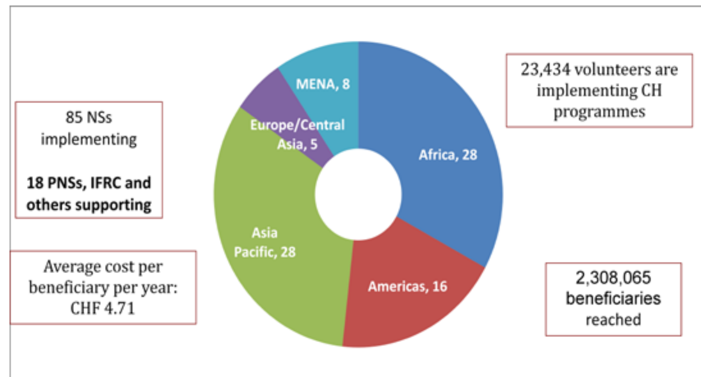
# of NSs using CBHFA approach in their community health programmes



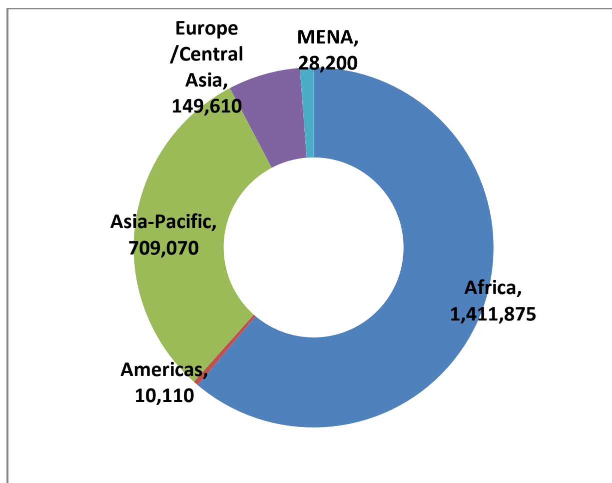
2010: 72 NSs with support from IFRC,14 PNSs and others
2011: 85 NSs with support from IFRC,18 PNSs and others (17% increase)

a clear trend of an increasing number of NSs using the CBHFA approach. In 2010 72 NSs started the implementation of CBHFA with support from the IFRC and 14 PNSs. Those numbers increased in 2011 to 85 implementing NSs and 18 supporting NSs (17% increase).

According to 2011 data, country-level trainings were conducted to train 872 facilitators and 23,434 Red Cross Red Crescent (RCRC) volunteers reached 2,308,065 beneficiaries in community health programming using CBHFA approach with an average cost of CHF 4.71 per beneficiary per year.



CBHFA 2011 mapping summary



# of beneficiaries reached in 2011 per zone

NSs are the major first aid educator and provider in the world. Almost all 188 NSs have first aid as their core activity. According to 2010 mapping, more than 17 million people received first aid courses. An additional 46 million were reached by first aid and preventive messages.

Technical support and capacity building

Health resource people were mobilised to provide technical support to train and design community health programmes using the CBHFA approach in different zones, regions and national societies.

Communication and networking among the resource people is an ongoing activities. A CBHFA Update for January – December 2010 was published early in 2011. The document included key updates and case studies from different NSs in different zones, as well as a summary of CBHFA 2010 global mapping and the CBHFA PMER toolkit. A new update is currently under development to document key case studies from NSs in 2011.

Technical support and capacity building were provided during the following events:

- CBHFA lessons learnt and M&E workshop (South Africa, 22-24 March 2011): main purpose

was to share updates and lessons learnt from African NSs implementing the CBHFA approach and other zones and disseminate the CBHFA PMER toolkit to improve programme quality. Representatives from implementing and partnering National Societies and from IFRC offices in Africa were among the participants.

- CBHFA M&E workshop (Haiti, May 2011): main purpose was to introduce CBHFA PMER tools to Haiti Red Cross Society, IFRC and PNSs supporting CBHFA implementation.
- CBHFA Programme Managers and Delegates' training (Panama, 30 August – 2 September 2011): main purpose was to increase the knowledge and skills of community health programme managers/delegates in CBHFA approach and the use of its materials and tools. The training focused mainly on Americas with high emphasis on Haiti as the demand was really high and many NSs already committed to support CBHFA approach there.
- CBHFA Asia Pacific lessons learnt workshop (Bangkok, 27 September – 1 October 2011): representatives from 13 implementing NSs, 7 Partner NSs and IFRC participants from 8 different country, regional, zonal and global offices attended. The purposes of the workshop were to go through the lessons learnt in implementation of CBHFA, present the pilots in M&E and integration, identify gaps and enhance participants' skills in BCC methodologies.
- CBHFA Global Meeting (Geneva, 15-17 November 2011): with representatives from 17 NSs and IFRC staff from different field offices among participants, the main purpose of this meeting was to go through key lessons learnt on CBHFA implementation and jointly plan for 2012. An NCDs working group meeting followed on 18 November 2011 to discuss key issues related to NSs implementation of NCD prevention programmes using the CBHFA approach.
- Two CBHFA master facilitator workshops were conducted in Americas Zone for Caribbean and Latin America National Societies during December 2011 in order to help NSs scale-up community health implementation within their NSs.

Close coordination between CBHFA and other programme areas in health and DRR led to active participation of CBHFA in various global events (a discussion paper on CBHFA/DRR way forward was developed and shared during the Global Resilience forum in Syria in March 2011) and also led to the development of joint programmes (e.g. integrated programme in Indonesia using a CBFHA/DRR approach). Additionally, a discussion paper on WatSan and community health was developed.

The First Aid European Education network annual meeting was conducted in Prague 6-8 October 2011 where 36 National Societies were present to share experiences in first aid and plan for future.

In 2011, 50 programmes from 26 European NSs have obtained the European First Aid Certificate accreditation. A study is under process to evaluate the opportunity to enlarge the European accreditation to a global level.

With support from American Red Cross, Belgian Red Cross and European Reference Centre for First Aid Education, a working session on first aid evidence based practices (EBP) was developed during the 18th session of the IFRC General Assembly in Geneva, 23-25 November 2011. The report of the working session underlines the following conclusions:

- Increase the support to the existing first aid and health evidence-based network;
- Consolidate the RCRC Movement as the leader in first aid science and practices thanks to first aid and health evidence-based principles;
- Promote evidence-based practices within the RCRC Movement;

- Develop global first aid support with relevant components such as the first aid and health evidence-based network, reference centre and regional networks.

A draft concept paper on global first aid support was developed and shared for feedback. This concept paper aims to coordinate and maximize the use of different mechanisms to support NSs' first aid programmes.

Many National Societies celebrated World First Aid Day (WFAD) on the second Saturday of September. The theme for 2011 WFAD was "First Aid for All".

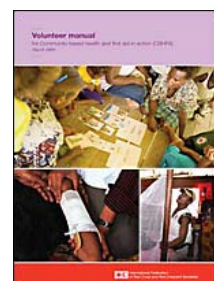
A working paper on NCDs was developed in consultation with different NSs. The paper included a long term vision on how to address NCDs in addition to key action points for 2011. RCRC NSs are in a unique position to be a pioneer in NCDs prevention programmes at community level. The IFRC was very active in promoting NSs role in this field. An intervention on the role of NSs in NCDs was presented during the World Health Assembly in May 2011.

Furthermore, a RCRC framework to address NCDs at the community level was developed and case studies from NSs were collected and documented. The framework focuses on five areas: prevention, innovation & research, monitoring & evaluation, as well as partnership & advocacy.

To find ways to engage broader community involvement in NCDs, prevention through dialogue and concrete action were the topic of the event co-hosted by the Federation and the International Federation of Pharmaceutical Manufacturers Association (IFPMA) at the UN General Assembly. The event took place on 19 September 2011. The panellists - who represented leaders among Red Cross Red Crescent National Societies, WHO, private sector and academia - reinforced the call for integrated multi-sector and multi-partner NCDs prevention initiatives.

Tools development and dissemination

CBHFA harmonized tools (implementation guide, volunteer manual, facilitator guide, community toolkit) were completed in 2009 after intensive consultation and piloting in different countries and regions. The tools were developed in English and translated into the other three official languages (Arabic, French and Spanish). During 2009-2011 NSs adapted and translated the materials into more than 39 languages. Materials in English, French, Spanish and Arabic were printed and distributed to all NSs worldwide. Other materials in local languages were developed at national levels and distributed locally to branches and volunteers.



