Mid-Year report

International Federation of Red Cross and Red Crescent Societies

Health

Appeal No. MAA00001

09/09/2011

This report covers the period 01 January 2011 to 30 June 2011.

Solomon Islands, water tank installed on a remote island.
Solomon Islands Red Cross Society.

In brief

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

Programme(s) summary:

During the reporting period, the Global Health Team continued to support National Societies' programmes based on their expressed needs in addition to global activities in tools development, representation, advocacy, and planning.

The Global Health Team have continued the process to develop a Strategic Operational Framework (SOF) for health. The SOF was signed off by the IFRC senior management during May 2011 and the team is now in the process of final edits and layout before wide dissemination.

In parallel, the health department in Geneva worked on its Long-Term Planning Framework (four years). The framework served as well as input for a Programme Services Division wide LTPF and a Secretariat wide LTPF.

The Global Health Team, comprising Geneva and Zone Health team members, met during June 2011 and concentrated on planning the roll-out of its Strategic Operational Framework for health 2011-2015 and reaching-out and working together with other departments and reference centres.

Main achievements made during the first half of 2011 include:

- **CBHFA:** The health team continued to identify linkages between CBHFA and other health programmes, as well as linkages with DRR programmes. Consequently, a discussion paper on CBHFA/DRR the way forward was developed in addition to some joint programmes being implemented at country level (ex. Indonesia).

- **Noncommunicable Diseases (NCDs):** The health team has started to address NCDs and developed a working paper in consultation with several NSs that includes a long-term vision and key action points for 2011. The IFRC will as well organize a side event during the UN General Assembly high-level meeting on NCDs in September 2011.
- **First Aid:** The IFRC launched the first International First Aid and Resuscitation Guideline at the beginning of 2011.
- **MNCH/Immunization:** The Global Measles & Polio Initiative funds were provided to seven NSs for measles and polio campaigns. A total of 4100 volunteers were so far mobilized to reach 700,000 households with vaccination messages. Furthermore, the IFRC co-hosted an event with Médecins Sans Frontières at the 64th World Health Assembly.
- **VNRBD:** IFRC celebrated World Blood donor Day on 14th June in collaboration with WHO and the Swiss RC.
- **WatSan/Emergency Health:** The team provided guidance and support to four emergency appeals and 43 DREF operations between January and June 2011. An external evaluation was conducted to review the Epidemic Control for Volunteers Manual and Toolkit and revealed the package to be an excellent concept. Additionally, the IFRC concluded a mid-term review of its Global Water and Sanitation Initiative. The initial ten year targets (5 Million beneficiaries and CHF 150 million funding mobilised) have been surpassed at the half way point.
- **HIV:** Seven NSs in Southern Africa and four NSs in Eastern Africa received support in the development of integrated HIV programmes 2011-2014 for proposal submission to the GFATM. Furthermore, a new module on gender was drafted in order to be included in the regular HIV training package. The module will be completed and piloted during the second half of 2011. The IFRC co-organized a side event during the UN High Level Meeting on AIDS in New York during June 2011 with the International HIV/AIDS Alliance. The event was co-hosted by the UK and South African governments, and had the aim to raise awareness for better access and human rights realization to key affected populations.
- **TB:** National Societies continued to support over 150,000 patients on a daily basis ensuring 90% of treatment completion. Together with the Stop TB Global Partnership, a TB advocacy report was published and a joint press briefing provided during March.
- **Harm Reduction:** The IFRC signed a partnership agreement with UNODC. The agreement is considered as a good advocacy tool for both organizations and particularly for National Societies to address the issues of drug use and related harm at the community level.
- **Malaria:** The IFRC supported malaria activities in 12 countries in Africa and Asia Pacific. In Nigeria, the project has received a total of 1,214,000 nets for distribution and sensitization by Nigeria RC volunteers. Operations research activities are ongoing in Togo and will soon start in Nigeria.

Financial situation: The total 2011 budget is CHF 6,695,682, of which CHF 6,711,410 (100 per cent) covered during the reporting period (including opening balance). Overall expenditure during the reporting period was CHF 2,157,739 (32 per cent) of the total budget.

The overall expenditure rate of 32 per cent does not reflect the actual implementation rate. The primary cause for the low percentage is that the health appeal MAA00001 has received malaria funds destined to the field (approximately CHF 1.8 million) and TB multi-year funds from Eli Lilly (till 2012). Action has already been taken to address this issue by finalization of plans and budgets at field level in order to transfer funds out of Geneva. The health department is as well looking into longer-term solutions with the finance team for future similar situations. An additional challenge has been that funding is received relatively late which caused delays to some of the planned activities to later during the year.

Click here to go directly to the financial report.

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

Context

During the reporting period, as a consequence of the poor infrastructure, inadequate sanitary conditions and severe poverty, a cholera outbreak started in Haiti from October 2010 and continued to worsen during 2011. During May and June 2011, the Movement components reported an increased number of cholera hotspots, particularly in the West and Grande Anse departments, believed to be linked with the start of the rainy season. Heavy rains beginning on 2 June flooded streets in the Port-au-Prince metropolitan area as well as in departments of West, South, Artibonite, and Nippes department, while the Artibonite River overflowed its banks resulting in the flooding of Grande Saline. During June the Ministry of Health and Population reported 50,405 cases, 26,170 hospitalizations and 233 deaths.

The importance of ensuring communities have improved resilience against cholera is paramount, particularly as humanitarian cholera programmes are largely scaling down. The recent increase in cholera cases demonstrates the importance of preparing communities for repeated outbreaks linked to the rainy season cycles. Interventions are needed to further increase cholera awareness, and the importance of hygeine, safe water and adequate sanitation.

The Haitian Red Cross with support from the International Federation of Red Cross and Red Crescent Societies (IFRC), the International Committee of the Red Cross (ICRC) and Partner National Societies (PNS) in the country continue to reach the affected and vulnerable with cholera prevention and control activities including: managing Cholera Treatment Centres (CTC), Cholera Treatment Units (CTU), maintaining Oral Rehydration Sachet (ORS) points, hygiene promotion, disinfections and distribution of cholera prevention and treatment materials. Water supply and sanitation interventions were at the same time reflected within the Haiti Earthquake appeal.

The story of the 'Arab spring' is another emergency that have required involvement from the health department with countries in the region going through different, but connected, changes. The persisting conflict in Libya in particular led to ongoing violence affecting individuals and communities, along with displacement of Libyan citizens and third-country nationals across land borders as well as by sea.

Health activities focused on the Al Hayet Transit Camp. Between 6 April and 10 July, the Transit Camp clinic provided at least 4,822 health and medical consultations to adults and children. Morbidity patterns remained normal with treatments being provided primarily for influenza, LRTI, gastroenteritis, injuries, gynaecological consultations and skin rashes or scabies. A few suspected cases of TB were referred to the local hospital for testing. Clinic staff coordinated with IOM and Tunisian civil defence authorities the referral of patients in need of emergency or advanced care. Sevices provided also focused upon safe water supply, sanitation and hygeine promotioin activities, crucial to maintaining or improving the health status of those affected.

