Annual report

International Federation
of Red Cross and Red Crescent Societies

Health and Care

MAA00001

16 April 2010

This report covers the period 1 January to 31 December 2009.

Sri Lanka Red Cross Society volunteers participating in a community-based health programme. **IFRC**

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 and social services programme in the secretariat supported National Societies based on their expressed needs, strengths, capacities and opportunities. Concrete achievements were made in 2009 at the field level, as demonstrated by the following actions:

- On World First Aid Day 2009, more than 32 National Societies across regions reported back on their activities using the theme “First Aid for Humanity”. More than 20 million people were reached globally, and more than 767,843 Red Cross Red Crescent volunteers and staff were mobilized.
- Over 42,000 Red Cross Red Crescent volunteers were mobilized during measles and polio campaigns in 23 countries throughout the year.
- Long-Lasting Impregnated Nets (LLIN) Hang Up and Keep Up activities were supported by National Societies in 17 countries, and mass LLIN distributions were supported in seven countries.
- In relation to voluntary non-remunerated blood donation, the most significant achievement in recent times has been the steady progress to voluntary blood donation across the world, and in particular, in developing countries.
- Both in “acute” post-disaster situations and “chronic” long-term developmental contexts, a total of one million vulnerable people have been served during the reporting period in the water,

sanitation, and hygiene sector.

- More than 10.6 million people were helped in Red Cross Red Crescent operations responding to epidemics in the first half of the year.
- Since the beginning of 2009, tuberculosis (TB) programmes have expanded in Eastern Europe, Central Asia, Southern Africa and East African regions.
- In 2009, the secretariat was able to compile a global report on HIV programme deliveries for 2008. From this report, the International Federation of Red Cross and Red Crescent Societies (IFRC) was able to conclude that in 2008, a total of 22,721,907 persons were reached with prevention messages, and received psycho-social support by the 72 National Societies in 2008.
- The IFRC has also successfully accelerated the pace of the human pandemic preparedness (H2P) programme at the global and country level, and expanded it to now cover 96 countries.

The department continued to ensure global leadership and programmatic coherence to the IFRC and its membership through the development and revision of health strategies, standards, generic tools and training curricula for delegates and volunteers. Among the generic tools produced, reviewed or translated to support the action of National Societies were:

- The Community-Based Health and First Aid materials (CBHFA implementation guide, facilitators' guide, volunteers' manual and community tools) available in English, Spanish, French and Arabic.
- The "Epidemic Control for Volunteers" training manual and toolkit.
- The Red Cross and Red Crescent Malaria toolkit (Supervision of community-based volunteers, malaria prevention in the community, LLIN scale-up and hang-up programmes, and behaviour change communication for community-based volunteers) available in English and French.
- The Spanish version of the IFRC's generic training package on HIV.

In 2009, the health and social services programme in the secretariat produced five advocacy reports on important health issues:

- *The epidemic divide*.
- *The winning formula to beat malaria*.
- *First Aid for a safer future, focus on Europe* (together with the European Reference Centre for First Aid Education).
- *Inequalities fuelling HIV pandemic, focus on Red Cross societies' response in Latin America and the Caribbean.*
- *The Red Cross response to the Cholera outbreak in Zimbabwe*.

In May 2009, an intervention was also made in the World Health Assembly to advocate the importance of integrated community-based health programmes in their contribution to the implementation of primary health care.

The health and social services department also maintained and further developed a wide range of partnerships. This includes global positioning, coordination, relationship management and technical support for a number of global initiatives, such as the Global Water and Sanitation Initiative (GWSI) or the global malaria initiative. The health and social services department has taken a leading role in positioning the IFRC within key health partnerships among civil society organization platforms. For example, the IFRC is currently chairing the Alliance for Malaria Prevention partnership, representing more than 35 government, business, faith-based, and humanitarian organizations.

In 2009, the health and social services department supported emergency response and preparedness in health as a continuum, and focused on disease prevention and health promotion in all of its health interventions.

Financial situation: The total 2009 budget is CHF 5,367,551 (USD 5,171,100 or EUR 3,607,950), of which CHF 7,023,110 (over 100 per cent) covered during the reporting period

(including opening balance). Overall expenditure during the reporting period was CHF 5,246,359 (98 per cent) of the budget.

Click here to go directly to the attached financial report.

Our partners: The IFRC works in coordination with UN agencies, humanitarian organizations, as well as non-governmental organizations (NGOs).

Context

Since April 2009, the H1N1 influenza pandemic attracted increasing attention from health professionals, governments, the media and the public. Though the virus is mild, it has been circulating rapidly across the globe and the damage that this pandemic may cause to society, in particular, in developing countries, is high. Communicable diseases do not only kill, they also widen the development gap, and cause whole communities to lose results of years of development efforts.

At the same time, the world is facing other major challenges due to an increasing number of people affected by non-communicable diseases, other infectious diseases, an increasing frequency and magnitude of disasters, poverty, and poor access to health care services, among others. The poorest and hard to reach populations - women, children, elderly, disabled and chronically ill - will remain the groups at highest risk.

The combined effects of crushing poverty, both rural and urban, and the fact that over one billion people still lack access to safe water, and over two billion lack access to basic sanitation, increasingly exacerbated by climate change, rapid urbanization and conflict or economic downturns has created a continuing incidence of death and disease, stress and loss of dignity most often seen in its extreme in post-disaster scenarios

Red Cross and Red Crescent National Societies, supported by the IFRC, have a long experience in addressing issues affecting the health of population in their communities. This has been translated into a wide range of essential health-related activities based on community participation and capacity. The unique position of National Societies, their number and their established access and reputation within local communities puts them in an unparalleled position to make a positive difference in health outcomes.

Progress towards outcomes

Community-Based health and First Aid in Action

Outcome(s)

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.

Achievements

In 2009, from a global perspective, the secretariat scaled up its support to National Societies worldwide with the rollout of the CBHFA *in action* materials. There were 1,326 copies sent out to National Societies via the zonal offices. At the end of 2009, the materials were translated into French, Spanish, Arabic, Bahasa Indonesia, Russian, Chinese, Portuguese and Urdu. These translated versions were field tested in subsequent master facilitators' workshops, which were funded by multilateral and bilateral funding streams. In Mozambique and Timor Leste, National Societies adapted and translated the materials in consultation with their Ministries.

Since the dissemination of the materials, more than 300 staff and volunteers from 80 National Societies have participated in nine CBFHA *in action* master facilitators' workshops. English, Arabic, French, Chinese, Portuguese and Russian-speaking workshops have been organized. A global database of resource people and team leaders has been developed. More than 30 master facilitators were mobilized in these activities, and more than 50 per cent of the National Societies that participated in these workshops are now at different stages of implementing their action plans. In South-East Asia for example, four National Societies have started implementing the CBHFA approach: 2,000 volunteers are working with about 75,000 beneficiaries in 100 communities. In Africa, Ethiopia, Namibia, Mozambique, Zimbabwe and others, are also implementing the approach.

A number of sensitization meetings were also conducted in order to disseminate the CBHFA approach, and to maximize its harmonization and integration with Red Cross and Red Crescent health programmes. They included the ERU health working group meeting, the Red Cross Red Crescent TB working group meeting, the Red Cross Red Crescent malaria planning meeting, zonal and regional health meetings, the pandemic influenza meeting and the European First Aid annual meeting.

A global lessons learnt workshop was organized in Jakarta in October 2009. There was an official launch of the CBHFA materials, and a web story was posted on the IFRC web site. Thirteen National Societies participated in this workshop. The outcome is an initial set of lessons learnt and recommendations to improve the implementation of CBHFA.