CBHFA Planning Monitoring Evaluation and Reporting toolkit (PMER) was developed in 2011 to ensure good programme management and quality assurance at all levels. The tools were translated into the four official languages. Notably, the Federation indicators are also linked with the Millennium Development Goals (MDG) indicators. The toolkit addresses the basics of setting up of and using the monitoring and evaluation system for community health programmes.

There is a noticeable trend of improving M&E during programme implementation. 66% of targeted communities developed annual community health plans of action (PoA). 43% of NSs have started

using CBHFA PMER toolkit in 2011 and 61% of NSs have logframes for their projects. 21 NSs conducted baseline surveys during 2009-2011 and 18 NSs are planning to do that soon. 6 NSs conducted and 32 NSs are planning to do that later after they complete their implementation cycle.
A CBHFA promotional video on YouTube was completed and disseminated. NS shared stories of their work within communities, engagement with volunteers, partnerships with local governments, and solutions they found to counter the challenges they face.
(http://www.youtube.com/user/ifrc#p/u/6/1bf9gFnpbTM)

Due to the increase need to scale-up, harmonize and standardize the key learning, reach further staff and volunteers and reduce cost of trainings, a concept paper for CBHFA elearning module was developed with support from Finnish Red Cross and Norwegian Red Cross Societies. The Federation is aiming to complete the CBHFA elearning module by end of 2012.

The first IFRC International First Aid and Resuscitation Guideline was developed and finalized in early 2011. These evidence based guidelines and recommendations will help and guide NSs to improve their FA education, training, practices and services. With support from French Red Cross, the guideline was translated to French. Translation into Arabic and Spanish were completed and the guideline is currently under layout.
(http://www.firstaidinaction.net/data-publications/technical-files/first-aid-guidelines-2011)

With support from American Red Cross, Belgian Red Cross and the European Reference Centre for First Aid Education a draft concept paper on first aid evidence based group was developed. The purpose of the group is to define and support evidence processes within first aid for IFRC and the member NSs.

Constraints or Challenges

- Lack of funding for FA and NCDs files at global level to enable the IFRC to take the lead in those files.
- Lack of funding at the country level to support long-term community health programmes.
- Delays in receiving 2011 funds from key partners led to uncertainty in planning and risk of no funding.
- Linkages and integration with other programme areas need to be clarified and tested.
- Increased commitment and persistence of host and partner National Societies is needed in health developmental programmes which demands long term strategies as well as volunteer's management and community development.

Maternal, Newborn and Child Health, and Immunization

Programme purpose

- Scale up the International Federation's work in maternal, newborn and child health in contribution to MDGs 4 & 5, in particular with an emphasis on promotion of routine immunization.
- Reach all eligible beneficiaries with measles and polio vaccination during national and sub-

national immunization campaigns.

Outcomes

- Harmonized Red Cross Red Crescent involvement in maternal, newborn and child health (MNCH) component areas through consolidated activities and increased involvement in global MNCH partnerships.
- Reduced morbidity and mortality due to measles, polio and other vaccine-preventable diseases from increased access and uptake of supplementary and routine immunization services. 90% global reduction in measles mortality and zero countries reporting polio cases
- In support of Millennium Development Goal #4: a two-thirds reduction in child mortality between 1990 and 2015, the International Federation of Red Cross and Red Crescent Societies liaised with global immunization partners to ensure its continued involvement in measles and polio supplementary immunization activities (SIAs).
- These activities serve to increase uptake of services during both mass vaccination campaigns and routine immunization services, and to reduce global measles and polio morbidity and mortality. The programme also aims to increase the IFRC's participation in key vaccination-related global health partnerships, mainly the Global Polio Eradication Initiative (GPEI), Measles Initiative (MI) and the GAVI Alliance.

Achievements

The programme helped to facilitate technical support and resources to the zones/regional offices and NS for their effective involvement in mass measles and polio immunization campaigns to reach related global immunization targets.

During the year funds from the Global Measles & Polio Initiative were provided to 9 National Societies for polio and measles campaigns, mobilizing over 7,300 volunteers to reach over 1 million households with vaccination messages. In Kenya Red Cross volunteers in 32 districts in Western Kenya reached 1,185,038 children during the Red Cross support to Ministry of Public Health and Sanitation which took place in September 2011. This was through pre-registration of <5 year olds, community education and mobilisation for vaccination against polio.

Despite flooding, 80 Pakistan Red Crescent volunteers from Sindh and Balochistan supported district health authorities in community mobilisation during the polio vaccination campaign in the last quarter of 2011.

Five further national vaccination campaign requests were made from Ministries of Health to National Societies during the last quarter of 2011 but due to insufficent funding the IFRC was unable to provide the funding support.

In addition to National Societies directly funded by the Global Measles & Polio Initiative, National Societies in Cambodia, Chad, Mali and the Republic of the Congo, participated in their vaccination campaigns through other support (emergency response funds or bilateral support). Outbreak response activities which had commenced in 2010 in countries such as Malawi, Republic of the Congo, Tajikistan, Uganda, were concluded during the first half of 2011.

The IFRC significantly scaled up its global voice in advocacy for vaccines, including through press releases and media events, statements at international fora (World Health Assembly, GAVI Pledging Conference), and by co-hosting an event with Médécins Sans Frontiers at the 64th World Health Assembly titled Global Immunization Vision and Strategy (GIVS): Getting the Balance Right.

Through its support to the GAVI Alliance, the IFRC increased its role as a key civil society partner during 2011. At the first GAVI Alliance Pledging Meeting, held in London, IFRC's Secretary General spoke on behalf of all civil society. IFRC began hosting the Communications Focal Point/Advisor to the GAVI Board member for the GAVI CSO Constituency position in June 2011 and organized the July and November GAVI CSO Steering Committee meetings in Geneva and Dhaka respectively.

Consultation with stakeholders on the development of the Global Vaccine Action Plan for the forthcoming Decade of Vaccines (DoV), announced by Bill and Melinda Gates in Davos (2010), continued in 2011. The IFRC participated in a working group of the DoV.

During the International Conference, Commission D launched the report on Eliminating health inequities 'Every woman and every child counts' in partnership with the Partnership for Maternal, Newborn and Child Health (PMNCH). The governments of Australia, Afghanistan, Canada and the United States of America and 24 National Societies pledged support to the subsequent Resolution 6 passed during the Conference on addressing health equity.

Partner National Societies including the Norwegian and Finnish Red Crosses and Canadian Red Cross continued to support the development of the Federation wide MNCH framework which will be shared globally and with external partners during the first quarter of 2012.

Constraints or Challenges

- As in previous years, the requests from National health authorities to National Societies were greater than the funds available and focus in future years will be on securing funds throughout the financial year to bridge the recurrent gap
- Insecurity due to natural disasters and conflict remain operational challenges in many of the countries where National Societies conduct and support MNCH and Immunisation interventions. However, Red Cross volunteers continue to reach remote and vulnerable communities and their families. An example of this was the exceptional negotiation between the health authorities and local groups in the rural areas of Afghanistan enabled vaccination campaigns to reach the most remote and often the most vulnerable populations during 2011.

Voluntary Non Remunerated Blood Donation

The Voluntary non remunerated blood donation programme (VNRBD) contributed to sustainable development by strengthening community resilience, inline with the International Federation of Red Cross and Red Crescent Society's (IFRC) Strategy 2020 (S2020).

The International Club 25's "New blood for the world" project aims to:
(1) Support country-based activities in blood donor recruitment involving Club 25 programmes with an additional focus on health promotion.
(2) Share lessons learnt and good practice from country-based programmes at the regional and global level. Develop a global network entitled International Club 25.

This programme is spread over five years, with 2011 recognized as phase two of the project. Phase two, as agreed with Swiss Humanitatrian Foundation (SHF), was focussed on increasing Club 25 membership by expanding communication campaigns and actively engaging Club 25 members in healthy lifestyle peer promotion, and monitoring progress including engagement in World Blood Donor Day country activities, training of leaders and utilization of the Club 25 international hub IFRC/RC3. Additionally this phase saw the adoption of the new IFRC blood policy for developing safe and sustainable national blood supplies and the distribution of tools and VNRBD standard self-assessments.

During 2011 the Red Cross Red Crescent (RCRC) International Club 25 project funded by the Swiss Humanitarian Foundation was implemented in thirteen countries: Kenya, Chile, Colombia, Ecuador, Guatemala, Honduras, Nicaragua, Suriname, Russia, Albania, Macedonia, the Philippines and Viet Nam.

