Community health strategy

Healthier and more resilient communities and individuals 2020-2030

IFRC

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ACRONYMS AND ABBREVIATIONS

BCC	Behaviour change communication
eCBHFA	Community-based health and first aid (online)
CCMs	Global Fund Country Co-ordinating Mechanisms
CEA	Community engagement and accountability
CCA	Climate Change Adaptation
CHWs	Community health workers
DCPRR	Disaster and Crisis Prevention, Response and Recovery
DRR	Disaster Risk Reduction
GAVI	Gavi, the Vaccine Alliance
GFATM	The Global Fund to Fight Aids, Tuberculosis and Malaria
GFF	Global Financing Facility
IFRC	International Federation of Red Cross and Red Crescent Societies
IT	Information Technology
LGBTIG	Lesbian, gay, bisexual, transgender, intersex and queer/questioning
MHPSS	Mental Health and Psychosocial Support
MoH	Ministry of Health
NCDs	Noncommunicable diseases
NGOs	Non-governmental organizations
PMER	Planning, monitoring, evaluation and reporting
PPP	Project/Programme planning
PSS	Psychosocial support
SDGs	Strategic Development Goals
UNICEF	The United Nations Children's Fund
UHC	Universal Health Coverage
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

Community Heal
Healthier and more r

Three strategic directions

National Societies and communities essential parts of health and care systems

Six goals

National Societies recognized actors in health and care systems

Communities recognized contributors to health and care systems

Six focus areas

Federation-wide leadership in community he

National Societies skilled up for community health leadership

Measuring quality and impact

th Strategy **2030**
esilient communities

All people have equitable access to quality health and care throughout life

Community level experience informs policy makers

Reaching geographically and socially isolated communities

Leveraging influence

Community-based health promotion, disease prevention at scale- aligned with and complementing health and care systems

Developing and leveraging partnerships

ealth

Shifting secretariat focus to support National Society community health leadership

Expanding learning and knowledge sharing

Mobilizing resources for strategy delivery

Operationalizing this strategy

1. BACKGROUND

As the 21st century unfolds we are experiencing great leaps in technology, connectivity and complexity. Real progress has been made in some areas of health - immunization, maternal and new-born health[1], and access to anti-retroviral treatment - yet progress has been uneven, and gains can quickly unravel as shown by the Covid-19 pandemic. Changing demographics means that nearly half of the world's poor live in urban settings, while more older people are becoming dependent on health and social care services. At the same time we are experiencing shifts in political and social power dynamics, low levels of trust in institutions, the growth of movements driving social change, and a demand from previously marginalized people to not only be seen, heard and included but also engaged in decision-making and priority setting.

The challenges remain both complex and inter-related. The impact of climate change and environmental degradation and its effect on health is a growing reality for millions of people, as is rapid, unplanned urbanization. New and unexpected health threats[2] and epidemics are contributing to migration and displacement. More than a billion people live in places where weak health systems, conflict and protracted crises leave them without access to basic health care[3], fostering environments where new and forgotten diseases emerge. An unacceptable number of people still live with basic deprivations that directly affect their health – poverty, inadequate nutrition, lack of access to safe water or basic sanitation, inadequate living space, environmental exposures, violence and crime. Half of the world's population, about 3.75 billion people, still do not have full coverage of essential health services with over 8.9 million preventable deaths occurring every year[4], as health systems struggle with the rising burden of noncommunicable diseases (NCDs) which kill 41 million people annually, equivalent to 71 per cent of all deaths globally[5].