A group of PMER experts and representatives from CBHFA implementing and Partnering National Societies also met in Jakarta in October 2009 for a global monitoring and evaluation meeting. It was agreed that a set of CBHFA indicators was to be further developed. This will be part of a monitoring and evaluation toolbox that will be completed in 2010.

The CBHFA approach adopts the revitalized primary health care programme, and an intervention was delivered at the World Health Assembly profiling the IFRC's commitment, using CBHFA as a developmental approach, in disease prevention and health education at the community level. The approach was also presented in a side meeting in the global health promotion meeting in Nairobi 2009. IFRC produced a position paper on health promotion, and this contributed to the discussion and the final call for action in the 7th Global Conference on Health Promotion: Promoting health and development – Closing the implementation gap in Nairobi.

In 2009, global health and care activities strived to support National Societies to implement longer-term community-based integrated programming using CBHFA as an integrated approach to work with vertical health interventions and other sectors.

World First Aid Day 2009 was held on the 12th September. More than thirty-two National Societies across the regions reported back on their activities using the theme "First Aid for Humanity". A total of 20,010,912 people was reached globally, and more than 767,843 Red Cross Red Crescent volunteers and staff were mobilized.

An advocacy report entitled *First aid for a safer future: Focus on Europe* was disseminated alongside a press release on World First Aid Day. The report was used by many National Societies in Europe to advocate for first aid education to be accessible for all, and to discuss with their governments about some of the key recommendations which are included in the IFRC's first aid policy.

Finally, a formal letter of agreement was signed between the IFRC and the International First Aid Advisory Board co-chaired by the American Red Cross and the American Heart Association. The IFRC will complete its involvement in the evidence-based scientific research to develop the

consensus of science on first aid in 2010. The IFRC will then develop its first international first aid guidelines.

Constraints or Challenges

Increased commitment and persistence of host and partner National Societies is needed in health developmental programmes which demands long term strategies as well as volunteers' management and community development.

There also needs to be a change of mind set and image of the organization to be recognized not only as an emergency-oriented humanitarian organization, but also as an organization which engages in development activities and preparedness in health.

Measles and Polio

For programme activities, please see the Global Measles and Polio Initiative (MAA00032) annual report.

Outcome(s)

Reduced morbidity and mortality due to increased access and uptake of supplementary and routine immunization services for measles and polio. Ninety per cent global reduction in measles mortality, and zero countries reporting polio cases.

- The global measles and polio initiative works with the zones/regions to provide technical support and resources to National Societies for their involvement in mass immunization campaigns.
- The initiative's goals are in line with those of the World Health Organization (WHO)/United Nations Children's Fund (UNICEF) Global Immunization Vision and Strategy (GIVS) targets: Ninety per cent global reduction in measles mortality by 2010 (compared to 2000), and completion of global polio eradication. The initiative also aims, through support to campaign social mobilization, to strengthen National Societies' involvement in routine immunization. The secretariat supports these activities through participation in related global partnerships (Measles Initiative and Global Polio Eradication Initiative), and through advocacy on behalf of National Societies for their inclusion in supplementary immunization activities (SIAs).
- The 2009 global measles and polio initiative provided direct funding to nine National Societies (Burkina Faso, Côte d'Ivoire, Liberia, Namibia, Niger, Nigeria, Swaziland, Tajikistan, and Togo) for supplementary social mobilization activities around their national vaccination campaigns.

Achievements

- Over 42,000 Red Cross Red Crescent volunteers were mobilized during measles and polio campaigns in 23 countries.
- The contribution of National Societies has been recognized in the global achievements recently celebrated, namely the 2009 announcement that global measles mortality had been reduced by 78 per cent (from an estimated 750,000 deaths in 2000 to 164,000 deaths in 2008). In addition, from 2000 to 2008, global routine measles immunization coverage reached an estimated 83 per cent.
- In the area of polio eradication, the IFRC was a leading civil society partner in 2009 through the launch of the Africa polio outbreak emergency appeal which raised approximately CHF 1.6 million to fund 15 National Societies' activities in 27 polio vaccination rounds. The successful performance of National Societies, and the IFRC's role as a global polio eradication advocate has garnered much attention in 2009.
- Within the secretariat, health and care staff continued to play a vaccination coordination role, including through participation in weekly teleconferences and annual planning meetings to ensure that National Societies are a part of the campaign planning process.

- The IFRC also continued to participate in various international immunization partnerships, in addition to the Measles Initiative and Global Polio Eradication Initiative. As a member of the GAVI Alliance Civil Society constituency, the secretariat supported the increased role of civil society in the Alliance's work. This included participation in the GAVI Alliance's 4th Partners' Forum, held in Hanoi in November 2009, where a civil society call to action was launched by the more than 30 civil society organizations represented.
- The secretariat continues to prioritize the analysis of National Society and volunteers' added value during mass campaigns. In 2009, an independent evaluation was conducted on the Africa polio outbreak emergency appeal, which included four country visits and over 200 polio stakeholder interviews. Results of the evaluation are available from the secretariat.
- In fulfilling the IFRC's role as a leading national social mobilization partner, it is building the capacity of National Societies themselves, while making a direct contribution to progress towards child survival and Millennium Development Goal (MDG) 4.

Constraints or Challenges

A challenge for the IFRC's Global Measles and Polio Initiative has been mobilizing local resources to support National Society activities, such as through UNICEF country offices or other partners. With the limited predictability of campaigns (due to a variety of influencing factors), last minute confirmation of campaign dates has posed a challenge to National Societies for timely resource mobilization. There has been some preliminary success, however, in countries where organizing agencies are looking for new partners (such as in Timor Leste), or in areas where the National Society can fill an operational gap (such as in campaign monitoring, or disease surveillance). There must be more concerted effort to support National Societies in local resource mobilization for immunization.

Availability of sufficient technical assistance to support National Society planning for campaigns is a continuous challenge. The IFRC continues to try and draw upon in-country partner human resources to support planning processes which include National Societies. However, adequate internal assistance must be available in order for campaign planning to be comprehensive and timely.

The availability of unearmarked funding to make firm advance commitments to National Societies has been a constraint. Ongoing advocacy at the global and regional levels and demonstrated effectiveness by National Societies in their campaigns is necessary if this is to be realized. The IFRC must maintain its visibility as a key contributor to GIVS goals, and to the child survival-related MDGs, if external resources will be generated.

Malaria

To respond in a timely and effective manner to National Society requests for technical support on the development and implementation of malaria activities. This will be achieved through expanded technical support from the IFRC at the regional level, and through exchange visits between National Societies. The programme focuses on three core activities:

- Immediate post-LLIN distribution Hang Up and multi-year Keep Up activities integrated within community based health and care activities (where they exist).
- Procurement and distribution of LLINs to fill unmet needs in large-scale LLIN mass distributions, during emergency situations, and Red Cross Red Crescent home-based care activities.
- Expansion of malaria-specific technical support provided to National Societies.
- Support to exchange visits between National Societies, participation in regional/global malaria networks, and an annual Red Cross Red Crescent malaria meeting.

Outcome(s)
Reduced morbidity and mortality from malaria through increased usage of LLINs and prompt diagnosis and treatment. Ten million children under five years of age receiving LLINs directly or indirectly as a result of Red Cross Red Crescent activities.