Outcomes

- **Increased Club 25 membership through expansion of communication campaigns**
  2011 saw each participating Club 25 develop and disseminate targeted promotional messages and materials. Media for dissemination was expanded during 2011 to incorporate and strengthen use of social networking platforms such as Facebook and Twitter, and popular websites such as YouTube. After the inclusion of these new methods of communication, a total of ten different methods were used by Club 25 programmes: newspaper, magazine, newsletters, radio, television, workshops, Facebook, Twitter, video clips (YouTube) and websites.
  Due to the expansion of communication campaigns and broadening of activities to reach the target population, 5,607 youth were registered as new Club 25 members during 2011. This increase in membership was experienced by all participating Club 25 programmes. Furthermore, a total of 611 new Club 25 branches were opened across seven of the thirteen participating NSs. A total of 354 Club 25 promoters were trained by the end of 2011.

- **Active engagement of Club 25 members in healthy lifestyle peer promotion and a broadening of health promotion messaging**
  During 2011, twelve of the thirteen Club 25s addressed eighteen different public health

topics. These topics included: HIV, non-violence, first aid, psychological first aid, substance use, nutrition, road safety, Sexually Transmitted Infections (STIs), hygiene promotion, teen pregnancy, peer engagement strategies, marketing the importance of voluntary non-remunerated blood donation (VNRBD), youth violence, healthy lifestyles, sexual education and more broad general health promotion and prevention activities. As a result of the varying needs within each country, there was no one topic which was addressed by all NS. From the feedback received, we can calculate that 46 per cent of participating NS addressed issues of HIV prevention, 38 per cent the importance of VNRBD and living a healthy lifestyle, while 31 per cent addressed the importance of first aid and STI prevention.

- **Training of leaders**
  Another project outcome which was addressed was the implementation of leadership training during 2011. The aim of this training is to increase individual Club 25 capacities, increasing national ownership and sustainability of the Club 25 project. As a result of leadership training having been highlighted as an important point of development, it was addressed by 83 per cent of participating Club 25s. Although data on the number of Club 25 members trained is not available for many of the participating countries, the three countries for which data is available trained a combined total of 115 Club 25 leaders.

- **Conduct awareness raising campaigns with various promotional events and Club 25 engagement in World Blood Donor Day (WBBD)**
  Many of the promotional activities of International Club 25 consist of awareness raising campaigns and promotional activities. According to available data, 50,021 community members were reached both directly and indirectly during WBBD 2011. Over 1,000 Red Cross staff and volunteers (976 volunteers and 111 staff) participated in WBBD 2011, ensuring the day's events were a success. Each Red Cross National Society (NS) approached the day's events differently, meaning that a wide variety of activities were undertaken. Chilean and Colombian RC harnessed the power of the internet by creating a website and YouTube video respectively. These, in conjunction with other activities, proved to be a success, with both NS reaching a combined total of more than 3,336 people. Those NS for which data is available collaborated with at least one national organisation, raising the profile and added value of the RCRC in VNRBD. Organisations include, but are not limited to: universities, Ministries of Health (MoH), Ministries of Education, National Blood Services and national lotteries.

Constraints or Challenges

- The translation, printing and distribution of IFRC's blood donation toolkit Making a Difference: recruiting voluntary, non remunerated blood donors has been postponed. A review of the material will be carried out during 2012 to ascertain if there is a need for the creation of an updated version prior to reproduction.
- The unexpected departures from Geneva of both the senior officer responsible for VNRBD in late 2010, followed by the unexpected departure of the senior health officer who assumed the portfolio impacted the dissemination of funds to NSs and the continuity of project management. Funds were not received until July 2011. This delay may have impacted the rate of implementation, potentially resulting in an under spend in 2011.

Water, Sanitation and Emergency Health

Outcomes

- IFRC concluded a mid term review of its Global Water and Sanitation Initiative. The initial ten year target (5 Million beneficiaries) has been surpassed and GWSI is on track to treble this to 15 million beneficiaries by 2015. There are now 303 projects mapped since 2005, including those concluded, on-going or about to commence. Over 75 RC/RC National Societies are engaged as prime implementers or partners.
- IFRC responded rapidly to the displacement of people from Libya into Tunisia, supporting the water, sanitation, and emergency health activities of the Tunisian Red Crescent through deployment of Federation WatSan/EH staff, FACT, and ERUs.
- The IFRC has a strong focus on preparedness and response to health in crisis, disasters and epidemics. Support to National Societies is organised around emergency health expert focal points in Geneva, Panama, Johannesburg and Kuala Lumpur with the aim to share knowledge and develop capacity at local, regional and global levels.
- Continuous work on building of National Society WatSan/EH capacity, representation, and advocacy within the Movement and with other partners continues to take place. The Geneva WatSan/EH team coordinates such capacity building and where gaps exist directly engages with field visits or inputs to training and workshops.
- The IFRC is increasing its role and interaction with the Global WASH cluster and is now a member of the Strategic Advisory Group (SAG) which will not only advise but influence key decisions on the Cluster. Three new IFRC support positions to the WASH cluster are established and operational one is Global (based in Nairobi) part of a three person inter-agency team that undertakes Rapid WatSan Assessment of major emergencies and two regional positions (Panama and Beirut) which provided WASH cluster capacity building at coutry level.
- The Geneva based Emergency Health team is the focal point for the Global Health Cluster, the International Coordination Group for Yellow Fever and Meningitis Vaccines, the Global Coalition for Cholera Prevention and Control, the Public Health Emergency Operations Centre Network, and the Global Outbreak Alert and Response Network.

Achievements

- By surpassing its initial targets, the GWSI has made a significant contribution towards the attainment of the MDGs, specifically Goal 7c ‘reducing by half those without access to safe water and basic sanitation’.
- In 2011 IFRC launched 27 Emergency Appeals and 87 DREF operations, most of which have benefitted from the technical guidance, input, information sharing, intervention, quality assurance, and institutional memory of the WatSan/EH team. Out of these, 28 were response operations to epidemic outbreaks.
- During 2011, emergency provision of water, sanitation and hygiene promotion served over 2 million beneficiaries worldwide.
- Experiences from the rollout of the Epidemic Control for Volunteers Manual and Toolkit were reviewed in an external evaluation. There is broad consensus among those National

Societies where it has been used that the ECV package is an excellent concept, and it has been very well received by its intended audience at NS level, who recognize its usefulness and relevance to the challenges confronting them in their public health activities. The toolkit, now available in eight languages, will be revised based on the user feedback from National Societies.

- The WatSan/EH team contributed to visibility on the global arena and strengthened its cooperation with academia. The IFRC made three presentations in chaired sessions in the main programme of the biannual World Conference of Disaster and Emergency Medicine in Beijing ("Emergency health response in Haiti earthquake 2010", "Working with volunteers in cholera outbreaks in Haiti 2010 and Zimbabwe", "Legal aspects in deployment of foreign medical teams"). The Red Cross experience of health response in Haiti was also presented in the scientific programme of the International Council of Nurses' conference in Malta.
- Federation was also represented at an Asian Development Bank sanitation consultation held in Manila that brought together over 500 key players and participants. Federation has renewed its interaction with and membership of the Water Supply and Sanitation Consultative Council (WSSCC) and participated at a Global Forum of this body in Mumbai in October.

Constraints or Challenges

- The variuos GWSI project outcomes are still only being measured to date in quantitative data (beneficiary numbers, cost per beneficiary and scale of programming primarily). However, as GWSI continues into the next five years to 2015, greater efforts are required and indeed need to be initiated to measure sustainability and impact, and this can only be done after projects are completed, and indeed revisited at least 2 to 3 years after completion. A new set of tools and new funding streams are required to undertake this crucial element.
- The provision of safe water, in both developmental and emergency contexts, is often seen as 'easier' and is therefore more interesting to donors. However, it must be acknowledged that poor or non-existent sanitation severely limits the positive effects of providing safe water. It is essential that programmes include a balance between water supply and sanitation activities. This was further underlined by the recent figures from the WHO/Unicef Joint Monitoring Project which shows that they are on track for meeting MDG Water Supply targets but woefully behind on sanitation targets thus the need for us to significantly scale up this component of our work.

