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Annual report Sahel region

 International Federation
of Red Cross and Red Crescent Societies

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**This report covers the
period 1 January to 31
December 2011.**

*Senegalese Red Cross
volunteers distributing food
items to a community
affected by the food crisis
in Kanel (north Senegal).*

Photo: SRCS/IFRC



In brief

Programme outcome

In line with the International Federation of Red Cross and Red Crescent Societies' (IFRC) Strategy 2020, the Sahel regional representation's disaster risk management department aims to provide support for disaster risk reduction, including adaptation to climate change, disaster preparedness, response and recovery services. Its health programmes focus on enabling safety and resilience at community level, along with increasing capacity of communities and volunteers to be prepared and able to respond to first aid needs and identify health priorities in their communities.

To effectively implement the core programmes of the revised regional plan for 2011, the regional representation has been working closely with nine National Societies in the Sahel region - Burkina Faso, Cape Verde, Gambia, Guinea Bissau, Guinea, Mali, Mauritania, Niger and Senegal. It also acts as an operational hub, providing technical programme support (including capacity building) to IFRC and National Societies throughout West and Central Africa.

Programme summary

The Sahel regional representation introduced a revised plan in July 2011. The main objective of this plan was to enhance the operational efficiency of the regional office and increase its capacity to engage with National Societies to scale up humanitarian work. The plan also brought both the disaster management and health programmes (along with organisational development and principles and values) under a single disaster risk management department. Services under these programmes were provided through risk preparedness, risk reduction, response and recovery.

During the reporting period, the regional representation continued to provide technical support in the areas of disaster management, including:

- Disaster risk management;
- Development of tools, standard operating procedures, databases and guidelines;
- Policy dissemination;

- Trainings such as the Regional Disaster Response Team (RDRT), Vulnerability and Capacity Assessment (VCA) and trainings of trainers;
- Hazards/risk mapping, implementation of early warning systems and contingency planning;
- Quality control including of Disaster Relief Emergency Fund (DREF) and emergency appeal operations;
- Provision of surge capacity including RDRT, Field Assessment Coordination Team (FACT) and Emergency Response Unit (ERU) deployment and capacity building;
- Strengthening sectoral technical expertise in early recovery capacity, emergency water and sanitation, health, shelter, food security, human resources, emergency logistics, disaster reporting, disaster risk reduction and its integration into programming and climate change adaptation;
- Support services including logistics (procurement, stocks, warehousing), finance accounting and analysis, communication, information and communications technology (ICT), resource mobilization, monitoring and evaluation, reporting, partnerships and networking, advocacy, research and knowledge sharing.

As a hub, the regional representation also led relief operations in the region and contributed to disaster response efforts and response to public health emergencies through the provision of humanitarian assistance, staff and technical support to National Societies in the region.

In the field of health, the regional representation made significant progress under the maternal, newborn and child health project being implemented in the West Africa Sahel National Societies of Gambia and Mali. The aim of the project was to improve people's knowledge on integrated management of childhood illnesses. In addition, the regional representation also continued to support National Societies in developing malaria activities to support communities in reducing the effects of malaria on their lives. An interesting health project was a tuberculosis pilot project initiated in Senegal during the reporting period.

Financial situation

The total 2011 budget was increased from CHF 3,493,532 (last approved at the beginning of mid 2011) to CHF 4,093,961, due to new funding opportunities that allowed further expenditure.

Of the revised budget of CHF 4,093,961, a total amount of CHF 4,737,927 (116 per cent) was covered during the reporting period (including opening balance). Overall expenditure during the reporting period was CHF 3,260,453, corresponding to 80 per cent of the revised budget and 69 per cent of the funds available.