As part of its operational re-orientation, the Federation has begun to actively support the TRC Health Clinic at Tataouine by providing essential medicines and equipment, along with non-food items (NFIs) for mother/infant distributions to be carried out by clinic staff and volunteers. In addition plans will include diapers, shampoo, soap and baby clothing for those up to 3 years of age along with hygiene pads. Health and hygiene promotion materials will be provided in partnership with qualified NGOs to encourage breast-feeding, proper nutrition - especially during Ramadan, and raise awareness on health matters linked to hot climates. The clinic has been in operation since late April and provides an average of 2,000 consultations per month oriented largely toward the 14,000 displaced Libyans in the area.

WatSan activities were as well a priority in the Al Hayet Transit Camp as 49 toilets and 26 bathing rooms were made available to beneficiaries, as well as 66 water taps. A total of 2,831,000 litres of

water were provided between 6 April and 18 July. Hygiene promotion messages have been disseminated to approximately 8,500 people. During the reporting period, there were intermittent water supply problems due to cuts in supply through municipal infrastructure. With rising summer temperatures, tap water was also lukewarm and unappealing to camp beneficiaries. Water trucking and distribution of bottled water ensured that sufficient quantities remained available.

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

Progress towards outcomes

First Aid, Community Based Health and First Aid and NCDs

First aid reduces deaths, injuries and impact not only in disasters, but also in daily emergencies. It provides an immediate response to an emergency, taking life saving measures until professional help arrives. National Societies provide high quality first aid education and skills to its volunteers, meeting approved standards set by different national authorities. The first aid programmes remain flexible and relevant by including skills and knowledge that respond to new vulnerabilities in injury, diseases and health priorities.

The Community-based Health and First Aid (CBHFA) is the Red Cross Red Crescent (RCRC) integrated primary health care approach to community health promotion. The CBHFA approach engages communities and their volunteers to use simple tools, adapted to local context to address the priority needs of a community and to empower them to be in charge of their own development. This comprehensive approach is a generic means to promote behavioural change and raise public awareness about health related risks and how to prevent or control them.

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

Outcome(s)

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

Achievements

Contribution to MDGs/Resilience (Reduce vulnerabilities related to injuries and diseases and build resilient communities):

According to 2010 mapping data, more 72 NSs are implementing CBHFA with support from the Federation and 14 PNSs. Over 55,000 volunteers reached more than 2.3 million beneficiaries in community health programming using CBHFA approach. The focus of 2011 is to scale-up implementation at the community level, roll-out PMER toolkit, quality control and better linkage/integration with other programme areas.

The Secretariat has started 2011 mapping exercise to better understand the global implementation of community health programmes using CBHFA approach. The mapping results will be ready during the second half of 2011.

Close coordination between CBHFA and other programme area in health and DRR has started and let to active participation of CBHFA in global events (a discussion paper on CBHFA/DRR way forward was developed and shared during Global Resilience forum in Syria in March 2011) and also let to develop joint programmes (e.g. Integrated programme in Indonesia using CBFHA/DRR approach)

NSs are the major first aid educator and provider in the world. Almost all 186 NSs have first aid as their core activity. According to 2010 mapping, more than 17 million people received first aid courses (less than 6 hours). An additional 46 million were reached by first-aid and preventive messages.

Technical support and capacity building (Improved NS capacity in implementing community health programming and First Aid programming):

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

Regular communication and networking among the resource people are continuing. CBHFA Update January – December 2010 was published in early 2011. The document included key updates and case studies from different NSs in different zones; also it included a summary of CBHFA 2010 global mapping and CBHFA PMER toolkit.

With support from Swedish Red Cross, CBHFA lessons learnt and M&E workshop was held in South Africa during 22-24 March 2011. 20 participants from ONSs, PNSs and Federation offices in Africa participated in the workshop. The purposes of the workshop were sharing updates and lessons learnt on CBHFA implementation from the African NSs, other regions and globally and identifying gaps and challenges, also introducing CBHFA PMER toolkit.

One day CBHFA M&E workshop was conducted in Haiti in May 2011 to introduce CBHFA PMER tools to HRC, IFRC and PNSs who are supporting CBHFA implementation.

European Education network meeting was conducted in Paris 1-3 April 2011 to prepare for the upcoming European First Aid network annual meeting in Prague in October 2011 where more than 30 National Societies will participate to share experiences in first aid and plan for future.

A request to conduct a workshop on evidence-based practices in first aid during the general assembly in November 2011 was submitted and approved. The workshop aims to raise the priority and promote the evidence-based practices in first aid.

Draft concept paper on global first aid network was developed and shared for feedback, the concept paper aims to coordinate and maximize the use of different mechanisms to support NSs first aid programmes.

World First Aid Day report for 2010 and an info pack for 2011 were developed and they are under lay-out.

A working paper on NCDs was developed with consultation of different NSs. The working paper included the long term vision on how to address NCDs in addition to key action points for 2011. RCRC is in a unique position to be a pioneer in implementing NCDs prevention programmes at the community level. IFRC was very active in promoting NSs role in this field. An intervention on the role of NSs in NCDs was presented during the World Health Assembly in May 2011. Also, IFRC is taking a leading role in participating during the high level meeting on NCDs during the UN general assembly in New York in September 2011.

Tools development and dissemination (Update and disseminate CBHFA/FA tools and materials to use in planning, implementation, monitoring, evaluation, reporting and training at all levels):

CBHFA materials in Spanish were shared with Spanish speaking NSs. Materials in French were shared with a couple of NSs and the rest will be shared with during the second half of 2011.

With support from Finnish Red Cross and Norwegian Red Cross, CBHFA PMER toolkit was developed to insure appropriate planning, monitoring, evaluation and reporting. The tools build on existing M&E tools used by CBHFA staff and volunteers from various NSs, and have been tested and revised during 2010. The toolkit was disseminated widely and now it is under translation to French and Spanish.

CBHFA promotional video on YouTube was completed and disseminated. NS shared their stories working with communities, engaging with volunteers, partnering with local government and finding local solutions from the challenges they are facing.
http://www.youtube.com/user/ifrc#p/u/6/1bf9gFnpbTM

CBHFA SharePoint website was developed and updated. The website includes key case studies, lessons learnt, photos, calendar, mapping, workshop documents, feedback on CBHFA tools and many other useful tools and materials.
https://fedteam.ifrc.org/global/collaboration/health/cbhfa/wsdocs/default.aspx

To better introduce CBHFA and work with other sectors and non-RCRC partners, the secretariat has started developing communication/marketing tools which will be ready before the end of 2011.