Humanitarian Pandemic Preparedness

Outcomes

After the close out of the Influenza Unit end of 2010, the IFRC has continued to pursue its efforts to support National Societies in pandemic preparedness collaborative planning through reaching the following outcomes:

- Humanitarian pandemic preparedness (H2P) experience and lessons learned as well as training on influenza and influenza pandemic are available globally.
- H2P dealt with health, food security and livelihoods, therefore is a perfect catalyst to promote global cross sectoral approaches like Towards a Safer World (TASW) and "One health"

- As part of the sustainability strategy, H2P messages and methodology are incorporated into existing institutional training at global level and upon request, through operations at country level.

Achievements

- Very positive feedback was received following the participation of IFRC and National Societies representatives in different events related to pandemic preparedness i.e.: Pandemic Panel at the ISDR Global Platform and presentation on community work at the Towards A Safer World conference (http://www.towardasaferworld.org). In addition, National Societies present at the Asia Pacific Strategy for Emerging Diseases (APSED) conference reinforced their potential as a credible partner aiming to strengthen the country's capacity to prepare for and respond to a pandemic and other public health emergencies and increased the collaboration with WHO, UNICEF, WFP and UNSIC.
- The two influenza online modules were made available for any further implementation in pandemic context planed by the humanitarian sector. They exist in English, French and Spanish (+ Russian for Influenza Pandemic) - https://ifrc.csod.com/client/ifrc/default.aspx
- About 1'500 learners from 115 countries registered for the online modules. Out of them, half were RCRC volunteers, 25% IFRC & ICRC staff and 25% non RCRC affiliated.
- The H2P Senior Officer continued to collect and share activities conducted by National Societies related to H2P such as community awareness campaigns, briefing sessions and coordination meetings with government authorities and United Nations agencies.
- Regular communication amongst different stakeholders was ensured and, in-country, the capacities of staff, volunteers were strengthened by carrying out influenza pandemic awareness campaigns in Belarus as well as specific trainings on influenza pandemic in conjunction with the Epidemic Control for Volunteers training in South Africa.

Constraints or Challenges

- The announcement from WHO declaring the 2009 H1N1 pandemic to be over and the withdrawals of key actors from the Pandemic Preparedness Network made it more difficult to continue the dialogue with National Societies and external stakeholders on the importance of pandemic preparedness and response.
- The drop in the value of the US dollar against the Swiss franc has again exacerbated the financial challenges however a No Cost Extension request was approved by USAID to make the optimal use of available funding.

HIV

Outcomes

- Improved NS's staff public health knowledge on programme development, planning and organization within the context of the Global Alliance on HIV approach.
- Improved programme performance tracking mainly focusing on program deliveries using preset reporting format.
- Improved NS's performance capacities through provision of generic tools.

- Supported zone office and NS's and enhanced resource mobilization at regional and national levels.
- Increased capacities of NS's through facilitation of knowledge and skills sharing that are acquired for programme implementation by NS's and from external sources.

Programme development, planning and organization

The IFRC's Global HIV programme is in line with the Millennium Development Goals and directly driven by the UNGASS Declaration of 2006 where governments committed to scale-up interventions towards universal access to HIV prevention, treatment, care and support by 2015.

The IFRC's global HIV programme is being implemented based on the Global Alliance approach as it provides a mechanism for development and implementation of Federation-wide, standardized and comprehensive HIV programme, mainly:

- Provided technical support to health coordinators in the regions and enabled them to deliver quality technical support to NSs in the development of HIV programme documents, plans and budgets for 2011-2015.
- NSs signatory to the GA on HIV in Asia Pacific and Africa engaged in the development of new plans. Seven NS in southern Africa and four NS in Eastern Africa were supported in developing integrated HIV programmes 2011-2014 in view of developing proposals for GFATM funding, round 11.
- Several technical missions to support NS in programme planning took place during the year, including missions to the Africa Zone (to reach a shared understanding on issues related to public health and HIV programmes), to Cambodia (to support the NS in finalizing its five year HIV plan in order to access in-country funding), as well as to South Korea, Ethiopia, Slovenia, Cameroon and Panama (to review NS experience in implementing the Global Alliance on HIV).
- A mission to consult 22 Central Asia practitionners in Alma Alty was undertaken as to identify HIV and TB training needs in prevention, care, treatment and support in working with key affected populations and to explore a potential partnership with PSI regional office for Central ASIA to conduct a TOT for 5 NS of Central Asia (Tajikistan, Turkmenistan, Kazakhstan, Kyrgyzstan and Uzbekistan).
- A mission to Haiti and Panama was undertaken aiming to facilitate the implementation of sexual and reproductive health and HIV related activities in the context of the Federation-Wide Strategic framework for Haiti Recovery.
- IFRC's commitment to partner with GNP+ was reaffirmed and the relationship revitalized so it can translate into concrete, more organized joint collaborative interventions as a continuation to the UNAIDS collaborating center agreement which ended in 2011.

Development of tools

- The advocacy tool "Out of Harm's way" and communication pack on harm reduction for injecting drug users was developed in Russian, printed and distributed to NSs, along with a CD encompassing guidelines & tools on Harm reduction.
- At the occasion of the UN High level meeting on AIDS in New York, a communication pack was developed to support NS in their advocacy efforts with governments in partnership with other civil society actors, in particular with PLHIV networks and rights-based organisations,

to advocate for laws, policies and practices that uphold the rights of people living with and affected by HIV.
- As part of our efforts to better address gender inequalities and sexual and gender based violence, a new training module on gender and HIV comprising guidelines for trainers, a volunteer handbook and leaflet for dissemination at houshehold was produced. This new training module was field tested in the second part of 2011 with trainers and volunteers from the South African and Trinidad and Tobago RC NS.
- 1000 copies of the overall HIV Prevention, Treatment, Care and Support training package for community volunteers were reprinted and distributed. In partnership with WHO, the French version of the training package was field tested in Kribi, Cameroon during a training of trainers for NS practioneers from Central Africa.
- The RCRC+ network has been supported in producing a leaflet to present the network in Spanish and English.

Resource mobilisation

An IFRC strategy and plan of action to access funding from the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) in round 2011 was developed while IFRC's senior management engaged in building the relationship between the GFTAM, the IFRC and NS. A mapping of current involvement of NS in accessing GFTAM funds and lessons learnt was undertaken by the Global Health team. The IFRC Secretariat as a whole was assessed by the GFTAM through its local fund agent, the Swiss Tropical Institute to determine our ability to become a GFATM primary recipient. An IFRC Round 11 orientation workshop to engage with GFTAM was organised for NS from Botswana, Liberia, Lao RC,Malawi and Togo which were planning to submit HIV proposals. Based on various consultations, a new concept paper "Building a strong partnership between the Global Fund to fight AIDS, Tuberculosis and Malaria and the International Federation of Red Cross and Red Crescent Societies" was developed; the paper offers several models for expanding the partnership to more effectively harness the strengths of both organizations in the fight against HIV, tuberculosis, and malaria and serves as a basis for the final negotations between the fund and the Federation.

In parallel, efforts were sucessfully deployed together with the Netherlands RC to secure multi year funding to support the Africa Zone and NS in Eastern and Southern Africa in their programmes supporting orphans and other vulnerable children.

Furthermore, a funding proposal on integrating gender and gender based violence into IFRC HIV prevention and care activities was developed.

Despite all efforts, only three NS (the Norwegian, the Swedish and Finish RC) pledged to the global HIV programme in 2011 resulting in a reduction of both financial and human resource capacities at global level to render services to zone offices and NS.

