

ANNUAL REPORT



International Federation of Red Cross and Red Crescent Societies
Fédération internationale des Sociétés de la Croix-Rouge et du Croissant-Rouge
Federación Internacional de Sociedades de la Cruz Roja y de la Media Luna Roja
الاتحاد الدولي لجمعيات الصليب الأحمر والهلال الأحمر

HEALTH AND CARE

May, 2006

The Federation's mission is to improve the lives of vulnerable people by mobilizing the power of humanity. It is the world's largest humanitarian organization and its millions of volunteers are active in over 183 countries. For more information: www.ifrc.org

In Brief

Appeal No. 05AA088; Appeal target: CHF 4,451,903; Appeal coverage: 107.6%.
<click here to go directly to the attached Financial Report>

This Annual Report reflects activities implemented over a one-year period; they form part of, and are based on, longer-term, multi-year planning. All International Federation assistance seeks to adhere to the Code of Conduct and is committed to the Humanitarian Charter and Minimum Standards in Disaster Response in delivering assistance to the most vulnerable. For support to or for further information concerning Federation programmes or operations in this or other countries, please access the Federation's website at <http://www.ifrc.org>

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Overall analysis of the programme

2005 has been an important year in terms of profiling the Health and Care activities within the Federation and, more specifically, as a contribution to the shaping of the Federation of the Future process. For example, the Health and Care document "The Power of One, Power of 100 Million" provided an opportunity to raise and promote the potential of National Societies to tackle some of the key health challenges they face at country, regional and global levels. As a result, the importance of Health and Care activities is now reflected in the International Federation's Global Agenda.

One of the major achievements of 2005 was to increase the visibility of the National Societies themselves (and their work in Health and Care) through the Global Health and Care Forum held in May 2005. The Forum gave National Societies the opportunity to exchange and share best practices, experiences, lessons learned, etc, thereby increasing their respective visibility, both within the membership and with relevant external partners. This reinforces the point that knowledge sharing is a prerequisite and essential element of scaling-up health and care activities and improving the overall capacity of National Societies to deliver and respond in the field of health.

Visibility, in the sense of National Societies' relationship with Ministries of Health, as auxiliaries to government has also been significantly advanced by putting into practice the IFRC-WHO official Letter of Cooperation signed on 11 May 2005. National Societies are indispensable players in their own countries in order to reach the Millennium Development Goals. It is important that both parties, National Societies and governments, realize the enormous value of their collaboration. Within this context, the Letter aims to position National Societies and clarify the interrelationship between Ministries of Health, the World Health Organization and National Societies.

During the year, the visibility of the different technical components of the Health and Care Department has been witnessed by several important developments in the technical fields. Significantly, the Evaluation of the HIV/AIDS Global Program 2002-2005 paved the way for important decisions such as the creation of an HIV/AIDS Special Representative expressing the fact that HIV/AIDS is an issue that goes far beyond Health and Care activities alone. The Global Water and Sanitation Initiative shows how far National Societies can go in this essential field in Health. For Blood, we have a historical responsibility to work with WHO in the struggle to make sure that blood donation remains voluntary and non-remunerated. With regard to Emergencies, the Tsunami and the Pakistan earthquake operations stretched our limits but also showed how crucial Emergency Response Units are to the success of operations.

The nationwide integrated Polio-Malaria campaign conducted in Niger in December 2005 was a very successful example of what can be achieved in partnership and at the community level, through concentrated community health activities and particularly the social mobilization of volunteers. Furthermore, the continued implementation of the Community Based First Aid Revitalisation Project, as well as the fact that the International Federation was nominated to and is now a member of the Stop TB Board, constitute major achievements.

Objectives, Achievements, and Constraints

Note: The contents of this section are based on objectives set in the 2005 appeal and should be read in conjunction with the first and second updates as well as regional reports.

COMMUNITY HEALTH AND REGIONAL COORDINATION UNIT

Increased the capacity and number of societies to use, and coordinate, the developed community-based health framework and lessons learned.

Global Health Promotion Meeting in Bangkok: the delegation headed by Dr Phua from the former health and care commission participated in the Global Health promotion meeting in Bangkok organized by WHO in August. The major outcome from the meeting is 'The Bangkok Charter for Health Promotion in a Globalized World'. The Federation's contribution and the voice of other community organizations (majority of the participants are ministry of health and WHO experts) made a difference to the Charter with the recognition of the role and focus of communities and civil societies in health. Key messages and a position paper on the International Federation's health promotion activities were produced. The Federation will participate in a follow-up meeting with other NGOs and civil societies in the implementation of this Charter.

Regional support and coordination: Regional conference calls were organized in the Asia Pacific to prepare and share information and materials on Avian Flu (September). Materials and reports are also made available on the Fednet. Support was provided to the South East Asia regional Avian Flu meeting organized by the Indonesia Red Cross where the Jakarta statement was made on the national society's commitment to Avian Flu preparedness and response.

The partnership between the International Olympic Committee (IOC) and the International Federation is strengthened in the South and South East region. In a meeting in New Delhi organized by the IOC and UNAIDS, the national Olympic committee and the Red Cross societies in the South Asia region and China have discussed and agreed on a set of recommendations to work on HIV&AIDS prevention through sport.

Support and coordination was given to the South Asia regional health meeting in New Delhi where health officers, Secretary Generals and health delegates discussed their health priorities and required support from the regional delegation and Geneva. One of the key outcomes is to have more coordinated technical support from Geneva in safe blood and HIV/AIDS. The meeting is also to develop a regional health team approach looking at more strategic directions and support from region and Geneva.

Support was provided in the SE Asia regional health meeting and the regional health team strategy is revised with consultation and input from National Societies.

First Aid (FA) and Community-based First Aid (CBFA): the first phase of the project to revitalize the CBFA program is now completed. Key stake holders from National Societies and health advisors have been involved in mapping CBFA activities globally. Based on the reviews and analysis of available evaluations, a report was also produced with key recommendations. A one-page fact sheet on CBFA and the CBFA framework with good practice will be produced for volunteers and staff in National Societies. The CBFA approach and framework have also been discussed in the first aid meetings organized in the Europe and MENA regions.

Support and advice were provided to the MENA region in its training of trainers workshops and the regional CBFA meeting in Abu Dhabi in December 2005. National Societies appreciated and started using the regional manual and the harmonized curriculum for CBFA volunteers and trainers. Although there are still differences in the understanding of CBFA, in general, the emphasis of the discussion has shifted from just first aid techniques to volunteers and community-based approaches and their participation. It was agreed that there are differences between traditional First Aid training and CBFA programme. However both of them can be organized by National Societies to complement one another.

Support and advice was provided to the European First Aid education network in the finalization of revised European First Aid certificates. The quality management will be strengthened by additional criteria and monitoring and support visits organized by First Aid representatives of National Societies in the Europe region. Representatives from the Asia Pacific region participated in the European First Aid meeting organized in Luxembourg in October. The operational model of the European First Aid regional reference centre was also shared. A working group will be set up to map and reflect on first aid with vulnerable groups in the better resourced National Societies in the Europe region.

A press release and web stories were put onto the Federation on World First Aid Day 2005. The theme is on 'First aid with the vulnerable people'. The web stories include helping people to protect themselves in Afghanistan, first aid programme to fight drug and alcohol addiction by the Australian Red Cross, young unemployed people learning valuable skills in Papua New Guinea, targeting the most vulnerable groups in Syria through CBFA and first aid as the first step in HIV/AIDS home care carried out by Red Cross volunteers in Zimbabwe. National Societies in different regions organized a mass media campaign to raise first aid awareness and some have worked and organized first aid activities with prisoners and staff and elderly population.

ERNA annual meeting in Kiev, September 2005: Advocacy and Partnership were the key words of the meeting. Participants agreed that Red Cross and Red Crescent Movement should strengthen internal and external advocacy to better address HIV/AIDS and TB issues in partnership and fight against the diseases by increasing the resources, implementing effective preventive programmes (including Harm Reduction programmes where not available), making treatment accessible for all, and ensuring comprehensive approach and cooperation at all levels. More initiatives for experience exchanges and more advocacy tools through the Federation are needed. Active help from Western European National Societies would be more than appreciated.

The ERNA meeting in Kiev was also one of the platforms for the preparation of the European Red Cross and Red Crescent conference in Moscow. Important messages from National Societies for the Moscow conference were formulated by participants during the meeting's working.

Red Cross and Red Crescent European Conference, Moscow, April 2006: The French Red Cross, as chair of the Health and Care Working Group for the Moscow Conference, shares the responsibility with the president of the

Tajikistan Red Crescent and the ERNA President. The last Steering Committee and Working Group meetings took place in December 2005 in Geneva. The health working group has identified the National Societies for presentations. The regional conference will be a unique opportunity to address the issues of health on the European level and strengthen the role of European Red Cross and Red Crescent societies, to open discussions with representatives of governments, international organizations, and invited experts.

Regional Partnerships: The Health and Care Department, together with the WHO EURO office, have organized a meeting between the Federation and WHO in November 2005. The meeting has been the first follow-up action after the WHO and the Federation signed the MoU for cooperation during the Health and Care forum in May 2005. The joint plan of action for Europe region has been drafted. The final version will be shared with all colleagues at European Societies, the Secretariat and field structures.