Achievements
- Immediate post-LLIN distribution Hang Up and multi-year Keep Up activities integrated within community-based health and care activities (where they exist).
    - Hang Up and Keep Up activities were supported in; Burundi, Cameroon, Guinea, Haiti, Kenya, India, Indonesia, Liberia, Madagascar, Mali, Senegal, Sierra Leone, Tanzania, and Uganda.

- Procurement and distribution of LLINs to fill unmet needs in large-scale LLIN mass distributions, during emergency situations, and Red Cross Red Crescent home-based care activities.
    - During 2009, mass LLIN distributions were supported in Burkina Faso, Burundi, India, Liberia, Madagascar, Senegal, and Sierra Leone.

- Expansion of malaria-specific technical support provided to National Societies.
    - The secretariat was able to support technical missions to the following National Societies; Burkina Faso, Burundi, Guinea, Indonesia, Kenya, Liberia, Malawi, Mali, Senegal, Sierra Leone, Nigeria and Uganda.
    - The English version of the malaria toolkit was also rolled out in the third quarter of 2009.

Constraints or Challenges:
The main challenges faced during 2009 were a lack of sufficient funding to support National Societies' programme activities. The ongoing secretariat change process has led to delays in programme implementation, and gaps in secretariat support to National Societies.

Blood

As auxiliaries to their governments, in advocating voluntary, non-remunerated blood donation (vnrbd), National Societies are able to build their capacity and effectiveness in strengthening the foundation for their nation's safer blood supplies. One of the highlights for 2009 has been the comprehensive review of risks associated with blood service delivery for National Societies engaged in blood programmes. This review, carried out by the Global Advisory Panel on Corporate Governance and Risk Management (GAP), noted in particular, the need to refresh resources available to National Services, and the increased need for guidance materials. Consequently, the GAP has been working in close consultation with the IFRC's health and social services department on a revision of the IFRC's 1999 blood policy and development manual. The resulting draft *Policy on Promoting Safe and Sustainable National Blood Systems*:

- Asserts the IFRC's primary focus on the promotion of voluntary, non-remunerated blood donations.
- Sets out the respective roles of the IFRC and the GAP.
- Outlines the responsibilities and expectations of National Societies in respect to their national blood programmes.

And the updated manual will set out explicit steps for National Societies to:

- improve the standards of their blood service; or
- systematically withdraw from their blood service activities to a role in promoting voluntary, non-remunerated blood donations.

A gradual shift in focus and more definite changes in outcomes has thus been noted for 2009. It has become apparent that **all** National Societies, irrespective of whether they are directly or indirectly involved in the administration of their national blood programmes, can contribute towards the development of a safe and sustainable national blood system. Advocacy and promotion of voluntary blood donation builds the foundations of global blood safety, which ultimately saves lives. National Societies with **no** formal involvement in blood programmes can support the process of changing attitudes and beliefs towards blood donation in their countries through advocacy, education campaigns and participating in blood donor recognition events, notably World Blood Donor Day (WBDD), on 14 June each year. Also, community health programmes supported by the IFRC and its member societies, can promote voluntary blood donation through strategies to prevent AIDS or hepatitis and to control diseases such as measles or cholera, promoting healthy lifestyles in local communities, and providing the basis for a low-risk blood donor population.

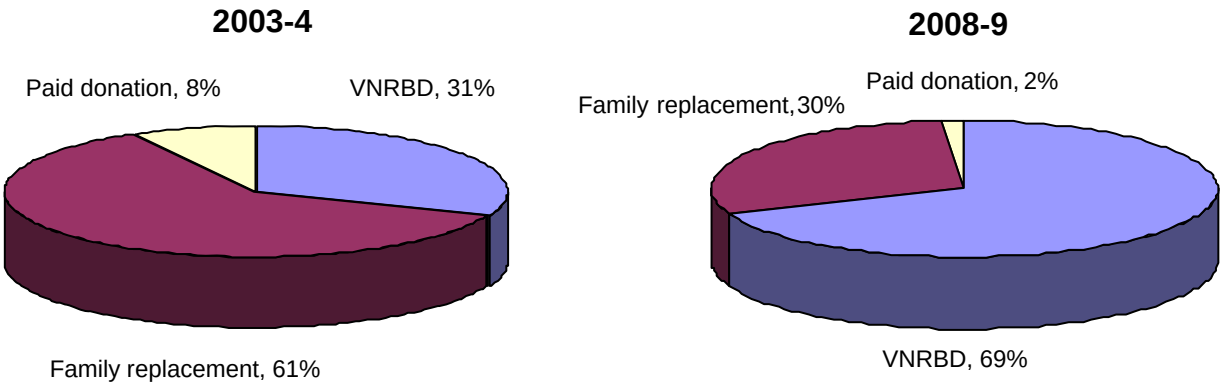
Outcome(s)

Improved blood safety with continued focus on voluntary non remunerated blood donation, so that 80 per cent of all blood donors will be voluntary in 60 per cent of countries by the end of 2010.

Achievements

1) Perhaps the most significant achievement in recent times has been the steady progress towards voluntary blood donation across the world, and in particular, in low human development index (HDI) countries. Please see the chart below.

Developing (Low HDI) Countries' Progression towards VNRBD



Source: World Health Organization Global Data Base, 2009

Preventing the transmission of infection through unsafe transfusion is one of the core strategies for HIV/AIDS prevention – and is, in fact, the only approach to HIV prevention that is almost 100 per cent effective. In most developed countries, the risk of HIV transmission is now extremely low because of the adoption of an integrated approach based on voluntary blood donation, stringent donor selection, the screening of all donated blood, and the use of transfusion only when no suitable alternatives are available. Varying degrees of risk remain in many parts of the world, but it is pleasing to note WHO's latest statistics for 2009, which suggest that there are substantial improvements in lives saved through safer blood, thanks to vnrbd.

(1) World Blood Donor Day, celebrated on 14 June, again provided a special opportunity to raise media interest for vnrbd in more than 150 countries. The core WBDD agencies, including the IFRC noted the statistics supplied from host country (Australia) for WBDD 2009. The Australian Red Cross Blood Service CEO stated that *"one-in-three Australians*

will need blood, but only one-in-thirty give blood". It is impossible to quantify precisely the number of beneficiaries globally when it comes to the clinical use of blood and blood components; but the IFRC can confidently suggest that in 2009, Red Cross Red Crescent was involved in around one third of the world's blood collection of over 81 million units. After processing this would account for treatment for more than 50 million of the most vulnerable people.

Constraints or challenges

There is little doubt that the sufficiency and security of national blood supplies remains a challenge. Blood transfusion services face a dual challenge of ensuring both a sufficient supply and the quality and safety of blood and blood products for patients whose lives or well-being depend on blood transfusions. Blood supplies need to be constantly replenished, since whole blood and blood components have a limited shelf-life. Most countries battle to meet current requirements, while at the same time responding to increasing clinical demands for blood.

Developed countries with well-structured health systems and blood transfusion services based on voluntary blood donation are generally able to meet the demand for blood and blood products. They must constantly strive to maintain adequate blood stocks in the face of rising clinical demands, increasingly stringent donor selection criteria and the loss of older donors who are no longer eligible to give blood. Nevertheless, even though there may be periodic or seasonal shortages, access to safe blood for all patients requiring transfusion can generally be taken for granted. Overall, developed countries are likely to have effective blood donor programmes, more voluntary donors, higher donation rates and more available blood.

In contrast, in developing and transitional countries, chronic blood shortages are common. Sophisticated health care provisions may be available in major urban centres, but large sectors of the population, particularly those in rural areas, often have access only to more limited health services in which blood transfusion may be unsafe or not available at all.

