

Annual report

 International Federation
of Red Cross and Red Crescent Societies

Health and social services

Appeal No. MAA00001

23/05/2011

This report covers the period 01/01/2010 to 31/12/2010.



Haiti earthquake 2010: mobile vaccination programme i camp. J. Dall.

In brief

Programme purpose: 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 summary: During the reporting period, the health department, both in Geneva and Zones, supported the programmes of National Societies (NS) based on their expressed needs, strengths, capacities and available opportunities. Main achievement made during 2010 include:

- Global mapping exercises were conducted on CBHFA and First Aid to identify successes, challenges, and opportunities for improved support.
- Funds from the Global Measles and Polio initiative were provided to 16 NSs where approximately 18,400 RC/RC volunteers were mobilized through vaccination campaigns to reach an estimated 7,552,515 beneficiaries.
- The IFRC was elected Chair of the GAVI Civil Society Organization Steering Committee in October 2010.
- Provided technical and financial support to 13 National Societies, mainly Burkina Faso, Malawi, Sierra Leone, Nigeria, and Burundi to distribute an estimated 1,847,374 LLINs.
- In collaboration with WHO and DataDyne, a Management Survey Tool was developed to enable NSs and its partners conduct health surveys with little need for support that allows evidence-based decision making.
- Twenty-four NSs supporting Club25 activities completed their plans of action.
- The WatSan/EH team continued the roll-out of the WatSan Disaster Response Kit concept

where to date kits are stockpiled in 19 countries to serve at least 168,000 beneficiaries.

- Seventy NSs conducted HIV prevention activities to reach a total of 17,859,735 persons and 281,453 PLHIV and orphans received psycho-social support.
- The IFRC's TB programme was implemented in over 40 countries where 150,000 TB patients received daily care (out of which 10,000 had MDR-TB). Over 5 million community members were mobilized through approximately 80,000 RC/RC staff and volunteers.
- A Program Review of the Humanitarian Pandemic Preparedness program was conducted during 2010.

The health department kept focusing on ensuring continuous and harmonized support to National Societies' staff and volunteers in order to maintain local and global leadership. This support was in the form of the development of tools, materials and guidelines for NSs, as well as strategic frameworks and guidances for IFRC health staff. Major materials included:

- An IFRC International First Aid and Resuscitation Guideline was drafted to help NSs improve their First Aid practices and trainings. This was the first of its kind.
- On CBHFA, the Secretariat developed a CBHFA / PMER toolkit for National Societies to adapt to their local contexts.
- French language training of the Malaria toolkit was rolled-out
- Further rolling-out of the Epidemic Control for Volunteers that is now available in eight languages
- Ongoing plans to increase and strengthen the e-learning portfolio of the department for 2011 & 2012
- The HIV prevention guidelines were printed in Spanish, French and Arabic and a new module on gender is being developed to be completed by 2011.

During 2010, the Health Department produced the following advocacy reports and publications as well as organised important advocacy events on important health areas:

- First Aid for a Safer Future
- Immunization: Unfinished Business
- An updated version of the Winning Formula to beat Malaria
- The WatSan/EH unit contributed to several publications in particular in the Humanitarian Exchange magazine
- Out of Harm's way
- Ms Gerry Elsdon, a South African TV celebrity, was selected as the RC/RC global TB advocate and several events were organized accordingly.

During the last quarter of 2010, the Health Department started the process to develop a Strategic Operational Framework for Health in order to provide direction to the Global Health Team in their application of Strategy 2020 with respective National Societies. The process is expected to take several months as it is participatory, transparent, inclusive, and structured. Several Think Tanks were created to address new subject areas. In parallel, a review of the Health & Care Strategy 2006-2010 was conducted. The new SOF will be based on the concept of resilience and will entail some restructuring of the health department in Geneva and Zones to address all existing and new portfolios, while ensuring that NSs receive the best support from the Federation.

During 2010, the Health Department supported mainly emergency response activities in Haiti and Pakistan, but also smaller scale operations through 29 emergency appeals and 129 DREF operations. Furthermore, preparedness in health has continued with a special focus on disease prevention and health promotion activities.

Financial situation: The total 2010 budget is CHF 7,070,332 of which CHF 10,198,505 (144 per cent) covered during the reporting period (including opening balance). Overall expenditure during the reporting period was CHF 6,501,574 (92 per cent) of the budget.

[Click here to go directly to the attached financial report.](#)

Our partners: The International Federation works in coordination with the United Nations (UN) agencies, humanitarian organizations, as well as non-governmental organizations (NGOs).

Context

The new strategy for the movement S2020 came into force and subsequently the need for a new strategic operational framework in order to operationalise S2020 emerged.

The year 2010 was marked by two major disasters: the earthquake in Haiti and floods in Pakistan.

A 7.0 magnitude earthquake struck Haiti on 12 January 2010, affecting 3 million people. The earthquake directly affected Port-au-Prince, Léogane, Petit and Grand Goâve and Jacmel, causing over 222,570 deaths and 300,572 injuries. Widespread destruction in Port-au-Prince left over 1.5 million people homeless and in Léogane and Gressier 70 per cent of homes were destroyed or damaged; vast numbers of those whose homes were destroyed or damaged resettled in over 1,354 spontaneous settlement sites across the earthquake-affected area while 661,000 people fled the capital for other regions.

The earthquake compounded pre-existing structural problems, severe poverty and low levels of development, very limited access to education, health and sanitation services. The cholera outbreak which started in October 2010 in the Haitian department of Artibonite extended throughout all ten departments in the country, including areas affected by the January 2010 earthquake. As of 17 December, 121,518 cases had been seen, with 63,711 hospitalizations and 2,591 deaths due to cholera. IFRC aimed to support the affected and the vulnerable population together with Haitian Red Cross by ensuring safe water supply, improving sanitation, carrying out preventive health and hygiene promotion and running and supporting curative health facilities.

IFRC supported the coordinated response of the International Red Cross and Red Crescent Movement to the outbreak, thus increasing the synergy and efficiency of the operation. The proposed activities include the strengthening of the Haitian Red Cross (HRC) volunteer network to improve resilience capacity in their own communities through cascade training and key messages on cholera treatment and prevention.

Torrential monsoon rains commenced in late July 2010, triggering the worst floods to hit Pakistan since 1929, sweeping through Baluchistan, Punjab, Khyber Pakhtunkhwa (KPK), Federally Administered Tribal Areas (FATA), Pakistan Administered Kashmir (AJK), Gilgit Baltistan, and Sindh. As of 24 October 2010, the government's National Disaster Management Authority (NDMA) reported that there have been 1,980 deaths and 2,946 people injured by the floods. Out of the estimated 22.2 million hectares of agricultural land, almost two million hectares had been destroyed in the floods, threatening severe food shortages in the months to follow. More than 20 million people out of Pakistan's population of 170 million were affected by the floods. More than 400 hospitals and health clinics were damaged or destroyed, as were education facilities, power and transmission lines, telecommunication networks and industrial infrastructure.

Progress towards outcomes

First Aid (FA) and Community Based Health and First Aid (CBHFA)

The community-based approach engages communities and their volunteers to use simple tools adapted to local context to address the priority needs and to empower them to be in charge of their own development. The approach is a generic means to promote behavioural change and raise public awareness about health or natural disaster related threats and their prevention and control. In health interventions the approach is called Community Based Health and First Aid (CBHFA).

First aid reduces deaths, injuries and impact not only in disasters, but also in 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. The first aid programmes remain flexible and relevant by including skills and knowledge that respond to new vulnerabilities in injury, diseases and health priorities. Skills are kept up to date using distance, web-based and e-learning methods.

Outcome(s)

Component 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.

Component 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

Technical programme support

Resource people were mobilised and technical support were provided on training and designing community health programmes using the CBHFA approach in different zones, regions and national societies.

Regular communication and networking among the resource people are continuing. A newsletter on CBHFA implementation

in 2009 was published in early 2010 and another update on January – December 2010 will be published in early 2011. Different case studies and lessons learnt were analysed and shared with CBHFA practitioners.



In addition to English, the CBHFA materials were printed in French and Spanish and will be shared with the French and Spanish speaking National Societies.

Close coordination to identify the linkages between CBHFA and other programme areas (e.g. DRR, WatSan, Emergency Health, Malaria, Nutrition...) has been started. This coordination will lead to better harmonization and working together among sectors.

Technical support was provided to the European First Aid network annual meeting. More than 30 National Societies discussed Strategy 2020 and first aid. National Societies agreed that the development of first aid education and services by 2020 will be based on the analysis of changing trends and needs in their countries. This includes vulnerability and the changing social and economic factors impacting on the accessibility of first aid to all.

An advocacy report on *First aid for a safer future* was released on the occasion of World First Aid Day

2010. The report followed the first edition which focused mainly

on first aid in Europe. For 2010 report, we broaden our approach beyond the European continent and emphasize the necessity to better prepare communities for the “unexpected” by making first aid available to all. The first edition of this report was welcomed

by many public health experts and was widely distributed to European decision-makers. Even though there was a consensus on many of the recommendations, more efforts are needed to convert support into policy.