Tuberculosis: the STOP TB Global Partnership (secretariat hosted by WHO in Geneva) suggested the Federation Secretariat host the Secretariat of the European partnership. Dialogue and consultation process is ongoing inside of the Secretariat as well as with Stop TB and WHO. The Federation participated in the Stop TB Coordination Board meeting, which took place in Assisi in November.

HIV/AIDS UNIT

Evaluate the Global HIV Programme 2002 – 2005, particularly progress against the scale-up objectives and the depth of the institutionalization of the response: the evaluation was led by an independent consultant and published as ‘8,000 Everyday: Evaluation of the HIV Global Programme 2002-2005’, see www.ifrc.org/8000everyday. Management endorsed all the recommendations of the evaluation, and the key recommendation to appoint a HIV/AIDS Special Representative reporting at the Secretary General level to drive forward the Federation’s HIV response will occur in 2006.

Support the implementation of the Red Cross and Red Crescent treatment access model in 6 countries, including development of necessary tools and guidelines, and support other National Societies to join the initiative: the secretariat initiated the development of a generic toolkit on ART programme components. By contracting SafAIDS and in close collaboration with WHO Geneva and WHO Africa region, the development of 8 modules is on the verge of completion. The modules focus on: Basic Facts on HIV/AIDS, Treatment Literacy, Treatment Preparedness, Adherence, Counseling, Nutrition, Palliative Care, and Caring for Caregivers. The first drafts were reviewed in a stakeholders meeting involving UN agencies, INGOs and CBOs and useful inputs were obtained. The second drafts were reviewed in workshops in 2 anglophone and 2 francophone African countries to ensure strong Ministry of Health buy in, and the results of that process were reviewed in a Federation-WHO/SafAIDS marathon in Harare in October. The consultations in the 4 African countries were funded by WHO. The final draft modules will be formally field-tested with Zimbabwe Red Cross in January 2006, and the process has started for formal WHO endorsement as part of the IFRC - WHO MoU. The modules are instrumental in increasing the knowledge and skills base of RC volunteers to enable them support roll-out of ART-based on holistic approach. A workshop on the 6 country pilot project was part of the General Assembly.

A Federation resource mobilization officer was assigned (based in Nairobi) to support National Societies to finalize their proposals and find donors. The position was fully funded by the Swedish Red Cross and Danish Red Cross for two years, and both have agreed that the position should contribute to quality start-up of projects, and advise National Societies on resource mobilization for all aspects of HIV programming given the holistic approach the Federation is taking to treatment access and support. The officer produced a detailed report on the challenges of this work after six months, and that report was reviewed by the HIV Governance Group.

In 2005, the resource mobilization delegate provided technical assistance to:

- the Kenya Red Cross in proposal development to access resources from a private Swiss Foundation through the Swiss Red Cross.

- the Namibia Red Cross in proposal development to access the GFTAM (5th round).
- the Zimbabwe and Danish Red Cross in finalizing their ART proposal and kicking off the implementation.
- the KRC in applying for PEPFAR funding in partnership with the American Red Cross and two other American-based NGO's JPHIEGO and Policy/Futures Group and ERC in accessing PEPFAR funding.
- the German Red Cross in applying to the EU for the ERC.
- the Federation's Regional Delegation in Harare to secure financial resources for Home-based and Community-care programming under the consortium with the Netherlands Government, the Swedish Red Cross and SIDA, the Irish Government and in mainstreaming the ART initiative into the overall HIV and AIDS Strategic planning 2006-2010.
- the Federation's Secretariat, in the context of its partnership with WHO/AFRO, together with SAFAIDS, developed the ART tool kit (through facilitation of the two consultative meetings with Government and Civil Society partners in Cameroon and Burkina Faso), and in the final review of the overall consultative process in Zimbabwe.

The resource mobilization delegate was nominated civil society representative in the Global Task team set up by UNAIDS to improve AIDS Coordination among multilateral Institutions and International Donors and participated in two high levels meetings in Geneva and New York, an opportunity to advocate and market the Federation's and the national society ART initiative at the highest levels possible.

Take a lead role in harmonization of the 7th International Conference on Home and Community Care of PLHIV, and 12th International Conference of PLHIV, in Lima Peru in October 2005, to strengthen good practice (support attendance of 15 PLWHA from within Red Cross and Red Crescent, 15 regional network representatives, HIV Governance Group, and 4 Secretariat resource persons). Sponsor the Home and Community Care Conference and organize high profile booth area, contribute to local and international organizing committees, and support development of quality abstracts and presentations for both these conferences): the Secretary General of Mozambique Red Cross was appointed Chair of the Home and Community Care Conference, and members of the Cambodia and China Red Cross (Xinjiang) were appointed to the Conference Programme Committee, while Bernard Gardiner represented the Federation in the International Organizing Committee. The Lima Delegation worked with the Peru Red Cross to develop a plan for implementation of the Peru Red Cross role as chair of the conference Volunteer Committee, and to clarify needs for external assistance. This led to the Spanish Red Cross providing two delegates for six months, to work with the Volunteers Committee and the Communications Committee of the Conference. These delegates were greatly appreciated by the local organizers, as they helped define tasks and work processes, and got the committee work back on track.

GNP+, as conference secretariat, suffered a set back when the International Co-ordinator left the organization. Donor support was inadequate to proceed with the Conferences in 2006, and the Netherlands Government has convened a donor conference to review this in January 2006. It is likely an international PLHIV Conference will proceed in Lima in 2007 and so utilize the capacity that has been built locally, and the organizations that make up the 'Living with HIV Partnership' will continue to work together to increase donor and government understanding of the contributions of PLHIV and the informal health sector to the HIV response.

Provide technical assistance to National Societies to prepare papers to submit for oral presentation at the Conferences: quality papers on HIV were presented by National Societies at the Health and Care Forum. The Australian Red Cross presented a paper to the ICAAP in July on its partnership and co-location with APN+, and African National Societies presented at the ICASA in December. Bernard Gardiner presented a paper on 'Spreading the Light of Science' to the Harm Reduction Conference in Belfast in March, and the Italian Red Cross/Senlis Council in December.

Mobilize National Societies, communities, and PLWHA groups to utilize the AIDS Competence process in partnership with the Constellation for AIDS Competence (develop a work plan with Constellation for AIDS Competence, to support Regional AIDS networks to utilize the process. Hold an AIDS Competence Fair in conjunction with the Conferences in Peru): the Constellation was formally created, and two meetings occurred to plan utilization of the AIDS Competence Network, particularly in the Americas in the lead up to the

Lima Conference. The full potential of this work was not realized as the 2005 Appeal was not supported enough to enable the Partnership position to be filled, but contact with the Constellation was maintained, and the Chair of RANWAC was mentored as a facilitator. It is planned that this work will be revitalized in 2006 in West/Central Africa and the Americas. Health and Care Coordinators from Uganda and Rwanda representing English and French-speaking National Societies were trained in the AIDS Competence Process.

Enhance good practice and accountability to beneficiaries though utilizing the NGO Code of Good Practice to guide the secretariat's work with National Societies: Phase 1 of the Code was completed, and all agree that the Federation was an excellent host. Donor support for Phase 2 implementation has not yet been realized, so a six-month officer was appointed in December to promote the Code to donors. That position is hosted by the International HIV/AIDS Alliance on behalf of the newly formed Phase 2 Steering Committee, which includes the Federation. The Federation remains the key website for the Code, and is strongly associated with the Code. Bernard Gardiner presented on the Code to European NGO's in October in Berlin, during a WHO Europe treatment-oriented consultation. The Federation has taken seriously its endorsement of the principles in the Code, particularly the commitment to a comprehensive and gender relevant approach to prevention work. This issue was discussed passionately at the Health Forum in week 19, and prevention is prioritized for attention in the Federation's 2006 programme. The commitment to the Code was renewed by the General Assembly HIV/AIDS resolution which referred specifically to the Code.

Further build-up the partnership with PLHIV and their organizations, and together undertake Phase 3 of the global anti-stigma campaign.

The Federation has completed two comprehensive annual reports to UNAIDS as part of its three-year work programme as a UNAIDS Collaborating Center for the reduction of stigma and discrimination in collaboration with GNP+ at local, regional and global levels. These reports included a round-up of country level work, and made recommendations to UNAIDS on a range of issues. Within the Eastern Africa region, promotion of skills and information exchange between PLHIV groups and National Societies to enhance knowledge on GIPA/MIPA with a view to reducing stigma and discrimination was enhanced through capacity building workshops on Advocacy, treatment literacy, and the development of community training and empowerment tools for advocacy by NAP+. The participation of PLHIV in the review and finalization of the Federation's Community-based ART training toolkits, Global HIV/AIDS evaluation, and documentation of Best practices (Uganda Case) are excellent examples of the Federation's uptake of GIPA principles. National Societies in the region (Eritrea, Ethiopia, Kenya, Uganda, Tanzania and Rwanda) have been supported to develop joint work plans highlighting common activities to be implemented with groups and networks of people living with HIV and AIDS at national level. National Societies continue to reach out to PLHIV Groups in line with the world aids campaign theme "Come Closer" in an attempt to reduce stigma and discrimination and to increase the visibility of PLHIV in Kenya, Uganda, Tanzania, Ethiopia the World AIDS campaign theme.