Project/programme yearly finance status			
Year budget	Expenditure	Per cent of budget	Per cent of available funds spent
CHF 4,093,961	CHF 3,260,453	80 %	69 %

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

Number of people we have reached

Programme	Activity	No. of people reached
Disaster Management	Relief activities regarding floods – populations movement – civil unrest	162,890
	NDRT, CDRT Contingency plan trainings	148
Health and Care	Distribution and hang up of long lasting insecticide-treated nets + awareness raising on malaria and its prevention	2,857,329
	Community based malaria activities	105,401
	Response activities related to cholera and yellow fever outbreaks	787,576

Our partners

The Sahel regional representation continued to work with both Movement and non-Movement partners that supported its disaster risk management programme and health initiatives. Movement partners that supported the disaster management programme included the Qatar Red Crescent, the Red Cross Societies of France, Ireland, Spain, Britain, Denmark, Sweden, Norway and China, as well as the International Committee of the Red Cross (ICRC). Partners outside the Movement included the African Union, United Nations agencies (including ISDR, UNICEF and WFP), United States Agency for International Development (USAID) and Organization of the Petroleum Exporting Countries (OPEC).

In the field of health, Movement partners included the Red Cross Societies of Canada, Sweden, Norway, Japan, Spain and France, along with ICRC. Outside the Movement, partners included government authorities such as the departments of health, departments of social welfare and development, national disaster coordinating councils, national food authorities, national malaria control programmes (under the Ministries of Health), overseas workers welfare administration and local government units. Collaboration was also established with WHO, UNICEF, Irish AID, USAID, ECHO and Lilly MDR partnership, along with non-governmental and community based organisations. IFRC and the national societies wish to thank partners for their collaboration and support during the year.

Context

The Sahel region is located in Sub-Saharan Africa and is the world's poorest region. Its countries face acute vulnerabilities that put them at high risk of hazards worsened by climate variations. Over the past decade, the region has faced recurrent disasters that have quickly destroyed several years of development efforts built from poor national resources. Moreover, this region, which is continuously at risk of hazards, has also been facing a food crisis of an increasingly alarming scale.

During the reporting period, several countries in the Sahel region continued to be at high risk of food insecurity and malnutrition. The localized deficits of cereal production and sustained high levels of food prices were among the causes for this. The most affected countries were Niger, Chad, Mali, Mauritania, Burkina Faso, Senegal and Gambia. Pregnant and breastfeeding women, along with young children, were the most vulnerable to malnutrition. To help its concerned National Societies to face this situation, the Sahel regional representation supported food security, nutrition and livelihoods assessments in the affected countries. These helped the National Societies gain a clearer understanding of the humanitarian situation in the field in preparation for launching relief operations focusing on assisting more vulnerable communities, in coordination with other humanitarian actors.

In addition to this, the National Societies of Guinea, Niger and Senegal responded to weather related disasters such as floods. Countries in the Sahel region also experienced population movements resulting from political crises. At the beginning of the Libya uprising in February 2011, the number of Nigerien returnees transiting through Dirkou in Niger reached 2,000 persons per day. The political violence in Côte d'Ivoire caused a population influx in Liberia. The ongoing political instability in Ziguinchor, in south Senegal, restricted the national distribution of long lasting insecticide-treated nets to achieve universal coverage in Senegal.

The Sahel region is also affected by a number of health issues, particularly maternal and child health problems, which pose a serious threat to the improvement of overall health status of countries in the region. Infant mortality levels remained high during the reporting period. As for maternal mortality, its main cause has been related to anaemia during pregnancy. Anaemia in both pregnant women and children has also been caused by malaria, hence focus was put on environmental sanitation and proper use of bed nets under the regional health priorities. Besides this, the region also witnessed a severe cholera outbreak in Mali and a Yellow Fever epidemic in Senegal during the reporting period.