WHO estimates that blood donation by 1 per cent of the population is generally the minimum needed to meet a nation's most basic requirements for blood; the requirements are higher in countries with more advanced health care systems. However, the average donation rate is 15 times lower in developing countries than in developed countries. Globally it is estimated that around 70 countries have a blood donation rate of less than 1 per cent (10 donations per thousand population). Many countries in the African region collect less than 50 per cent of the estimated annual blood requirement, and in South-East Asia (which accounts for about 25 per cent of the world's population), blood collection is around 9 per cent of the world's blood supply. Globally, over 81 million donations of blood are collected annually, but only 45 per cent of these are donated in developed and transitional countries, where 81 per cent of the world's population lives.

The secretariat's response

In 2009, the secretariat addressed these challenges by joining forces with WHO and releasing a working document on World Blood Donor Day: *Towards 100 per cent vnrbd" - a global framework for action*. For many decades, the WHO and the IFRC have together been active in reminding all countries about the benefits of voluntary blood donation. With the publication of this global framework for the benefit of policy makers and blood transfusion services around the world, the IFRC has provided all stakeholders involved in blood donor programmes with the necessary vision and constructive ideas to help bring about a dramatic change in attitudes and practice, leading to the objective of 100 per cent voluntary blood donation.

Developing global partnerships

The attainment of 100 per cent voluntary blood donation for any country brings with it sustainable, long-term human development benefits. The relationship between a country's voluntary blood donation programme and the capacity of its government and civil society to meet their broader responsibilities reflects the true value of voluntary blood donors in human development. For example, one of the strategies contained in our joint framework refers to Pledge/Club 25 programmes. Through this international network, young blood donors experience social interaction and collaboration at the global level, resulting in the acquisition of significant leadership skills which can later be of benefit to their own country in wide-ranging activities. Young blood donors first make a contribution to human development by giving blood. Then, by becoming HIV/AIDS peer educators or participating in other health promotion activities, they extend their community involvement. They forge strong solidarity links, helping to build their capacity to provide leadership for improved health and well-being in their communities over several decades. With international Club 25 programmes now gaining a foothold in numerous countries around the world, it may not be too strong to suggest that voluntary blood donation is a practical and positive step towards a greater understanding between countries and a tolerance of different cultures: evidence of such understanding was apparent in Nairobi, June 2009, when we conducted the world's first ever Club 25 and health promotion workshop attended by 80 young participants from 43 countries.

By the end of 2009, with an absolute zero global budget for vnrbd activities, the secretariat remained the focal point and global coordinator for pilot Club 25 programmes in excess of 60 countries. It is manifestly obvious that resourcing this global network now demands a dedicated project officer person with sufficient resources to effectively capture and harmonize efforts from around the world. It is important that possibilities exist for lessons learned in one country can be shared in others for the benefit, not just of safer blood, but also for other areas of health promotion which are now the focus of Club 25 membership at the grass roots level.

The IFRC will to need to grasp this opportunity immediately if it is to remain at the forefront of exciting developments in the amazing expansion of Club 25s; or it may wish to pass up this moment to other organizations that more readily recognize the potential of the Club 25 model for health promotion and human development in general.

Water, sanitation and hygiene promotion

The water and sanitation unit, guided by the IFRC's water and sanitation policy and Strategy 2020 provides a technical and programming support service to Red Cross Red Crescent National Societies. This unit provides support to both disaster management and long-term development programming through capacity building, relevance, quality control, human resource identification and development, resource mobilization, training and disaster management (DM) "surge" capacity coordination.

In line with the UN MDG targets, the water and sanitation unit provided better access to appropriate, and where possible, sustainable safe water, basic sanitation and promotion of improved hygiene to the most vulnerable, both in "acute" post-disaster situations and "chronic" long-term developmental contexts. The IFRC met the needs of some one million vulnerable people in the water, sanitation and hygiene sector.

Outcome(s)
National Societies are enabled to recognize and respond increasingly to water and sanitation needs in emergency situations, as well as in chronic situations through longer-term/development water and sanitation programmes aiming at a more sustainable impact.

Achievements
In 2009, further use of the water and sanitation ERU mass sanitation module and its integration with health ERUs was noticeable (e.g. Zimbabwe cholera operation). Further training and "roll-out" of the prepositioned water and sanitation disaster response kits was also made available in the zones. During the reporting period, a new mapping of GWSI projects was concluded, which indicated that over 100 projects in over 40 countries with 60 Red Cross Red Crescent National Societies met the needs of over four million beneficiaries to date since 2005.

An important and globally recognized field manual was produced by the unit for the use of "household water treatment in emergencies," and further progress on standardized tools for hygiene promotion (for both emergency and developmental contexts) was produced both in-house and globally with the water, sanitation and hygiene (WASH) cluster. A revised GWSI CD and booklet was also produced to assist National Societies in project proposal development, and to provide tools for project management. In 2009, the health and social services department undertook a restructuring exercise during the period which was part of the global "right sizing" effort, but this process did require significant and time consuming inputs from both the department and the head of the water and sanitation unit.

Constraints or Challenges:
Overall, the decentralization process has tended to make roles and responsibilities and indeed accountability unclear at times. This combined with the "right sizing" exercise, also left some key functions or positions vacant or not operating to their full potential, although this is expected to improve over time. Meanwhile, the need for intervention and providing support to the field by the secretariat in Geneva has in some cases increased. 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 and sanitation activities.

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. In addition, the water and sanitation disaster response kits are still in their infancy, and further work is required to ensure their appropriate use and impact. Integration and joint deployment between FACT/RDRT and ERU/RDRT is still weak and needs to be 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.

Public Health in Emergencies (PHE)

Outcome(s)
National Societies staff at the local, zonal and global level are responding more timely, appropriately and efficiently applying increasingly agreed and standardized public health approaches to natural disasters and health emergencies, as well as for longer-term development programmes.

Achievements
Support to emergency operations
Several major and mid-size emergencies caused widespread human and material devastation in the past year. The massive outbreak of cholera in Zimbabwe continued well into 2009, and response and recovery efforts of the operations were ongoing. Meanwhile, an earthquake affected Sumatra in Indonesia; cyclones hit Samoa, Philippines, and Vietnam; droughts and

population movements affected Syria; a big dengue outbreak affected Cape Verde; AWD in Ethiopia; polio spread through 14 unaffected countries in Africa; and a new strain of influenza virus spread throughout the world causing an influenza pandemic.

Meanwhile, several smaller crises occurred, mainly epidemics, including dengue, diarrhoeal diseases, yellow fever, meningitis, and others, which affected Africa and Latin America.

Continuous support was given to major and to smaller emergency operations. Follow up for the outbreak of cholera in Zimbabwe was carried out, and technical support and advice given to other operations by the secretariat. Those included field deployments, support to emergency appeals, technical support to the influenza team in the secretariat, DREF operation advice, and deployment of global health-related DM tools.

A significant part of the operations was focused on efforts to improve knowledge management and sharing as part of the emergency health (EH) approach to support emergency operations. This included better reporting, but also improved mutual learning and exchange of experiences. This was especially noticeable in the use of information, education, and communication (IEC) materials in Portuguese, brought from the Brazilian Red Cross into Cape Verde, among others.

One of the better practices during emergencies was the use of the integrated approach of water and sanitation ERU mass sanitation module (MSM), and its integration with basic health care ERUs. This has started in the Zimbabwe operation, and taken keenly as a useful lesson learned to be practiced in future operations.

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.