In April 2005, the 3rd phase of the anti-stigma campaign, called 'Come closer...', was launched in Panama in an event attended by REDLA+. This 3rd phase of the campaign builds on the previous phase of the campaign with messages like Hug! Hug! You cannot get HIV by hugging! And 'Touch! Touch! You cannot get HIV by touching!'.

While encouraging National Societies to strengthen their partnerships with people living with HIV and develop joint workplans, the 'Come closer...' phase aims to build the capacity of National Societies to adapt material and ultimately develop their own behaviour change targeted materials. The campaign visuals can be viewed at www.ifrc.org/what/health/hivaids/antistigma.

The 3rd phase of the campaign also developed a CD-Rom called 'Leading by example', which collated all anti-stigma campaign resource material developed by the campaign since its launch in 2002. Over 2000 copies of this CD-Rom were printed and distributed to all National Societies, regional delegations and partner organizations.

Complete handover of moderation of the Pass-It-On e-forum from Health and Development Network (HDN), but continue partnership with HDN to mentor moderators, and train key correspondents. Expand membership from 400 to 600, and increase the number of people participating actively in the forum: a training event for moderators occurred just before the Health and Care Forum and a second training began in

December 2005. The training of two moderators in May, 2005 enabled the total handover of the e-Forum to the International Federation. Currently, the Federation handles the day-to-day management of the e-Forum, previously done by HDN. A team of four moderators began a training in December 2005, pre-empting the development of a wider resource team to moderate the Forum and support discussions. The regionally representative moderators come from Europe, Africa and South Asia. The aim is to train moderators in most regions of the world to encourage regional contributions to the forum and more engaging discussions. The Pass It On e-forum has become the main way the global HIV programme communicates key HIV information. No themed discussions were held in 2005, and non Red Cross Red Crescent postings were significantly minimized. Contributions from outside Geneva are still infrequent unless Geneva follows up with individuals when topics for posting are identified by the manager of the HIV global programme. The number of subscribers has increased to 416, after a careful checking to remove redundant subscriptions.

Undertake the development work to renew the campaign tag line (e.g. Humanity...Pass it on...) to reinvigorate the campaign in late 2005 and to remove ambiguity, and via communications experts assist National Societies to develop the capacity to identify stigma issues at country level, and develop appropriate interventions: the Turkish Red Crescent work with Saatchi and Saatchi Turkey was redeveloped for the global 'Come closer....' campaign with major input from the HIV Unit in Geneva. Three sets of materials were sent electronically to National Societies and delegations for focus testing for local use ahead of World Red Cross Day. The materials can be viewed in four languages as a flash file heading of the page at <http://www.ifrc.org/comecloser>.

Produce two editions of the Pass-It-On newsletter, one communications pack, and one audio visual product. Through a shared Partnership position and work plan (based on the Nairobi model) support the capacity-building of PLHIV organizations and National Societies utilizing the Global Network of People living with AIDS (GNP+) resource 'Positive Development', and enhance GNP+ efforts to increase representation work with international organizations based in Geneva: the appeal was not being supported sufficiently to fill the partnership position. However, a communications pack for 'Come closer...', including an edition of Pass-It-On...newsletter was produced for World Red Cross day, and a double CD-rom of 3 years of campaigning work '*Leading by Example*' was released with another communications pack. This CD resource contained all Communication Packs, Newsletters, audio visual material and other resources developed by the anti-stigma campaign. Resources from partner organizations such as UNAIDS and GNP+ were also included ahead of World AIDS Day, the first issue of an electronic Newsletter was developed and distributed to more than 350 individuals including partner organizations. A workshop on the partnership with PLHIV was part of the General Assembly programme, which featured reports of excellent collaboration in Namibia, Argentina and Laos.

Introduce Ambassadors' of Hope missions to at least 2 regions that urgently need this work, and media training: the Harare delegation appointed a partnership officer to work with regional network of PLHIV, to support Ambassador of Hope missions and other work. Contact between National Societies and PLHIV networks was facilitated in Korea, Ukraine, Panama and Sweden in particular.

A paper on issues arising in HIV reporting in the media was distributed to all communications officers, and HIV technical advisers to continue the process of awareness raising and collaboration between communications and HIV activities.

Refine draft HIV prevention guidelines 'Educating Desire' with a particular focus on gender, community mobilization, mass communications, targeting for effectiveness, and publish multiple languages. HIV prevention must be revitalized to parallel treatments roll-out: the issues involved in prevention work were discussed at the Health and Care Forum, and the HIV Governance Group, with a paper prepared by Australian Red Cross. This set the stage for prioritization of the work in 2006, and a Prevention Officer position is approved for advertising in 2006. The Panama Delegation has worked with the Panama Red Cross and other National Societies in that region to roll out a high quality 'Faces' campaign promoting protection through consistent use of condoms, which could potentially be rolled out globally.

Further develop the community home based care model though testing and implementation of care for carers guideline: Care for the Carers has been included as Module 8 of the ART Toolkit.

Define a Red Cross and Red Crescent Palliative Care model, and develop partnerships and a proposal for implementation in at least one country: a meeting on palliative care occurred on 17 February in Geneva agreed that the British Red Cross would work with some National Societies to develop case studies in two places, and the Federation will use these as the way to clarify what guidance is necessary and next steps to support and strengthen the quality of home care implementation through inclusion of palliative care measures. Palliative Care is the subject of Module 7 of the ART Toolkit. It will also be included in the tool being developed to support home care volunteers with ART scale up.

Continue to support the harm reduction capacity building work plan for Eastern Europe and Central Asia in partnership with the Italian Red Cross: since the summer of 2004, 15 national Red Cross and Red Crescent societies in Eastern Europe and Central Asia expanded their HIV response with harm reduction activities to reduce sharing of needles. The 2005 annual ERNA meeting, which took place in Kiev, highlighted the positive impact of the Red Cross and Red Crescent harm reduction initiatives. National Societies shared their own experience to peers, compiled the problems faced and mapped ways to increase commitment and capacity. In most countries National Societies will multiply the pilot projects. There are a few countries where there is a need for stronger collective advocacy to create a context where harm reduction programming is feasible.

The quality of the training offered by Villa Maraini has improved with experience, facilitator skill development and thorough evaluation of each training. In October the training organized for central Asian National Societies was simultaneously translated into the Russian language, and discussion has opened about a workshop in Mandarin in 2006.

Support development of a HIV Strategic Plan for Europe, development of the India HIV/AIDS Consortium, and scale-up of the response in China and Indonesia: HIV is identified as one of major health themes for the coming European Red Cross and Red Crescent Conference planned for Moscow in 2007. This will be the forum where European societies will agree on a roadmap for scaling-up collective HIV activities in Europe.

The Red Cross Society of China has developed and adopted its five years HIV work plan and it is introduced to the branches. Working with bilaterals, except the Yunnan and Xinjiang provinces, the HIV programme is now implemented in Sichuan, Qinghai, Gansu, Inner Mongolia, Jilin, Heilongjiang and Liaoning provinces. Programs also started in Shandong and Henan. The scale of prevention and anti stigma and discrimination activities has expanded its scale. Meanwhile, the experience to work with PLHIV is also increasing in some branches.

The Indonesia Red Cross has its HIV strategic plan and is now incorporated into the national society's development plan for 2005-09. The leadership recognized this as a key priority. Its hotline phone counseling service has been evaluated and this may expand to other provinces. The prevention, care and support programme will focus more on care and support to key population groups.

In the beginning of the year, staff and HIV coordinators were recruited and peer education and prevention work started in Tamil Nadu, Maharashtra and Andhra Pradesh. Care and support for PLHIV program has also started in Tamil Nadu through community centre and at the Tambaram hospital in Chennai. However, this work has been affected after changes at the leadership. Partners in the consortium will be brought together by the Indian Red Cross and discuss ways forward.

Collaboration with ICRC and UN Office for Drugs and Crime (UNODC) to develop a Federation model for HIV response in the prison system building on existing relationships and TB interventions: the Federation Delegation in Moscow and Russian Red Cross are working closely to develop a model for integration of HIV component into ongoing USAID TB projects. The programme includes activities in prisons. The draft model will be presented for discussion during the planned Red Cross and Red Crescent Working Group meeting on Tuberculosis in February 2006.

The ICRC gave formal permission for its representatives in Latin America to work with the Federation to highlight HIV work in prisons as part of the Home and Community Care Conference. Despite the fact that this conference was cancelled, this collaborative work can still be developed for inclusion in the PLWHA Conference programme in Lima in 2007. The Federation vice President Massimo Barra participated in a key UNODC meeting in 2005 and spoke strongly in favor of harm reduction and drug substitution. This was followed up by an

intervention in the UNAIDS Programme Co-ordination Board to maintain a comprehensive and evidence-based approach to HIV prevention.