Progress towards outcomes

Disaster Risk Management

<p>Programme component 1: Disaster preparedness</p>	<p>Outcome: Improved risk reduction and disaster preparedness within National Societies that builds safer and resilient communities.</p> <p>Achievements: The regional representation, with support from the Irish Red Cross, conducted training programmes to support the National Societies of Mauritania, Senegal, Mali and Guinea to improve their disaster management capacities at national and community levels. As part of this, workshops on contingency planning along with training of Community and National Disaster Response Teams (CDRT and NDRT) were conducted in these four countries in November 2011. A culture of prevention was also promoted through disaster risk reduction programmes, which contributed towards saving lives and preserving the living conditions (livelihoods) of vulnerable communities at risk of climate hazards and without response capacity. For instance, in Kindia region of Guinea, 20 volunteers from the local committee of Coyah and 15 volunteers from regional committees were trained. Similarly, 10 National Society staff members were trained in Mali, 60 people were trained in Senegal, and 42 were trained in Mauritania on CDRT, NDRT and contingency planning.</p>
<p>Programme component 2: Disaster response and recovery</p>	<p>Outcome: National Societies are supported in developing and implementing disaster response and recovery strategies.</p> <p>Achievements: In August 2011, Mali faced heavy rainfall that resulted in flooding in some locations and overflows of ponds in others. Mali Red Cross, with support from IFRC and other partners, focused on assisting 7,500 most vulnerable community members in 1,500 households directly hit by the floods. These included children under five years of age, elderly and disabled people, women who had not received any support, pregnant women and homeless people. A DREF allocation was released to assist these beneficiaries, reducing their vulnerability through the provision of tarpaulins, blankets, sleeping mats and kitchen sets, as well as preventing spread of disease through distribution of bed nets, hygiene supplies, disinfection of flooded latrines and wells, along with building awareness on good health and hygiene practices.</p> <p>With the outbreak of the Libya crisis in February 2011, the number of returnees in Dirkou, Niger reached 29,844 by April 2011 (including 2,365 other nationals) and 66,178 by May 2011, according to the International Organization for Migration (IOM) and Niger authorities. In addition, approximately 1,200 male migrants were reported to have arrived in Assamaka, north-western Niger. At the Egypt-Libya border, 100 unregistered Nigerien returnees were identified by the IOM. The Niger embassy in Tripoli requested support to evacuate 4,000 Nigerien migrants trapped in Al Qatron and 3,000 in Sabha waiting to be repatriated to Niger.</p> <p>In response to this situation, IFRC allocated CHF 250,318 from its DREF on 8 June 2011, to support the Red Cross Society of Niger in delivering assistance to 4,270 families (29,890 beneficiaries). With this support, the Red Cross Society of Niger rehabilitated water facilities and carried out sanitation activities in communities along the Libyan border. In Dirkou transit centre, 20 trained Red Cross volunteers provided first aid, primary health care and basic health services, along with psychological support to 1,613 registered refugees. The volunteers also successfully conducted 20 sensitization sessions (including promoting the</p>

	<p>use of condoms) for these refugees, along with 6,000 additional people in Dirkou town. Further, 200 hygiene kits were distributed to 200 refugees in Dirkou transit centre and Dirkou town.</p>
<p>Programme component 3: Food security</p>	<p>Outcome: Food security community based projects are implemented and beneficiaries and Red Cross/Red Crescent volunteers are trained to achieve project objectives in Mauritania, Niger, and Guinea.</p> <p>Achievements: A food security assessment was undertaken in Mauritania during the last two weeks of October 2011 by IFRC, jointly with the Mauritanian Red Crescent Society, and with support from the French and Spanish Red Cross Societies. As part of this, a rapid food security, nutrition and livelihoods assessment was carried out in different regions of the country. This helped to gain a clearer understanding of the humanitarian situation, in preparation for launching a larger scale programme focusing on assisting more vulnerable communities, in coordination with other humanitarian actors.</p> <p>A food security assessment was also undertaken in Senegal (in the north of the country, along the Senegalese river basin) at the end of December 2011, to evaluate the food insecurity in the country and prepare for a DREF allocation.</p> <p>Further, a nutrition workshop was conducted for National Societies from Burkina Faso, Mali, Senegal and Niger, to give participants an understanding of IFRC's new nutrition guidelines and obtain their feedback and suggestions for improving these. The workshop led to an increased common knowledge among participants of IFRC's role in screening and referral of acute malnutrition, of different potential partners in their respective countries, and the importance of community awareness in improving infant and young child feeding behaviours and practices. Participants developed a draft concept note on what their National Societies would do in nutrition education, screening and referral.</p> <p>In an effort to monitor the food security crisis in the Sahel region, the early warning system was used. Disaster Management Information Systems (DMIS) bulletins were posted on the IFRC website in October 2011. Assessments were undertaken and National Societies were warned to start planning for an emergency appeal early. DREF allocations were made for Burkina Faso, Chad, Senegal, and Niger, while a preliminary emergency appeal was launched in Mauritania. The regional office took an active part in the discussion initiated to have Partner National Societies supporting food security and nutrition programmes in the region.</p>