The first IFRC International First Aid and Resuscitation Guideline was developed and will be finalized in early 2011. This evidence based guidelines and recommendations will help and guide NSs to improve their FA education, training, practices and services.

Capacity Building

A delegate CBHFA training workshop was organised in Finland supported by Finish and Swedish National Societies in February 2010. The first CBHFA delegate training workshop was developed to help Federation and bilateral delegates conceptualise and streamline their work to support National Society CBHFA implementation. Twenty-five delegates from ten National Societies attended the training, with priority given to delegates with experience of CBHFA implementation. Sessions were designed to engage participants in discussing the key challenges identified at the October 2009 global lessons learnt workshop in Jakarta. These included the fundamental principles of the CBHFA approach, integrated programming, fundraising, and M&E. Participants shared practical solutions to tackling these issues.

Asia Pacific CBHFA developers and practitioners met for a week in Bangkok in October 2010 to share experiences on programme implementation, volunteer management, integration and evaluation, development of monitoring and evaluation tools and to decide the way forward. Recommendations from the workshop included: strengthen CBHFA M&E systems, develop better volunteer management within CBHFA, focus on behaviour change communication (BCC), use the Malaria BCC module, carry out operational research to validate CBHFA, develop thinking around linkage and integration between programme areas.

CBHFA global meeting was organized in Geneva in December 2010. 19 National Society and secretariat participants came together to discuss CBHFA global mapping, evaluations and lessons learnt, and strategic planning for the future. Key recommendations include: work to measure CBHFA impact and cost effectiveness, use FedNet to share learning between National Societies, work to clarify integration with disaster risk reduction (DRR), develop innovative ways to recruit and support community volunteers, update and revise materials in late 2012.



Support to monitoring and evaluation

To meet the need for appropriate planning, monitoring, evaluation and reporting tools, the secretariat has developed a CBHFA PMER toolkit for National Societies to adapt to their local context. The tools build on existing M&E tools used by CBHFA staff and volunteers from various National Societies, and have been tested and revised during 2010.

This toolkit deals with the basics of setting up and using a monitoring and evaluation system for a community health programme. It clarifies what monitoring and evaluation are, how to plan them, how to design a system to monitor programmes and an evaluation process that brings it all together. It helps in selecting appropriate process and outcome indicators for various CBHFA topics, and tools to measure them.

The toolkit includes an overview of the various tools presented, as well as suggestions for how these can be incorporated into a M&E system. It also links CBHFA activities to MDG indicators.

The tools will be translated into other official languages during 2011, and disseminated to National Societies. Many National Societies showed interest in translating, adapting, and using the tools in their community health implementation.

CBHFA global mapping 2010

During 2010 the secretariat carried out a global mapping exercise to better understand how National Societies are implementing CBHFA, and identify new linkages and opportunities for the future.

Out of the 92 Operating National Societies who participated in master facilitator workshops last few years, 72 have started sensitization workshops and CBHFA implementation (more than half of them are already at the community level).

Over 55,000 CBHFA volunteers reached 2.3 million beneficiaries during 2010 and aim to reach over 3 million during 2011.

CBHFA materials (Implementation Guide, Facilitator Guide, Volunteer Manual and Community Toolkit) were adapted and translated into more than 30 languages (*some will be finalized during 2011*).

The majority of the funds to implement CBHFA during 2010 came from emergency appeals through the Federation and bilateral development funds from Partner National Societies.

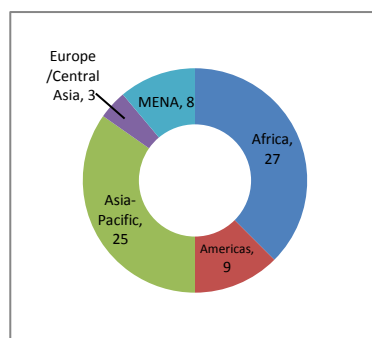
First Aid global mapping 2010

During 2010 the secretariat carried out a global mapping exercise to better understand the successes and challenges of implementing First Aid activities by the National Societies.

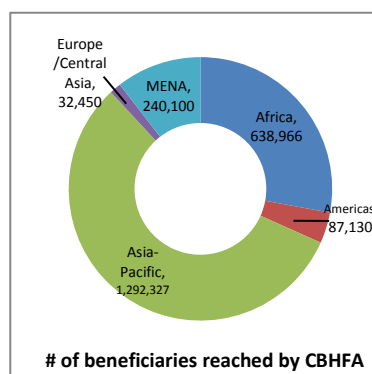
More than 7 million people trained worldwide by National Societies in the 52 countries covered by the IFRC 2010 mapping. This is a 20 per cent increase compared to 2006.

More than 17 million people received first aid courses (less than 6 hours). An additional 46 million were reached by first-aid and preventive messages.

Worldwide, there are more than 36,000 active first-aid trainers and 770,000 active volunteers serving their



of NSs implementing CBHFA during 2010



of beneficiaries reached by CBHFA messages during 2010



communities in first aid education and services, making first aid for all. The total number of voluntary hours in first aid given globally is at least 3,224,880 per year.

Constraints or Challenges

Lack of funding at the country level to support long-term community health programmes.

During the last years, the Secretariat did not receive any funding to provide technical support to First Aid activities.

CBHFA must be seen as an approach to integrate different components of community health rather than a vertical programme.

Increase 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.

Linkages and integration with other programme areas need to be clarified and tested.

The coordination with the ICRC should be strengthened to harmonize the different first aid approaches with the aim to have one RCRC first aid approach in future which can be used for different settings (e.g. conflict, community-based, commercial first aid...).

Maternal, newborn and child health (MNCH) and immunization

In 2010, there was significant expansion of the immunization portfolio in the areas of technical and financial support to national societies, partnership building, and global IFRC profiling. In the area of MNCH there was progress on further developing the IFRC MNCH Framework, though this was limited due to a lack of human and financial resources and a decision by the Health Department to await the forthcoming Strategic Operational Framework (SOF).

Over the course of the year, funds from the Global Measles & Polio Initiative were provided to 16 National Societies for polio and measles campaigns. An additional 5 National Societies were funded through other means (bilateral funding, or through disaster response mechanisms). A total of approximately 18,400 Red Cross/Red Crescent volunteers were mobilized to provide supplementary social mobilization support during these campaigns, helping to reach an estimated 7,552,515 people with sensitization messages and children (or other age groups targeted) for vaccination.

Within the global vaccination community, increasing emphasis is being placed on better linking immunization to broader benefits in newborn and child health. Immunization, as a key maternal, newborn and child health (MNCH) intervention, has the potential to *further* reduce child mortality by an additional 25 per cent (through the introduction of new vaccines against pneumonia and diarrhoea). Recognizing the key role of the GAVI Alliance in introduction of new vaccines, and the work of the IFRC as a global player in convening civil society, in 2010 the IFRC supported a global process to develop the GAVI civil society organization (CSO) Constituency into a robust and active network of more than 185 organizational members. The IFRC was elected Chair of the GAVI CSO Steering Committee in October 2010.

Outcome (s) :

- 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.

- 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.

Achievements:

In 2010, the IFRC started a process of developing a Maternal, Newborn and Child Health (MNCH) Framework in coordination with interested national societies. A series of teleconferences were convened with the IFRC Global Health Team and partnering national societies to discuss the need for a more comprehensive MNCH Framework, and what elements should be included. Through the generosity of the Canadian Red Cross (CRC), a Staff on Loan consultant spent one month with the Geneva Health Department facilitating a process to produce an initial draft of the Framework. In the fourth quarter 2010, the draft was circulated for consultation. Of the 26 respondents, ten (10) were from national societies in Africa, Americas and Asia Pacific; nine (9) were from partnering national societies (PNSs); and seven (7) were from IFRC zonal and/or regional health staff, and topic experts. In November 2010, the Health Department decided to delay finalizing the MNCH Framework in order to await the Strategic Operational Framework (SOF), and ensure that the forthcoming MNCH Framework was aligned with the new direction of the Global Health Team.

Building upon the International Federation's strength in immunization, and working with vaccination partners, progress towards contextualizing the contribution of routine immunization to child survival has been further developed in 2010. The process, commenced through the Decade of Vaccines (DoV) planning process (led by WHO and UNICEF), has emphasized the changing role of vaccines in broader health interventions; for example, the introduction of Human Papilloma Virus (HPV) vaccine should be planned in the context of other women's health interventions. In 2010, the IFRC has participated in the DoV process and see this as a good means of broadening our immunization work to more comprehensively address MNCH-related areas.