The first IFRC International First Aid and Resuscitation Guideline was developed and finalized in early 2011. This evidence based guidelines and recommendations will help and guide NSs to improve their FA education, training, practices and services. With support from French Red Cross, the guideline was translated to French and will be available in September 2011.
http://www.firstaidinaction.net/data-publications/technical-files/first-aid-guidelines-2011

Research and Learning Agenda (Design and implement a research and learning agenda around key community health, NCDs, first aid and resilience issues, including behaviour change):

Based on the recommendations from the CBHFA global meeting in Geneva in December 2010 and with support from Canadian Red Cross, the development of a concept paper on CBHFA Operational Research was start. A draft paper will be ready during the second half of 2011 and will be shared widely for feedback and inputs.

With support from American Red Cross, Belgian Red Cross and European Reference Centre for First Aid Education a draft concept paper on first aid evidence based group was developed. The

purpose of the group is to define and support evidence process within first aid for IFRC and the member NSs.

Constraints or Challenges

Lack of funding at the country level to support long-term community health programmes. Delays in receiving 2011 funds from key partners led to uncertainty in planning and risk of no funding.

Again during this year, the Secretariat did not receive any specific funding to provide technical support to First Aid activities, so we are still using CBHFA budget to cover first aid support.

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

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

Maternal, Newborn and Child Health and Immunization

The purpose of the programme is to:

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

For an update on immunization activities, go to the Global Measles & Polio Initiative update.

Outcome(s)

- **Component outcome 1:** Harmonized Red Cross Red Crescent involvement in maternal, newborn and child health (MNCH) component areas through consolidated activities and increased involvement in global MNCH partnerships.
- **Component outcome 2:** Reduced morbidity and mortality due to measles, polio and other vaccine-preventable diseases from increased access and uptake of supplementary and routine immunization services. 90% global reduction in measles mortality and zero countries reporting polio cases.

Achievements:

The programme helped to facilitate technical support and resources to the zones/regional offices and NS for their effective involvement in mass measles and polio immunization campaigns to reach related global immunization targets. During the first half of the year, funds from the Global Measles & Polio Initiative were provided to 7 National Societies for polio and measles campaigns; 4 of these funded campaigns occurred during the first half of 2011, mobilizing 4,100 volunteers to reach approximately 700,000 households with vaccination messages.

The IFRC significantly scaled up its global voice in advocacy for vaccines, including through press releases and media events, statements at international fora (World Health Assembly, GAVI Pledging Conference), and by co-hosting an event with Médecins Sans Frontiers at the 64th World Health Assembly titled *Global Immunization Vision and Strategy (GIVS): Getting the Balance Right.*[1] For a full listing and links to the IFRC's advocacy-related work, please see the Global Measles & Polio Initiative Programme Update.

[1] For the WHO WHA interventions please see http://www.ifrc.org/en/news-and-media/opinions-and-positions/speeches/2011/routine-immunization-systems-must-be-significantly-strengthened-to-prevent-polio-outbreaks/ and http://www.ifrc.org/en/news-and-media/opinions-and-positions/speeches/2011/more-than-

Through its support to the GAVI Alliance, the IFRC increased its role as a key civil society partner during the beginning of 2011. At the first GAVI Alliance Pledging Meeting, held in London, IFRC's Secretary General spoke on behalf of all civil society. IFRC began hosting the Communications Focal Point in June 2011 and organized the second meeting of the GAVI CSO Steering Committee at its Headquarters in early July, which was immediately followed by a broader meeting of the CSO Constituency.

A decision was made in late 2010 to not finalize the IFRC's MNCH Framework until the completion of the forthcoming Global Health Team Strategic Operational Framework (SOF). The SOF was finalized in April 2011, at which time it was noted that additional human resources would be needed in the Health Department if the MNCH file was to be taken forward in a meaningful manner. At the time of this report, the IFRC is planning to advertise a Senior Health Officer for MNCH position (Staff on Loan) once the MNCH Framework is finalized.

Voluntary non remunerated blood donation

Outcome(s)

The International Federation supports the advancement of global health security by promoting safe and sustainable blood systems, with a particular emphasis on promoting Voluntary Non-Remunerated Blood Donation (VNRBD) and advocating effective blood system governance and risk management. With a focus on Global Agenda Goals 1 and 2, the Secretariat, in association with GAP (Global Advisory Panel on corporate governance and risk management for RC/RC blood services), has the following objectives for 2010-2011:

- Provide context specific development support in vnrbd for NSs.
- Promote best practices for recruitment and motivation of vnrbd.
- To develop/enhance partnerships to maximize available resources to promote vnrbd.
- To maintain the International Federation's leadership role in promotion of voluntary, non-remunerated blood donation in order to secure improved global blood safety and adequacy.

Achievements:

The VNRBD programme has been on hold since the departure of the Senior Officer for VNRBD in October 2010. Without proper human resources, the programme has not been able to accomplish its objectives set for the first half of 2011.

The IFRC is in Phase 2 of a five-year grant from the Swiss Humanitarian Foundation (SHF) to promote VNRBD. In 2011, Phase 2 funds have been allocated to 13 Red Cross Red Crescent National Societies in the Americas, Europe, South-East Asia, and East Africa. Results from this activity will be shared in the 2011 annual report.

IFRC celebrated World Blood Donor Day (WBBD) on 14th June in collaboration with WHO and the Swiss Red Cross. Activities were organized at WHO, including the formation of a "human blood drop" and tents for the public to donate blood.

Water, Sanitation and Emergency Health

Outcome(s)

- IFRC concluded a mid term review of its Global Water and Sanitation Initiative. The initial ten year targets (5 Million beneficiaries and 150 M CHF funding mobilised) have been surpassed at the half way point. By March 2011, the 161 projects globally included under the GWSI umbrella

---

20000-community-based-volunteers-mobilised-by-national-societies-to-support-immunisation-activities-in-2010/. For information on the IFRC/ MSF side event please see http://www.msfaccess.org/main/vaccines/event-getting-the-balance-right-global-immunisation-vision-strategy/

showed 4.2 million beneficiaries had been reached to that time, out of 8.4 million targeted (by completed and ongoing programming). The total cost of these fully funded projects now stands at CHF 267 million.

- IFRC responded rapidly to the displacement of people from Libya into Tunisia, supporting the water, sanitation, and emergency health activities of the Tunisian Red Crescent through deployment of Federation WatSan/EH staff, FACT, and ERUs.
- The International Federation has a strong focus on preparedness and response to health in crisis, disasters and epidemics. Support to National Societies is organised around emergency health expert focal points in Geneva, Panama, Johannesburg and Kuala Lumpur with the aim to share knowledge and develop capacity at local, regional and global levels.
- Continuous work on building of National Society WatSan/EH capacity, representation, and advocacy within the Movement and with other partners continues to take place.
- The Federation is increasing its role and interaction with the Global WASH cluster and is now a member of the Strategic Advisory Group (SAG) which will not only advise but influence key decisions on the Cluster. Three new Federation support positions to the WASH cluster will be established and the agreement and funding package for this new initiative is in its final stages of completion.