This function focuses on several “layers” of coordination and representation. The first is within the secretariat where emergency health is represented with other sectors and functions. This gains more importance with an increased recruitment of EH delegates in the zones where the EH as a global function of the IFRC, requires the team of EH representatives in the secretariat to function as one team with harmonious approaches and functions. The second layer is the representation of the EH function within the IFRC which covers advocacy, coordination of initiatives such as the health ERU working group and the Field School among others, and the organization of mutual learning and exchange of experiences. The third and last layer is the coordination and representation of the IFRC technically with external partners including WHO, UNICEF, international non-governmental organizations (INGOs), and others.

The main activity in 2009 was the organization of the health ERU working group in Berlin including all the Participating National Societies who deploy health ERUs and several observers. The health ERU working group aimed at restoring more effective organization and communication between the IFRC and Participating National Societies which led to several agreements and follow-up decisions.

Technical standardization and integration with water and sanitation continues, in coordination with the health ERU working group. The health ERU working group meeting was integrated with the water and sanitation ERU working group, and it was agreed to continue these common meetings in the future.

The IFRC also promoted the recruitment of further emergency health capacity in the zones. This was concluded by the recruitment of an emergency health delegate, with a focus on epidemics, in Africa. The delegate will begin in 2010.

Working relationships continued to take place with community health, measles and polio, psychosocial support (PSP) through the reference centre, and HIV/AIDS.

Joint coordination mainly took place with the IASC, WHO/Health Action in Crises (HAC), the Global Health Cluster, UNICEF, the International Coordinating Group (ICG) on yellow fever and meningitis, and others.

Development of emergency health, monitoring and evaluation, and knowledge management

Efforts were made to mainstream monitoring, evaluation, lesson-learning, and knowledge management in health interventions. This task took a more central stage during the past year, and work was carried out to improve reporting, information sharing, and coordination. However, much work remains to be done to achieve a knowledge cycle that is intuitive and integrated. Better human resources in the field focusing on EH, and more close coordination with National Societies as a global EH team will be needed, if integration is to improve.

The epidemic control for volunteers (ECV) was further developed. It was translated into Spanish, and printed by the Americas zone; translated into French and printed in Geneva; and translated into Arabic by the MENA zone, with printing planned in 2010. Furthermore, the English version was used in Zimbabwe in the follow up to the cholera operation. It was also used as basis for IEC materials for the first response to the influenza pandemic, the polio outbreaks, and dengue outbreaks.

In coordination with the communications team at the secretariat in Geneva, the emergency health function produced a report, *the Epidemic Divide*, as an advocacy paper. This was released in conjunction with ECOSOC, and was covered heavily by the media. Similar papers and reports are planned, and will serve for advocacy, fund raising, and sharing information.

The fourth Field School took place in Kenya. The FS was extended to cover, in addition to EH, more on team leaders, FACT, and ERU. The fourth FS was a big leap forward for the approach and methodology, and has succeeded in integrating several disciplines, including emergency health, team leader refresher trainings, FACT refresher trainings, and ERU practical exercises. A detailed external review is underway as part of the evaluation of the FS. This includes reviewing the previous three pilots, and a real time review of the fourth FS in Kenya.

Work continued with the PSP reference centre in Copenhagen on several common subjects. Those included a PSP module for the health ERUs which was created, standardized, and will be tested when needed in an ERU deployment. (Note: the PSP component was deployed to Haiti and will undergo a real time review). Another subject commonly approached was writing a chapter on PSP in a book about disaster response produced by Routledge publishers.

The emergency response items catalogue (ERIC) was finalized in 2009, and included updated health ERUs, kits, and sets.

Capacity Building

The PHE training aims at providing National Society health professionals with the comprehensive knowledge and skills to act in emergencies. This is a transformation from clinical approaches into public health ones that focus on dealing with the community, addressing priorities and providing prevention and promotion in addition to managing the sick. The PHE training was fundamentally revised in 2008, however, it was still a heavy lecture-based training that ignored more innovative approaches to adult education. That in mind, the PHE training methods were revised again to put more focus on problem-solving and team work rather than lectures. The new training package, finalized in December 2009, builds heavily on team work, scenarios, and puts most of the emphasis on *learning from the point of view of beneficiaries rather than providers.* The package will be available on FedNet during the first quarter of 2010.

Continuous support to PNSs in ERU trainings took place in 2009 as part of the core business of the EH function in Geneva. With the build up of the human resources for EH in the field, this will be partially decentralized in 2010.

Tuberculosis Programme (TB)

Until very recently, the approaches to TB care and control have been focused on essential public health and medical interventions, with very limited community involvement. The contribution to the national health authorities by non–medical, often non-governmental staff and communities has been ignored by many sceptics involved in TB control. However, the experience gained, reassured those at the national and international levels, that the participation of communities (community member, workers, volunteers) has made remarkable changes in TB control, even from an economic viewpoint.

In this context, Red Cross and Red Crescent community–based programmes play a key role in global tuberculosis control efforts. They increase access to tuberculosis treatment for vulnerable and marginalized groups, and ensure higher treatment completion through a "personalized" approach to patients, including the provision of supplemental food and psychosocial support. Today, National Societies worldwide are addressing TB in their community–based health and care work, concentrating on the most vulnerable patients and the communities most-at-risk.

The IFRC's global TB programme aims to accelerate progress in fighting against TB by promoting the implementation of the global plan to Stop TB (by WHO), and by harmonizing National Societies' efforts within a joint framework of action. Main strategic directions are to:

- facilitate National Societies' coordination of TB activities to achieve, as well as to demonstrate an added value to the global efforts to stop TB;
- build the capacity of National Societies to further support the role of civil society, affected communities, and people with TB supporting and participating in TB control efforts; and
- ensure the full integration of TB activities with HIV and other community health activities.

Outcome(s)

National Societies contributed to the Global Plan to Stop TB through increased access to TB services to the most vulnerable.

Achievements

The programmes supported by the IFRC are people-centered: they focus on rapidly scaling up services to reach people quickly, and to dramatically reduce illness and death. In parallel, these programmes build sustainable systems within National Societies over time. The way the programme results are measured and monitored mirrors this: it counts real people receiving services relevant to preventing or treating an infection from TB.

A. As the IFRC has no international field staff expertise in TB, the technical aspects of the programme mainly relies on the TB health officer in Geneva and experts of the Global Red Cross and Red Crescent TB working group, made up of some 15 National Societies. The working group is coordinated by the health and social services department. The 2009 Global Red Cross Red Crescent TB working group meeting took place in Beijing, China from 6 to 8 April 2009. The following key decisions were made in this meeting:

1. To revise standardized indicators, including the ones for TB/HIV activities for TB programmes.
2. To develop recommendations for National Societies to be involved in multi-drug resistant

(MDR) TB-focused TB programme (particularly for HIV high endemic countries).

3. To develop the toolkit for the CBHFA manual and the HIV global alliance.
4. To further develop the guidelines for Red Cross and Red Crescent staff and volunteers on additional safety measures, particularly in high MDR TB/HIV settings.

B. Since the beginning of 2009, TB programmes have expanded in Eastern Europe, Central Asia, Southern Africa and the East African regions. By the end of 2009, the Indian Red Cross Society finalized the work plan, and started the MDR TB programme. Some 700 most vulnerable people affected mainly by MDR TB were included in these initiatives, and received daily support from National Societies. It represented 30 per cent of the total number of people with MDR TB served by all National Societies, and around 1.4 per cent from a total burden of MDR TB globally. In addition to direct support to people with MDR TB, over 20,000 new community members, civil society groups, traditional healers and religious groups participated in trainings and awareness campaigns organized by societies. Support groups made up of people cured from TB or are at-risk supported Red Cross and Red Crescent TB activities.