Health and Care

<p>Programme component: Community-based health programmes and first aid</p>	<p>Outcome: The protection of vulnerable populations against malaria has increased in Nigeria, Togo, Liberia, Senegal and Burkina Faso.</p> <p>Achievements: In Senegal, 140,464 long lasting insecticide-treated nets (LLINs) were distributed to 54,032 households (approximately 379,000 people) in the fourth phase of the mass campaign distribution led by the National Malaria Control Programme (NMCP). Of these households, 46,475 benefitted from communication and sensitization on malaria, including its prevention and treatment, through door-to-door visits by Senegalese Red Cross volunteers. During the household visits, volunteers were able to note that the rate of net utilisation was at 83 per cent in areas which benefitted from a Red Cross intervention.</p>
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In Cross River State in Nigeria, 994,720 LLINs were distributed to approximately 547,000 households (approximately 2,197,000 people). Nigerian Red Cross volunteers went door-to-door to assess the need for LLINs per household, as well as distribute and hang up the nets in these households. The volunteers also disseminated key information on malaria prevention and treatment. An external end process evaluation showed that approximately 87 per cent of households having benefitted from a Red Cross visit were able to correctly identify the causes of malaria and over 70 per cent were aware that sleeping under mosquito nets was the best way to protect themselves. A final evaluation and report on the impact of the distribution on the population's health is still pending. The results of the Cross River State project will better inform IFRC programming and will contribute to the global-level discussions around the feasibility of accounting for previously distributed nets during mass distribution activities.

In addition to this, the Rapid Assessment Mobile Phone (RAMP for malaria) survey was successfully implemented in the Cross River State. This was the third pilot to assess the methodology, technology and support requirements for rolling out the RAMP with National Societies (the other two surveys took place in Kenya and Namibia). For implementation of the RAMP, 19 Nigerian Red Cross volunteers were trained in using mobile phones to conduct surveys on the LLIN distribution. Further, the National Society's Calabar branch health coordinator and an independent consultant chosen by the Cross River State government were trained to manage the roll out of the survey. The RAMP allows preliminary data to be presented within 24 hours of the survey being completed and was welcomed by both the National Society and the state government.

In Liberia, where hospital records show that malaria is the leading cause of inpatient deaths and the leading reason to attend outpatient departments, 176,651 LLINs were distributed for the benefit of approximately 263,000 people (including 71,590 children below the age of five and 11,792 pregnant women) in the districts of Grand Gedeh, Grand Kru and Maryland. In addition, 42,000 households (approximately 252,000 people) were reached with key information on the dangers of malaria and malaria prevention through the Liberian Red Cross Society's community based malaria prevention project in the districts of Bomi, Grand Bassa and Gbarpolu.

In the Democratic Republic of Congo, the National Society carried out a community sensitization campaign on the dangers of malaria and best malaria prevention methods in the areas of Nioki and Inongo in the district of Maindome. With support from the Netherland Red Cross, 100 Red Cross volunteers visited 1,500 households, performed 2,000 community talks on malaria prevention and 1,000 sensitization sessions on health and hygiene.