Achievements

- By surpassing its initial targets, the GWSI has made a significant contribution towards the attainment of the MDGs, specifically Goal 7c. This has been done via a combination of factors: a close alignment with the developmental thinking of the wider WatSan community, increased availability of funding, a more unified approach between the various Red Cross and Red Crescent partners, more clarity of the vision, and increasingly some good results to demonstrate the past work.
- During the first 6 months of 2011 IFRC 4 Emergency Appeals and 43 DREF operations, most of which have benefitted from the technical guidance, input, information sharing, intervention, quality assurance, and institutional memory of the WatSan/EH team.
- Experiences from the rollout of the Epidemic Control for Volunteers Manual and Toolkit were reviewed in an external evaluation. There is broad consensus among those National Societies where it has been used that the ECV package is an excellent concept, and it has been very well received by its intended audience at NS level, who recognize its usefulness and relevance to the challenges confronting them in their public health activities. The toolkit, now available in eight languages, will be revised based on the user feedback from National Societies.
- The WatSan/EH team contributed to visibility on the global arena and strengthened its cooperation with academia. The IFRC made three presentations in chaired sessions in the main programme of the biannual World Conference of Disaster and Emergency Medicine in Beijing ("Emergency health response in Haiti earthquake 2010", "Working with volunteers in cholera outbreaks in Haiti 2010 and Zimbabwe", "Legal aspects in deployment of foreign medical teams"). The Red Cross experience of health response in Haiti was also presented in the scientific programme of the International Council of Nurses' conference in Malta.
- Federation was also represented at an Asian Development Bank sanitation consultation held in Manila that brought together over 500 key players and participants. Federation has renewed its interaction with and membership of the Water Supply and Sanitation Consultative Council (WSSCC) and will participate at a Global Forum of this body in Mumbai in October.

Constraints or Challenges

- Despite the success of the GWSI in setting technical criteria and resource mobilisation efforts, and having provided significant support to both 'host' and 'participating' National Societies, the various project outcomes are only being measured to date in quantitative data (beneficiary numbers, cost per beneficiary and scale of programming primarily). However, as GWSI continues into the next five years to 2015, greater efforts are required and indeed need to be initiated to measure sustainability and impact, and this can only be done after projects are completed, and indeed revisited at least 2 to 3 years after completion. A new set of tools and new funding streams are required to undertake this crucial element.

- The provision of safe water, in both developmental and emergency contexts, is often seen as 'easier' and is therefore more interesting to donors. However, it must be acknowledged that poor or non-existent sanitation severely limits the positive effects of providing safe water. It is essential that programmes include a balance between water supply and sanitation activities.

Humanitarian Pandemic Preparedness

Outcomes

IFRC is pursuing its efforts to supporting National Societies in pandemic preparedness planning by reaching the following outcomes:

- Humanitarian pandemic preparedness (H2P) lessons learned are available online for any further implementation by the humanitarian sector in the areas of health, food security and livelihood in pandemic context or other threats (https://ifrc.csod.com/client/ifrc/default.aspx)
- The tools developed are posted on various virtual libraries (www.pandemicpreparedness.org, www.influenzatraining.org; http://www.ifrc.org/docs/evaluations/ …)
- Three TASW discussion papers reflect the IFRC and NSs work within Community-based pandemic preparedness, Health preparedness and whole of Government planning (http://www.towardasaferworld.org/learn)
- In-country capacities of staff, volunteers in Belarus are strengthened to carry out the influenza pandemic preparedness awareness amongst orphans. Other National Societies got same proposal and could develop some activities plan in Q2-2011.

Achievements

- IFRC continues to sustain the humanitarian pandemic preparedness methodology at the global and while requested, at country level.
- As stated in IFRC's previous reports, the H2P staff is participating in different events related to the Pandemic preparedness i.e.: Pandemic Panel at the ISDR Global Platform.
- The H2P staff collects any activities conducted by National Societies related H2P approach i.e.: community awareness campaigns, briefing sessions and coordination meetings with government authorities and through, United Nations agencies.
- As part of the sustainability strategy, the H2P staff strengthen the incorporation of H2P messages and methodology into broader topics such as epidemics through the revision of the Epidemic Control for Volunteers training or through Webex conference on pandemic preparedness and lessons learned to be used to control Emerging Infectious Diseases and Zoonoses (Americas Zone meeting on management of Epidemics in April)
- Strengthen the connection between H2P and partners on "Towards a Safer World" initiative and participate into Health, Whole of Government planning and Community Based Pandemic Preparedness papers with WHO, UNICEF, WFP, UNSIC
- Prepare messages and information for IFRC high level participation to September conference
- Ensure regular communication amongst different stakeholders

Constraints or Challenges

- The drop in the value of the US dollar against the Swiss franc has exacerbated the financial challenges. However, the reallocations of balance from field to Geneva allow increasing the budget and foreseeing activities up to at minimum end of 2011. A No Cost Extension request was submitted to USAID for that purpose.
- The announcement from WHO declaring the 2009 H1N1 pandemic to be over has however made it even more difficult to continue the dialogue with stakeholders on the importance of pandemic preparedness and response.

HIV

The International Federation's global HIV programme is being implemented based on the Global Alliance approach as it provides a mechanism for development and implementation of Federation-wide, standardized and comprehensive HIV programmes. IFRC's efforts to support national HIV and AIDS programmes to reduce vulnerability to HIV and its impacts are organised around three programmatic objectives and one enabling objective:

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

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

Outcome(s)

- Improved NS's staff public health knowledge on program development, planning and organization withinn the context of the Global Alliance on HIV approach.
- Improved program performance tracking mainly focusing on program deliveries using preset reporting format.
- Improved NS's performance capacities through provision of generic tools.
- Supported zone office and NS's and enhanced resource mobilization at regional and national levels.
- Increased capacities of NS's through facilitation of knowledge and skills sharing that are acquired from programme implementation by NS's and from external sources.

Achievements

Programme development, planning and organization

Provided technical support to HIV and health coordinators in the regions and enabled them to deliver quality technical support to National Societies in the development of HIV programme documents, plans and budgets for 2011-2015. NS signatory to the GA on HIV in Asia and Pacific and Africa are engaged in the development of new plans.
Seven NS in southern Africa and four NS in Eastern Africa were supported in developing Integrated HIV programmes 2011-2014 in view of developing proposals for funding to the GFTAM, round 11.
A mission to Africa Zone by Unit manager to come out with a shared understanding on issues related to public health and HIV programmes was undertaken.Another mission was dedicated to support the Cambodian RC in finalizing its five years HIV plans that the NS can access in country funding.

HIV in emergencies

The HIV and emergency health team at the Secretariat in Geneva continued to support the mainstreaming of sexual and reproductive health, HIV into the IFRC's emergency response activities. The HIV team actively participated in the review of the Health programme contribution to Federation-wide Strategic framework for Haiti Recovery. The Federation HIV team is part of the global IASC sub-committee on HIV in humanitarian settings. A mission to Haiti and Panama was undertaken with specific efforts underway to facilitate the implementation of sexual and reproductive health, HIV related activities in the aftermath of Haiti's earthquake.