Co-ordinate fundraising for at least 6 national society treatment programmes: the HIV resource mobilization officer has reported separately to the HIV Governance Group on this work, and that detailed report is available on request. Following the numerous efforts undertaken in 2005 by the 6 pilot National Societies and the overall Red Cross family at large, (Swedish, German, Danish, French, Swiss RC Societies) and through country applications to access various resources providers (Global Fund in Namibia, Uganda and Zambia), EU in Namibia and Kenya, PEPFAR in Kenya and Ethiopia, World Bank MAP program, Private sector,...), by the end of the year around USD 11 million had been raised collectively to finance the Federation's and national society initiative on Community and Home Based Care support for Antiretroviral Therapy. In Ethiopia, Kenya, Zimbabwe, and Namibia, 9,400 clients (31% of our total target, with 20% sure and 11% depending on the success of proposals) will benefit from such initiatives over the next five years. All PNS supporting bi-laterally HIV and AIDS Home Based and Community Care programmes have mainstreamed costs related to ART literacy for volunteers and community preparedness into their funding support. This is considered a great achievement even if there remains a long way to go in the implementation phase and in mobilizing more resources for National Societies.

Support GFATM development, including advice to Vice Chair and Developing Country NGO alternate board member, and advocacy to ensure renewal and expansion of the Fund: Razia Essak-Kauaria served one year as alternate developing countries NGO board member of the GFATM Board with support from Bernard Gardiner, who also participated in the northern NGO delegation including one Board meeting and the delegations strategic planning meeting in September 2005. The delegations were successful on many fronts including the setting of standards for the functioning of CCM's, and preparations for a funding round six.

Enhance national society ability to undertake advocacy work and access and co-ordinate local funding opportunities from GFATM, embassies, private sector and other donors: advocacy opportunities have been highlighted via the Pass-It-On e-forum in particular, and via the anti-stigma campaign materials and newsletters, which included specific guides for national society action. The partnership with Nestle led to a small nutrition for PLHIV project, and a WATSAN pilot project focusing on PLWHA in home based care. The HIV resource mobilization officer has reported separately to the HIV Governance Group on other aspects of this work.

Support National Societies to successfully manage principle recipient or sub-recipient roles in the GFATM structure: the Sierra Leone Red Cross successfully manages the Principle Recipient role and was asked to present on this to other National Societies during the Health and Care Forum. The Iran Red Crescent presented in the same forum on the difficulties they have had with GFATM processes. This led to a rich discussion and highlighting of the opportunity for long-term sustainable funding presented by GFATM, as long as National Societies can build strong partnership with Ministries of Health.

Support the strategic direction of the Big 7 Alliance of CEO's of large youth organizations to collaborate to scale up the involvement of youth in the HIV response: momentum has been lost as funding for implementation of the Big 7 model has not been located. The Big 7 Alliance was weakened when the International Youth Foundation (IYF) was granted PEPFAR prevention funding that did not include education about condoms as per the model previously agreed by Big 7 members. IYF committed to raising complementary funds to enable a comprehensive approach to be implemented, but those funds did not materialize. Some members refused to participate in a limited programme, and also questioned the need for IYF to scale up its own organization rather than work through partners. IYF was ultimately asked to leave the Big 7, which is now searching for a new youth orientated resource mobilization partner.

COMMUNICABLE DISEASES UNIT

Malaria: this year's appeal funding enabled the Federation to serve as a major global player in the coordination, planning and programming of innovative and large scale malaria control programmes. Specifically, the important all partners' weekly global conference calls on malaria planning and resource mobilization served as the foundation for working with U.N. agencies, public and private donors, technical groups, and other interested partners. Building on the Measles Initiative Partnership model, this new malaria global partnership, while virtual (regular telecommunication) with no distinct staff or structure, served as the most important impetus for scaling

up malaria control in Africa since the start of Roll Back Malaria. Many of the Federation's malaria activities in 2005 are directly related to this successful and ongoing "malaria partnership" mechanism with the Federation playing a leading role. Following the successful implementation of the first nationwide bednet distribution effort in Togo in late 2004, the Federation's experience in building a Togo partnership of more than 30 partners to achieve an unprecedented scaled-up project was presented at multiple meetings and special occasions throughout the world. PowerPoint presentations on the Togo Integrated Measles and Malaria Campaign were made in Brussels to the European Union Parliament's Development Committee, to audiences in Manchester and Liverpool, England, to the Measles Partnership in Washington, D.C. and to RBM audiences at WHO, at the launching of the World's Malaria Report, and at numerous other global meetings. Funds in the appeal, provided for advocacy on many levels including participation at the Global Malaria Donors' High Level Partnership Meetings in New York City, Geneva, and Paris where the Federation and its Red Cross societies were singled out as leading the way forward in malaria control through free distribution of long lasting insecticidal nets (LLINs) and successful partnerships. Advocacy on all levels attracted the attention of corporations and other private donors in 2005 resulting in substantial contributions to the separate Malaria Programme Initiative Appeal where more than 20 million CHF were raised. The resulting activities for 2005 are impressive and summarized below. Fuller descriptions of achievements are available in the Annual Reports on the Malaria Programme Initiative Appeal (M05PI001) and on Polio and Measles Appeal (05AA089).

The large-scale distribution of long lasting insecticide nets (LLIN's) occurred:

- in mainland Equatorial Guinea in August (70,000 LLINs from other donors) and the Federation's procurement of 20,000 LLINs to be distributed to the population of Malabo Island in early 2006 with support from the Equatorial Guinea Red Cross society;
- in Mozambique with 440,000 LLINs procured directly by the Canadian Red Cross in November and December; and
- in Niger's nationwide (2,030,000 LLINs) polio and malaria integrated campaign in December supported by the Federation, GFATM and Canadian Red Cross funding. An additional 265,000 LLINs were procured with Canadian Red Cross funding for a final distribution in Niger's capital, Niamey, in early 2006.

These large-scale efforts were made possible by the generous support of the Global Fund for AIDS, Tuberculosis, and Malaria (GFATM), the Canadian Red Cross, the Norwegian and American Red Cross societies, and Exxon-Mobil working with UNICEF, WHO, and the Measles Initiative Partnership.

Funding to this appeal also enabled the Federation to pioneer and demonstrate the importance of post-campaign follow-up to ensure that households receiving nets actually hang them and use them correctly. Thus the Federation's trademark "Keep-Up" programme initiated in Togo after the December 2004 campaign has attracted the attention of global partners. WHO and UNICEF are committing to similar programmes in all countries where mass distribution of LLINs is planned. These 2005 community level experiences have led to collaborative plans for "Keep-Up" efforts in Equatorial Guinea, Mozambique, Niger and other campaign countries in 2006. This is leading to a clear and well defined role for Red Cross and Red Crescent volunteers at the community level and is expected to grow substantially. It is a perfect match with the Movement's Community-Based First Aid (CBFA) strategies.

Another important 2005 activity made possible through this support has been the collaborative programming and resource mobilization between Roll Back Malaria (RBM) staff at WHO and the Federation for the following:

- EU Commission proposal for malaria support to the Central Africa RBM Network (CARN) for USD 600,000 to national societies in Central Africa (final approval expected in early 2006);
- a major RBM/Federation proposal to the Netherlands government for EUR 6 million which was approved for procurement of LLINs and re-treatment of existing nets and is currently being implemented in 6 African countries (Burkina Faso, Chad, Gambia, Guinea Bissau, Madagascar, Mali) with support for Red Cross volunteers in those countries; and
- a Bill and Melinda Gates Foundation proposal from the Federation's Brussel's office for malaria advocacy and resource mobilization and support to 3 European National Societies for malaria advocacy. The initial letter of intent to the Foundation was favorably approved and a full proposal is currently under preparation for submission.

Measles: Appeal funding enabled staff to continue serving as active global partners in the Africa Measles Initiative Partnership with attendance and presentations at the annual partnership meeting in Washington and at other WHO and related events to promote the incredible impact of this 5-year-old initiative. In September 2005, WHO singled out the Measles Initiative and the Red Cross leadership for achieving a 60% reduction in childhood mortality in Africa since the start of the Initiative in 2001. Clearly successful, global donors, including the U.N. Foundation, have committed to another five-year commitment to further reduce measles deaths in Africa. Prior to 1999 more than 800,000 child deaths were reported. Today, WHO is reporting approximately 250,000 annual deaths. Future funding of the Federation's Measles and Polio Appeal (2006-2007) is critical to reach targets of 80-95% reductions in mortality. This achievement and those in the area of polio eradication have been fully described in the Federation's new document "Partnering for Impact, the incredible reduction in measles mortality and overcoming the last barriers to polio eradication" published in December. This document was widely circulated to donors and partners and provides a summary of contributions, country activities and achievements from 2000 to 2005. The 2005 Measles and Polio Appeal Annual Report provides more detail on national society achievements.