In 2010, the International Federation participated in a number of global immunization fora, including high level meetings, coordination and management meetings, and technical consultations. For region-specific meetings, the IFRC facilitated the participation of relevant zonal/regional health managers through provision of financial support and technical briefings. The most notable meetings in 2010 included participation in the high level financing meeting for vaccines hosted by the government of the Netherlands in the Hague; delivering two statements at the WHO World Health Assembly (WHA) on the items related to progress towards polio eradication, and global eradication of measles (jointly done with the American Red Cross); participating in the Decade of Vaccines development process (described above); organizing a side event on drawing lessons from polio eradication towards other health-related MDGs at the UN MDG Summit in New York; the Global Measles Advocacy Meeting organized by the American Red Cross; and the first meeting of the newly constituted Polio Independent Monitoring Board (IMB), among others. In each of these fora the International Federation contributed information on the role of the IFRC and national societies in immunization programmes and reaching global vaccination targets. Communications materials were also developed to support these efforts, including an advocacy report entitled *Immunization: Unfinished Business* (produced jointly with the GAVI Alliance), and two short videos.¹

¹ *Immunization: Unfinished business* (2010) can be viewed at

http://www.ifrc.org/Global/Publications/Health/Immunization_Advocacy_Report2010_EN.pdf.

For videos please see <http://www.youtube.com/user/ifrc#p/search/0/5i9oGAY9Z3Q> and

http://www.youtube.com/user/ifrc#p/u/1/_r0nIPymzOA

As a global civil society partner in immunization, the International Federation scaled up its role in facilitating the work of the GAVI CSO Constituency in 2010. This work underscores the role that the International Federation can play as a convenor of civil society, and in the area of humanitarian diplomacy for increasing access to life-saving vaccines. After a meeting of CSOs convened by the GAVI Alliance in March 2010, the IFRC was requested by the CSO group to host a part-time consultant (financed by the GAVI Alliance) to support the work of the Constituency. With the help of this consultant, the CSO Constituency was further solidified in 2010, and now has a formal structure and official positions on various GAVI governance structures. In October 2010, the IFRC hosted the first meeting of the GAVI CSO Steering Committee at its Geneva Headquarters; participants came from twelve (12) countries representing large international non-governmental organizations (NGOs) and local NGOs in GAVI-eligible countries. At that meeting, the IFRC was elected Chair of the CSO Steering Committee.²

Support to national societies to participate in their national and sub-national measles and polio campaigns continued in 2010 through the Global Measles and Polio Initiative (GMPI – MAA00032). For a complete update on this activity, [please see the Global Measles and Polio Initiative Annual Report, 2010](#). Activities financed by the Global Initiative, which is a flexible global fund to enable Red Cross Red Crescent national societies to respond to their Ministries of Health requests for supplemental social mobilization during vaccination campaigns, enabled approximately 18,400 volunteers to be mobilized.

Constraints or challenges:

Adequate human resources to accomplish all of the objectives set for 2010 was a challenge. Despite the generous Consultant on Loan from the Canadian Red Cross, the MNCH file was not progressed as much as planned. It has been recognized that in order to further develop the MNCH file, additional human resources will be needed.

Requests from national societies for technical support on immunization programme planning, and in preparing for vaccination campaigns, have been difficult to fulfil. Whenever possible, immunization staff from partner agencies (WHO, UNICEF) have generously supported national societies during their country missions. Funds from the Global Measles and Polio Initiative have also been used to deploy consultants to countries needing additional support. The American Red Cross measles delegate, based in Nairobi, has been critical in providing immunization expertise to African national societies. There is a significant need to have more sustainable IFRC human resources for the immunization programme.

Lastly, within the Global Measles and Polio Initiative, there has consistently been greater demand for funding than is available. In 2010, the Global Measles and Polio Initiative received funding from a new donor (Bill and Melinda Gates Foundation) which was instrumental in supporting national society involvement in interrupting polio transmission in West and Central Africa. New donors must continue to be cultivated to meet all requests from national societies, so that they can in turn respond positively to their Ministry of Health requests for support to reaching important immunization goals.

Malaria

Programme summary

The International Federation's global malaria programme is focused on working with National Societies' networks of volunteers to support achievement of the Roll Back Malaria and

² For more information on the GAVI CSO Constituency, please see <http://www.gavicoconstituency.org/> and http://www.gavialliance.org/about/in_partnership/cso/index.php.

Millennium Development Goal targets focused on reducing child, maternal and malaria-related mortality by scaling up access to prevention and treatment for malaria for all populations at risk of the disease. Specifically, the global malaria programme has the following objectives:

- To reduce the number of deaths and incidence of illness related to malaria;
- To support communities and National Societies to improve the quality of malaria programmes and their capacity to reduce the burden of malaria.

The global malaria programme is focused on:

- **Prevention (short term):** the high impact strategy of free, mass distribution of long-lasting insecticide treated nets (LLINs) combined with social mobilization activities pre, during, and post LLIN distributions.
- **Prevention (long term):** the community-based health and first aid integrated approach to sustaining gains in malaria prevention and treatment through volunteer dissemination of messages during house-to-house visits and community gatherings.
- **Treatment:** ensuring that populations in malarious areas understand the signs and symptoms of malaria and know where to go to get appropriate testing and treatment; bringing malaria testing and treatment closer to communities with low health facility access by providing volunteers with training and effective treatment.
- **Capacity building:** Africa-based malaria community health delegates work hand-in-hand with National Societies to develop proposals, plan and implement activities, train and supervise volunteers, monitor project roll out and develop and submit timely and high quality reporting.

Funding available is allocated to countries based on malaria burden, upcoming National Malaria Control Program planning and the capacity of National Societies to successfully implement the program. At the end of 2010, the secretariat had expanded malaria technical support across Africa Zone. In addition, a finance advisor specific to malaria was brought on with a global overview role and based in the Africa Zone office in Johannesburg.

Programme outcome

The following are specific outcomes for 2010 in terms of reporting on the forward planning provided in the 2009 report. Achievements are reported on below (in addition to the programme outcomes).

- Provided 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.
- Rolled out the French language malaria training using the malaria toolkit and crosscutting behaviour change communication and supervision modules.
- Implemented the first roll out of the Management Survey Tool, a cell-phone based survey that will allow for project monitoring by National Society staff and volunteers.
- Continued resource mobilization for malaria activities in 2010 and 2011.

Progress towards outcomes

Since 2002, Red Cross Red Crescent national societies and their extensive networks of volunteers have protected over 25.5 million people with nets, helping save an estimated 420,000 lives in some of the world's most vulnerable communities.³ In 2010 over 18,000 volunteers reached 2.2 million households or 11 million individuals with messages on how to prevent malaria and what to do when fever is detected in a family member.

³ *Beating Malaria through partnership and innovation*, IFRC, April 2011

Three priorities were identified for 2010 and progress was made towards achieving these priorities. The first priority was to roll out the malaria toolkit French language training, which took place in the first quarter of 2010. The second priority was to expand technical capacity at National Society level and with the secretariat at country, regional and zone level. At the end of 2010, the secretariat community health and malaria delegate positions were all filled in the Africa zone. In addition, a finance analyst is working globally to support the delegates and the National Societies with budget development, financial management and reporting. The final priority was to ensure that sufficient funds were in place for 2010 and 2011 activities and this was achieved for 2010 activities, though not for activities in 2011.

Achievements

French language malaria toolkit training*

In February 2011, representatives of French-speaking National Societies from malaria-affected countries gathered together in Dakar, Senegal for training on the malaria toolkit (malaria in the community, mass LLIN distribution) and the crosscutting modules (supervision, behaviour change communication). In total 36 participants from 23 National Societies in Africa, Asia and the Americas attended the training. The training lasted for six days and National Society, PNS and IFRC secretariat staff facilitated sessions. Evaluations of the training highlighted the exchange of country experiences as a benefit, while funding shortfalls to actually implement malaria activities were underlined as a barrier to use of the tools and methods for achieving impact in households and communities.

Distribution, hang up and keep up of LLINs

With funding from the Netherlands Red Cross, Norwegian Red Cross, the IFRC secretariat procured 675,000 LLINs for distribution in Burkina Faso, Malawi and Sierra Leone. In Burkina Faso and Sierra Leone, the LLINs purchased were a contribution to a larger scale national LLIN distribution, while in Malawi, the LLINs purchased were used for a pilot distribution prior to the country's GFATM round 9 distribution. In all three countries, the LLIN distribution plans of the National Society were integrated into broader Ministry of Health plans. The National Societies in these countries used their networks of volunteers to inform the population of the LLIN distribution, mobilize household and community participation and ensure hanging, use and maintenance of nets received by households. In Sierra Leone and Malawi, a longer-term communities fighting malaria project is still being implemented until the end of 2011.

In Nigeria, with funding from USAID, volunteers have been mobilized by the Cross River State branch for a State-wide campaign to move from coverage of children under five with LLINs to coverage of the total population with LLINs. Volunteers have been responsible for registering all households in the State and assessing the number of people and nets in each to determine the needs for reaching the total population. Following the needs assessment, Nigeria Red Cross volunteers have distributed LLINs using a door-to-door methodology involving confirming nets available and then hanging (with nails and string) nets needed to ensure all members of households are protected with nets. A total of 614,000 nets were provided for the project.