Global Alliance on HIV programme performance

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 2010. In total, 63 National Societies submitted data on programme deliveries. Most of the reporting National Societies are those which have adopted the GA on HIV approach. The 63 National Societies represent a great majority of all National Societies involved in implementing HIV programmes. Thus the data obtained give us good insight into the volume of work done by the Federation worldwide. This is the third year that the HIV team is able to capture programme performance data at the global level from such a significant number of National Societies.

The compilation and analysis of the received data reveals that in 2010, a total of 325,204,824 persons were reached with prevention messages and 224,730 PLHIV and orphans received care and psycho-social support from 63 National Societies. A total of 51,146 volunteers were specifically trained on HIV prevention, care, treatment and support;they engaged in programme implementation and invested nearly 8,569,771 volunteer hours during the year.
Despite efforts to engaged Zone offices in reporting on HIV/TB programme performance, the TB reporting in the context of HIV programming remains unsatisfactory.

With respect to resource mobilization, a total of CHF 26,011,323 were mobilized by the 63 National Societies (30 per cent less as compared to 2009). This could be because of the global financial crisis. It could also mean that we might not have excerted enough efforts in accessing the funds available at country level from international donors. This, in effect, is our biggest problem and weakness. We need to design a better approach for accessing more funds to *"do more and do better"* in our interventions to contribute our share for limiting the spread of HIV and to mitigate its impacts. However, it is important to note that the Federation, with modest funds can deliver more at the community level than other organizations simply because of its grass-root network and capacity to systematically involve community members to address their own public health concerns.

Development of tools

As a follow up to World AIDS Day 2010, the advocacy tool " Out of Harm's way" and communication pack on harm reduction for injecting drug users has been developed in Russian, printed and distributed to National Societies.

A CD encompassing guidelines and tools on Harm redcution was produced.

At the occasion of the UN High level meeting on AIDS in New York, a communication plan and tools were developed to support NS in their advocacy efforts with governments to reach out the most vulnerable; NS were encouraged to partner with other civil society actors, in particular with PLHIV networks and rights-based organisations, to advocate for laws, policies and practices that uphold the rights of people living with and affected by HIV.

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

Resource mobilisation

A Federation strategy and plan of action to access GFTAM funding in round 2011 was developed and on going consultations between the senior management teams of the two institutions took place on possible colaboration between the GFTAM, the Federation and NS.
A mapping of current involvement of NS in accessing GFTAM funds and lessons learnt was undertaken by the Global Health team.
The HIV team and Secretariat as a whole was assessed by the GFTAM through its local fund agent, the Swiss Tropical Institute to determine our ability to become primary recipient.
Based on the various consultations, a new concept paper " Building a strong partnership between the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) and the International Federation

of Red Cross and Red Crescent Societies (IFRC)" was developed; it offers several models for expanding the partnership to more effectively harness the strengths of both organizations in the fight against HIV, tuberculosis, and malaria and serves as a basis for the final negotations between the fund and the Federation.
Efforts were deployed together with the Netherlands RC to secure multi year funding to support the Africa Zone and NS in eastern and southern Africa in supporting orphans and other vulnerable children.
A funding proposal on integrating gender and gender based violence into IFRC HIV prevention and care activities was developed.

Only two NS the Norwegian and Finish RC pledged to the global HIV program in 2011 resulting in a reduction of both financial and human resource capacities at global level to render services to zone offices and NS.

Knowledge sharing

The International Federation, in line with this theme and the outcome of the XVIII International AIDS Conference "Rights Here, Rights Now", has join forces through its membership to advocate for human rights and to stand up against stigmatization and discrimination towards the most marginalised and affected populations so that they can access services.
The Federation was represented at the International Harm conferecne in Beirut, Lebanon and facilitated sharing of publications on Harm reduction and related subjects.
In collaboration with the Federation New York office, and in the context of UN High Level Meeting on AIDS in New York (08-10 June 2011) , organised a side event to raise awareness of good practice on realizing human rights and increasing access to quality HIV services for key affected populations. The event was being co-organized by IFRC and the International HIV/AIDS Alliance and is hosted by the UK and South African Governments. A small team comprising USG Programme services, Head of health and Senior Officer HIV together with the NY office and colleagues from Argentina, Norway, Finland, and USA represented the Federation.
The global HIV team in Geneva supported the Southern Africa Zone office to conduct the final evaluation of the GA on HIV programme performances of the ten National Societies in Southern Africa for the period 2006-2010.
The Asia Pacific team had been supported in fundraising and organising a RC/RC Satellite meeting and participation of NS to the upcoming International AIDS conference for Asia and Pacific.
The frist draft of the Netherlands RC initiated good practice on NS working with commercial sex workers in Kenya, Ethiopia and Malawi was reviewed.

The Masambo Fund Foundation

The Masambo Fund board met, and acknowledge the current particular and fragile situation of the fund with 117 applications and no fund available. The situation was brought to the attention of the Federation's Governing Board, which recall NS on their responsibilities in kepping the fund alive and operational. In the meantime all new applications have been frozen until current applications have been processed.
Only 8 nominees from Zimbabwe Red Cross received a grant in 2011. The actual amount of financing needed to support the remaining 117 pending applications is CHF 791 000 – a stark difference from previous years where funding was readily available but the number of applications received was low due in large part to the stigma and discrimination surrounding people living with HIV. For more information on the Fund, please refer to the 2010 Programme Update available on Fednet.

Constraints or Challenges

For National Societies and zones, the major constraint remains a shortage in funding for scaling up HIV programme implementations in line with the GA on HIV approach.There is a need for strengthening and supporting National Societies to enable them connect with national funds disbursing bodies and to access sizable resources for programme implementation.

To attract in country funding, National Socities need to participate actively in the existing country coordination mechanisms (CCM's) , show leadership and be more visible.
Resource mobilisation and performance tracking needs to be further systematized.

NS also need to be prepared to refine their programme interventions as to stay in line with current scientific evidence based knowledge on the epidemic and to be of relevance to the needs of the most affected populations. We have not done enough in addressing key populations highly exposed to the risk of HIV infection such as: sex workers, injecting drug users, men having sex with men, mobile populations and prisoners. Thus, there is a need for readjusting our target populations in accordance to the epidemiological profile in our catchment areas.
The Federation must continue to emphasise the tackling of gender within the context of HIV and promote the greater involvement of PLHIV, to better address stigma and discrimination.

We should evaluate next year the Federation-wide roll-out of the GA on HIV in as much as the resources available allow us. It is also important that we continue refining the approach from lessons learnt using the final impact evalution of the GA on HIV in southern Africa.