Polio: In addition to the remaining six endemic (polio virus originating countries), there was spread to as many as 20 other countries in 2004. The Federation accelerated its collaboration with WHO's Global Polio Eradication Programme to confront this spread and to meet the 2006-2007 eradication target. This year's efforts successfully achieved complete control and prevention of further virus transmission in almost all of the 20 countries where cross-country contamination had occurred. This was in large part due to the implementation of a series of continent-wide synchronized polio vaccination campaigns in contiguous countries throughout 2005. At the end of 2005, there were encouraging signs that the eradication goal is in sight. Red Cross and Red Crescent volunteers in many countries responded by serving as house to house vaccinators, as educators and motivators at the community level and in logistics support. National Societies efforts are well described in the Appeal's Annual Report for 2005. It is gratifying to see that WHO has repeatedly acknowledged in all of its polio publications the contributions and participation of the Federation and its member National Societies.

BLOOD UNIT

Blood: have retained international leadership in the promotion of voluntary, non-remunerated blood donation, ensuring a source of low-risk donors continues to be available.

Activities for 2005 include:

- World Blood Donor Day, 14 June: World Blood Donor Day, which was celebrated only for the second time in 2005, established itself as a powerful tool for the forging of partnerships across the entire spectrum of countries, blood services, hospitals, National Societies, ministries of health and Governments. More than 100 countries participated in WBDD celebrations 14 June 2005 (an increase of 25% on previous year) helping to create a sense of solidarity among the world's voluntary blood donors.
- The Federation's Global Advisory Panel on risk management and corporate governance for National Societies with blood programmes (GAP) continued its work in focusing on the distribution of the Self Assessment and conducting regional discussions to ensure all NS understand the importance of adhering to quality standards in blood service delivery and minimizing risk to themselves and the Federation. Consolidated responses from more than 30 National Societies in 2005 provides a check list for further action from GAP in assisting sister societies improve their services in this specialized area.
- Two successful regional workshops were undertaken in Africa and Asia towards the end of 2005, using the new curriculum materials prepared in conjunction with WHO. In total an estimated 1200 people, mainly in Africa and China and Asia, were trained in 2005 using our new workshop materials, Developing a Voluntary Blood Donor Programme for Blood Safety and Making a difference...recruiting voluntary, non-remunerated blood donors. Insufficient funding and shortage of personnel resources prevented the materials being used to a greater extent across all regions.

Maternal and Child Health thus affording us an opportunity to directly relate safer blood with two of the Millennium Goals: more than 100 countries participated in WBDD 2005 and more are expected to be involved in 2006: a regional plan of action for a major media event has been drawn up in conjunction with a working party led by the Singapore and Thai Red Cross National Societies.

PUBLIC HEALTH IN EMERGENCIES (PHE) UNIT

RESPONSE TO EPIDEMICS, INCLUDING NEWLY EMERGEING DISEASES (e.g. Avian Influenza).

This task is now to a great deal covered by the PHE Unit after the position for senior officer for epidemiology ended.

- **Avian Influenza (AI).** PHE Unit has taken firm action in terms of preparation for possible pandemic and contributed to the work on influenza preparedness by WHO and partner states to WHO. It resulted in guidance notes to states on national and international measures during influenza pandemics. The document was finalized in April and circulated during the World Health assembly. It is posted on the WHO website and circulated to health advisors, regional health officers at the Secretariat and to regional health delegates.

The disease so much feared is a man to man transmittable version of the virus, which does not exist so far. However, two factors causes alarm: a) when the current AI virus (H5N1) infects people, the case fatality is high i.e. more than 50% of people contracting the disease, die. b) the H5N1 virus frequently mutates and incorporates genetic material from other viruses. If the virus incorporates certain genetic material that enables transmission man to man, the risk for facing a rapidly spread, highly contagious and deadly disease is very high. Such material can be incorporated from the “normal”, seasonal flu and therefore minimising the circulation of such a seasonal flu virus is vital.

A major concern is now that migratory birds are infected and that will accelerate the spread worldwide. Also, other mammals are infected.

Since the man to man transmittable virus does not exist yet, the possibilities to produce an effective vaccine is not bright. Furthermore, the most effective antiviral drug, Tamiflu, may not be that effective against the man to man transmittable version of the AI virus.

The PHE Unit has been represented in various international AI conferences and a document “Avian Influenza: Facts and Recommendations for National Societies, Delegations and Secretariat” was circulated in October. Since then 17 teleconferences have been held with national societies worldwide, Regional Delegations and others, to keep all and everyone abreast with facts and further development technically as well as keeping track on NS actions on the preparedness side.

A mapping exercise is planned for, screening the activities and needs of the national societies, their roles and responsibilities vis a vis their own governments.

All relevant documents are posted on the FedNet and a dedicated AI page is under construction on the Public Federation Website.

Preparedness includes information sharing as well as pre positioning of antivirals (like Tamiflu) on strategic places, has been accomplished.

- **Meningitis.** PHE unit participated in the ICG meetings for meningitis, coordinating emergency vaccine stocks. Within this group led by WHO a new toolkit is developed for immunization campaigns which is about completed.
- **Goarn.** PHE Unit participated in the GOARN (Global Outbreak Alert Response Network) meetings and to develop a more effective use of the system. We supported the Marburg virus outbreak control in Angola with coordination and technical support and deploying one delegate to support the operation for 4 weeks. A generic document on dealing with such outbreaks is to be drafted.
- **Yellow Fever.** Outbreaks in West Africa and in Sudan (South Kordufan) for the first time after decades called for additional technical support. To support the Sudanese RCS and delegation, the PHE Unit fielded a consultant to assess and investigate the outbreak. Together with the WHO and Sudanese RC, he pushed for a better coordinated operation and the use of SRCS volunteers. Federation is part of the management committee for the emergency stock on Yellow Fever vaccine and supported the release of 1.7 million doses. Phase 2 vaccination campaign and technical follow up support will be facilitated to start up volunteer trainings, capacity building and branch development in S Kordufan as part of the starting pan-Sudan health program.
- **The Marburg Disease Outbreak** in Angola was of major concern. The disease had never behaved in such a way; spreading rapidly and with very high case fatality rate, worse than many of the Ebola outbreaks. The NS volunteers made serious efforts in their support to Government, WHO and others. The PHE Unit sent a consultant with extensive Ebola outbreak experience to make sure that the volunteers took on reasonable responsibilities.

DEVELOPMENT OF TOOLS, GUIDELINES, TRAINING

- **PHE Workshops.** Trainings were held in Panama in March and April (one week each) focused on building up better knowledge of Public Health and capacity of Central American and Caribbean national societies, the Regional Delegation and PADRU. The development of a PHE training curriculum with a full set of presentations is made in response to poor operational capacity and poor PHE knowledge found in the field and amongst people involved in relief. The feedback from these workshops is very good.
- **PHE Briefing of PNS** health advisors brought them up-to-date with the process, the need for it and what objectives to be achieved. Next year, another four workshops are planned for
- **Operational Standardisation.** Memory sticks loaded with all current operational standards, rules and regulations, policies and guidelines, reference websites, standard formats and job descriptions for emergencies and key health presentations were distributed to all participants at the PHE workshops. The intentions are to provide a generic operational tool for national societies, delegations and others. Participants appreciated this tremendously.
- **Regional Disaster Response Teams (RDRT)** were used in a grand scale in the Pakistan earthquake operation. More than 60 individuals from some 16 countries were used (East Europe, Central Asia, Africa, South East Asia and Asia –even Afghanistan contributed). The experience is that this system has big a potential but is in need of a general review to establish the core elements for training, preparedness package, uniform support mechanisms etc necessary for global use. PHE Unit drafted such a review paper as a base for further discussions and a review meeting will take place early next year.
- **Guidelines for Emergency Assessment.** After nearly two years of work where the PHE Unit has supported a consultant, the Guidelines were completed October 2005. It is available in several languages and on the Web. The Guidelines are made simple, targeting non specialists, to undertake basic, step by step assessment in an emergency. It outlines what information is vital to collect, how to collect it and analyse it in an effective way and how to report.
- **The Public Health Guide for Emergencies Manual** had to be reprinted due to extraordinary demand. Revision is ongoing with Hopkins University: a number of chapters need updating and others are added like Reproductive Health, PSP, AIDS in Emergencies, new type of disasters, emerging diseases etc.
- **PHE Training Curriculum and Training Manual** further development is probably to be done with the Hopkins University, in support to the PHE courses next year and in the attempt to further establish a standardized approach about the main PHE issues. The printed version when developed, and additional background material will form the backbone later on (2007) for the Regional Delegations and national societies to use by themselves and forming their own PHE training courses and further build capacity in the regions and among RDRTs.
- **Guidelines for Gender Based Violence Interventions in Humanitarian Settings** was published by the IASC working group where the PHE Unit has been omnipresent, in September 2005.
- **Managing Stress in the Field** manual was revised and the new version is now available and in high demand. It was translated into various languages including to an Arabic version which was designed and printed in Amman.
- **The Food Basket Calculator (FBC)** is ready and ICRC is testing it in various settings. The attempt to test it in the Niger Food Security operations, but that failed. TUFT University is contacted for field testing and possibly suggest further improvements whilst looking into, using a similar technology, the development of a calculator for HIV/AIDS patients in need for correct foods. The FBC is now followed by a Distribution Module (DM), ready to use early 2006.
- **Management of Dead Bodies After Disasters.** A Field Manual for First Responders has been drafted by PAHO, WHO, ICRC and the Federation. Will be released early next year.
- The **Interagency Emergency Health Kit (IEHK)** is now replacing the New Emergency Health Kit. It took two years and there are more than 25 changes. Officially, the contents and the release will take place early next year. The Federation, WHO, MSF, UNICEF and some few other NGOs have worked hard on this.