In Burundi, with funding from the Belgian and Canadian Red Cross Societies, LLINs were provided for two provinces to support the Ministry of Health's rolling LLIN distribution campaigns to reach the universal coverage targets. In total, 558,374 LLINs were distributed. The Burundi Red Cross volunteers undertook information, education and communication campaigns, household registration, LLIN distribution and door-to-door hang up with hammers, nails and string. The Burundi Red Cross success in demonstrating the value-added of the hang up approach through rigorous evaluation of activities led to increased resources available to the National Society from USAID for participation in hang up activities after future distributions.

Roll out – management survey tool (MST)

The rapid spread and use of mobile technology throughout the globe offers researchers a new and exciting means of data collection. 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 Management Survey Tool (MST), which uses mobile devices for data entry, has been developed. The MST 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 fashion, 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 manner.

The first country to roll out the use of the MST was Kenya in Malindi and Lamu where the home management of malaria project is taking place. For the survey, MST questionnaires are created using DataDyne's mobile phone based *EpiSurveyor* software. The *EpiSurveyor* application is downloaded directly to standard mobile phones and questionnaires are subsequently uploaded to the handsets. In the field, Red Cross Red Crescent volunteers use these phones to collect and store data without the need for a network connection. Once in range of a 2G-network connection, data is sent to a secure server, allowing partners anywhere in the world with *EpiSurveyor* account access to view, analyze and export results in a variety of formats. It is expected that the MST will dramatically decrease the time and monetary costs associated with data collection in health surveys.

Development of standardized proposal and reporting templates

In order to streamline the work of the secretariat malaria team, templates were developed for proposal development and project reporting. The proposal documents include templates for the narrative, budget, budget narrative, and log frame for project monitoring and evaluation. The reporting documents include templates for the narrative and financial reports, as well as the log frame.

Capacity building

In 2010, the secretariat malaria team expanded, allowing direct support to be provided to National Societies throughout the Africa Zone. At the end of 2010, the secretariat malaria team included two delegates based in East Africa Regional Office (community health and malaria and operations research), one delegate based in Southern Africa Regional Office (community health and malaria) one delegate based in Sahel Regional Office (community health and malaria) and one Africa Zone and finance analyst. The Geneva Senior Health Officers provide support to the IFRC malaria delegates who, in turn, provide support to National Societies.

In 2010, IFRC-supported malaria programs were implemented in 13 countries: Senegal, Burkina Faso, Togo, Liberia, Democratic Republic of Congo, Nigeria, Sierra Leone, Kenya, Malawi, Angola, Zimbabwe, Uganda and India.

Delegates based in the Africa Zone provided support for all aspects of proposal development and reporting. The secretariat malaria team sees value-added in the face-to-face interactions with National Societies for effective capacity-building.

Malaria in emergencies

In collaboration with the Africa Zone emergency health team a malaria in emergencies presentation was developed.

Communications / Advocacy

The secretariat malaria team has made enormous efforts to advocate on behalf of malaria activities. In an effort to highlight successes, in 2010 the malaria team accomplished the following:

- Launch of the Kenya Red Cross Home Management of Malaria (HMM) report. This report was produced as a 20-page document explaining the roles and responsibilities of KRCS volunteers and the ever important relationship and partnership with the Ministry of Health.
 - The Kenya Red Cross HMM report was launched at events in Nairobi, New York, Ottawa and Brussels.
 - The HMM report was released by KRCS and partners at the MDG summit at the UN in New York
- Release of an updated version of the Winning Formula to Beat Malaria report.

Operations research

In 2010, the Secretariat malaria team recruited an operations research (OR) delegate. The delegate will plan and implement a similar project to one taking place in Uganda, where an study is being undertaken to assess the value-added of hang up visits post-LLIN distribution. The country for implementation is not yet identified. The objective of the OR project is to evaluate the effectiveness and cost of different approaches to post LLIN campaign home visits by volunteers to enhance LLIN hang-up and utilization.

The hypothesis to be tested is: in settings with low or moderate net use culture (less than 50% and 70% respectively of existing nets are being used) one or more home visits following the mass distribution of LLINs by community volunteers providing IEC messages and support in hanging the nets will increase LLIN utilization by at least 10%-points over a period of 6 months irrespective of other effects such as general messages during the campaign or stimuli on net use through the rainy season.

The primary outcome measures will be:

- Proportion of all surveyed households with at least one net that use⁴ all of the nets found in the household at the time of the survey compared between the three study arms and at each time point
- Proportion of all surveyed households with at least one net where all family members (and/or children under 5) present the previous night slept under a net/ITN compared between the three study arms and at each time point

Programme integration

In the new organizational structure of the health department, HIV, Malaria and TB global the three diseases using CBHFA as an approach and a platform to nurture a greater and sustainable community health response. Currently efforts are underway to facilitate programme integration wherever feasible.

Constraints or Challenges

The main constraints or challenges faced during 2010 were delays in finalizing National Society 2010 – 2011 proposals due to difficulties with Ministry of Health National Malaria Control Programmes defining their strategies to scale up malaria control measures. An additional constraint was identifying the correct human resources at the IFRC and National Society level to support the project.

Voluntary non remunerated blood donation (VNRBD)

During the second half of 2010 the work of the VNRBD portfolio was affected by the departure of the Senior Officer.

⁴ Use will be defined as any person sleeping under the net the night before the survey

With the support of GAP and its members and through wide consultation with National Societies who are currently running level A and B types of the blood programmes, a revised draft blood policy was finalised and translated into all official languages.

There was also technical support mainly from the Legal Department to provide feedback to GAP when it revised its Terms of Reference and status.

There has been quite a lot of progress in the development of the Club 25 and the Health Promotion model. In 2010, 24 National Societies supporting Club25 activities completed their plans of action. Sixteen clubs identified specific health promotion activities and incorporated them into their plans of action. Leaflets and materials with health messaging were distributed, and baseline data ready for evaluation was also provided. Club25 planning is one part of a five year project – ‘New Blood for the World’ – which is funded by the Swiss Humanitarian Foundation.

In the America’s Zone an evaluation was conducted to capture the lessons learned by National Societies in Club 25 and VNRBD activities. Detailed plans of actions were drawn up by National Societies which participated. A continental Club 25 meeting for the Americas was also held in Panama in September 2010. Seven Club 25 National Societies from the Americas zone, including the Haitian Red Cross Society, attended the meeting. The Singapore Red Cross Society was one of the resource facilitators to share information on innovative ways of recruiting and retaining voluntary blood donors. There were also sessions on life skills and health promotion, emphasizing the impact of behaviour change in healthy lifestyles.

Copies of the Global Framework for Action to achieve 100 per cent VNRBD were disseminated to National Societies. The Framework was jointly produced by IFRC and WHO. More than 80 countries have reported using the IFRC Making a Difference (MAD) Toolkit.

Constraints and challenges

Since October 2010, the tasks and responsibilities of the VNRBD file were placed with the Unit Manager in the Community Health Unit. This gap of human resource will remain until a decision is made on what to do with the VNRBD portfolio.

Water, Sanitation and Emergency Health (WatSan/EH)

The water, sanitation and emergency health unit, guided by the IFRC’s Strategy 2020 provides a strategic, technical and programming support service to Red Cross Red Crescent National Societies. This unit provides support to disaster management, recovery and rehabilitation, and long-term developmental health programming through capacity building, quality control, human resource identification and development, resource mobilization, training and disaster management (DM) “surge” capacity coordination.

These two technical sectors, water and sanitation and emergency health (WatSan/EH), have always worked in a complimentary fashion, however were merged into one Unit from January 2010, to encourage further synergy and streamline objectives, consolidate activities and resources and add further value.

Our overall objective, in line with the Health department’s strategic direction, is to **address vulnerabilities while building community resilience** through our client National Societies, be that from global, zonal, regional and country level wherever appropriate. Increasingly we contribute to cross-cutting trends and themes, such as climate change, disaster risk reduction, nutrition and the increasing demands created by urbanisation and non-communicable diseases.

The emergency health team in particular have been increasingly approached to give federation wide positioning and analysis on emerging health trends.

Outcome(s)

National Societies are enabled to be better prepared and respond increasingly to water, sanitation and emergency health needs in 'acute' as well as in 'chronic' situations through well managed and relevant disaster response mechanisms and approaches and longer-term/development water, sanitation and health programmes, aiming at a more sustainable impact.

Achievements

In 2010, large scale emergency operations in Haiti (earthquake and cholera) and Pakistan (floods) dominated the year, where further use of the water and sanitation and Health ERU's were deployed. Further integration was evident between WatSan and Health ERU's especially in Haiti. Further prepositioning and use of water and sanitation disaster response kits and cholera and other medical kits increased our overall surge capacity and gave increased opportunities for zone and country level disaster response.