In Togo, the National Society implemented a community based malaria prevention programme in the region of Kara. A total of 708 volunteers (made up of 20 mothers club members over two districts) were trained in community sensitization on the dangers of malaria and best prevention and treatment methods. These trained volunteers reached 15,426 households. This programme had good visibility and a roll out effect in the region, with other communities starting their own mothers clubs. In addition, these volunteers were also trained on some components of IFRC's malaria toolkit to enable community sensitization during and after the mass distribution of LLINs to reach universal coverage. Togolese Red Cross volunteers visited 18,329 households through door-to-door visits to mobilise them for household registration, encourage them to collect their nets on the correct days, sensitise the households on the importance of sleeping

	<p>under LLINs, as well as manage the LLIN distribution sites during collection days. In addition, with support from the Swiss Red Cross, the National Society distributed 41,000 LLINs as part of its community based health intervention in the plateau region.</p> <p>IFRC, with support from the Norwegian and Canadian Red Cross Societies, supported an operational research on the effectiveness of hang up activities for greater net utilisation. This qualitative and quantitative research is expected to be completed in mid-2012. A cost analysis of the hang up operation is currently being finalised and will support a cost benefit analysis of the implementation of hang up activities.</p>
	<p>Outcome: National Societies are supported to contribute to the promotion of good health and welfare of neonate, infant and pregnant women in the West Africa Sahel region.</p> <p>Achievements: All Sahel Red Cross Societies continued to work closely with the Ministries of Health in their respective countries. As a result of interventions, health facilities observed a drop in the referrals from village health workers and other health facilities surrounding them. A reduction of childhood illnesses in targeted areas was an indicator of success for National Societies.</p> <p>In Gambia, 40 Red Cross health volunteers who were trained during previous years received a refreshing training on new innovations. In addition, another 40 volunteers and nine community health nurses were trained on key practices of integrated management of childhood illness (IMCI)¹.</p> <p>Baby friendly initiative clubs were established in 20 communities, with approximately 50 mothers registered in each club. The mothers were requested to exclusively breast feed their babies for six months and start giving weaning food after the sixth month. Recognition of the symptoms of childhood diseases helped the mothers to take prompt action if they observed any sign of sickness in their children. The clubs also embarked on environmental sanitation as well as visits to members homes to assess their levels and practices of cleanliness at home. Support was provided to members who were unable to go the Mother and Child Health clinics by taking their children to these clinics.</p> <p>A total of 40 children who were seriously ill and indigent were supported for the purchase of medicines and cured. As malaria is one of the childhood illnesses affecting children and is the leading cause of death amongst them, weekly community cleansing was encouraged, which all communities under the intervention area adopted.</p>

¹ IMCI strategy was started by WHO and UNICEF in 1992.

Outcome: National Societies are supported to build capacities of volunteers on key family practices as specified in the IMCI strategy and stated in Strategy 2020.

Achievements: The Gambia Red Cross Society embarked on a number of sensitization sessions. A total of 80 volunteers and community health nurses were trained to sensitize and train traditional birth attendants, village health workers and traditional communicators. These trained volunteers in turn trained 500 women, from 18 primary health care circuit villages, as traditional birth attendants and village health workers. These women further sensitized 20,000 women and care takers on the best practices of IMCI in 80 communities, some of which were satellite primary health care villages. Traditional communicators were also trained to disseminate messages through songs and role plays in nine circuit villages. All women were encouraged to take their children to the Mother and Child Health clinics on a monthly basis for routine immunization, weighing and medication in case of sickness. In some communities a fine was levied for households where a child was not taken to the clinic.

Similar trainings of volunteers were also conducted in Mali, which enabled the mobilization of 80 National Society volunteers and eight supervisors of Municipal Committees. The trainings covered knowledge of the Red Cross Movement, information on malaria, acute respiratory infection, diarrhoea, vaccinations and nutrition, along with communication skills.