The IFRC's approach to addressing TB and MDR TB is more and more through active partnerships which include the private sector. Recently, the IFRC expanded its partnership with Eli Lilly, the pharmaceutical company, which allows the Armenian Red Cross Society and the Namibia Red Cross to start new activities, as well as the South Africa zone to organize training activities in TB Advocacy for 10 National Societies. Activities will be supported for a three-year period. New projects with the support of USAID have been implemented in Kazakhstan, South Africa and India. The support from Eli Lilly (around 400,000 US dollars) is in addition to the two million US dollars that the IFRC received under the framework of the global partnership between Eli Lilly and the IFRC. USAID provided 475,000 US dollars for 2009, and the same amount for 2010. Eli Lilly supported the TB workshop in the youth village during the Solferino celebrations, as well as contributed to the youth award in health projects (in Côte d'Ivoire and Indonesia).

1. During the reporting period, the IFRC together with the Italian Red Cross developed a joint harm reduction training in Rome: (1) The IFRC supported and co-facilitated the training for the Cambodian Red Cross Society and The Thai Red Cross Society; (2) Prepared the training in Russian for Eastern Europe and Central Asia; and (3) developed the action plan for 2010.

   The TB input was provided in HIV and CBHFA guides and manuals.

   Technical input was provided to the proposal development for MDR TB projects in Southern Africa, India and Eastern Europe through monitoring trips at the project sites; and through facilitation of, and participation in, zonal and regional meetings.

C. The IFRC actively collaborated with the Stop TB Global Partnership, WHO offices and other major stakeholders:

   1. In October 2009, the work with the NGO constituency on NGO nomination and the selection process for the seat in the Stop TB coordination board was successfully completed. The process started in early 2008 and was chaired by the IFRC.
   2. The IFRC continued to work as a chair of the selection committee for Stop TB call for proposals - "Challenge Facility for Civil Society". During the year, together with the partnership, the methodology documents, as well as the process were further developed. A call for proposals was opened, and the nomination and selection of projects will take place in March 2010.
   3. The IFRC is the member of the steering committee in the adaption process of global

MDR TB training modules for the European region.

4. The IFRC is a member of the steering committee to prepare the TB/HIV working group meeting during the AIDS conference in 2010 in Austria.
5. 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 trainings took place in Brazil (March 2009) and in South Africa (June 2009).
6. Support was provided to the Europe zone, following the meeting on joint activities with WHO EURO in Copenhagen (October 2009). A joint action plan was developed, where TB is a priority area. This meeting was a follow up to the signed memorandum of understanding between WHO and IFRC in 2008.

D. Media/Advocacy/communication

- Together with the media unit, the TB communication plan was developed for 2009.
- The IFRC hosted the World TB Day event on 17 March focusing on MDR TB. The briefing for Geneva-based diplomatic missions was organized together with partners under the Lilly MDR TB Partnership and WHO.
- The South African celebrity, local TV star Gerry Elsdon-TB advocate, visited the IFRC in December 2010. Discussions are ongoing on best ways to engage Ms Elsdon in advocating Red Cross and Red Crescent TB activities.
- A media tour took place in March in Kazakhstan, which highlighted TB and TB/HIV, as one of the major threats for communities, underlining the importance of Red Crescent interventions. The media tour was conducted by the British Red Cross.

HIV

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.

Outcome(s)

By 2010, to harmonize (using the GA on HIV approach) Red Cross Red Crescent Societies' response to HIV, and to scale-up related activities by 100 per cent from 2005, in order to reduce HIV vulnerability and its impacts with expanded coverage, improved quality and resourcing. The following are the expected specific outcomes for 2009:

- Continue to familiarize the zone/regional offices (through the health and HIV focal points) and National Societies with the conceptual framework of the Global Alliance on HIV.
- Provide technical support to ensure the quality of the support provided, including building the capacity of health/HIV focal points in the zone/regional offices and National Societies.
- Review additional GA on HIV programme documents/proposals received from National Societies. Address quality issues with National Societies, health/HIV focal points in the zone/regional offices and bilateral partners, and help them with their funding submissions to their donors.
- Contribute to the development of National Societies' technical capacity in collaboration with the secretariat in the zone.

- Develop tools that support National Societies in the implementation of programmes.
- Efforts made to mobilize significant funds for programme implementation.
- Render 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.

Achievements

Progress on the Global Alliance on HIV

- In 2009, the management of the Global Alliance on HIV was handed over to the HIV team at the secretariat in Geneva.
- A total of 56 National Societies signed up for the GA HIV approach, developed programme documents and started implementation.
- In December 2009, a meeting was held in Amman to conduct an orientation session on the GA on HIV for health coordinators of the National Societies in the Middle East (the only zone/region left to get orientated on the GA on HIV approach). A subsequent step was to organize a sensitization meeting for the senior management of National Societies; and based on their consent, National Societies could be included in GA on HIV and assigned professionals assisted in HIV programme development.
- 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 2008. In total, 72 National Societies submitted data for the report. Of these, 52 National Societies were from the 56 who signed up to the GA on HIV approach, and developed comprehensive programmes on HIV (93 per cent). This is the first time that the HIV team was able to capture programme performance data at the global level from such a significant number of National Societies.
- From this report, the HIV team concluded that in 2008, a total of 22,721,907 persons were reached with prevention messages and received psycho-social support from 72 National Societies. Of these, 62 per cent were reached in Africa, showing that the National Societies in Africa exerted more efforts to scale up their programmes and reach more people with prevention messages, as well as render support to those infected and affected.
- With respect to resource mobilization, the report showed that a total of 46,407,217 Swiss francs were mobilized by the 72 National Societies. This represented only 0.3 per cent of the global spending on HIV (13.7 billion US dollars) in 2008. 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.
- A technical review was conducted on the GA on HIV programme manual, and an updated version was completed. Version 6.1 was translated into French, Spanish, and Arabic, and dispersed to the zones and National Societies in June 2009.
- The GA on HIV newsletter was reinstated, with its first issue being distributed in December 2009.

Development of tools and facilitation of knowledge sharing

- The *Minimum Standards for HIV Peer Education Programmes* was finalized, and translated into French, Spanish, Arabic and Russian.
- In May 2009, a global HIV prevention meeting was held in Geneva for health/HIV focal points from zones/regions and the HIV team at the secretariat in Geneva. Guest speakers from the Young Women's Christian Association (YWCA) and UNAIDS also participated in the meeting.
- The *HIV Prevention Guidelines* was also completed in English. This guideline and the *Prevention Guidelines* were officially launched by IFRC on World AIDS Day 2009 (1st December). Translation of the *Prevention Guidelines* will begin in early 2010.
- The English version of the pioneering community-based training package on *HIV Prevention, Treatment, Care and Support,* developed jointly with WHO and the Southern African HIV

AIDS Information Dissemination Service (SAfAIDS), has been translated into Spanish and Portuguese and distributed to National Societies for use .

- The Pass-It-On e-forum continued to provide members with relevant HIV-related information until summer 2009, when the e-forum platform was moved to another host. In 2010, the HIV team at the secretariat in Geneva plans to explore new opportunities to encourage the continuation of disseminating information, and sharing knowledge and experiences.