While the two major operations in Haiti and Pakistan have dominated much of the support given by the WatSan/EH team Zones and National Societies, much was also done towards the numerous other smaller operations. The IFRC in 2010 had 29 Emergency Appeals and 129 DREF operations, most of which have benefitted when needed from the technical guidance, input, information sharing, intervention, quality assurance, and institutional memory of the WatSan/EH team. Those include feedback and support to at least 3 FACT teams, more than 20 ERU WatSan and Health ERU deployments, and technical feedback on dozens of emergency DREFs and Appeals.

Strategic planning and direction

Strategic direction was further refined both for the WatSan/EH team and for the Zones.

The WatSan and EH disciplines, and as part of the Strategic Operational Framework of the Health department, have defined their plans, directions, and needs for the coming five years and gone through the needed forecasting and planning. This give a more coherent direction that benefits from the integration of WatSan and EH over the past year.

Neither Europe nor MENA Zones currently have dedicated WatSan or EH resources, this has resulted in lack of capacity to support NSs in the Zone both for their internal operations, preparedness and for their interventions when needed. The WatSan/EH team in GVA have agreed and coordinated with the Zone offices and conducted to two strategic planning missions. The outcome of both missions was setting up a clear and achievable plans for increased WatSan/EH capacity in the Zone, increase the interest and political will to adapt more proactive work towards the disciplines, and define the support needed from GVA until such capacity is obtained.

Capacity building and tools

Further 'rolling out' of the epidemic control for volunteers (ECV) was undertaken worldwide this has seen the tool and approach rolled out in Africa through two regional (East Africa and West Africa) trainings that aimed at creating regional teams of NS personnel, French and English speaking, who can then support the Zone in further implementation of the ECV. The increased roll out enabled extensive use in Africa that added to the already successful use and integration of the ECV in the Americas. The tools was also used in Asia Pacific for the first times especially in a training for the Afghanistan RC.

The ECV is now available in 8 languages (English, Arabic, French, Spanish, Pashtu, Dari, Haitian Creole, and in process translation to Urdu).

Further capacity building efforts focused on supporting AP Zone in their EH efforts including a Zonal EH training that took place in Singapore for mainly SE Asia NSs partially funded and facilitated by the EH team in GVA. This increases the strong roster of EH professionals in the AP Zone with about 30 new members.

The Geneva based WatSan/EH team contributed to WatSan and Health ERU trainings in six national societies: British, Canadian (CHM), German, Japanese, Norwegian, Spanish RC's.

Plans are ongoing to increase and strengthen our E-learning portfolio in 2011 and 2012 benefiting from experience gained from the pandemic preparedness project just recently concluded..

The WatSan/EH team continues to roll out the WatSan Disaster Response Kit concept through prepositioning of equipment and training of WatSan RDRT. To date, over 100 WatSan technicians have been trained in the deployment of the Kits. 2010 saw deployments of Kits in Tanzania, Chile, and Nepal. Technicians trained in the use of the Kits were also deployed in the Haiti Earthquake and Pakistan Flooding operations. Kits are now stockpiled in 19 countries worldwide and have the capacity to serve over 168,000 beneficiaries. However, there remain regions without prepositioned stock. Furthermore, recent disasters have highlighted the need to have more stock in regional logistic hubs.

The WatSan/EH unit is currently working with the Logistics department to increase the number of locations with prepositioned Kits.

Developmental programming

In water and sanitation developmental programming, under the umbrella of the Federations ten year Global Water and Sanitation Initiative (GWSI 2005-15) further new projects were established with support from both existing and new donors identified, and for both bilateral and multilateral projects. The collective total now exceeds over 140 projects in 40 countries worldwide. GWSI is on track to meet its original target of reaching 5 million beneficiaries by 2015 which will now probably reach at least 7 million. A mid-term review of the Initiative will be concluded in early 2011 to guide the next five years of the GWSI to 2015.

Knowledge Management

This includes better assessments, monitoring, evaluations, knowledge sharing, learning, and connection with the academic world.

While much of the above is ongoing and continuous work, some specific achievements have been done in 2010 including several publications, especially in the Humanitarian Exchange magazine and more connections with the academic world. Notably, contacts with the World Association for Disaster and Emergency Medicine (WADEM) promise to provide more access to universities and researchers around the world.

The Global Team

A key new focus was put on the concept ---- of a global WatSan and Emergency Health team that extends the work beyond Geneva as separate from the Zones and regions. It is clearly recognized that, in order to be able to deliver optimal outcomes for NSs, the WatSan/EH capacities in the IFRC have to work as a globally positioned team.

The proactive application of the concept in 2010 has lead to increased use of EH and WatSan resources in terms of collaboration, better communication, mutual and horizontal learning, and direct support and deployment. This approach will be further operationalised and will contribute to the wider application of the Global Health Team concept.

Human resources

Increased efforts contributed into further strengthening of the HR availability, capacity, and resources in GVA EH team and in the field. The addition of one EH senior office in GVA (as SoL from Norwegian RC) has resulted in a significant boost in the capacity of the EH team.

In the field, the support in recruiting and managing the Africa EH delegate has resulted in a significant increase in capacity for EH management in Africa, this position should be replaced and supported further.

The Global WatSan Software focal point continued to provide support to hygiene promotion activities in emergency and developmental programming. This included developing the Federation's role in community led total sanitation (CLTS).

Constraints or Challenges:

Overall, the decentralization process continued to make roles and responsibilities and accountability unclear at times, especially in Africa.

Meanwhile, the need for intervention and providing support to the field by the secretariat in Geneva has in some cases increased as zonal technical capacity in some cases has decreased during 2010.

A balanced approach is required for the secretariat to operate in a more integrated manner, and to ensure that geography does not serve as an impediment when carrying out water, sanitation and emergency health activities.

While WatSan programmes now almost universally attempt a balance between hardware and software, with Emergency Appeals and long term programming including hygiene promotion activities, sanitation activities are not matching water supply in terms of coverage or allocated budget. The WatSan/EH unit is attempting to remedy this disparity.

There have been late and at times inappropriate global and field level disaster response tool deployments. Weaknesses that are recognised are late and poor field assessment and a general lack of knowledge on which tool to use and when. Integration and joint deployment between FACT/RDRT and ERU/RDRT is still weak and needs to be better addressed. In longer-term programming GWSI late delivery has been common for most projects, needing more realistic setting of timelines and greater efforts to ensure human resource continuity to improve project delivery. GWSI projects setting more realistic time scales for implementation – most projects now planned for 4 to 5 years on average.

Coordination and representation

Coordination and representation gained more prominence over the past year, especially with the progress made in the decentralization process, and the roll out of several functions to the zones. Coordinating global efforts and representing the IFRC is a function which is gaining increased importance for maintaining homogenous approaches and activities, as well as enabling mutual learning. The once Geneva based position of a global Hygiene Promotion Specialist continues to provide this support by being based in a Zone Office.

Furthermore, through the incorporation of H2P staff into the WatSan/EH Unit which is planned for 2011, the IFRC will strive to mainstreaming Humanitarian Pandemic Preparedness and Response activities (H2P) with regular programs and sustaining the good practices and behaviour change messages beyond the H1N1 pandemic. Messages and lessons learned from H2P will be related to activities found in other programs such as the Epidemic Control for Volunteers (ECV).

HIV

Programme summary

The International Federation's global HIV programme is being implemented based on the Global Alliance approach which is anchored on the public health approach. The purpose of the Red Cross Red Crescent Global Alliance on HIV (GA on HIV) is to scale-up the IFRC's efforts to support national HIV and AIDS programmes to reduce vulnerability to HIV and its impacts through three programmatic objectives and one enabling objective:

1. Preventing further infection.
2. Expanding care, treatment and support.
3. Reducing stigma and discrimination.
4. Strengthening community and National Red Cross Red Crescent Societies' capacities to deliver and sustain scaled-up programmes.

The implementation of GA on HIV programmes is well aligned with Strategy 2020 contributing to strategic aim two and enabling action 3. Efforts are underway for further refining this alignment with S2020.

Programme outcome

The following are specific outcomes for 2010:

- In collaboration with the Middle East Federation Zone office oriented the National Societies within the region on the conceptual framework of the GA on HIV.
- Provided technical support to HIV and health coordinators in the regions and enabled them to deliver quality technical support to National Societies.
- Contributed to the development of National Societies' technical capacity in collaboration with the secretariat offices in the Zones.
- Developed tools that support National Societies in the implementation of programmes.
- Rendered technical support to zone offices and National Societies, and enable them to conduct assessments and evaluations of HIV programme performances as per scheduled time frame.
- Facilitated knowledge sharing among National Societies on lessons learnt from evaluations and from organizations of centres of excellence in public health areas.

Progress towards outcomes

A total of 17,859,735 persons were reached with prevention messages and 281,453 PLHIV and orphans received psycho-social support from 70 National Societies.