Poverty is a key determinant of health with almost half the world's population (46 per cent) living on less than 5 Swiss francs (5.50 US dollars/4.65 euros) a day[6]. In many parts of the world health inequalities and service gaps result from increased vulnerabilities emanating from ongoing, chronic and acute conflict. Other communities are left behind as they face inequalities due to ethnicity, socio-economic status, gender identity or place of birth, or simply from living far from health facilities and water, sanitation and hygiene (WASH) infrastructure or face substantial barriers to accessing basic services. Fear and mistrust, stigma and discrimination, prohibitive out-of-

1. "Neonatal deaths accounted for 47 (45, 49) per cent of all under-five deaths in 2018, increasing from 40 (39, 41) per cent in 1990 due to a faster global decline in mortality among children aged 1–59 months than for children in their first month of life." Levels and Trends in Child Mortality Report (2019) UN.
2. Including endemic and emerging diseases such as zoonotic diseases - infectious diseases caused by bacteria, viruses and parasites that spread between animals (usually vertebrates) and humans e.g. Ebola, Coronavirus etc.
3. https://www.who.int/vietnam/news/feature-stories/detail/ten-threats-to-global-health-in-2019
4. WHO Tracking Universal Health Coverage: 2017 Global Monitoring Report.
5. https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases
6. The World Bank, Poverty and Shared Prosperity 2018, Piecing Together the Poverty Puzzle, October, 2018.

pocket payments or poor quality and poorly resourced services all impact on health outcomes. These issues coupled with an often unequal allocation of resources can lead to a cycle of vulnerability, exclusion and inability to exercise one's right to health[7] - a cycle exacerbated when disaster strikes[8].

Depression, anxiety and the impact of loneliness and involuntary isolation all place increased strain on individuals, communities and health systems. Countries across the globe are struggling to manage the rapidly increasing cost of health care due to the pressure on curative services, while often under-investing in public health and preventive interventions. At the same time there are challenges to maintaining levels of development assistance and an acute global shortage of health workers, a gap projected to grow to 18 million by 2030[9].

Strategy 2030: A platform for Change – Local Action, Global Reach guides the work of 192 Red Cross and Red Crescent Societies and the IFRC secretariat, as they respond to the human consequences of these challenges and to shifting vulnerabilities. Strategy 2030 looks beyond crisis response and resilience, to ensuring that individuals and communities can thrive. It proposes an urgent shift of leadership and decision-making to the most local level – placing communities at the very centre of change and demonstrating the reality of the localization agenda[10], an approach central to the IFRC.

Strategy 2030 re-imagines the core volunteer foundation of the Red Cross Red Crescent Movement within the context of the 21st century, aiming for a more dynamic Federation of 192-member National Societies - independent organizations, collaborating, learning and engaging together in support of communities across all corners of the globe. The strategic goals, rooted in the Fundamental Principles of the Movement, contribute to major global humanitarian and development frameworks including the Sustainable Development Goals (SDGs), the Sendai Framework, the Paris Agreement on Climate Change and the Grand Bargain[11]. Reducing the impact of climate change on human health is a key priority of Strategy 2030.

The IFRC **Health and Care Framework 2030** sets out a renewed focus on, and contribution of, National Red Cross and Red Crescent Societies to the global health agenda and its work across the humanitarian-development nexus. The framework identifies three interconnected priority areas: 1) Community health, 2) Emergency health and WASH, and 3) Strategy, policy and advocacy. It sets out an approach for IFRC leadership in community health, enabling people from all corners of the globe to lead safe, healthy and dignified lives with the opportunity to thrive, as set out in Goal 2 of Strategy 2030.

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7. The human right to health means that everyone has the right to the highest attainable standard of physical and mental health, which includes access to all medical services, sanitation, adequate food, decent housing, healthy working conditions and a clean environment. WHO, https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health
8. The IFRC's 2018 World Disasters Report.
9. WHO, https://www.who.int/health-topics/health-workforce#tab=tab_1
10. Commitments made as part of the 2016 World Humanitarian Summit Grand Bargain.
11. The Grand Bargain, launched during the World Humanitarian Summit in Istanbul in May 2016, is a unique agreement between some of the largest donors and humanitarian organizations who have committed to get more means into the hands of people in need and to improve the effectiveness and efficiency of the humanitarian action.

The seventeen **Sustainable Development Goals** which aim to "end poverty, protect the planet, and ensure prosperity for all", each have specific targets to be achieved by 2030. The work of National Societies contributes primarily to SDG 3: "ensure healthy lives and promote well-being for all at all ages" and to SDG 6: "ensure availability and sustainable management of water and sanitation for all". National Societies' programmes also contribute to SDG 5 (gender equality) and SDG 10 (reduced inequalities).