Knowledge sharing

- The IFRC was represented at the International Harm Reduction conference in Beirut, Lebanon and facilitated sharing of experiences.
- In collaboration with the IFRC New York office, and in the context of the UN High Level Meeting on AIDS in New York (08-10 June 2011), and under the auspices of the UK and South African Governments, a side event to raise awareness of good practice on realizing

human rights and increasing access to quality HIV services for key affected populations was co-organized by IFRC and the International HIV/AIDS Alliance.
- The Southern Africa Zone office was supported in the design of the final evaluation of the Southern Africa regional HIV and AIDS programme 2006-2010 "Sustaining commitment" published in July 2011.
- The Asia Pacific team was supported in fundraising in order to in turn support NS in participating in the 10th International Congress on AIDS in Asia and the Pacific (ICAAP) in Busan, Republic of Korea, IFRC's pre-conference meeting and the Asian Red Cross and Red Crescent HIV/AIDS Network (ART) annual meeting. Twelve NSs participated in ICAAP and presented 18 oral/ poster presentations. IFRC pre-confrence and ART side meetings dealt with strategic directions for NS in the context of strategy 2020 and the Global Alliance on HIV, resource mobilisation and building relationships with Country Coordination Mecahnisms to facilitate access to GFTAM funding, the meaningful involvement of PLHIV and the development of the RC/RC+ network in Asia, HIV in the workplace and the future of ART and ART plan of action for 2012.
- The Europe Zone was supported at the ERNA general annual meeting where 62 participants from 25 NSs, the Global Network of People living with HIV (GNP+), Belarus Network of PLHIV, WHO, UNODC, and IFRC discussed the role of NS in Humanitarian Diplomacy in addressing the stumbling blocks that impede progresses in HIV, TB and drug related harm reduction programming. ERNA evaluation findings were reviewed.
- At the occasion of the 16th International conference on AIDS and STI's in Africa, a RCRC pre-conference meeting was organised; Health and Care representatives from 16 African NS gathered to discuss effective ways of strengthening HIV programming and reaffirmed their engagment through a declaration "Sustaining our committment to the HIV epidemic".
- To mark World AIDS day 2011, in partnership with UNAIDS and GNP+, a side event had been organised at the International RCRC conference to share the French, Thai, Italian and Argentina RC contribution to the UNAIDS 2011-2015 strategy on getting to zero new infections, zero deaths and zero stigma and discrimination, and in working with key affected populations (injecting drug users, men who have sex with men, transgender persons and commercial sex workers).
- Supported the mid term review of the Global Alliance on HIV in the Americas (2008-2010). The Global Alliance on HIV is well alive and of relevance to the NS in the America's and Caribbean, expanded in 2010 to Trinidad and Tobago and looking to expand into two additional countries in 2012 (Bahamas & Costa Rica). The number of people reached over the last three years by the 11 NS has overall trippled.
- A training of trainers course on implementing comprehensive prevention, care, treatment and support interventions for most at risk populations was conducted for 25 RC/RC NS representatives from Central Asia (11-15 Dec).
- In partnership with WHO, 15 trainers from 8 Central African NS were trained on HIV prevention, care, treatment and support for community volunteers in Kribi, Cameroon.

The Masambo Fund Foundation

The Masambo Fund board met twice in 2011 and acknowledged the current particular and fragile situation of the fund with 117 pending applications since 2009 and very limited funding. This was brought to the attention of the Federation's Governing Board, which recalled NS on their

responsibilities in keeping the fund alive and operational. In the meantime all new applications were frozen until current applications are processed.

Only eight nominees from Zimbabwe Red Cross received a grant in 2011. The actual amount of financing needed to support the remaining 117 pending applications is CHF 791 000.

As of December 2011, nine National Societies had honoured their commitment, leaving the fund with a financial gap to fulfill its commitments to support 119 applicants.

The Masambo Fund Board decided:

- To change the legal nature of the fund, transforming it into an internal IFRC fund.
- Existing funds will be balanced against current applications, the Masambo Fund Board will review criteria and the allocations to be made in order to transfer the available funds to the largest number of applicants.

Achievements

Global Alliance on HIV programme performance

In 2011, 65 National Societies submitted data on programme deliveries, through their respective IFRC zone office, out of which 58 National Societies had adopted the GA on HIV approach .

The compilation and analysis of the received data reveals that in 2011, a total of 11,047,748 persons were reached with prevention messages and 115,980 PLHIV and orphans received care and psycho-social support reflecting more than a 50 % decline in the total number of beneficiaries reached. A total of 56,402 volunteers which are specifically trained on HIV prevention, care, treatment and support delivered the services.

With respect to resource mobilization, a total of CHF 16,053,000 were mobilized by the 65 National Societies (38.28% as compared to 2010). All zones are reporting continuous decline in funding allocated to HIV. Between 2009 and 2011, we experienced a reduction in the overall funding of NS in HIV programming of more than 55%. All efforts to build capacities of NS in accessing the Global Fund resources available at country level fell short as the GFTAM entered also in a major financial crisis.

Despite this challenging context, the major findings of the southern Africa HIV and AIDS 2006-2010 end of programme evaluation, the first region to complete a 5 years programme planning cycle using the GA on HIV approach and programmatic framework, showed that the programme had made significant progress in achieving its targets, that the strategies employed were effective and efficient and significant impact had been made. Beneficiaries considered the NS' HIV and AIDS activities as highly relevant to their needs. The programme provided services that, in many instances would not be accessible to most beneficiaries.

In Malawi, the Girl's empowerment groups and Young men as Equal Partners activities are reportedly changing behaviour of youths; in Namibia, the health staff reported that adherence to ART had improved significantly because of the Namibia RC Home based care programme. HIV prevalence, incidence and mortality has declined over the past five years in most Southern African

countries although this cannot be attributed to RC interventions alone, it is logical that a programme of this extent (based on coverage) has contributed significantly to the observed trends.

Constraints or Challenges

- Decreasing funding and thus decreasing capacity to render services to zones and NS at global level.
- For National Societies, the major constraint remains a shortage in funding for scaling up HIV programme implementation in line with the GA on HIV approach. There is a need to strengthen and support National Societies in adjusting their response to the epidemic, in reducing their dependency towards external funding to enable them to connect with national funds disbursing bodies, demonstrate the impact of their interventions, and access sizeable resources for programme implementation. To attract in-country funding, National Societies need to become a credible performing partner and participate actively in the existing country coordination mechanisms (CCM's), show leadership and be more visible.

Tuberculosis / Harm Reduction

The purpose of the global TB programme is to scale-up and coordinate the IFRC's global response to TB and achieve the TB related Millennium Development Goals through promoting and advocating for RCRC role in TB control at community level.

The purpose of the global Harm Reduction programme is to promote and advocate for increased activities by RC RC through a comprehensive harm reduction approach for drug users through increased communication / visibility, training and capacity building.

Outcomes

- Well-facilitated coordination of TB and harm reduction activities by National Societies to achieve and demonstrate an added value to the International Federation's global efforts to stop TB.
- Provide technical support and guidance to further build the capacity of National Societies and participate in TB control efforts and harm reduction programmes. To support the role of civil society, affected communities and people living with TB.
- Ensure full integration of TB with HIV and other community health activities.

Achievements

Programme support

In 2011 global TB and Harm Reduction Programmes were supported by the following donors:

- USAID TB Grant – 2008-2011: The programme included three countries (India, South Africa and Kazakhstan), as well as coordination at the global level. Funds are transferred to the global budget and based on approved country budgets, funds are reallocated to respective

country codes. The total budget for FY2010 (Oct2010 – Sep2011) was USD 600,000. Funding for FY2011 (Oct2011 – Sep2012) will cover activities in South Africa, phase out activities in Kazakhstan, evaluation of the programme and coordination. The project in India ended in January 2012.

- Lilly Grant 2008 – 2011: This is the last year of a four years multi country project. The total grant was 1.6 million USD. It covered activities in 10 countries as well as coordination at global level. Negotiations are ongoing for the next phase of the programme support in 9 countries.
- Lilly Grant 2009 – 2012: supports MDR TB activities in Southern African region and is allocated to National Societies based on plans. The total grant amounts to some USD 260,000. Funding for 2011 covered training activities in Africa. Additionally, Lilly grants to Ethiopia and Russia (USD 180,000) were directly booked at country level.
- Italian Red Cross Grant for harm reduction – EUR 200,000 included programme support to five National Societies, training activities in Villa Maraini and support to ERNA Secretariat. Additional EURO 300,000 will be allocated to continue project activities in 2012.

In all cases, the IFRC health department takes responsibility of overall coordination, communication with National Societies and respective offices of the IFRC, technical support as well as reporting.

The budget overview gives an impression that the TB and Harm Reduction programme (project code G00040) is overfunded. However, the above details show that overall budget includes global programme activities as well as country level support. Funds are regularly transferred to country accounts.

World TB Day Events 2011

On 22 March the health department organised a round table between RCRC Societies and partners. The meeting was attended by representatives from five National Societies, WHO, ICRC, Stop TB Partnership, Lilly and other key partners as well as few diplomatic missions.

On 23 March, a joint IFRC / Stop TB Partnership TB Advocacy Report was launched during a press conference at Palais de Nations together with WHO Stop TB Department and Stop TB Partnership. The Federation's USG together with senior representatives from WHO, Stop TB Partnership and Global Fund were part of the panel, with representatives from six National Societies in attendance.