The achievements being registered are encouraging. There is a positive move towards meeting the target set for the end of 2010 of doubling our beneficiary outreach. The biggest stumbling block affecting progress is the lack of financial resources..

Achievements

GA on HIV programme deliveries

Based on data collected from the Zones and National Societies, the HIV team at the secretariat in Geneva was able to compile a global report on HIV programme deliveries for 2009. In total, 70 National Societies submitted data on programme deliveries. Over 90% of the National Societies which submitted reports are those which signed up for GA approach and are also implementing comprehensive HIV programmes. This is the second time that the HIV team is able to capture

programme performance data at the global level from such a significant number of National Societies.

The compilation and analysis of the received data reveals that in 2009, a total of 17,859,735 persons were reached with prevention messages and 281,453 PLHIV and orphans received psycho-social support from 70 National Societies. Of these, 51 per cent were reached in Africa, showing that the National Societies in Africa exerted more efforts to scale up their programmes and reached more people with prevention messages, as well as rendered support to those infected and affected.

With respect to resource mobilization, the report showed that a total of 34,721,176 Swiss francs were mobilized by the 70 National Societies. This represented only 0.3 per cent of the global spending on HIV (13.7 billion US dollars) in 2009. It is important to note here that Red Cross Red Crescent National Societies, because of their capacity to mobilize and involve the community, are able to reach more people and deliver services with relatively little resources. On the other hand, this is also a reminder that the IFRC needs to work harder to get a better share of the globally available resources for addressing the challenges of HIV.

Development of tools

The HIV Prevention Guidelines were printed in Spanish, French and Arabic and distributed to Zones and National Societies in 2010. Moreover an advocacy tool on harm reduction for injecting drug users has been developed in English, French, Spanish, Arabic and Russian, printed and distributed to National Societies.

As part of our efforts to better address gender inequalities and sexual and gender based violence, the HIV team in Geneva, in collaboration with SAfAIDS , began the development of a new module on gender to be included in the HIV Prevention, Treatment, Care and Support training package for community volunteers. The module will be completed and piloted in 2011.

Capacity building

In February 2010, the HIV team at the secretariat in Geneva in collaboration with its Zone office in Panama organized a master trainer's course on the Federation's training package. Twenty-two professionals from nine National Societies and from the Zone office were trained as master trainers on all 8 modules to help the respective National Societies conduct training of trainers (TOT) courses, and to cascade down these skills to the branch and volunteer level.

In December 2010, the HIV team also organized in collaboration with the Zone office in MENA, a master trainer's course in Amman, Jordan. 17 professionals from 10 National Societies and from the Zone office were trained. To date, a total of 147 master trainers were trained from National Societies in Southern and Eastern Africa, South and South East Asia and in the Americas.

Knowledge sharing

The global HIV team in Geneva supported the Southern Africa Zone office to conduct a mid-term evaluation of the GA on HIV programme performances of the ten National Societies in Southern Africa.

In July 2010, the IFRC, with the support of Zone offices, organized for 72 representatives from 36 National Societies to participate in the 18th International AIDS Conference in Vienna. National Societies submitted abstracts and many were selected to present in the poster exhibition at the Conference. Prior to the Conference, the IFRC arranged a two day satellite meeting for National Societies, Zones and partners, focusing on facilitating experience and knowledge sharing among National Societies, lessons learnt from the Southern Africa midterm evaluation, from other region's performances and from invited professionals from WHO, UNAIDS and UNODC on the integration of TB and HIV programmes and on the scaling up of harm reduction programmes related to injecting drug use and HIV infection.

On the eve of the Conference, participants acknowledged that the HIV epidemic remains one of the biggest public health problems in low and middle income countries affecting the lives of millions of poor and marginalized populations. They expressed their commitment to:

- 1) Reach more people with information on prevention using appropriate strategies.
- 2) Do better and further scale up efforts to reach out to more people in need of care and support.
- 3) Continue using the Global Alliance approach for designing comprehensive HIV and TB programmes while refining it from lessons learned during performances.
- 4) Make the utmost efforts to scale up programme implementation and support the efforts of governments in rolling out antiretroviral therapy through enhancing adherence to treatment and by providing psychosocial support to people infected and affected by HIV and TB.
- 5) Scale up harm reduction programmes related to injecting drug use in countries where the problem is prevalent.
- 6) Exert all possible efforts to systematically integrate TB and HIV programmes at service delivery levels and support PMER of these services.
- 7) Work actively to support National Societies to enable them access resources at the country level. In addition, to make all possible efforts to mobilize resources at regional and global levels.
- 8) Ensure workplace programmes are developed.
- 9) Finally, we admire the important role played by members of the RCRC+ Network in promoting awareness and fighting stigma and discrimination within National Societies and commit ourselves to support their efforts in all possible ways.

HIV in emergencies

The HIV team at the secretariat in Geneva continued to support the mainstreaming of sexual and reproductive health, HIV into the IFRC's emergency response activities. The HIV team in Geneva is actively participating in the global IASC sub-committee on HIV in humanitarian settings. The HIV team in Geneva has sent the newly developed IASC guidelines for addressing HIV in humanitarian settings to Zone offices, with specific efforts underway to facilitate the implementation of HIV related activities in the aftermath of Haiti's earthquake and in the context of the Health programme contribution to Federation-wide strategic framework for Haiti recovery.

Partnership with people-living with HIV (PLHIV)

The HIV team at the secretariat in Geneva continued to support the Red Cross Red Crescent network of PLHIV (RCRC+) in 2010.

The RCRC+ members in the Americas have been active in expanding their membership within the region. They have also been active in supporting the implementation of GA on HIV programmes. All members of RCRC+ in the Americas actively participated in the master trainers' course that was conducted in Panama in February 2010. Following the master trainers course, RCRC+ focal points from 4 National Societies met in Panama in which the zone's health coordinator and the manager of HIV, TB and malaria programmes in Geneva also participated to create a 3 year action plan for the network. Priorities included:

- ✓ To improve the recognition and position of the RCRC+ network as a leader in responding to HIV (members to be visible at the AIDS 2010 Conference and in other regional conferences)
- ✓ To contribute to the reduction of stigma and discrimination within the Movement (identify situations and promote implementation of the assessment tool on stigma and discrimination; focus on advocacy for PLHIV within the Global Alliance on HIV; and help to implement and disseminate the workplace policy)
- ✓ To strengthen and develop the RCRC+ network mandate
- ✓ To build the capacity of the RCRC+ network

- ✓ To ensure mechanisms to improve internal and external communication of the RCRC+ network to share information and support
- ✓ Continue to champion the Masambo Fund Foundation within National Societies

To date, over 172 Red Cross Red Crescent volunteers and staff living with HIV have become part of the RCRC+ network

Advocacy

The International Federation, in line with this theme and the outcome of the XVIII International AIDS Conference "Rights Here, Rights Now", would like to join forces through its membership to advocate for human rights and to stand up against stigmatization and discrimination towards the most marginalised and affected populations so that they can access services. To do so, NS were encouraged to partner 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.

On World AIDS Day 2010, the HIV team capitalized on the presence of the Governing Board members in Geneva and organized an in-house event at high profile. A mapping of NS involved in Harm reduction programmes and a new Advocacy report, on harm reduction "*Out of Harm's Way*", was launched. The report depicts the stark reality of injecting drug users and HIV transmission in relation to the booming HIV epidemic in Eastern Europe and Central Asia. Moreover useful publications for World AIDS Day were sent to all National Societies to help them organize events in their respective countries. Accordingly many National Societies organized different events at high profile including launching the harm reduction advocacy paper in different languages.

Programme integration

In the new organizational structure of the health department, HIV, Malaria and TB global programmes have been structured under one unit. This allows a closer integration of HIV and TB and when possible with Malaria using CBHFA as an approach and a platform to nurture a greater and sustainable community health response. Currently efforts are underway to facilitate programme integration wherever feasible.

The Masambo Fund Foundation

Since 01 January 2009, the Masambo Fund received 182 applications (the largest number of applications received in any period since its foundation in 2003). Of these 182 applications, the Masambo Fund was able to help 65 nominees from various National Societies around the globe including Red Cross Red Crescent staff and volunteers from Argentina, Côte d'Ivoire, Malawi, Mozambique, Panama, Togo and Zimbabwe. This increase in applications is largely due to the HIV team in Geneva's commitment over the last year to reignite interest in the Masambo Fund through various awareness-raising campaigns and through the development of a Masambo Fund booklet entitled "The Ties That Keep Us Together." This publication is now available on request from the HIV team in Geneva and was made possible in part by the support of the Norwegian Red Cross and Saatchi and Saatchi (an advertising company who provided their design expertise pro bono to the project).

As a result of these awareness-raising activities, the Masambo Fund now finds itself in a new position: the Fund is now receiving more applications than it can support. These applications are arriving at an alarming rate (79 new applications were received in 2010 alone).