Further, the operational capacity of community health centres was strengthened through the training of eight health workers from these centres. Facilitation of the training was carried out by the health department of the Mali Red Cross and supported by IMCI focal points. Each health worker received a training manual and the health centres were provided with kits and nutritional inputs.

The door-to-door strategy to raise awareness at a household level was adopted in Mali. This was carried out through 80 National Society volunteers divided into eight teams of 10 members each, with a supervisor who was responsible to oversee the process, organize volunteers to compile data and send feedback to the health department of the Mali Red Cross. Volunteers and supervisors received training manuals, tools and boxes of images for data collection in households.

Outcome: National Societies are able to prevent and respond to public health emergencies in the region.

Achievements: During the reporting period, the public health emergencies response activities were related to a cholera outbreak in Mali and yellow fever epidemic in Senegal. DREF allocations were made to support the Mali and Senegalese Red Cross Societies in responding to these crises. The Senegalese Red Cross undertook a preventive vaccination campaign by mobilizing its volunteers for social mobilisation activities. The Mali Red Cross also mobilised its network of volunteers to limit the spread of the cholera outbreak. Following the implementation of these activities, the two National Societies reached beneficiaries through the dissemination of preventive messages and the use of a range of simple, yet effective communication tools developed to help target communities improve their knowledge and practices to prevent further infection and spread of these diseases.

A tuberculosis (TB) pilot project was initiated in Senegal during the reporting period. Under this, the Senegalese Red Cross aimed at supporting the objectives of the national TB programme (PNT) in districts with a high risk and poor performance vulnerabilities.

A workshop to develop educational and communication tools for the project was organized at National Society headquarters. Participants included 20 technicians from the Senegalese Red Cross, PNT and the national service of health education. Communication tools and advocacy programmes used in the fight against TB in Senegal were reviewed. Materials available were adapted to the Senegalese context. Further, it was decided to reproduce the community guide manual on TB.

The curriculum for first aid and instructors training was also upgraded to include aspects related to the knowledge of TB. A total of 30 first aid instructors (from the 14 administrative regions of Senegal) were trained on new strategies to fight against TB in the country. Following the training, four regions (Fatick, Kaffrine, Tambacounda and Kedougou) were identified for test training the volunteers, based on the criteria that these were regions with low performance in activities to fight against TB, as well as taking into account the commitment of instructors who had completed the initial training in TB.

A Memorandum of Understanding was signed between the Senegalese Red Cross and PNT, for joint implementation of prevention activities and to support community based TB interventions.

Constraints or Challenges

The main challenges were related to health issues. In Liberia, for instance, the population influx following the political crisis in Côte d'Ivoire caused major challenges for the Liberian Red Cross, which suddenly found itself with a greater number of beneficiaries than expected for LLIN distribution. The National Society, with support from the Canadian Red Cross and IFRC, worked under guidance of the National Malaria Control Programmes (NMCP) to ensure that both the displaced and host population benefitted from the distribution.

Besides this, delays in receiving funds to implement activities also constituted a constraint. For instance, though most activities under the TB project were achieved during the reporting period, two activities on the sideline of the world day to fight against TB could not be conducted - mobilization of Senegalese Red Cross volunteers and project evaluation. These activities were delayed due to the fact that the celebration of the world day to fight against TB was extended in Senegal to 21 April 2012, due to the election-related political situation. The Senegalese Red Cross decided to take part in it with its own funds.

Working in partnership

With technical support from the regional representation, the National Societies in the Sahel region continued to support the Ministries of Health NMCP in their respective countries in the fight against malaria. This was done either through scaling-up of LLIN distribution to achieve universal coverage or through community based malaria activities for community sensitization and behavioural change. IFRC benefitted from Canadian Red Cross support for project management in Liberia. The Norwegian Red Cross continued to support IFRC in developing and implementing malaria activities in the region, including operational research and testing of new data collection methodologies. IFRC also enjoyed a good working relationship with USAID, which supported mass distribution activities in Nigeria and Liberia. The IFRC malaria team hosted the Alliance for Malaria Prevention.