Technical Support

- During the reporting period, support was provided to EU funded and Italian RC/Villa Maraini coordinated research project that aims to increase access to HIV and TB testing for drug users in Slovak Republic, Netherlands, Italy and Czech republic. The IFRC is a member of the technical advisory committee as suggested by Italian RC. Working meetings took place in Turin in March and Bratislava in September, focusing on technical aspects of TB and HIV diagnoses. The project ends in Sep/Oct2012. Results will be presented during the final meeting in Rome in October 2012.
- In May 2011 the health department started development of a toolkit that outlines a step by step process of planning and implementing MDR TB programmes and builds practical skills for carrying out respective activities. The draft paper was focused on MDR TB prevention,

treatment support, community focused advocacy, communication and social mobilization, all based on RCRC experience. Discussion is ongoing with USAID to finalise the document and print the publication.

- During Apr–Jun2011, a total of four TB projects were monitored and supported globally (two projects South Africa, one in India and one in China). During 20-24 June together with Zonal Health Coordinator, Red Cross Society of China (RCSC) and China MoH monitored Lilly supported TB project in Changzhi prefecture, Shanxi province. Main objectives were to highlight achievements made so far, identify challenges and assist RCSC to overcome them, and communicate with stakeholders. During the visit Lilly office in China and UNION representatives were met.
- Lilly MDR TB Partnership media tour took place in South Africa and Swaziland during 24-28 Jan2011. TB activities by respective NSs supported by Lilly were closely highlighted. The tour was well coordinated between Lilly Geneva / South Africa, IFRC Geneva, Zonal office, South African Red Cross and Swiss Red Cross Societies (Lilly supports Swaziland TB project through Swiss Red Cross).
- The IFRC, together with Project Hope and WHO, conducted an assessment and mapping of TB issues among labor migrants in Central Asia. The IFRC health department, IFRC offices and respective National Societies were actively involved in the process.
- A side event on Tuberculosis was organized during the International Conference with the participation of WHO, Stop TB Partnerhship, Lilly and leaders from key National Societies of TB affected countries to discuss progress of National Societies in TB control, challenges and opportunities.
- A meeting was organised betwen the President of Italian Red Cross and the Portfolio Manager for Ukraine at the GFATM. The progress and role of Ukraine Red Cross within the ongoing grant was discussed.
- During 2011 the Health Officer Participated and co-facilitated three harm reduction training for National Societies in Europe, Asia/Pacific and Africa. It took place in the premises of Villa Maraini and was organized by the Italian RC.
- The health department produced a video on harm reduction activities in Villa Maraini.
- During the UNODC's 55th session of the Commission on Narcotic Drugs (25 March), the IFRC, the Italian RC, and Villa Maraini Foundation organised a lunch side event on integrated approaches of TB/HIV services for drug users. A total of 33 participants from 18 countries participated in the meeting with representation from all geographic regions. The group discussed ways to strengthen collaboration and coordination between services, and ways to provide integrated and holistic care to most at risk populations. Participants also shared experiences and best practices.
- On 19 May, the IFRC signed a partnership agreement with UNODC. The agreement is a useful advocacy tool for both organizations and particularly for National Societies to address the issues of drug use and related harm at the community level.
- In the beginning of January 2011, the Kenyan government had stepped up the war on illicit drugs and chemical substances leading to a drastic reduction in supply of the various types of substances abused locally. Most drug abusers thus were unable to access the drugs. Following the crisis in the coast area, the health department, together with the regional office, coordinated technical support through Italian RC experts deployed to Kenya to conduct an initial assesssment of training and develop a proposal. In consequence, funding for the programme was provided and a promotional/educational video produced.
- The senior health officer chaired the selection process for CSO projects for Stop TB specific

funding to strengthen focus of TB programmes at the community level. The selection process took place in early 2011. The Committee included members from WHO, UNAIDS, as well as other NGO representatives.

- The decisions from the 24th meeting of the IFRC's Governing Board (Sep2011) inlcuded a list of activities related to substance abuse. First results will be reported during the next meeting in June 2012.
- At the end of 2011, the health department revitalised the discussion with Italian RC regarding the Partnership agreement on providing technical expertise in harm reduction activities. During the visit, extensive discussions took place between the leadership of Italian RC and Villa Maraini, head of health department and legal adviser. The signature of the MoU will take place in the nearest future.

Global Representation

- The IFRC participated in the TB Training and Education Collaborative organised by WHO and the Norwegian Heart and Lung Patient Organisation (LHL) in Oslo, Norway (5-6 May 2011). A Half-day workshop addressed the issue of human resources and quality of care in the view of scaling-up diagnosis and treatment activities of MDR-TB. The second part of the meeting focused on more collaborative training.
- The IFRC participated/presented its activities during a UNODC organised Experts Group Meeting focused on "Basic socio-economic assistance as a precondition for effective drug dependence treatment and related HIV/AIDS prevention". The meeting took place in Vienna at UNODC headquarters in the Vienna International Centre from May 10 - 12. Fabio Patruno from Italian RC represented the Federation.
- 25-27 May: Together with the Europe zonal health coordinator, the IFRC participated in the WHO organized meeting for National TB Programmes in the Netherlands, Wolheze. A special presentation was delivered during the session related to cross border TB and possibilities for RC RC to be involved. Examples of projects implemented by the IFRC were given where TB-related assistance to migrants is provided as part of specific interventions to migrants (e.g. Central Asian Red Crescent Migration Programme) or to socially-vulnerable groups (e.g. Rehabilitation Centre for IDU in Rome) or of TB projects where migrants are one of the vulnerable groups to support (e.g. project in Almaty/Kyzylorda). The presentation underlined the importance of collaboration between migrants' origin and host countries and with the national TB programmes and the need for TB and migration programmes of IFRC to be more integrated and guided by operational research.
- 13 March: TB health officer attended a round table at the European Parliament in Brussels on "Drug-resistant TB and TB-HIV co-infection - *What can the EU do to curb the threat?"* The round table was organised together with European Parliament Working Group on Innovation, Access to Medicines and Poverty-Related Diseases. On this occasion, a side meeting was organised with Mrs. Medeline Kajorenko, Head of Unit European Neighbourhood Policies – Sectorial issues, European External Action Service.
- The health department together with the Europe zone office and Red Cross EU office was actively involved in the organisation of the Field visit to Hungarian Red Cross / Europe Zonal office for parliamentarians during the ACP-EU Joint Parliamentary Assembly in May in Budapest. During the visit we introduced to parliamentarians TB problems globally with the focus on East Europe and RC RC role.
- On 25-26 June a meeting was organised with Project Hope to follow-up discussion on joint

Project Hope/IFRC/WHO proposal on TB among labour migrants in Central Asia. Project Hope will take the lead and start assessment and mapping. IFRC offices and respective National Societies will be actively involved.

- During Oct2011, the health officer together with the Russian RC and representative from IFRC Moscow office participated in Lilly MDR TB Summit organised in Lille. Discussions included RCRC participation in MDR TB partnership, as well as key achievements and plans for the next phase.
- In Dec2011, the IFRC together with Stop TB partnership organised a workshop for National TB Champions/Advocates. Celebrities from 11 countries as well as selected National Societies participated in the workshop highlighting roles and responsibilities for TB advocacy and working modalities with TB advocates. The workshop was followed by a two day field trip to Stop TB Italy and a visit of the Harm Reduction centre in Torino, where participants visited TB services for drug users.

Work with IFRC Global TB Ambassador, Gerry Elsdon

The Health Officer continued an active engagement with Gerry Elsdon on events and activities, where she profiled and advocated for MDR TB and the role of RC RC. As per agreed plan, Gerry Elsdon participated in following events:

- General Assembly and International conference
- Workshop for TB Ambassadors organised together with Stop TB Partnership

Constraints or challenges

Global programmes (both TB and Harm Reduction) should be a solid platform for National Societies to build upon and expand activities at country level with locally available resources. The support from donor community to global programme will include less and less country focused activities. Therefore, it is important to work out together with Zonal and country offices well developed resources mobilization strategies. The health department will continue to provide technical support and advocacy.

Malaria

Malaria programmes that are being implemented by National Red Cross and Red Crescent Societies contributed to achieving the RBM 2010 targets and the UN Secretary General's call for "universal coverage of all population at risk from malaria by the end of 2010."

In 2011 more than 18,900 Red Cross and Red Crescent volunteers reached more than 8.1 million people with malaria messaging through household visits and net distribution activities.