ERU OPERATIONS, DEVELOPMENT AND CHANGES

- **Health ERU Training.** Supported in four health ERU trainings and in the French PIRAC training (facilitation, support with the field exercise and participants evaluation). Training input was provided in FACT and TL courses

- **Utilisation of Health ERUs** has never been so high. During the year, 9 were used in the Tsunami operations, 7 in Pakistan, 1 in Chad and 1 in Haiti, all together 18 (3 hospitals, 2 double ERU hospitals and 12 Basic Health ERUs). Apart from that the ERU concept was used for establishing one health care unit in Bagh (Qatar RC) and one Hospital in Abbottabad (Federation, supported by Norwegian RC), both in Pakistan.
- **Performance Indicators and ERU Performance.** The operational capacity and performance assessment of Basic Health ERUs during the Tsunami operations was finalized end of May: Main findings were presented at the general ERU working group meeting in Vienna, at the ERU health Working Group meeting in Oslo and at the DMWG in Ottawa. The report was circulated to national societies, key Federation staff and to the health advisor's group (Stockholm group). It contains relevant recommendations to further improve and adapt, but also to clarify and recall the health roles of BHC ERUs. The more serious issue is the weak community health component. Interestingly, several conclusions on workload intensity and disease pattern can be made, issues seen in virtually all ERU health operations. The report was circulated to national societies, key Federation staff and to the health advisor's group (Stockholm group). It contains relevant recommendations to further improve and adapt, but also to clarify and recall the health roles of BHC ERUs. The report will be printed.
- **Health ERU WG** meeting was hosted by Norwegian RC. A set of technical and standard issues were addressed and followed up from the previous years. "New" national societies interested in joining the ERU system participated and new approaches such as mixed NS teams, new ERU developments, streamlined training schedules, inviting more delegate from non ERU national societies, possible triage ERU, links with FACT and RDRT etc were addressed. From now on the health ERU WG meetings will be held bi-annually to better keep abreast of developments and monitor implementation of e.g. the recommendations made in the ERU Performance report.

MAJOR OPERATIONS, ASSESSMENTS, LESSONS LEARNT

- **Chad:** The PHE Unit contributed to the follow up mission and evaluation team for the Chad population movement operation in January with one SRO who had led the FACT team 6 months prior. This was to follow up on implementation of the Plan of Action designed by the FACT mission to Chad in 2003. Refugee influx from Sudan from the war torn Darfur region prompted the population movement operation. Malnutrition, malaria, meningitis and other infectious disease like Hepatitis E plagued the displaced apart from frequent cross border raids. A meningitis outbreak in January was controlled by an urgent release of meningitis vaccines through the ICG mechanism (managed by WHO, MSF, Federation and UNICEF).
In addition, the Chad management set was strengthened as part of supporting the National Society, which already was engaged in Central Africa Republic refugee operations in the south. This is also a measure taken for being better prepared for possible further massive influx
- **Sudan.** The peace agreement in Sudan with the South, and the Darfour crisis, prompted the Federation to conduct a three week Pan Sudan health assessment aimed at capacity building of the Sudanese RC and establishing a more clear future role and profile of the Sudanese RC to address key health and water and sanitation needs in communities and disaster response, including fighting epidemics and communicable disease. The 13 member team composed of various donor societies, Sudanese RC and Federation, supported by WHO and MoH, was spearheaded by a PHE Unit Senior Officer from Secretariat. They split into four smaller groups teams to assess all regions of the country using the same protocol. The consolidated report "Towards capacity building and complementarity in health programming – a Multi-sectoral and integrated health assessment in Sudan" outlines a number of problems, Sudanese RC potentials and possible action to be taken by the Sudanese RC, supported by the Federation and its donor societies. Clearly, this is Not Business as Usual. The peace agreement with a very precarious health situation in the South, a high number of IDPs returning, the Darfur internal conflict and other factors put further emphasis on how important it is that the Sudanese RC and its Movement partners scale up reaching out to the most vulnerable in the communities. The document includes a comprehensive analysis as well as a Plan of Action Framework.
- **Tsunami:** 26/12 2004 an earthquake outside Sumatra caused a tremendous Tsunami wave, killing around 250 000 people in all. The wave hit the south western part of the island, Nicobar and Andaman Islands, Thailand, Malaysia, India and Sri Lanka suffered from serious damages and high death toll. The waves

reached as far as East Africa, where Somalia suffered most and the wave reached several kilometres inland, killing several hundred people.

A month later, another quake hit the Indonesian Nias island, with devastating effect.

The Appeal was met by an unprecedented response, and it is calculated that in total, around CHF 2 – 3 billion has been collected, and about 80% if it being public money. In all, 17 ERUs were deployed, virtually all that was available – such a scale of deployment has never happened before.

The PHE Unit was involved in setting up the massive health intervention programmes, the RAT process etc, operating from Geneva level as well as on the ground, most importantly covering general health, community health, psychological support and water and sanitation. Furthermore, the switch from relief to rehabilitation has been very complicated, especially with so many bilateral efforts that need coordination and the huge rehabilitation efforts of health infrastructure rehabilitation, an area the Federation rarely do.

Many new approaches and operational alliances are tested which requires continued involvement from the PHE Unit, learning for the future. Heavy military involvement, domestically as well as internationally, shows a clear trend towards a need for clearer operational responsibilities between the pure humanitarian actors and the military. Furthermore, National Societies quickly run out of trained delegates, a matter of concern for the future. The PHE Unit conducted a Basic Health Care ERU review, which was made real time and on the ground, looking into performance and critical factors that can be improved, also comparing with similar interventions made during Gujarat and Bam earthquakes.

The Indonesian National Society, PMI, had local volunteers on the ground successfully intervening very early later backed up by other volunteers deployed from all over the nation and cross border support from e.g. Malaysia. Last but not least, these cross border interventions were successful and clearly indicate a regional rapid response capacity, a potential to build further on.

Other approaches were tested; Real Time Evaluation and RAT (Rehabilitation Assessment Team). Due to the extraordinary funding situation, many PNSs preferred bilateralism, even at an early stage. Because of that, a Federation Service Centre was created to serve PNSs with multilateral as well as bilateral ambitions, as long as they are within a certain, agreed framework for interventions.

A supporting PHE Tsunami Rehabilitation Health Officer was requested already in January 2005, but for various reasons that has not materialised. It was – and still is – absolutely essential that this monitoring, guidance and support functions are carried out regularly from central level, a task which the current two PHE Senior Officers have been unable to fulfil to the extent needed, simply because of extreme work overload. The result is that the intended programmes are slow in starting up in earnest.

In the Maldives - Health wise, psychological support programme is successfully implemented apart from distribution of dressing kits and medical supplies. The provision of psychological support counselling is made at the community level and training at least one teacher from each island in psychological support for children. Bilaterally, housing and basic health care infrastructure rehabilitation is ongoing.

- **Pakistan Earthquake:** 8 October, a 7.6 magnitude earthquake hit northern Pakistan. Widespread devastation was seen in North Western Frontier Province and Azad Jammu Kashmir. Some medium size towns like Balakot, were simply erased. More than 70 000 people died and many more suffered serious injuries. Around 80% of the casualties were women and children

The Federation responded quickly with setting up a massive relief operation, launching a CHF 152 million Appeal. Shelter and Health were the two major issues. FACT and 8 Health ERUs (including 6 for ICRC) were deployed and so far more than 60 RDRT personnel have been used, recruited from 16 countries. The ICRC successfully used Basic Health Care ERUs for the first time.

The emergency was of an unprecedented scale and complicated, both technically and politically. The PHE Unit had to be directly involved on the ground in support to the FACT and later to ensure that the health response was adequate and of the right quality. A health strategy was developed and presented to the government, highlighting our support to the health care system at the most peripheral level health care system and beyond clinics, in the community. It was well appreciated.

PHE Unit supported with four long field operational missions, as well as vigorous support at Geneva level, backstopping operations in the resource mobilisation incl. Human Resources. Internationally, much attention was required for the development of the IASC Health Cluster in Islamabad as well to the cooperation with ICRC.

- **Niger Food Security and Nutrition.** Drought hit the country badly, necessitating major efforts to support their indigenous drought response system that fell short in meeting the high demand for feeding. Federation and several sister national societies already operational in the country, contributed well to food distribution, supplementary feeding and more intensive feedings. Doubtful quality of interventions

necessitated the PHE Unit to send a nutritional specialist, who is well acquainted with the country as well as with the RCRC way of working, to assist with practical support, training and identifying the major gaps in the programme and to have those corrected. In future, the PHE Unit need to have better capacity to design and conduct major Food and Nutrition programmes in Emergencies

PSYCHOSOCIAL SUPPORT PROGRAMME (PSP)

Beyond doubt, PSP support programmes is growing in importance and this particular specialist area is now well recognised as a very important aspect of essential emergency and recovery support in the community. During the Tsunami, WHO highlighted this to be one of the most important interventions.