Emphasis should be on the quality and consistency of our delivery as much as on coverage, but also on a closer integration between HIV and TB and when relevant with Malaria, as well as a broader integration of HIV across programmes wherever feasible.

Tuberculosis / Harm Reduction

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

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

Outcomes

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

Achievements

Programme support

Currently global TB and Harm Reduction Programmes are supported by the following donors:

- **USAID TB Grant – 2008-2011**: The programme includes 3 countries, as well coordination at the global level. The proposal covers 3 countries – India, South Africa and Kazakhstan and activities at the global level. Programmes in India and South Africa and monitoring by Zonal and Regional colleagues respectively. The grant includes 3 country activities are coordination costs. Funds are transferred to the global budget and based on approved country budgets, funds are reallocated to respective country codes. The total budgets for fy 2010 (October 2010 – September 2011) is USD 600,000.
- **Lilly Grant 2008 – 2011**: This is the last year for 4 years project multi country project. The total grant was 1.6 mln USD. It covered activities in 10 countries as well as coordination at global lever. The budget for 2011 was more than USD 400,000. As per agreement with the donor,

funds are kept at global level and reallocated to country projects only after we receive reports from previous allocation and proposal for the next period.
- **Lilly Grant 2009 – 2012**: supports TB training activities and is allocated to National Societies based on training plan. The total grant amounts to some USD 260,000. Funding for this year (USD 60,000) has already been allocated to Southern Africa. Additionally, Lilly grants to Ethiopia and Russia (USD 180,000) were directly booked at country level.
- **Italian Red Cross Grant for harm reduction** – EUR 200,000 includes programme support to five National Societies, training activities in Villa Maraini and support to ERNA Secretariat.

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

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

World TB Day Events 2011

On 22 March the Health Department organised a round table between Red Cross / Red Crescent Societies and partners. Meeting was attended representatives from 5 National Societies, WHO, ICRC, Stop TB Partnership, Lilly and other key partners as well as few Diplomatic missions.

On 23 March, the launch of the joint IFRC / Stop TB Partnership TB Advocacy Report and a press conference at Palais de Nations together with WHO Stop TB Department and Stop TB Partnership. The Federation's USG together with senior representatives from WHO, Stop TB Partnership and Global Fund were part of the panel. Representatives from 6 National Societies attended the event.

Technical Support

During reporting period, support is provided to Participated EU funded and Italian Red Cross / Villa Maraini coordinated research project that aims to increase an access to HIV and TB testing for drug users In Slovak Republic, Netherlands, Italy and Czech republic. The IFRC is the member of technical advisory committee as per suggestion / request of Italian Red Cross. The meeting took place in Turin on 1-3 March and focused on technical aspects - TB and HIV diagnoses.

In May 2011 the health department started working on the toolkit that outlines the step by step process of planning and implementing MDR TB programmes and builds practical skills for carrying out respective activities. The publication will be finalised by end September 2011 and will focus on MDR TB prevention, treatment support, community focused advocacy, communication and social mobilization, based on RC RC experience.
During April – June 2011 23 have been conducted in total 4 monitoring of TB projects supported globally – 2 in South Africa, 1 in India and 1 in China. During 20-24 June together with Zonal Health Coordinator, Chinese Red Cross and China MoH monitored Lilly supported TB project in Changzhi prefecture, Shanxi province. The key objectives included to screen the achievements made so far, Identify challenges and assist Red Cross of China to overcome them, communicate with stakeholders. During the visit Lilly office in China and UNION representatives were met.

Lilly MDR TB Partnership media tour took place in South Africa and Swaziland during 24-28 January 2011. TB activities by respective National Societies supported by Lilly were closely highlighted. The tour was well coordinated between Lilly Geneva / South Africa, IFRC Geneva, Zonal office, South African Red Cross and Swiss Red Cross Societies (Lilly supports Swaziland TB project through Swiss Red Cross).

In May 2011 the Health Officer Participated and co-facilitated the harm reduction training for Georgian Red Cross programme staff. It took place in the premises of Villa Maraini and was

organized by Italian Red Cross. This is the first training in 2011. Two additional trainings will be organized for National Societies in Asia and Europe during October – November 2011.

During the UNODC ‘s 55th session of CND (commission on Narcotic Drugs) – 25 March, the International Federation of Red Cross and Red Crescent Societies, the Italian Red Cross and Villa Maraini Foundation organised a lunch side event on integrated approaches of TB/HIV services for drug users. A total of 33 participants from 18 countries participated to the meeting with representation from all geographic regions. Participants were briefed about the programme, objectives and expected outcomes. The group discussed how to strengthen collaboration and coordination between services, how to provide integrated and holistic care to most at risk populations. Participants also shared experiences and best practices.

On 19 May The IFRC signed a partnership agreement with UNODC. The agreement is a good advocacy tool for both organizations and particularly for National Societies to address the issues of drug use and related harm at the community level.

In the beginning of January 2011, the Kenyan government has stepped up the war in on illicit drugs and chemical substances leading to a drastic reduction in supply of the various types of substances abused locally. Most drug abusers thus were unable to access the drugs . After the crisis started in Coast area, Health Department together with regional office coordinated technical support through Italian Red Cross experts.
The Senior Health Officer chaired the selection process for CSO projects for Stop TB specific funding to strengthen focus of TB programmes at the community level. The selection process took place in early 2011. The Committee included members from WHO, UNAIDS, as well as other NGO representatives.

Global Representation

IFRC participated in Meeting and presented activities at the TB Training and Education Collaborative organised by WHO and the Norwegian Heart and Lung Patient Organisation (LHL) in Oslo, Norway. during 5 to 6 May 2011. A Half-day workshop on how to address the issue of human resources and quality of care in the view of up-scaling of MDR-TB diagnosis and treatment activities. The second part of the meeting focused on more collaborative training.
IFRC Participated / presented its activities during UNODC organised Experts Group Meeting focused on “Basic socio-economic assistance as a precondition for effective drug dependence treatment and related HIV/AIDS prevention” ;. The meeting took place in Vienna at UNODC headquarters in the Vienna International Centre from May 10 - 12. Fabio Patruno from Italian Red Cross represented the Federation.

25-27 May: Together with the Europe Zonal Health Coordinator, the IFRC participated in the WHO organized meeting for National TB Programmes in the Netherlands, Wolheze. A special presentation was delivered during the session related to cross border TB and possibilities for RC RC to be involved. We gave examples of projects implemented by the International Federation of Red Cross and Red Crescent Societies (IFRC) where TB-related assistance to migrants is provided as part of specific interventions to migrants (e.g. Central Asian Red Crescent Migration Programme) or to socially-vulnerable groups (e.g. Rehabilitation Centre for IDU in Rome) or of TB projects where migrants are one of the vulnerable groups to support (e.g. project in Almaty/Kyzylorda). The presentation underlined the importance of collaboration between migrants’ origin and host countries and with the national TB programmes and the need for TB and migration programmes of IFRC to be more integrated and guided by operational research.