Outcome(s)

The following are specific outcomes for 2011 aligned with two enabling actions within Strategy 2020. Strategic aim 1 Save *lives, protect livelihoods, strengthen recovery from disaster and crises* & Strategic aim 2 *Enable healthy and safe living*:

- Provided financial and technical support, through Africa Zone based delegates or Geneva-based staff, to National Societies focused on proposal development, project implementation, monitoring and evaluation and report writing.
- Supporting the development of technical capacity at National Society level continued. One key area of capacity building was the roll out of the Management Survey Tool in Kenya, Namibia and Nigeria during the first half of 2011.
- The Alliance for Malaria Prevention was strengthened in the first half of 2011 with both additional partners and expanded technical support to countries.

Achievements

During 2011, IFRC supported Malaria programmes in 13 countries in sub-Saharan Africa namely Angola, Burkina Faso, Burundi, Democratic Republic of Congo, Kenya, Liberia, Malawi, Namibia, Nigeria, Sierra Leone, Tanzania, Togo and Uganda.

The overall objective of activities being carried out across the 13 countries is to reduce morbidity and mortality from malaria. All programme countries, National Malaria Control strategies call for universal coverage with preventative technologies and access to effective treatment within 24 hours of the onset of fever.

Volunteers are active in all phases of net distribution campaigns: before, during and after the net distribution. Before the distribution, RCRC volunteers make sure their local community is aware that the distribution is taking place and they encourage families to go and get a free net. They ensure that families know where to go to receive LLINs, when the distribution will take place, the criteria for distribution (such as specific age groups or when vouchers are used to identify people at risk), how many LLINs the family will receive and the importance of using the LLINs every night to prevent malaria.

During the campaign itself, volunteers help with the logistics and distribution of the LLINs. Volunteers organize and run ‘hang up’ pavilions at each distribution site. These ‘hang up’ pavilions show LLINs hanging correctly, and messages from volunteers emphasize that all members of the family should sleep under their LLINs every night.

The material used to demonstrate correct net hanging and use in ‘hang up’ pavilions varies with the local context. In all cases, locally available hanging materials and beds will be used to ensure that beneficiaries see a demonstration of correct net hanging and usage in an environment that reflects their own situation. During the campaign, volunteers continue to follow-up with community members to ensure that they have benefitted from the interventions being offered by the Ministry of Health.

The “Hang up” and communities fighting malaria initiative

‘Hang up’ activities take place immediately following net distributions, and again just before the start of the rainy season.

During house-to-house ‘hang up’ visits, volunteers are assigned a number of households that they are responsible for visiting. Volunteers make sure household members understand the danger signs of malaria and refer sick people to health facilities where they can be diagnosed and treated. During the household visit, they ensure the net is correctly installed and check that families and community members know how to use the net (for example, that the net should be tucked in under the sleeping mat to prevent entry of mosquitoes) and in different situations (for example, that the net can be used outside in situations where families sleep outdoors during the dry season, or planting, harvest season).

RCRC volunteers pass the message that everyone should sleep under a LLIN every night. In situations where households do not have enough LLINs to cover every sleeping space, messages are passed that the populations most vulnerable to malaria (children under five years of age, pregnant women, people that are living with HIV) should be given priority for sleeping under the LLINs available in the household.

The formula to beat malaria comes through empowering communities to comprehensively respond to the disease. When community-based volunteers provide knowledge, prevention and treatment options, communities are genuinely empowered to be the most effective first responders to this ancient scourge.

Rapid Mobile Phone Survey (RAMP)

Most humanitarian work consists of three stages: assessment, implementation and evaluation. To effectively carry out the first and the last, above all, good data is essential. Crucially, assessment data must be gathered and analyzed quickly to be valid. The rapid spread and use of mobile technology offers researchers new and exciting means of data collection.

“Survey data probably makes up about half the information decision-makers use in the public health arena,” says Mac Otten, a paediatrician and epidemiologist who has worked for the US Centers for Disease Control (CDC) and the World Health Organization (WHO). The IFRC has pioneered testing of this innovative technology in the field of malaria. In collaboration with WHO, epidemiologists at the CDC and DataDyne, a RAMP survey which uses mobile devices for data entry, has been developed. The RAMP aims to provide a survey methodology and operations protocol that will enable National Societies, governments and NGOs to conduct health surveys at reduced costs, in a timely manner, and with limited technical assistance. The resulting high quality data allows health managers to make evidenced-based decisions and inform programming and policy in a timely and relevant way.

In the three countries selected for RAMP roll-out in 2011 – Kenya, Namibia and Nigeria - the surveys were intended to provide, firstly, estimates on access to and usage of LLINs, as well as information about factors like how children suffering from suspected malaria were treated and the use of “indoor residual spraying” – the coating of interior walls with insecticide.

The surveys were carefully designed to be as representative of entire communities.

The 2011 African RAMP established conclusively was the speed at which analytical results are obtained once the fieldwork is done. With the RAMP we are producing preliminary results bulletins

within 24 hours and a full bulletin within three days, as opposed to three months with pencils and clipboards.

Constraints or Challenges

The main constraints or challenges in 2012 were delayed implementation of activities and delayed or poor quality reporting. Technical support was provided by the Africa zone based malaria team to ensure delays were addressed and where possible projects got back on schedule. An additional constraint was identifying the correct human resources at National Society level to provide adequate technical and management support to project activities.

Working in partnership

The health team also maintained and further developed a wide range of partnerships. This includes global positioning, coordination, relationship management and technical support for a number of global initiatives, such as the global water and sanitation initiative (GWSI) or the global malaria initiative.

In many instances, the team took a leading role in positioning the IFRC within key health partnerships among civil society organization platforms. For example, the IFRC is currently chairing the Alliance for Malaria Prevention partnership and vice-chairing the GAVI civil society constituency. We are also part of the Strategic Advisory Group of the Global WASH Cluster.

In addition to our primary partners comprising Red Cross Red Crescent National Societies as well as our traditional partners such as the World Health Organization, different UN organizations, private sector and various government agencies, the team has initiated and developed partnerships in order to foster its resilience approach with multi-stakeholder collaboration, ensure longer term gains and sustainability, and scale-up health activities. Such new partnerships include the International Federation of Pharmaceutical Manufacturers & Associations, the Global Fund to fight AIDS, TB, and Malaria, the Partnership for Maternal, Newborn and Child Health, the WatSan Inter-agency Group. The Emergency Health team is the focal point for the Global Health Cluster, the International Coordination Group for Yellow Fever and Meningitis Vaccines, the Global Coalition for Cholera Prevention and Control, the Public Health Emergency Operations Centre Network, and the Global Outbreak Alert and Response Network.

More specifically, the IFRC health team conducted the following activities, among others:

- Applied to and succeeded in becoming a member of the World Bank Civil Society Consultative Group on Health, Nutrition, and Population.
- Participated in series of meetings and workshops before and during the Global Platform for DRR 8-13 May 2011 where IFRC was seen as a key actor in reducing health risks along with WHO, UNICEF and other major actors. A joint statement on “Scaling-up the community-health workforce in Emergencies” was launched by the Head of IFRC Health department during the platform on behalf of WHO, UNICEF, IFRC, UNHCR and GHWA. RCRC volunteers were recognized by the organizations that indorsed the statement as key health actors along with other actors (e.g. community health workers…). During the Global platform the presence of the Federation European Reference Centre for First Aid Education facilitated

contact with NS and established a link between the disaster preparedness and the daily risk accident preparedness for the lay public.