At the end of 2010 the Fund is left with only CHF 74,082 in its account. However, of this amount, 56,000 CHF has been committed in 2010 to support 8 nominees from Zimbabwe Red Cross. Once the final paperwork has been finalized, the transfer will be made to Zimbabwe – thus leaving the Fund with 18,082 CHF for pending grants in 2011. The actual amount of financing needed to support the remaining 117 pending applications is CHF 791 000 – a stark difference from previous years where funding was readily available but the number of applications received

was low due in large part to the stigma and discrimination surrounding people living with HIV. For more information on the Fund, please refer to the 2010 Programme Update available on Fednet.

Constraints or Challenges

For National Societies and zones, the major constraint remains a shortage in funding for scaling up HIV programme implementations in line with the GA on HIV approach.

At the secretariat in Geneva, a major challenge for the HIV team in the first semester of 2010 has been the shortage of a technical person. The work on HIV has been coordinated only by the manager of the unit in addition to coordinating the TB and malaria programmes. In the new structure in addition to the manager only one senior officer post has been allowed for HIV. The new senior officer resumed his post in September 2010.

No technical staff member at secretariat in Geneva is dedicated to output 3 of the GA on HIV, which is still underdeveloped. The Principles and Values department is keen to create a position in their department to work on HIV-related stigma issues, and to take the lead on delivering the three-year UNAIDS collaborating centre agreement.

Most donor National Society support for the HIV part of the health and care appeal has come six months or later into the year and is earmarked, making it very difficult to effectively carry out programme activities. Therefore, most of the expenditure for the first six months had to be recoded, doubling the workload for the HIV unit, with its already limited human resources.

TB

Programme summary

The International Federation has been actively involved in the global fight to prevent and control tuberculosis (TB) in countries with the highest burden of disease. Over the past 6 years, Red Cross and Red Crescent Societies globally allocated approximately CHF 20 million to save lives and prevent the spread of TB and multidrug-resistant TB (MDR-TB).

TB programmes supported by Health Department in 2010 include:

1. USAID fiscal year 2010 activities (450 000 USD). Programme includes 3 countries, as well coordination at the global level.
2. 2011 is the last year of the second phase of the Eli Lilly / IFRC global partnership 2008-2011 (1.7 million USD). The partnership supports activities in more than 10 countries.
3. Health department supports country TB activities in Ethiopia, Russia, Namibia as well as regional TB trainings in Southern Africa (400,000 USD).

Programme outcome

Scaling up and coordinating the International Federation's global response to TB, a major public health problem, through promoting and advocating for National Red Cross and Red Crescent Societies to become credible players in TB control programmes at the country and regional levels.

Progress towards outcomes

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

Achievements

Worldwide, in more than 40 countries in 2010, the Red Cross Red Crescent provided daily care to 150,000 TB patients, out of which 10,000 were patients with MDR-TB. 30 000 new cases were detected due to Red Cross and Red Crescent referral. Furthermore, 5 million community members were mobilized, with 14 million hours allocated through 80,000 Red Cross and Red Crescent staff and volunteers.

Technical programme support / Partnership / Advocacy

Since the beginning of 2010, TB programmes coordinated by the International Federation continued in Eastern Europe, Central Asia and expanded in Southern Africa, East African regions and Asia. During the reporting period, with the support of the global TB programme, Indian Red Cross, Namibian Red Cross, Azerbaijan Red Crescent, Chinese Red Cross, Ethiopian Red Cross Societies finalized their work plans, and started the MDR TB programmes. The Southern African region received support to organize trainings in TB / MDR TB / TB and HIV for staff and volunteers of 10 National Societies. Trainings were organized in South Africa, Swaziland, Malawi and Lesotho.

The informal global working group on TB is coordinated by the health department. The 2010 Global Red Cross Red Crescent TB working group meeting took place in Cape Town, South Africa from 28 February to 02 March 2010. The following key decisions were made in this meeting: to finalize standardized indicators, including the ones for TB / HIV activities; to work out recommendations on infection control for National Societies involved in TB programmes; to develop the TB advocacy toolkit; to further develop components of TB Programme related to psychosocial support, facilitation of support groups, and training.

The IFRC took part in the development of inter-professional trainings together with the International Council of Nurses (ICN), the World Medical Association (WMA) and the International Hospital Federation (IHF) in the care and protection of health care workers dealing with MDR TB. The training took place in Benin in September 2010.

The Health department together with the Global Advocacy Partnership organised a TB Advocacy Workshop in Geneva in June 2010. The training was organised with the support of Eli Lilly. Ten participants from Red Cross and Red Crescent Societies of Russia, Belarus, Georgia, Armenia, Kazakhstan, as well as the IFRC regional office in Almaty, and three Advocacy NGOs participated in the four days workshop. One of the working documents developed was a draft advocacy toolkit.

In May 2010, an evaluation took place of the TB components of the Liberian Red Cross Community (LRCS) based health project (CBHP) together with British Red Cross, as the TB Component receives support by Astra Zeneca through British Red Cross. The Evaluation found that TB is as a major and very effective component of CBHP. It is cost effective, voluntary based and focused on community involvement and participation. The evaluation recommends expansion, closer links with National programmes and to advocate strongly together with LRCS to be more involved in GFATM supported TB activities. The detailed report is now available on request.

During 2010, the IFRC initiated an implementation overview of the Lilly / USAID-supported projects in South Africa, Kazakhstan and India, examining the Red Cross Red Crescent projects in the areas of:

- clarity of commitment
- coordination
- monitoring, reporting and documentation
- technical competence
- International Federation support mechanisms

The overview took the form of interviews, meetings, focus group discussions with key informants using semi-structured questionnaires and observation of practice whenever possible.

After two rounds, the programme managers were better conversant with the project components and the relationship between the project framework and work plan. They were also more confident in identifying and working with key stakeholders. There is a significantly improved reporting and recording system.

Participation in ERNA 2010 Annual Meeting, 24-26 September 2010 in Minsk. Interventions have been made on July HIV GA meeting, as well funding opportunities for RC RC TB programmes.

Technical support was given to Ethiopian Red Cross: mission to Ethiopia, working with NS in planning, meetings with governmental as well as other partners.

Participation in the Europe Zone Senior Management meeting in Budapest: A special session on TB HIV / Drug Use was included in the agenda. The International Federation participated together with the ERNA President and Zone Health Coordinator.

Harm reduction

The Health department coordinates trainings in harm reduction together with the Italian Red Cross, taking place in Villa Maraini in Rome. During 2010, four trainings took place. The trainings are co-facilitated by the Senior Health Officer. A specific session on TB and HIV for drug users was developed.

In addition the grant includes the programme activities in 6 countries: Azerbaijan, Kazakhstan, Kenya, Uganda, Cambodia and Argentina. Overall coordination and reporting is done by the health department.

Funding is confirmed to continue in 2011 for the Federation coordinated harm reduction programmes for drug users. The funding – 200,000 EURO will cover programme activities in six countries and trainings in harm reduction conducted jointly by Italian Red Cross and the Federation in Villa Maraini.

IMPACT programme – The IFRC (Senior Health officer) is a member of the technical advisory committee as per suggestion / request of Italian Red Cross. Of the EU funded and Italian Red Cross / Villa Maraini coordinated a research project that aims to increase an access to HIV and TB testing for drug users in Slovak Republic, Netherlands, Italy and Czech Republic. Three meetings took place in Rome, Amsterdam and Turin. Technical input was provided to the action plan and working manual.

Global representation

- ✓ High level advocacy: the Senior Health Officer is a member of the Steering Committee for the WHO TB/HIV. A meeting was held before the International AIDS Conference in Vienna, July 2010. The Senior Health officer is the member of WHO collaborative in TB trainings.

- ✓ Global TB Meetings in Berlin, Germany. The series of TB events marked beginning of November, in connection with the annual conference of International Union of Lung Diseases and TB and Lilly MDR TB summit. Brief outline of meetings / events:
 - TB Alliance (groups of organisations / institutions focused on research for vaccine / diagnostic / treatment) has been briefed on RC activities and potential for new / innovative ways of partnership.
 - Lilly MDR TB Summit, attended by representatives from 2 Zones – Europe and Africa, Russian Red Cross, South African Red Cross, Health department, resources mobilization and communication departments.
 - Round Table on TB in Europe highlighted issues / challenges re emergency in Europe, mobilizing resources at EU level, advocacy strategies. Europe Zone will be involved in activities at most possible level.
 - Round tables on TB in South Africa and Russia have been attended by respective Red Cross Societies with specific presentations.
 - Meeting at German Red Cross: “Dialogue with Gerry Elsdon”. Sensitization meeting has been organized at German Red Cross HQ in Berlin with the staff members. The IFRC Global TB Ambassador together with global health team (Zones + Geneva), representatives from Russian Red Cross and South African Red Cross highlighted challenges in TB worldwide, specifically in East Europe and Africa. The meeting was organized by Health Adviser of German Red Cross – Christiane Haas. Million thanks to her.