13 March TB Health Officer attended the meeting / round table at European Parliament in Brussels on “Drug-resistant TB and TB-HIV co-infection - *What can the EU do to curb the threat?”* The round table was organised together with **European Parliament Working Group on Innovation, Access to Medicines and Poverty-Related Diseases.** During a trip meeting was organised with Mrs. Medeline Kajorenko, Head of Unit European Neighbourhood Policies – Sectorial issues, European External Action Service.

Health Department together with Europe Zonal Office and Red Cross EU Office is actively involved in organisation of the *Field visit to Hungarian Red Cross / Europe Zonal office for parliamentarians during the* **ACP-EU Joint Parliamentary Assembly** in May in Budapest . During the visit on 15 May we will introduce to parliamentarians TB problems globally with the focus on East Europe and RC RC role.

June 25-26 the meeting was organised with Project Hope to follow up discussion on joint Project Hope / IFRC / WHO proposal on TB among labour migrants in Central Asia. The Project Hope will take a lead in the process and start assessment and mapping. IFRC offices and respective National Societies will be actively involved in the process.

Work with IFRC Global TB Ambassador, Gerry Elsdon

The Federation offices in Geneva and South Africa prepared a draft plan together with Gerry Elsdon of events and activities, where she will profile and advocate for MDR TB and the role of Red Cross & Red Crescent. The draft plan includes the following events:

- Participation in regional African Red Cross network meetings
- Organise a Humanitarian Diplomacy Dialogue on Food Security in Africa (to highlight link between nutrition and TB, HIV), Youth (role of youth in leadership and health)
- International conference - possible side event on Women in Leadership
- EU event on how EU can support a decrease in TB in Africa
- Participation in the event (s) organised together with Lilly MDR TB Partnership
- Activities will be financially supported by Global TB Programme.

Constraints or challenges

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

Malaria

Three priorities were identified for 2011 and progress was made towards achieving these priorities. The first priority was to provide financial and technical support to National Societies implementing malaria prevention, diagnosis and treatment programmes. The second priority was to expand technical capacity at National Society level and with the secretariat at country, regional and zone level. The third priority was to chair the global Alliance for Malaria Prevention partnership and position the federation at global and country level as a credible community based partner with evidence based programming that support the achievement of ministry of health malaria related targets and MDGs.

Outcome(s)

The following are specific outcomes for the first half of 2011.

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

Achievements

Prevention, diagnosis and treatment

With funding from the Netherlands Red Cross, Norwegian Red Cross, USAID the IFRC supported malaria activities in 12 countries in Africa and Asia Pacific. Activities focused on malaria prevention through the free mass distribution of LLINs and ongoing activities to ensure high LLIN usage is achieved and maintained. Community based diagnosis and treatment activities expanded with Red Cross Red Crescent volunteers extending access to effective treatment beyond health facilities to community and household level.

All Red Cross and Red Crescent malaria activities support national Ministry of Health plans to achieve malaria related targets and MDG's. The National Societies in these countries used their networks of volunteers to inform the population of the LLIN distribution, mobilize household and community participation and ensure hanging, use and maintenance of nets received by households. In Kenya activities continue to diagnosis and treat malaria in children under five years of age.

In Cross River State, Nigeria volunteers have been mobilized for a State-wide campaign to move from coverage of children under five with LLINs to coverage of the total population with LLINs. Volunteers have been responsible for registering all households in the State and assessing the number of people and nets in each to determine the needs for reaching the total population. Following the needs assessment, Nigeria Red Cross volunteers have distributed LLINs using a door-to-door methodology involving confirming nets available and then hanging (with nails and string) nets needed to ensure all members of households are protected with nets. A total of 1,214,000 nets were provided for the project.

Cell phone base health survey the Management Survey Tool (MST)

The rapid spread and use of mobile technology throughout the globe offers researchers a new and exciting means of data collection and analysis. The IFRC and National Societies in collaboration with WHO, epidemiologists at the CDC and DataDyne, developed the Management Survey Tool (MST), which uses mobile phones for data entry. The MST aims to provide a survey methodology, training guideline and operations protocol that will enable National Societies to conduct health surveys at reduced costs, in a timely fashion, and with limited technical assistance. The resulting high quality data allows health managers to make evidenced-based decisions and inform programming and policy in a timely and relevant manner.

The MST was rolled out in Kenya, Namibia and Nigeria in the first half of 2011. For the survey, MST questionnaires are created using DataDyne's mobile phone based *EpiSurveyor* software. The EpiSurveyor application is downloaded directly to locally available inexpensive cell phone (average price USD 75) and questionnaires are subsequently uploaded to the handsets. In the field, Red Cross Red Crescent volunteers use these phones to collect and store data without the need for a network connection. Once in range of a network connection, data is sent to a secure server, allowing partners anywhere in the world with *EpiSurveyor* account access to view, analyze and export results in a variety of formats. It is expected that the MST will dramatically decrease the time and monetary costs associated with data collection in health surveys.

Capacity building of National Societies

During the first half of 2011 National Society malaria activities were supported in 12 countries: Angola, Burkina Faso, Burundi, Democratic Republic of Congo, Kenya, Liberia, Malawi, Namibia, Nigeria, Senegal, Togo and India.

Malaria delegates based in Africa zone provided support focused on building the capacity of National Societies in all aspects of the project cycle from proposal development, project implementation to reporting and where possible ensuring malaria activities were integrated within

existing community based health programmes. The secretariat malaria team sees the value-added in project level interactions with National Society staff for effective capacity-building.

Operations research

Operations research activities are ongoing in Togo and will take place in Nigeria during the second half of 2011. Operations research activities in Togo will evaluate the effectiveness and cost of different approaches to post LLIN campaign home visits by volunteers to enhance LLIN hang-up and utilization.

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

The primary outcome measures ion Togo will be:

- Proportion of all surveyed households with at least one net that use[2] all of the nets found in the household at the time of the survey compared between the three study arms and at each time point
- Proportion of all surveyed households with at least one net where all family members (and/or children under 5) present the previous night slept under a net/ITN compared between the three study arms and at each time point

In Nigeria the following areas will be evaluated:

- Evaluate LLIN ownership, hanging, usage in rural vs. urban distributions.
- Evaluate LLIN ownership, hanging, usage depending on how many LLINs are hung in the HH – 0 LLINs hung – 1 of total # of LLINs hung – 2 of total # of LLINs hung - 3 of total # of LLINs hung – all available LLINs hung.
- Evaluate LLIN ownership, hanging, usage if only a % of HH in a community are targeted for Hang Up visits by NRCS volunteers

Constraints or Challenges

The main constraints or challenges in the first half of 2011 were delayed implementation of activities. Technical support was provided by the Africa zone malaria team to ensure delays were addressed and where possible projects got back on schedule. An additional constraint was identifying the correct human resources at National Society level to provide adequate technical and management support to project activities.