- Kept close coordination with the First Aid International Advisory Board, RCRC European Education network, European Reference Centre for First Aid education and European Resuscitation Council.
- Coordinated with the ICRC on a regular basis in order to share tools and future plans. For instance, the team has agreed to work with the ICRC on a One First Aid concept.
- Partnered with IFPMA in the UN High Level Meeting on NCDs in New York, September 2011 and continued to build the relationship aiming for a longer term partnership on NCDs prevention.
- Chairs a highly successful, results focused health partnership on malaria, the Alliance for Malaria Prevention (AMP). AMP supports scaling up coverage and utilization of LLINs. In this role, the IFRC liaises with all partners involved in malaria control and represents a major voice within the Roll Back Malaria partnership. AMP is partners implementation-focused partnership whose core group includes USAID (President's Malaria Initiative [PMI] and Centres for Disease Control and Prevention [CDC]), Johns Hopkins University Centre for Communication Programs (JHU-CCP), Malaria No More (MNM), Population Services International (PSI) UNICEF and the World Health Organization (WHO).
- Hosts the Roll Back Malaria Central Africa sub-regional network (CARN) focal point in Yaoundé, Cameroun. The CARN focal point is responsible to convene public and private sector partners to improve coordination and facilitate communication of ten countries in central Africa.
- Reaffirmed its commitment to partner with GNP+ and revitalized the relationship so it can translate into concrete, more organized joint collaborative interventions as a continuation to the UNAIDS collaborating center agreement which ended in 2011.
- As Chair and Vice-chair during 2011, continued to demonstrate active leadership in the development of the GAVI Alliance Civil Society Constituency, the body's Steering Committee and CSO representation on the GAVI Board. In addition the Constituency's Communication focal point and Advisor to the CSO representative on the Board Member is hosted in the Community Health and Innovation unit
- Hosts a position on behalf of the Stop AIDS Alliance (SAA). The permanent presence of SAA in Geneva allows for regular and ongoing collaboration with the IFRC's HIV Senior Officer, as well as regular engagement with key agencies including UNAIDS, the Global Fund to Fight AIDS, Tuberculosis and Malaria, UNITAID and WHO. The position is focused on policy and advocacy work to support a continued, effective and well funded HIV response.

Contributing to longer-term impact

Following the development of the Strategic Operational Framework for Health early in 2011, the Global Health Team (GHT) is working to achieve the following main goals:

- Goal 1: Build National Society capacity to enable safe and healthy living and to respond appropriately to health emergencies and crises, by reducing vulnerabilities and building resilient communities.
- Goal 2: Position the Red Cross Red Crescent as a leading strategic partner to improve global health.

The SOF clarified the GHT's objectives for the next four years and set the course for more comprehensive, inclusive and coordinated support to NS health programmes and global advocacy. The GHT will thus support National Societies under one overarching, consistent, evidence-based framework that allows for enhanced collaboration and synergies, long term thinking on global challenges and innovation, and compilation of evidence to improve its support to National Societies. New areas of expertise were or are about to be included: maternal, newborn and child health (MNCH), prevention of non communicable diseases, ageing, urban health, etc.

The SOF is based on the "holistic approach to health and resilience", in line with IFRC's strategy 2020. The holistic approach to health and resilience is based on the classic determinants of health framework that is multi-sectoral and includes the four levels at which the RCRC operates: the individual, the community, the national and the global levels.

Furthermore, the GHT works towards contributing to the Millenium Development Goals (MDGs).
For example, the Global Water and Sanitation Initiative inputs were identified as directly contributing primarily to Goal 7c – 'reducing by half those without access to safe water and basic sanitation' but also to goals 1, 2, 3, and 4. In support of MDG #4: the RCRC continued to support Ministries of Health in social mobilisation during measles and polio supplementary immunization activities (SIAs). Community health programmes contribute to MDGs 4, 5, 6 and 7. Key outcome indicators were added to the CBHFA indicator guideline to ensure measuring the contribution of community health activities to the MDGs. Several NSs have started conducting baseline/endline surveys to measure the outcome of their interventions.

We constantly seek to collect accurate and meaningful data that will inform our future programming. In the malaria programme, the team is testing new tools and software. The Rapid Mobile Phone Survey (RAMP) tool has been developed to provide National Societies will an easy to use, inexpensive method of generating accurate data to make informed programme decisions. The RAMP has been designed to ensure it can be rolled out by National Societies with little to no external support to ensure longer-term impact.

Within the holistic approach to health and resilience, we approach various levels from the community. By working at a level of peer education within schools, universities and youth clubs, RCRC youth members play a vital role in carrying out the mandate of the RCRC. Being part of Club 25 provides young people with the peer support that is crucial for the maintenance of a healthy lifestyle; creating a sense of belonging, purpose and achievement. In this way Club 25 not only contributes to strengthening VNRBD but also to raising social values such as solidarity and responsibility among young people.

Looking ahead

The holistic approach to health and resilience needs to be based on evidence. The department is preparing a research and learning agenda to ensure that the important assumptions RCRC makes when designing a health intervention are valid.

Research and learning is an ongoing process. Questions are proposed, discussed, and adopted following a set of criteria: the research needs to be feasible and affordable, findings need to be

directly applicable, findings can be generalised to more than one type of programme (e.g. conditions under which task shifting is feasible is of interest for NCDs and MNCH) or directly relevant for all programmes (use of mobile phones for data collection). As research questions are answered and innovations tested, new questions are set on the agenda.

The secretariat is not a research organisation. The health department therefore partners with academic institutions or research firms to ensure the results are unbiased and methodologically sound. The recently hired IFRC in-house research coordinator provides also a second opinion and advice on the technical aspects of the research. Results are shared and disseminated in research seminars, conferences, workshops and online.

Ongoing research:

- Malaria - effectiveness of a second household visit in hangup campaigns (randomised control trial)
- Use of mobile phones for data collection (field tests)
- Task shifting and NCD prevention (review of the literature)
- Innovation research - emergency sanitation equipment for urban environments
- Field research of a chlorine dispenser in emergencies
- WatSan/EH Unit currently hosting two master's students creating a database of emergency Health and WatSan activities reg. the nature of small scale disasters and the level of volunteer participation and satisfaction in ECV (Epidemic Control for Volunteers Manual)
- CBHFA research agenda is framed around three areas: case studies, evaluations and operational research. A literature review of eight lessons learnt workshops and evaluations during 2009-2011 informed the agenda.

While there are specific future plans for every programme area, here below a few examples:

- Development of e-learning modules, starting with CBHFA
- Development of evidence-based tools for NCDs prevention and control by NSs volunteers
- Conduct reviews and evaluations of various programmes and approaches, disseminate lessons learned, and provide guidance for future programming. For example, the GWSI midterm review and lessons learned so far need to be disseminated to NS's and provide guidance to the next five years programming to 2015. The health team will review the Federation-wide Global Alliance on HIV as to assess its impact and effectiveness. This evaluation in line with IFRC committment to accountability and organisational learning and will be used to inform future programming. Health projects need to have a system in place to start measuring sustainability and impact as opposed to quantitative data.
- Merge the Immunisation portfolio into the Maternal, Newborn and Child Health (MNCH) file as IFRC's MNCH framework is finalised in early 2012.
- Conduct, in collaboration with National Societies and partners, a RCRC global mapping of immunisation and MNCH activities, partners and research will be carried out early 2012 to inform and frame MNCH and immunisation interventions leading up to 2015 and beyond.
- Decentralise The Global Measles and Polio Initiative funding to Africa and Asia Pacific zones so as to strengthen response to the regions' vaccination campaign needs.
- Develop evidence based tools and knowledge management, such as RC specific guidelines for cholera operations and dengue control.

- Continue operations research activities and consolidate learning from the whole membership.
- Continue to position the RCRC as an important player in global health
- Roll-out successful initiatives in other projects and programmes. For instance, the RAMP survey will be rolled-out during 2012 in all IFRC supported malaria programmes and other programmes within IFRC both health and non health.
- Continue the roll-out of our health inequities advocacy report and follow-up on the health inequities resolution to advocate for the rights of disadvantaged populations and marginalized groups.
- Continue preparedness and prevention efforts to strengthen resilience. Studies suggest that for every single US dollar (USD) spent on prevention and risk reduction, an estimated USD 10-15 are saved in economic losses from disasters. Through participation in global and multi disciplinary initiatives such as Towards a Safer World (TASW) and One Health, IFRC aims to address further risks that emerge at the animal-human-ecosystem interface. Their recommendations should help IFRC to refine its Holistic Approach to Health and Resilience.

How we work

All IFRC assistance seeks to adhere to the Code of Conduct for the International Red Cross and Red Crescent Movement and Non-Governmental Organizations (NGO's) in Disaster Relief and the Humanitarian Charter and Minimum Standards in Disaster Response (Sphere) in delivering assistance to the most vulnerable.

The IFRC's vision is to inspire, encourage, facilitate and promote at all times all forms of humanitarian activities by National Societies, with a view to preventing and alleviating human suffering, and thereby contributing to the maintenance and promotion of human dignity and peace in the world.

The IFRC's work is guided by Strategy 2020 which puts forward three strategic aims:

1. Save lives, protect livelihoods, and strengthen recovery from disaster and crises.
2. Enable healthy and safe living.
3. Promote social inclusion and a culture of nonviolence and peace.

Find out more on www.ifrc.org

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