In 2018, the IFRC's Governing Board approved a plan to scale up IFRC's work and advocacy related to **universal health coverage**[12] (UHC), based on the principle of "leaving no one behind". This decision aligned IFRC with WHO's programme of work[13] and three-pronged focus of UHC, health emergencies and health promotion.

In the decades **since Alma-Ata**[14] when there was a clear move toward primary health care, the international community has focused more on diseases rather than on individuals, on treatment rather than prevention and on biomedical interventions rather than on community well-being. The renewed emphasis on universal health coverage provides an opportunity for a renewed focus on health promotion and disease prevention and for communities and individuals to again be put at the centre of the global health agenda.

This Community Health Strategy is intended to provide inspiration and direction for the whole of the International Federation of Red Cross and Red Crescent Societies by harmonizing and guiding approaches in community health and supporting implementation of Strategy 2030 (S2030) and the Health and Care Framework. It relates specifically to community-based health activities provided through communities, local volunteers and community health workers that complement and strengthen other parts of the health system. It provides a foundation for each National Society and the IFRC secretariat to collectively contribute to better health outcomes. It is also written for our governments and our partners to enable them to understand who we are, what we do and the difference we make in the world.

This strategy responds to the shifting vulnerabilities of today's world with different groups "at risk" and emerging as isolated and excluded. As we move to the new decade we plan to be on the "front foot" engaging rural and urban communities, responding to shifting dynamics and setting new agendas.

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12. WHO defines UHC as the means by which "all people and communities can use the promotive, preventative, curative, rehabilitative and palliative health services they need (which should be of) sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship".
13. https://www.who.int/about/what-we-do/gpw13-expert-group/Draft-GPW13-Advance-Edited-5Jan2018.pdf
14. The core principles of the Alma-Ata declaration of 1978 emphasized local ownership and the full spectrum of health care, from households to hospitals, with prevention as important as cure.
https://www.who.int/publications/almaata_declaration_en.pdf

2. OUR VISION AND GUIDING PRINCIPLES

Present in 192 countries before, during and after any crisis or event, National Red Cross and Red Crescent Societies are continuously present in their "own" communities. National Societies are neither governmental institutions nor wholly separate non-governmental organizations (NGOs). Established by national law, their relationship to the authorities is defined by their role as "auxiliary to the public authorities in the humanitarian field"[15]. The auxiliary role can be described as "a specific and distinctive partnership, entailing mutual responsibilities and benefits, based on international and national laws, in which the national public authorities and the National Society agree on the areas in which the National Society supplements or substitutes public humanitarian services"[16].

The IFRC is at the same time both local and global. Working through local branches, National Societies are globally connected through their secretariat and regional offices. Based on the principle of voluntary service through a foundation of people who live and operate in the communities they serve, Red Cross Red Crescent branches are effective because they understand their community – its history, inequalities, risks and vulnerabilities.

National Societies already play a significant role in the provision of health services, providing a wide variety of community-based health programmes including first aid, community epidemic and pandemic preparedness, outbreak response, WASH, mental health and psychosocial support (MHPSS), HIV and TB prevention and care[17]. In 2018 the IFRC had a total of 13.7 million volunteers and 465,000 staff across the globe[18] - a large proportion providing both professional health services through qualified paid staff as part of the formal health system and volunteer-based community-based health and first aid (CBHFA) and care and support in the community[19]. Looking to the future National Societies aim to play a wider role in the provision of community-based health interventions, contributing to universal health coverage.

15. Statutes of The International Red Cross and Red Crescent Movement (adopted by the Twenty-fifth International Conference of the Red Cross at Geneva in 1986, amended in 1995 and 2006).
16. Resolution 2, 30th International Conference of the Red Cross and Red Crescent (2007).
17. Internal IFRC survey of National Societies on UHC.
18. IFRC Annual report, 2018.
19. The range of health related programmes provided by National Societies is wide and varied including first aid courses, health centres and mobile clinics, nursing schools, blood banks, health school clubs, mothers'/fathers' clubs, community-based health promotion, community mobilization during immunization campaigns, distribution of mosquito nets, ambulance services, first aid during public events, health services in refugee camps, psychosocial counselling, etc.