Capacity building

- In August 2009, the HIV team at the secretariat in Geneva in collaboration with its regional office, organized in Bangkok, a master trainer's course on the Federation's training package. Twenty professionals from eight National Societies were trained as master trainers to help the respective National conduct training of trainers (TOT) courses, and to cascade down these skills to the branch/volunteer level. To date, a total of 108 master trainers were trained from National Societies in Southern and Eastern Africa, and South and South East Asia.
- The HIV team at the secretariat in Geneva, in collaboration with the regional office in Nairobi, supported the Kenya Red Cross Society conduct a mid-term evaluation of the comprehensive HIV programme that has been implemented by the Kenya Red Cross Society in Nakuru, with funding support from the Swiss Red Cross Foundation

HIV in emergencies

The HIV team at the secretariat in Geneva continued to support the mainstreaming of HIV into the IFRC's emergency response activities.

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 2009.
- Five members of the RCRC+ were supported to facilitate the sessions on HIV during the 150th anniversary events taking place in Solferino, Italy in June 2009. These members also participated and helped with the HIV booth located in the global village during the events.
- The RCRC+ network was also supported to champion the Masambo Fund Foundation in their respective zones/regions. In 2009 alone, the HIV team at the secretariat in Geneva received 100 applications to the fund, and was able to support 57 of these nominees before the end of the year.

Stigma and discrimination

- The IFRC renewed the UNAIDS collaborating centre agreement and work plan.
- The HIV team at the secretariat in Geneva helped facilitate the hand over of *The Code of Good Practice for NGOs Responding to HIV* to the Global Network of People Living with HIV (GNP+).
- World AIDS Day campaign materials were adapted to "Promote access to prevention, treatment, care and support through the Global Alliance on HIV." Campaign posters (in English, French, Spanish and Arabic) were distributed to zones/National Societies for the event, along with the new publications that were launched on that day (*HIV Prevention Guidelines* and *Peer Education Standards*).

HIV advocacy

- In collaboration with the zone office in Panama and the communications team at the secretariat in Geneva, an advocacy report was developed for World AIDS Day 2009. The report focused on *Inequalities fuelling the HIV Pandemic: Focus on Red Cross Societies in Latin America and the Caribbean*. The report was accompanied by interviews, and a short video which captured footage from various National Societies from the region.

The Masambo Fund Foundation

- The Masambo Fund Foundation was established by the secretariat in 2004, with the objective of supporting Red Cross Red Crescent volunteers and staff living with HIV in accessing ART and related assistance like nutrition transport etc. The HIV team at the

secretariat in Geneva managed to compile a report on the performance of the fund in the last five years, and distributed this report to all partners. Moreover, a booklet that captured performances, including testimonies of beneficiaries and future funding needs, was developed in collaboration with Saatchi and Saatchi (an advertising company who provided their design expertise pro bono). The printed version was sent to all partners in 2009. The booklet is intended to serve as a resource mobilization/marketing tool.

Governance support

- The HIV team at the secretariat in Geneva organized meetings for the HIV Governance Group and the Masambo Fund Foundation Board in Paris and Geneva in 2009.
- The HIV team also contributed to the health and care advisory body meetings throughout the year.

Health in prisons

- The *Health and Prisons: Red Cross Red Crescent HIV, TB, and Psycho-social support activities with prisoners and former detainees* has been completed. Feedback from the ICRC has been incorporated, and the document will be posted on FedNet in early 2010.

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 Global Alliance on HIV approach

- At the secretariat in Geneva, a major challenge for the HIV team in 2009 was a lack of human resources/capacity throughout the year (the team was effectively reduced to two from five persons, not including the additional Global Alliance on HIV team or Special Representative on HIV who also left). Despite this, the remaining team was able to successfully absorb the Global Alliance on HIV project into its HIV programme in the health and social services department. In addition, technical core health and social services programme staff in zone offices were not fully in place until the end of 2009. Some zones have lost their HIV technical staff as well, making it difficult to coordinate at a global level, as technical advice and quality controls various considerably.

- No technical staff member at secretariat in Geneva is dedicated to output 3 of the Global Alliance 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.

Influenza

Outcome(s)

IFRC will support National Societies in doing implementation on avian influenza prevention through the following activities:

- Humanitarian pandemic preparedness messages and tools created in the areas of health, food security and livelihood.
- A well-functioning network of NGO partners is developed in the areas of health, food security and livelihood.
- In-country capacities of staff, volunteers and selected NGO partner(s) are strengthened to carry out the influenza pandemic preparedness and response plans and protocols.

- An action plan (either comprehensive country plan or plan of action) is developed for in-country H2P partners that summarizes overall strategy, roles and responsibilities; priority tasks; and monitoring and evaluation plan, including indicators.

Achievements

- The IFRC has successfully accelerated the pace of the H2P programme at the global and country level, and has now expanded it to cover 96 countries. Forty-seven National Societies are funded by DFID, 48 National Societies from USAID and 1 National Society from unearmarked funds. Among those 96 countries, 26 National Societies are implementing "H2P long" (comprehensive preparedness and response) projects, 47 are implementing H2P "accelerated projects" (emergency response), and 23 have received H2P mini funds to conduct countrywide communication campaigns.

- In cooperation with WHO, UNOCHA, United Nations System Influenza Coordination (UNSIC), the UN Pandemic Influenza Coordination (UNPIC), and UNICEF, IFRC published to all National Societies on 21 August a "call to action" summarizing the coming steps essential to responding to the pandemic, and urging National Societies to respond. This "call to action" changed the emphasis of IFRC's direction to all 186 National Societies, suggesting energy and resources previously being used for preparedness, to be used for response. Suggested immediate activities included:

  - Identify populations most-at-risk of disease and death from H1N1.
  - Reduce death and disease by training staff and volunteers to identify symptoms from H1N1 and provide home care for the ill.
  - Reduce the spread of disease by disseminating risk communication material.
  - Continue critical services and plan for the worst by jump starting business continuity planning and securing personal protective equipment.
  - Re-affirm the need to partner and coordinate at the country level.

- The IFRC developed and distributed a "ready-to-use package" to all 186 National Societies during the first week of September. The package included a comprehensive set of information kits and tools that National Societies could use to respond to H1N1, such as:

  - Basic guidance covering the three essential elements of a response: business continuity planning, protection of staff and volunteers, and effective pandemic mitigation and response activities. The basic guidance was shared with H2P partners who provided useful feedback before dissemination.
  - Global Communication and Media Campaign guidance "Your best defence is you" consisting of generic material to be adapted and printed locally. This guidance included six posters with key messages to promote non-pharmaceutical interventions, a radio script and a 30 second video clip.
  - A web-based e-learning package that targets National Society staff and volunteers, as well as the general public.

  Many National Societies have used this package to train their volunteers and inform their communities by adapting the generic H1N1 campaign to their country context, translating material into local languages, printing posters and distributing leaflets, all with the approval of their ministry of health. Many National Societies conducted training on preventive measures in communities, but also in schools. At least 25 National Societies have formal agreements with their ministries of education to help prepare for and respond to the pandemic. Eleven National Societies were compelled to use the official campaign developed by their ministry of health, and Tajikistan used the WHO campaign.

- The H2P country plan has been adapted and refined into a plan of action to help National

Societies accelerate project design and implementation consistent with the more urgent risk posed by H1N1. National Societies have been receptive to the original and revised guidance. Mini-workshops were conducted in nearly every zone to prepare National Societies to complete the country plan or plan of action. Additional mini-work shops were conducted at InterAction-led meetings in Addis Ababa, Pretoria and Hanoi. Approximately 30 per cent of National Societies with signed projects have begun completing either the original country plan or the more recent plan of action. IFRC will need to facilitate further testing of the country plan and plan of action guidance, and continue to provide support to National Societies to fulfil this milestone.