Working in partnership

- Primary partners of the Health Department include Red Cross Red Crescent National Societies who implement the programmes and/or provide technical and financial support to sister National Societies (PNSs).
- Over the years, the department has built partnerships with external actors including the WHO, different UN organizations, some private sector organization, as well as different government and funding bodies.
- Following a series of meetings around the Global Platform for Disaster Risk Reduction (8-13 May 2011), a joint statement on “Scaling-up the community-health workforce in Emergencies” was launched by the Head of IFRC Health Department on behalf of WHO, UNICEF, IFRC, UNHCR and GHWA. A case study on CBHFA from Uganda Red Cross was one of the key four

[2] Use will be defined as any person sleeping under the net the night before the survey

case studies in the joint statement. RCRC volunteers were recognized by the organizations that endorsed the statement as key health actors at the community level.

- The IFRC remains the chair of the highly successful, results focused health partnership on malaria, the Alliance for Malaria Prevention (AMP). AMP supports scaling up coverage and utilization of LLINs. In this role, the IFRC liaises with all partners involved in malaria control and represents a major voice within the Roll Back Malaria partnership. AMP is an implementation-focused partnership whose core group includes USAID (President's Malaria Initiative [PMI] and Centres for Disease Control and Prevention [CDC]), Johns Hopkins University Centre for Communication Programs (JHU-CCP), Malaria No More (MNM), Population Services International (PSI) UNICEF and the World Health Organization (WHO).
- The partnership with the Global Network of People living with HIV (GNP+) has been revitalized as both organizations have been collaborating for the High level meeting in New York and on the organisation of the Positive leadership summit and XIII Global PLHIV meeting to be organised in Washington prior to the International AIDS conference in 2012. Additionally, the HIV team at the Secretariat in Geneva continues to support the Red Cross Red Crescent network of PLHIV (RCRC+) that counts today over 172 Red Cross Red Crescent volunteers and staff living with HIV. More efforts are to be excerted to expand the network beyond the America's region and efforts are currently underway to develop the RCRC+ network in Asia and Pacific at the occasion of the International conference on AIDS for Asia and Pacific (ICAAP) in August as well as in other regions.
- The health department has continued to support, and in many cases lead, the development of the GAVI Alliance civil society organization (CSO) Constituency. The Constituency is a broad network of approximately 180 organizations world-wide who support the mission of the GAVI Alliance to increase access to immunisation in the world's poorest countries. The health department currently hosts the defacto Constituency Secretariat, a funded position sitting in the Community Health and First Aid team, and until very recently also chaired the group's Steering Committee.
- When addressing TB and MDR TB, the IFRC collaborates regularly with Stop TB Global Partnership, WHO (member of WHO training collaboratives), and other stakeholders. The IFRC will continue to chair the selection committee for the STOP TB Partnership supported grants for programme by civil society organizations.
- In WatSan, the IFRC participates in the UNICEF led Global WASH Cluster, and collaborates with EuropeAid, ECHO, Oxfam, DFID, Nestle, Procter and Gamble as well as The Water Supply and Sanitation Collaborative Council (WSSCC).
- The Emergency Health team works in close cooperation with the Global Health Cluster, UNISDR, and WHO Health Action in Crisis.

Contributing to longer-term impact

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

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

While continuing to work on the technical files (vertical programming), the GHT will start working in a cross-sectoral and cross-departmental towards a holistic health and resilience approach linking programmes when appropriate. Consequently, the GHT will develop/update tools and guidelines to enable National Societies to better respond to community needs and context.

Additionally, the GHT works towards contributing to the Millenium Development Goals. More specifically, the Global Water and Sanitation Initiative inputs were identified as directly contributing primarily to Goal 7c – 'reducing by half those without access to safe water and basic sanitation' but also to goals 1, 2, 3, and 4. Furthermore, community health programmes contribute to MDGs 4, 5, 6

and 7. To measure the contribution of community health activities to the MDGS, key outcome indicators in CBHFA indicator guideline are now being used by NSs in baseline/endline surveys.

The Management Survey Tool (MST) is a cell phone based health survey and supporting manuals that has been developed to provide National Societies with an easy to use, inexpensive method of generating accurate data to make programme decisions. The MST has been designed to ensure it can be rolled-out by National Societies with little to no external support to ensure longer-term impact.

Looking ahead

The GHT will work towards a holistic, evidence-informed approach to health programmes by 2015, where NSs will be able to adapt their own health programmes to the needs of their communities. The implementation of the holistic health and resilience approach will require the GHT to make use of the varied expertise within the movement and the wider public health community through mapping of existing competencies and facilitation of thematic partnerships. Additionally, a research and learning agenda will be implemented to ground the holistic health approach in evidence and develop the team’s understanding of key issues.

Among other priorities, improving access to diagnosis and high-quality treatment for TB and more specifically multidrug-resistant TB (MDR-TB) is necessary. TB/HIV/Harm Reduction interventions will need to be scaled-up and included in proposals and appeals, with more advocacy for proper care and support services.

In Water & Sanitation, the GWSI midterm review and lessons learned so far need to be disseminated to NS’s and provide guidance to the next five years programming to 2015. GWSI projects need to have a system in place to start measuring sustainability and impact as opposed to quantitative data. Further efforts are required in resource mobilisation, to seek major grants, for further GWSI scaling-up. Additionally, the IFRC’s increased role in improving the effectiveness of the Global WASH cluster has to show results within the next 12 months with both key personnel identified and deployed, and effective impact through the Strategic Advisory Group, to the key activities and impact of the cluster.

In Emergency Health, the IFRC aims to consolidate and secure the regional emergency health support capacity by ensuring a longer term perspective by establishing Zonal Emergency Health Delegate positions in all the Zones. These positions are currently filled in Africa, Asia Pacific, and the Americas. The need for a similar focal point in MENA Zone has been identified.

In CBHFA, the focus of 2011 is to scale-up the implementation of community health programmes using the CBHFA approach at the community level, roll-out the PMER toolkit, control quality, ensure better linkage/integration with other programme areas, identify better mechanisms to support NSs in their first aid programmes and take the lead in NCDs’ prevention and control.

In Malaria, the remainder of 2011 will be focused on ensuring the Management Survey Tool is available to National Societies planning and evaluations. Operations research into behaviour change related to Red Cross Red Crescent volunteer action activities will continue in Togo and will get started in Nigeria. Two advocacy reports one on malaria prevention activities in Nigeria and one on the Management Survey Tool will be released.

How we work

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

The IFRC's vision is to:	The IFRC's work is guided by Strategy 2020 which puts forward three strategic aims:
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.	1. Save lives, protect livelihoods, and strengthen recovery from disaster and crises. 2. Enable healthy and safe living. 3. Promote social inclusion and a culture of non-violence and peace.

Contact information

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

Stefan Seebacher, Head of Health Department
Email: stefan.seebacher@ifrc.org, Tel.: +41 22 730 4435, Fax: +41 22 733 0395