Our vision

Communities, households and individuals can thrive, leading safe, healthy and dignified lives[20].

Our approach and guiding principles

This strategy is firmly rooted in the agency and action of people to drive change for themselves, for their communities and for the world. It is based on a systems approach, recognizing the inter-connectedness of all aspects of health and well-being, of emergency preparedness and response and of development work, while devoting particular attention to people and communities who are vulnerable, excluded or marginalized.

We are guided by the following principles:

- Humanity, impartiality, neutrality, independence, voluntary service, unity and universality: these seven Fundamental Principles provide an ethical, operational and institutional framework to the work of the Red Cross and Red Crescent Movement. They are at the core of our approach to supporting people in need. These principles unite the components of the Movement – the International Committee of the Red Cross, the National Societies and the International Federation – and are key to its distinct identity. Adherence to these principles ensures the humanitarian nature of the Movement's work and brings consistency to the broad range of activities it undertakes around the world.

- People-centred and community led: we put the people we serve and support at the centre of our actions – they are the experts in their own context and must remain as the key architects and agents of change in any effort to meet their needs and improve their health status.

- Respecting the rights of the people we serve, including gender and diversity in all its forms[21].

- Focusing on those who are "left behind" – marginalized and vulnerable populations and individuals, people with disabilities, migrants, older people and the socially isolated and excluded. Not just providing services but supporting communities and individuals to claim their right to health and care, including mental health and psychosocial support, within the principles of community inclusion.

20. Goal 2, IFRC Strategy 2030.
21. https://media.ifrc.org/ifrc/wp-content/uploads/sites/5/2017/01/IFRC-Strategic-Framework-on-Gender-and-Diversity-Issues-EN.pdf

- Prioritizing access, participation, safety, and dignity: ensuring that affected people are empowered, informed and appropriately resourced to make healthy lifestyle choices, and can access quality and sustainable health programmes.

- Working across the humanitarian–development nexus: including where prevention and preparedness activities take place - in conflict, fragile settings and protracted crises and across the diversity of low, middle and high-income countries. Adapting these principles to respond to community health needs of people in the widest range of contexts and settings while building on the interconnectivity between health and other sectors.

- Being accountable to the people and communities we serve while being data and evidence driven

3. OUR APPROACH TO COMMUNITY HEALTH

"People spend 99 per cent of their time outside the health system, what they do during that time determines their health and quality of life"[22].

In today's world, communities are evolving faster than health and social policies - occupying roles as agents of change and acting as political power centres, often offering different solutions to those provided by formal systems. Addressing the social determinants of health is required in order to see an impact on health across diverse communities. A shift is required from "downstream" solutions to more "upstream" solutions[23], with a greater focus on health promotion and preventive health and on participation and shared responsibility, through community engagement and local responses.

Inter-sectoral dialogue, planning, and action between health systems, local government, private sector actors, community-based organizations and community representatives are priorities. So is the inclusion of community-based solutions and evidence-informed population-based primary and community care and support in government health strategies. These approaches constitute additional pathways, particularly for geographically and socially isolated communities, providing relief for strained health systems and workforce - allowing primary, secondary and tertiary level facilities to focus on delivering their specialized services. Strategies are additionally required to ensure that skilled, motivated, supervised personnel are available and working in partnership across sectors.

The foundation of this strategy is for community led health interventions – interventions that are community identified and community driven. It focuses on all communities, including those at the "last mile" - often marginalized, discriminated against, stigmatized or criminalized; communities that are more often not reached by formal health and WASH services and risk being left behind. This strategy relates specifically to community-based health activities, generally provided through local volunteers and community health workers, complementing formal health systems and resulting in greater responsiveness to needs.

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22. Katie Lorig, Director, Patient Education Research Center Stanford School of Medicine - Communities as Part of the Delivery System. PHAO Community Health Expert's Meeting: Defining Community Health in the 21st Century, June 2017.
23. Upstream interventions and strategies focus on improving social and economic structures in order to decrease barriers and improve supports that allow people to achieve their full health potential. Downstream interventions and strategies focus on providing equitable access to care and services to mitigate the negative impacts of disadvantage on health.