IFRC TB Ambassador

Work with celebrities and well-known people, helps to engage public support, mobilise people and raise awareness. In 2010, the South African TV Celebrity, Ms. Gerry Elsdon has been the Red Cross Red Crescent Global TB Advocate. Special TB Advocacy events were organised at UNAIDS in April 2010 and in Washington, DC during the World Health Conference in June 2010.

Global Stop TB Partnership

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 May 2010. The Committee included members from WHO, UNAIDS, as well as other NGO representatives.

Constraints or challenges

Numbers reached (approximately 150,000 most vulnerable TB and MDR TB patients, are relatively small in comparison with programmes that involve mass campaigns but, this kind of intervention is extremely labour intensive, life saving (particularly for MDR TB) and the results prove that it is an intervention that works well.

The projects report that, of the directly observed patients selected by Red Cross Red Crescent Societies are difficult to be reached by National Systems, represent most vulnerable groups of population, and still, the majority continued with their treatment.

Influenza

The **Influenza Unit (IU)** supported National Societies (NSs) with financial and technical support, to contribute towards minimizing human morbidity and mortality, social disruption and related suffering caused by an influenza pandemic. Essential to the programme’s success was the ongoing collaboration and coordination with multiple implementing partners, including NGOs, UN agencies, local governments and Movement partners. NSs implementing H2P projects developed pandemic preparedness and response plans, trained staff and volunteers, provided consistent messages to communities, in addition to ongoing in-country coordination with all stakeholders.

Through the USAID, DFID and private funding, the program was reaching 94 countries and in early 2010, the IU started a reassessment of H2P projects to ensure a better distribution of funds according to needs.

To review the H2P program, a team (PRT) was formed by external consultants and representatives from IFRC and partner organizations. The team visited 10 countries, conducted 21 interviews of global partners, and surveyed a large number of National Societies.

Outcome(s)

- National Societies (NSs) are enabled to provide humanitarian pandemic response messages and tools for implementation in the areas of health, food security and livelihood.
- A well functioning network of NGO partners is developed as well as action plan for in-country H2P partners that summarizes overall strategy, roles and responsibilities, priority tasks, and monitoring and evaluation plan, including indicators.
- The in-country capacities of staff, volunteers and selected NGO partner(s) are also strengthened to carry out influenza pandemic preparedness and response plans and protocols aiming at a sustainable impact.

Achievements

Since the H1N1 pandemic in April 2009, the IFRC accelerated the pace of the H2P programme at the global and country level. Beside the basic guidance and the communications campaign “Your best defence is you” provided to all 186 National Societies in 2009, the IFRC has provided more comprehensive support for preparedness and response projects with 72 National Societies and their communities. These projects helped NSs develop partnerships, train volunteers and community leaders, and prepare detailed business continuity and pandemic response plans. Additional 22 NSs received financial support to conduct the “Your best defence is you” campaign.

Consultative and coordination meetings were organized by NSs with their local governments, UN and NGO partners during the Contingency Plan development. About twenty NSs have completed the plan and most were endorsed by their local Governments.

Forty or so NSs have adapted and disseminated the IEC materials developed. Most IEC materials were translated in local languages taking into account the socio economic, cultural and religious aspects.

Mapping activities for potential partners were conducted as part of baseline assessment. However for those who did finalize their mapping activities, key contact persons at country, provincial and district levels were identified, and have been updated regularly.

Most National Societies conducted or participated in briefing sessions and coordination meetings with government authorities, United Nations agencies and Non-Governmental Organizations in order to coordinate efforts and develop action plans that summarize the overall strategy to respond to the pandemic.

The H2P curricula package was used to train volunteers and inform communities by adapting the generic H1N1 campaign to country context and, translating material into local languages, printing posters and distributing leaflets, all with official approvals. Materials developed are available on www.pandemicpreparedness.org.

Personal Protective Equipments were purchased and pre-positioned for the use of first-responders in case of emergency.

A Program Review of the H2P program was a major activity during 2010. The review focused at both the global partner level and ten randomly selected country projects. The program review team (PRT) was formed by external consultants and representatives from IFRC and partner organizations. By the end of October 2010, the Program Review report was finalised and

provided an interesting assessment of the impact of H2P, findings and conclusions. <http://www.ifrc.org/docs/evaluations/Evaluations2010/Geneva/Report%20H2P.zip>

Constraints or Challenges

The drop in the value of the US dollar against the Swiss franc has exacerbated the unit's financial challenges. The loss of approximately 1.5 million US dollars had jeopardized obligations made to National Societies and led to necessary adjustments of projects.

Although the IFRC was pleased to receive, along with the rest of the world, the announcement from WHO declaring the 2009 H1N1 pandemic to be over, it has however made it even more difficult to continue the dialogue with stakeholders on the importance of pandemic preparedness and response.

Working in partnership

- The primary partners for achieving our health department goals are National Societies and PNSs, which implement the programmes and conduct large-scale social mobilization activities. At the national level, National Societies participate in the Ministry of Health-convened Inter-Agency Coordinating Committees and different task forces and working groups.
- The IFRC continues to work with relevant external health partners, including the WHO, GFATM, and different UN agencies, the US Centers for Disease Control and Prevention (CDC), as well as several government and funding bodies. The IFRC continues to expand its partnerships with private sector organizations such as Eli Lilly and Company, Exxon Mobil, Nestlé, Shell, and other development and funding agencies such as the Gates Foundation.
- The health department works in close cooperation with the First Aid International Advisory Board, the RCRC European Education network, the European Reference Centre for First Aid education and European Resuscitation Council.
- In 2010, the GAVI Alliance Civil Society Organization Steering Committee was established, which includes 20 civil society organizations from 16 different countries. Members include representatives from international organizations (such as Médecins sans Frontiers, World Vision, Catholic Relief Services); academic institutions (Emory School of Public Health); professional associations (International Paediatric Association); and local NGOs in affected countries. The IFRC is the Chair of the Steering Committee.
- The International Federation chairs a global health partnership, the Alliance for Malaria Prevention, which is focused on 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 an 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) the World Health Organization (WHO).
- In 2010, and in line with current trends promoting the integration of HIV into global health and development strategies, IFRC joined the Stop AIDS Alliance project, which comprises the International HIV and AIDS Alliance and Stop AIDS Now, with the aim to influence the HIV and health agenda, through working with internal and external stakeholders including UN agencies, permanent missions of key EU member states, the EU and US delegations as well as other Geneva based civil society organisations. A senior policy adviser was jointly recruited by the Federation and Stop AIDS now to foster policy engagement with key Geneva based institutions, policy analysis and synthesis, and proactive communication.
- The International Federation is an active member of the Stop TB Global Partnership. The Senior Health Officer chairs the CSO selection process of Stop TB funded mechanism for civil society organizations.

Contributing to longer-term impact

Community health programmes contribute to MDGs 4, 5, 6 and 7. Key outcome indicators were added to the CBHFA indicator guideline to insure measuring the contribution of community health activities to the MDGs. Also, the health department is working closely with the disaster risk reduction department to better identify the CBHFA contribution to resilience.

Vaccination is one of the most cost-effective health interventions, and a key tool in reducing child mortality due to vaccine-preventable diseases. New vaccines, such as pneumococcal vaccine and rotavirus vaccine, present the opportunity to reduce child mortality by a *further* 25 per cent. Red Cross Red Crescent national society participation in vaccination campaigns helps to increase vaccination coverage (particularly when consistently done in set intervention areas), which helps to reach campaign goals. For example, in a series of polio campaigns organized in Senegal in 2010, campaign coverage (according to independent monitoring results) increased more drastically in areas where Red Cross volunteers were active over the course of three campaigns than in areas where no volunteers were active.

The efforts of reaching more people, in particular the most at risk populations, with informed, evidence-based prevention and treatment, combined with information, education, social mobilization and behaviour change communication will move our beneficiaries closer to achieving the 2015 MDG targets and to healthier and safer living.

Looking ahead

Strategy 2020 has a wide range of implications for health programming, at all levels: individual, community, national, and global levels. The Global Health Team will work as per its Strategic Operational Framework to achieve S2020's ambitious goals in order to build resilience and reduce vulnerabilities.

Among other priorities, our work in malaria prevention and control has begun to shift to look beyond scale up and towards sustainability. Given that malaria represents a major hurdle in reaching the MDG targets there is a lot of work to be done. Additionally, major effort will be exerted to significantly increase the funding support for scaled up programme implementation. National Societies, as part of their overall health plans, will be encouraged and supported to develop new integrated HIV, TB programmes documents 2011-2015, to strengthen their relations with governments through humanitarian diplomacy and in accessing funding support.

<p>All Federation 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 is committed to the Humanitarian Charter and Minimum Standards in Disaster Response (Sphere) in delivering assistance to the most vulnerable.</p>	
<p>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.</p>	<p>The IFRC's work is guided by Strategy 2020 which puts forward three strategic aims:</p> <ol style="list-style-type: none"> 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 non-violence and peace.
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