Multilateral and bilateral efforts have flourished during this year, trying to meet some of the demands. Early assessments connected with FACT and RAT have been conducted after the Tsunami (in particular in Indonesia and Sri Lanka) setting the stage for PSP support programmes which are now ongoing. In post earthquake Pakistan, major efforts are made, whilst more long term programmes have been supported in e.g. Iran and Russia (Beslan).

- The **Federation – Danish RC Framework Agreement** outlining a better the working relationships, roles and responsibilities. The PHE Unit is responsible to respond in PSP in emergencies, a major task.
- To make the Federation – Reference Centre more effective and meet the growing demand, a rooster meeting was held in Canada, where specialist needs in various operational areas were identified and discussed. This **competence diversification** has been identified during last year's operations. Psychosocial specialists are needed for **urgent assessments** and related to FACT, **developing programmes, managing long term programmes** as well as for **evaluations and training** respectively.
- Several Nordic countries have actively supported PSP development and the operations, in particular the Danish and Icelandic Red Cross. **A similar set up in Latin America is under further development.** More and more national societies are developing capacity PSP and interestingly, some of the MENA national societies.
- The new **"Managing Stress in the Field"** manual is a best seller, available in several languages including Arabic. "Coping with Crisis" continue being distributed in various languages. Still, the Reference Centre Website is underutilised.
- The changes in the status of the PSP Reference Centre with a more international orientation have meant considerable work. However, the previous PSP Staff on Loan position at the H&C Department was discontinued, making the PHE Unit the focal point in emergencies. It has been a very hectic year and the PHE Unit has had it very hard to cope with the PSP demand in emergencies, therefore risking missed opportunities as well as quality of the PSP interventions.

COORDINATION, COOPERATION AND STRATEGIC PARTNERSHIPS

The PHE Unit working relations with international partners has moved ahead considerably, especially with WHO/HAC (Health Action in Crisis) and IASC (Inter Agency Standing Committee).

- PHE Unit /H&C department made a **statement at the WHA in May, outlining the Federation's health response mechanisms in emergencies**, highlighting partnering activities and complementarity's to governments, agencies and UN system.
- PHE Unit worked with the World Bank, **preparing for the High Level Forum on health in fragile states**
- A global collaboration **agreement between International Federation and WHO** was signed in May 11, 2005. The basis of cooperation is their complementary approach to vulnerability to disease, in particular when targeting the most vulnerable in affected communities. Regional and country office and delegations, as well as the relevant headquarters units, are urged to explore opportunities for strengthened collaboration, especially in the following sectors: **Emergencies and Health Action in Crisis situations, HIV/AIDS and Advocacy.**
- PHE Unit Participated at the **WHO global measles management** meeting in Delhi.
- PHE Unit contributed to a **WHO/HAC consultation on Child Health in Emergencies**
- PHE Unit provided **training support to OSD** department for the FACT (on health and PSP assessment in emergencies) and Team Leader (on Management of Stress for TLs) training in France and Finland
- Based on the OCHA "Disaster Response Review", IASC formed various technical clusters to address identified operational gaps and shortcomings in the delivery of relief. The PHE Unit was much involved in the **creation of the Health, Food and Nutrition** clusters and separately, **one for Mental Health.** In

particular, the **PHE Unit became involved in the design of the Health cluster** where WHO/HAC was chosen the lead agency. The aim is to create an international body that provided NGOs, UN and other organisations an operational coordination and cooperation platform in support to government and its Ministry of Health in emergencies.

- Amidst this work, Pakistan earthquake happened and the cluster was far from operationalised. However, a **Health cluster cell was set up in Pakistan** and the PHE Unit became **much involved in setting it up** there and run it in the beginning, periodically chairing it. The outcome is reasonable, but there are some short comings to be looked into.

WATER AND SANITATION (WATSAN) UNIT

The Federation WatSan Policy (adopted in 2003) lays out responsibilities in both the disaster response context and the approach to developmental WatSan programming. Developments and events in 2005 have continued to underscore the policy and in fact have broadened these responsibilities wider, into four core areas of focus thus:

- (a) WatSan in effective Disaster Management (Both Disaster Preparedness & Disaster Response)
- (b) WatSan in effective recovery and rehabilitation (Linking Recovery, Rehabilitation & Development).
- (c) WatSan as effective, sustainable development (Federations Global Water & Sanitation Initiative - GWSI).
- (d) Cross-cutting to all three above elements, is the further establishment and development of WatSan 'software' (community participation, capacity building and hygiene promotion).

WatSan in Disaster Response and Preparedness remains a core activity. Operationally, this has been clearly indicated in the scale of effective response to the Tsunami-affected countries (Indonesia, Sri-Lanka & Maldives) with the largest WatSan ERU and staffing deployment in its history. Despite the sheer scale of the Tsunami operation, significant responses to the Pakistan Earthquake, food security operations in three regions of Africa, responses to the hurricane season in Central America & Caribbean and other smaller operations were served by Federation coordinated WatSan interventions during 2005.

Increasingly, the more effective application of recovery and rehabilitation methodologies has led to a new approach, still being structured, to implement medium and longer term WatSan interventions (especially post-Tsunami) and thereby benefit from an improved linkage between relief and development. A significant proportion of Tsunami funding is allocated to this process.

The Global WatSan Initiative (GWSI) is perceived as the way forward to a ten year developmental commitment to the Federation's contribution to meeting the WatSan MDGs and being an effective WatSan player during the second UN Decade for Water (2005-2015) and was officially launched in March, 2005. A significant buy-in from National Societies, the EU and corporate donors has led to the identification of 11 large-scale, three year WatSan programmes to commence in 2006 as a result of GWSI resource mobilisation, with others in the preparation phase.

The establishment of a Global focal person for WatSan 'software' and increasing emphasis on its development and application in all aspects of WatSan interventions has been accomplished in 2005, and is leading to an expanded number of field positions to effectively 'roll-out' this increased emphasis, as well as provide a pool of expertise to feed into the further development of tools, processes and 'best practice' for the Federation.

The activities and new developments during 2005 have been demanding on the Unit, but have been mostly met, and have also resulted in a significantly increased demand for field staff, not only to undertake the variety of field operations and support responsibilities, but also to where possible reduce the workload and demands upon the Unit in Geneva. This trend will most likely continue in 2006/7.

Disaster Preparedness and Response Activities: coordination and technical support in disaster response, research and further development of response mechanisms will continue in cooperation and coordination with other humanitarian organizations active in Disaster Response. The ERU/FACT/RDRT system maintains a 'pool' of trained human resources for rapid deployment, combined with mostly standardized equipment/material packages.

The Federation's proven capacity in safe water supply continues to operate well by providing effective rapid assessments, deployment of experienced WatSan delegates and/ or ERU modules. However, much of the morbidity and mortality in post-disaster scenarios relates to poor or inadequate sanitation facilities, or poor hygiene practice. The existing response capacity to sanitation needs in disasters only partly addresses the problem, and needs upgrading together with the National Societies concerned.

Planned activities:

- Produce a field manual 'Excreta Disposal in Emergencies' together with Oxfam, Water, Engineering and Development Centre (WEDC), and UNHCR.
- Redesign the Mass Sanitation ERU module, field test it, and include the 'rapid' latrine concept.
- Adapt the PHAST methodology to be integrated into the standard disaster response and the ERU system.
- Revisions and updates of the WatSan ERU manual and parts and the CD 'WS Mission Assistant'.
- Continue coordination of the ERU technical working group where deployment experiences are shared, new technologies are reviewed, and planning of joint ERU training and curricula development is carried out.

The Global WatSan Initiative (GWSI): the GWSI concept provides a framework within which National Societies can increase their contribution to meeting the WatSan/Health components of the Millennium Development Goals. The GWSI does not limit national society participation to multilateral activities, but encourages a common approach, methodology, timescale and economy of scale.

- Develop a new support function, at the global and regional/country level, to assist National Societies to assess and identify beneficiary groups that meet with some basic criteria as expressed in the GWSI, and develop long-term WatSan programmes accordingly.
During 2005, the WatSan Unit at the Secretariat supported by the EU Red Cross Office in Brussels and Regional WatSan Delegates and staff in Panama, Nairobi and Harare assisted in detailed preparation of 8 multilateral large scale, long-term projects of which 5 have been successfully funded to commence during 2006. GWSI in its first year of operation is therefore on target, and has in fact exceeded the targets set. A total of 26M CHF has been mobilized to provide long-term sustainable WatSan facilities to 1.5 Million people over the next three years.
- National Societies requesting assistance in their WatSan programming will continue to be supported at the regional or country level, or directly from the Health & Care Department in Geneva (WatSan Unit), but with greater emphasis on larger and longer term WatSan programming.
This has continued during 2005, with support services being provided to both ONS and PNS WatSan activities globally and at regional level from Panama, Harare, Nairobi, Bangkok and Sahel (Niger).
- Further internalize and fine tune the GWSI at all levels leading to an official launch. Further engagement with potential partners and donors at all levels.
The launch took place in February, 2005 and GWSI has been disseminated at internal and external meetings, workshops and seminars. A new set of GWSI publications was finalized and distributed to ONS and PNS, Regional Delegations, potential external partners & ICRC.
- Establish the preparation of 5 GWSI country proposals worldwide with National Societies who meet the GWSI criteria for presentation to potential partners and donors. In addition to the multilateral proposals already mentioned, 6 bilateral proposals under the GWSI criteria were prepared and funded during 2005.
- Continue and expand key representation at international fora to improve Federation positioning and external partnering vis-à-vis the UN Decade for water to be launched 2005. Continue playing a key role with external partners at the Inter-Agency Groups Public Health Forum during 2005 and other such opportunities. Implement a Global Watsan Delegates workshop covering core DR/DP issues as Developmental WS Issues especially the GWSI and PHAST.
The annual WatSan Coordination meeting held in Dubai in March 2005 was an opportunity to further disseminate GWSI criteria, and an in-depth preparation was undertaken for further dissemination at the World Water Forum in Mexico in March 2006.