A focus on engaging communities, strengthening grassroots organizations and building trust is emphasized. These approaches are even more critical in fragile settings, conflict and crisis situations - where formal health systems are disrupted, where health risks are higher and where community actors are on the front-line meeting immediate needs and supporting long-term recovery. The IFRC membership will build on its role as a community health[24] actor in emergency and non-emergency settings, engaged in both humanitarian action and long-term development and advocating for the incorporation of National Societies' community health, preparedness and response plans into national legislation, policies and plans.

Our focus over the coming decade will be on creating the opportunities for all communities to have timely, equitable, affordable access to health services and to decision-making about their own health and care. Strengthening community resilience will be prioritized as will investing in those who volunteer as front-line responders and early risk detectors[25], with their role being recognized by the authorities. We will enhance our work to promote positive mental health and well-being, providing psychosocial support to those in vulnerable situations and those affected by the impact of climate change[26], conflict, disasters, epidemics and other risks. We will work with formal health systems and other partners to improve access to affordable, quality health care based on principles of social inclusion. We will invest in technology and innovations for better solutions, predictions and analysis.

Many Red Cross and Red Crescent Societies are currently leading community health approaches. For others this strategy will provide the opportunity for reflection and refocusing of the National Society to enable it to develop its future role in community health.

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24. For the purpose of this strategy community health includes non-emergency WASH programmes and elements of community preparedness and response related to epidemic and pandemic preparedness and response.
25. Including community epidemiological surveillance.
26. Climate change is being shown to increase the impact of disasters, water stress, food insecurity, environmental crises, migration, displacement of vectors, etc.

4. STRATEGIC DIRECTIONS

Strategic direction 1

National Societies and communities positioned as essential parts of health and care systems

National Societies working to inspire informed and engaged communities and contributing as equal partners at the community level is essential to achieving better health outcomes and universal health coverage[27]. Linking formal health systems and informal community-based systems as a continuum enables more effective disease prevention, early detection, health promotion[28], service delivery and care and support. In many countries community responses are already an essential part of the overall system for health, combining with and complementing the work of governments and the private sector. In others, interventions to engage with communities and community systems remain insufficiently acknowledged, prioritized or integrated into national plans and budgets.

Community designed and delivered health programmes, adapted to the local context, are one of the most promising and flexible ways to ensure better health outcomes for all, particularly for the vulnerable, marginalized and hard-to-reach individuals and communities. Programmes designed with and by the communities themselves can result in increased preparedness and resilience while strengthening the overall health system. For this reason, we advocate for recognition of the role of communities in health and social care and for the incorporation of National Societies' community health and preparedness and response plans into national legislation, policies and plans, including as auxiliaries to state actors and in the implementation of the International Health Regulations[29].

In the face of an acute global shortage of health workers, equitable ways need to be developed for including the contribution of Red Cross Red Crescent volunteers. Clarity on the difference yet complementarity between paid community health workers (CHW) and unpaid volunteers - who commit time, energy and passion, contributing to meeting heath needs and filling gaps - is needed. At times a closer alignment of roles may be required between paid staff and volunteers, for example during emergency situations or in contexts where there are major gaps in formal health systems. In these circumstances the increased role and responsibilities of volunteers, for example first aid responders,

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27. Sustainable Development Goal 3.8: Achieve universal health coverage, including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all.
28. Including mental health and psychosocial support.
29. The International Health Regulations (2005) are a legally binding instrument of international law that aims to assist countries to work together to save lives and livelihoods endangered by the international spread of diseases and other health risks. The purpose and scope of IHR 2005 are to prevent, protect against, control, and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks and that avoid unnecessary interference with international traffic and trade. (Art. 2, IHR (2005)).

or of those more highly trained volunteers or community workers such as paramedics, need to be fully acknowledged and appropriately supported[30] and remunerated. Dialogue between National Societies and their governments is required to determine how this can be best achieved. There are already good examples of National Society volunteers working in both the formal health systems and in the more informal community system. Some National Societies have substantial numbers of volunteers seconded from the Ministry of Health (MoH), for example Myanmar Red Cross Society. Others like Italian Red Cross are subcontracted to the MoH to carry out health checks and referrals for incoming migrants.