In the area of food security, nutrition and livelihoods, IFRC's regional officer has been working in partnership with different Partner National Societies working in these areas. A nutrition workshop for the French speaking National Societies in the region was organised by the regional office and co-facilitated by the French Red Cross nutrition specialist in Niger. Another key actor, the Belgian Red Cross, also participated. Further, a joint food security assessment was organised in Mauritania, with support from the French and Spanish Red Cross Societies present in-country. Information sharing with UN agencies,

NGOs and the donor community was done through the food security and nutrition working group. Partnership agreements were in the process of being negotiated with WFP, to support the upcoming food crisis.

Contributing to longer-term impact

IFRC supported National Societies' programmes, which were developed under policies and guidance from Ministries of Health NMCP. Most governments in Africa have adopted the WHO, Roll Back Malaria and UN Millennium Development Goal (MDG) targets to reduce morbidity and mortality due to malaria. Further, implementation of the Rapid Assessment Mobile Phone (RAMP) survey, as well as the results of the operations research ongoing in Togo, supported IFRC in obtaining detailed results on the impact of National Societies' programmes in malaria prevention. These monitoring mechanisms ensure that programmes are developed that will continue to improve the impact of Red Cross Red Crescent initiatives in reducing malaria morbidity and mortality.

It would be relevant to mention that National Societies community based malaria prevention activities encouraged households to ensure that pregnant women and children under five years old sleep under mosquito nets and receive prompt and effective treatment from health facilities in cases of fever. Pregnant women were educated on the need to attend antenatal care visits, during which they would receive at least two doses of intermittent preventive treatment for pregnant women to protect them and their unborn child from malaria. Concentrating on this target group contributes towards achieving the UN MDG focused on maternal and child mortality.

In spite of delays in the reception of funds, National Societies were able to meet objectives of various components of their country plans for 2011, as well as build on their community and emergency health capacities by maintaining a pool of trained volunteers who were aware of the major diseases for under five year old children as well as communicable and water-borne diseases. The National Societies were also active in building partnerships and working with other national stakeholders to focus on longer-term impact of programme implementation.

In the area of food security, many operations were initiated in 2011 and will be extended in 2012. Once the overall food security programme is launched and fine tuned, an expansion of community based programming might be considered, to include a greater number of vulnerable communities either within the regions where the Movement is established or to expand to other regions where need may be greater. Similarly the deployment of additional mobile clinics could also be considered feasible. These objectives would require additional funding.

Looking ahead

The regional representation will continue to scale-up disaster management capacities as a priority support area for National Societies in the Sahel region. Focus will be on developing a 'one stop shop' for all National Societies' health, disaster management and organisational development programmes, along with development of tools and policies that strengthen organizational readiness in health and care, disaster risk reduction, emergency response and recovery as well as research and training.

Food security will continue to be a priority programme area in the region. This will include emergency assistance in the form of nutritional support to more remote and vulnerable communities, strengthening and/or diversifying livelihoods as part of an integrated programming approach to build resilience to future shocks, promoting water and sanitation, conducting health and nutritional awareness campaigns, as well as relying on active community participation with the objective of changing behaviour.

With regard to malaria activities, the reduction in available funding will require malaria programmes to be more efficient, effective and innovative. IFRC's malaria team is working in collaboration with the community based health and first aid team to assess how to best integrate malaria activities as part of larger community based health programmes.

Focus will be on delivering improved and more integrated programming, with systematic monitoring and accountability. Programmes will be rolled out in a step-by-step process, which will allow the IFRC and National Societies in the region to fine tune, strengthen and build on their existing capacities to better service the needs of the population.

How we work

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

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

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

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

Find out more on www.ifrc.org

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