Federation WatSan Reference Center:

In an attempt to "outsource" and with the aim to address a wider range of much needed activities, discussions are ongoing with the Austrian Red Cross to establish a WatSan Reference Centre, to:

- Screen and test new technologies.
- Conduct operational research, studies, and evaluations.
- Document and disseminate of best practices, lessons learned.
- Establish and strengthen links to universities, joint partnerships and projects.
- Market, publish, print documents, presentations, train.

A workshop was organized in October 2005 to screen and test new mobile water treatment units.

The ‘software’ component in developmental WatSan: without sound base line data, effective engagement with beneficiary groups, improved and more realistic monitoring and evaluation and in general, true long term developmental objectives cannot be realized.

Develop and publish a PHAST field guideline and easy to use base line and M&E toolkit and provide TOT courses for use of these guidelines at select regional/country delegations, and conduct follow-up missions to measure PHAST usage and replication.

Further operationalize and internalize a standard approach globally to WatSan software related issues in emergency situations as well as in developmental programmes.

CONCLUSION: WORKING TOGETHER TO ACHIEVE THE GOALS

This document has outlined some of the key areas in which the work of the International Federation of Red Cross and Red Crescent Societies contributes to the achievement of the Millennium Development Goals. There are many thousands of other examples from National Societies and Federation delegations around the world that could be added.

This document has also illustrated the key advantage of the International Federation – it is the largest humanitarian network in the world, made up of national voluntary organizations which work closely with communities. The community-based volunteers that characterize many National Societies form a unique bridge between governments, civil society and vulnerable people, the essential missing link needed to be able to achieve the Goals. Through the Federation, they have access to an international level of support, technical assistance and representation, as well as to potential partnership with millions of members and volunteers around the world.

It is this characteristic of being both locally focused and globally connected that makes National Societies and their Federation a natural, established and essential partner to help governments achieve the Goals by 2015.

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[Financial report below; click here to return to the title page and contact details](#)

International Federation of Red Cross and Red Crescent Societies

HEALTH & CARE

Selected Parameters	
Year/Period	2005/1-2005/9998
Appeal	M05AA088
Budget	APPEAL

All figures are in Swiss Francs (CHF)

I. Consolidated Response to Appeal

	Health & Care	Disaster Management	Humanitarian Values	Organisational Development	Coordination & Implementation	TOTAL
A. Budget	4,451,904					4,451,904
B. Opening Balance	970,553					970,553
Income						
<u>Cash contributions</u>						
American Red Cross	46,247					46,247
Belgium - Private Donors	1,455					1,455
British Red Cross	441,166					441,166
Canada - Private Donors	5,995					5,995
Canadian Red Cross Society	19,740					19,740
Danish Red Cross	258,443					258,443
Finnish Red Cross	167,430					167,430
France - Private Donors	1,140					1,140
German Red Cross	19,309					19,309
Great Britain - Private Donors	7,480					7,480
ICASO	0					0
Italian Red Cross	91,770					91,770
Nestle	200,000					200,000
Netherlands Red Cross	15,570					15,570
Norwegian Red Cross	800,392					800,392
On Line donations	11,939					11,939
Orles Foundation	6,632					6,632
Other	0					0
Procter & Gamble US	0					0
Spain - Private Donors	774					774
Swedish Red Cross	532,260					532,260
Swiss Red Cross	240,554					240,554
Switzerland - Private Donors	73,000					73,000
UNICEF (UN Agency)	16,100					16,100
United States - Private Donors	7,438					7,438
C1. Cash contributions	2,964,834					2,964,834
<u>Outstanding pledges (Revalued)</u>						
American Red Cross	91,840					91,840
British Red Cross	18,120					18,120
Danish Red Cross	67,093					67,093
Swedish Red Cross	0					0
C2. Outstanding pledges (Revalued)	177,053					177,053
<u>Reallocations (within appeal or from/to another appeal)</u>						
American Red Cross	0					0
Belgium - Private Donors	0					0
British Red Cross	0					-0
Danish Red Cross	0					0
Eli Lilly Export SA	0					0
France - Private Donors	0					0
Great Britain - Private Donors	0					0
Italian Red Cross	0					0
Norwegian Red Cross	0					-0
Swedish Red Cross	-11,751					-11,751
Switzerland - Private Donors	0					0
United States - Private Donors	0					0
C3. Reallocations (within appeal or	-11,751					-11,751
<u>Inkind Personnel</u>						
British Red Cross	143,633					143,633
Danish Red Cross	23,354					23,354
Norwegian Red Cross	152,520					152,520

International Federation of Red Cross and Red Crescent Societies

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<i>Other</i>	1,447				1,447
<i>WHO</i>	74,400				74,400
<i>C5. Inkind Personnel</i>	395,354				395,354

Other Income

<i>Miscellaneous Income</i>	-32,704				-32,704
<i>C6. Other Income</i>	-32,704				-32,704

C. Total Income = SUM(C1..C6)	3,492,786				3,492,786
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D. Total Funding = B +C	4,463,339				4,463,339
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II. Balance of Funds

	Health & Care	Disaster Management	Humanitarian Values	Organisational Development	Coordination & Implementation	TOTAL
B. Opening Balance	970,553					970,553
C. Income	3,492,786					3,492,786
E. Expenditure	-3,933,614					-3,933,614
F. Closing Balance = (B + C + E)	529,724					529,724

Selected Parameters	
Year/Period	2005/1-2005/9998
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III. Budget Analysis / Breakdown of Expenditure

Account Groups	Budget	Expenditure					TOTAL	Variance A - B
		Health & Care	Disaster Management	Humanitarian Values	Organisational Development	Coordination & Implementation		
A		B					A - B	
BUDGET (C)		4,451,904					4,451,904	
Supplies								
Clothing & textiles		290,576					290,576	-290,576
Food		8,034					8,034	-8,034
Water & Sanitation		75,140					75,140	-75,140
Medical & First Aid		28,005					28,005	-28,005
Teaching Materials		2,726					2,726	-2,726
Other Supplies & Services		2,388					2,388	-2,388
Total Supplies		406,869					406,869	-406,869
Land, vehicles & equipment								
Vehicles	20,000							20,000
Computers & Telecom	19,000	21,973					21,973	-2,973
Others Machinery & Equipment		-3					-3	3
Total Land, vehicles & equipment	39,000	21,970					21,970	17,030
Transport & Storage								
Storage		3,209					3,209	-3,209
Distribution & Monitoring		4,247					4,247	-4,247
Transport & Vehicle Costs		11,083					11,083	-11,083
Total Transport & Storage		18,539					18,539	-18,539
Personnel Expenditures								
Delegates Payroll	2,470,000	1,420,137					1,420,137	1,049,863
Delegate Benefits		332,543					332,543	-332,543
National Staff		13,386					13,386	-13,386
National Society Staff		20,657					20,657	-20,657
Consultants	203,000	172,319					172,319	30,681
Total Personnel Expenditures	2,673,000	1,959,041					1,959,041	713,959
Workshops & Training								
Workshops & Training	341,600	78,318					78,318	263,282
Total Workshops & Training	341,600	78,318					78,318	263,282
General Expenditure								
Travel	382,930	440,357					440,357	-57,427
Information & Public Relation	454,000	314,215					314,215	139,785
Office Costs	105,520	99,867					99,867	5,653
Communications	76,480	109,764					109,764	-33,284
Professional Fees	90,000	15,600					15,600	74,400
Financial Charges		-899					-899	899
Other General Expenses		32,838					32,838	-32,838
Total General Expenditure	1,108,930	1,011,743					1,011,743	97,187
Federation Contributions & Transfers								
Cash Transfers National Societies		23,228					23,228	-23,228
Cash Transfers Others		100,000					100,000	-100,000
Membership Fees		1,090					1,090	-1,090
Total Federation Contributions & Tr		124,317					124,317	-124,317
Program Support								
Program Support	289,374	254,015					254,015	35,359
Total Program Support	289,374	254,015					254,015	35,359
Operational Provisions								
Operational Provisions		58,802					58,802	-58,802
Total Operational Provisions		58,802					58,802	-58,802
								0
Total								0

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TOTAL EXPENDITURE (D)	4,451,904	3,933,614	3,933,614	518,289
VARIANCE (C - D)		518,289		518,289