- At least 38 National Societies have conducted briefing sessions and coordination meetings with government authorities, UN agencies and non-governmental organizations in order to coordinate efforts and develop action plans that summarize overall strategy to respond to the pandemic. For example in Belarus, coordination and planning meetings with key stakeholders were held in Minsk city, Brest, and Grodno districts with chairpersons, staff and volunteers of the regional organizations.

- Sixteen National Societies have conducted mapping activities, and identified focal persons and existing response capacities to coordinate work and to avoid duplication. In El Salvador, for example, the National Society developed tools and questionnaires and conducted a comprehensive survey in five districts.

- Although simulation exercises were not formally required in project agreements due to the response urgency of the H1N1 crisis, seven National Societies conducted such exercises that eventually proved to be very useful to sensitize government authorities and other agencies to the pandemic situation. As an example, The Gambia Red Cross Society (GRCS) initiated a pandemic preparedness simulation exercise for health authorities and key partners. Priority areas for rapid response, coordination, surveillance, prevention, control and communication were highlighted. Other partner organizations were encouraged to imitate the GRCS experience. For more information on this story, please visit: http://allafrica.com/stories/201001130519.html

- More than 30 National Societies have conducted workshops to adapt existing H2P training curricula to address generic health, food security and livelihood messages for in-country use. For example, Nepal Red Cross Society conducted three trainings for 90 health professionals in Kathmandu and Nawalparasi, two trainings for 58 community leaders in Ilam, and five trainings for 125 female community health workers in three districts. To increase country coverage, the Nepal Red Cross Society also conducted one-day trainings in 10 districts to reach 511 staff, volunteers and partner organizations' representatives.

- Twenty-five National Societies have trained volunteers and community members as first responders during an influenza outbreak. All other National Societies have reported that similar trainings will take place in 2010. In South Africa, for example, the National Society organized trainings for 754 volunteers and 1,874 staff, as well as for 278 staff members from other NGOs. The community was approached through 685 campaigns, reaching 373 taxi ranks (approximately 7295 people), 418 shopping malls (approximately 11,220 people), 135 schools (135,000 pupils), and over 35,149 individuals were reached through 363 door-to-door activities.

- As stated earlier in the report, the IFRC has provided small funds to support 23 National Societies to adapt and translate the global H1N1 campaign to the local context, or to coordinate and support their ministries of health or education in the government response. National Societies printed and distributed posters, leaflets and brochures, and ran radio messages or the H1N1 video clip on local channels. Several innovative ideas were reported such as the adaptation of H1N1 preventive messages on children's school diaries and paper

games by the Yemen Red Crescent Society, as well as on carton fans by the Algerian, Tunisian and Libyan Red Crescent Societies.

Constraints or Challenges

- The greatest challenge facing the programme is that demand for financial and technical support from vulnerable communities to prepare for, and respond to, the H1N1 pandemic has far exceeded the resources available to the IFRC. Rather than hope the pandemic would be mild, IFRC was obliged by its mission to support its members and help prepare vulnerable communities. As a result, IFRC has obligated funds to National Societies exceeding the present obligations of its donors. While IFRC has been moderately successful in raising additional funds, it is not sufficient to close the projected deficit.

- Delays in starting the implementation of H2P projects: Although many National Societies signed their sub-agreements in September or October 2009, many started the implementation only in December 2009 or January 2010. This is mainly due to the difficulty of finding the appropriate H2P focal person.

- Translation and adaptation of training materials: Delays in testing and revising working group material and subsequent delays in translating and finalizing the materials have caused some anxiety among zone staff who felt pressured by National Societies in their regions. Efforts have been made to alleviate this pressure, by forming working groups to revise and publish shorter and more simplified material for immediate use by zones.

- The drop in the value of the US dollar against the Swiss franc has exacerbated the unit's financial challenges and increased the projected deficit. When the IFRC first received this grant on September 30, 2007, the exchange rate was 1.16 Swiss francs for 1 US dollar. On September 30, 2009 it was 1.03 Swiss francs for 1 US dollar. This huge loss of approximately 1.5 million US dollars may jeopardize obligations made to National Societies. IFRC will ask USAID to consider this loss when contemplating a potential financial commitment in fiscal year 2011.

Working in partnership

The IFRC continues to work with relevant external health and social services partners, including GFATM, the UN Foundation, UNICEF, US Centres for Disease Control, WHO, government funding bodies like DFID, EU, NORAD, Royal Netherlands Embassy, SIDA, USAID and a number of NGOs. The IFRC is also expanding its partnerships with private sectors, such as Eli Lily and Company, Exxon, Nestlé, Shell, and other development and funding agencies, such as the Gates Foundation. It is supporting National Societies in their respective efforts to strengthen collaboration at the national level with government funding bodies. Also, the IFRC's Global Alliance approach on HIV has contributed to a conducive environment for forging partnerships, and has facilitated operational harmonization among Red Cross and Red Crescent partners. All these partnerships bring additional resources to support National Societies to scale up their health activities.

Strategic partnerships with national and global academic institutions and recognized research centres are also being strengthened. The IFRC is hosting and coordinating the efforts of the Alliance for Malaria Prevention which involves over 30 partners. Similar collaboration is also happening with regards to campaigns on polio and measles. Finally, the IFRC has linked up with the International First Aid Advisory Body to develop consensus of science in first aid.

Contributing to longer term impact

The global water and sanitation and polio and measles initiatives, as well as the global alliance on HIV have substantially increased coverage and scale of longer-term programming, and thus contributed further to the Millennium Development Goals.

The IFRC is committed to promoting community-based health and first aid as a long term and integrated approach that positively impacts on needed behavioural changes at the individual and household levels.

The strengthening of National Society capacities have contributed to solidifying the IFRC's recognized role in both social mobilization and in addressing public health emergencies. Overall, the IFRC can show good collective results in the implementation of the global health and care strategy.

Looking ahead

There is a need for the IFRC to evaluate some of the global health initiatives before further expanding the programme. It must strive to increase evidence-based programming. Effective monitoring, performance tracking and evaluation systems will enable the IFRC to assess and improve the quality of programme delivery at the community level.

Being in a better position to measure impact of its health and social services work, as well as its contribution to the Millennium Development Goals is necessary in order to further position the Federation health and care agenda internally and among external partners.

The global health and care team's key priority is to build the capacities of National Societies, through the engagement of vulnerable communities and volunteers, to scale up their health programmes. This includes bringing specific disease interventions and long-term community health as an integrated approach, and strengthening the emergency and preparedness capacity in health and water and sanitation. The present water and sanitation unit will be merged with emergency health, effective from January 2010. This is a most welcome step to further integrate these complimentary technical areas at the global and field level. This is intended to be a major step in improving joint impact in preparedness to disasters and epidemics.

How we work

The IFRC's activities are aligned with its Global Agenda, which sets out four broad goals to meet the IFRC's mission to "improve the lives of vulnerable people by mobilizing the power of humanity".	**Global Agenda Goals:** • Reduce the numbers of deaths, injuries and impact from disasters. • Reduce the number of deaths, illnesses and impact from diseases and public health emergencies. • Increase local community, civil society and Red Cross Red Crescent capacity to address the most urgent situations of vulnerability. • Reduce intolerance, discrimination and social exclusion and promote respect for diversity and human dignity.

Contact information

For further information specifically related to this report, please contact:

Matthias Schmale, Acting Head, Health and Social Services department,
e-mail:matthias.schmale@ifrc.org, phone: +41 22 730 4686; and fax: +41 22 733 0395.