National Society volunteers contribute not only as implementers and by creating linkages between the MoH and the community, but their understanding of communities means that they can act as agents for change and influencers of strategies and policies at the local and national levels.

Goal 1

Positioning National Societies as recognized actors in health and care systems

- **Developing clear frameworks for the National Societies' role in community health, as auxiliary to the public authorities.** Strategy 2030 and government commitments for achieving the SDGs and UHC provide an opportunity for reopening the conversation on the National Society's contribution and auxiliary role in the country's health and care system. The Epidemic and Pandemic Preparedness Resolution (2019)[31] and implementation of the International Health Regulations provides the framework for National Societies to re-enter negotiations with their governments to ensure that health is consistently considered in national laws and regulations, including the role of the National Society in sectoral strategies, priorities and programmes at national, sub-national and local level.

- **Positioning National Society volunteers in the health and care system within a clear regulatory framework,** including volunteer protection[32], at the national, regional and municipal level. The framework would include the role and accountability of each partner and could focus on the opportunities and limitations of volunteer workers; their relationship with and complementary role vis-a-vis paid community health workers; task sharing where appropriate; volunteer management and retention; reporting, training and capacity-building; the relationship with primary health care facilities and staff; and situations when additional responsibilities, appropriately remunerated,

30. Support includes capacity-building to ensure minimal technical competencies of volunteers, as well as making sure they are supported in their operational tasks, their safety and well-being.
31. 33rd International Conference of The Red Cross and Red Crescent, Geneva, Switzerland 9 – 12 December 2019. Time to Act: Working together to prevent and respond to epidemics and pandemics.
32. 32nd International Conference of The Red Cross and Red Crescent, Geneva, Switzerland 8-10 December 2015. The safety and security of humanitarian volunteers. Includes health and safety, mental health, psychosocial well-being and safeguarding

may be required[33]. The role of volunteers within UNGA 73[34] Resolution on "Volunteering for the 2030 Agenda for Sustainable Development" also needs to be considered.

- **Strengthening the capacity of providers engaged in primary health systems** - including health workers, networks and community members – with a focus on better understanding communities in all their diversity, identifying community health issues through community participatory approaches and in provision of quality interventions and effective management of community-based health care. This will involve developing, revising, or adapting capacity-building programmes and training modules, with an emphasis on engaging those community members with lived experience as central contributors.

Goal 2

Positioning communities as recognized contributors to health and care systems

- **Engaging community, in all its diversity, to improve health outcomes at the individual and community level.** Knowing that better health outcomes are achieved by empowering people to take responsibility for their own health and that community-based participatory approaches and assessments coupled with local volunteer led interventions build trust, understanding and community ownership, irrespective of context, National Societies and their volunteer base can make an important contribution to improving national health outcomes. This is particularly so where communities themselves - who understand trends, customs and other external factors that affect the decisions and choices they make - are involved in designing, implementing and evaluating services in their own communities and are empowered to take responsibility for their own health outcomes.

This requires National Societies to focus on engaging and positioning communities in identifying priorities and delivering community-based health interventions, including health promotion and disease prevention; extending reach and reducing barriers to existing services; identifying how to best fill service gaps; and how to "go the last mile" to reach marginalized, vulnerable and hard-to-reach communities. These approaches require a National Society to be embedded in the communities that they are both part of and serve. It requires them to deploy participatory approaches as presented in the IFRC's eCBHFA programme, its integrated primary health care approach to community health promotion. It is acknowledged that some National Societies will need to do more to engage marginalized communities and in deploying community-based approaches during the life of this strategy. At the same time there is significant knowledge held by others and the opportunity for learning from each other.

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33. Refer to the IFRC Volunteering Policy, including when there is the need or opportunity for a National Society volunteer to carry out paid work as casual or contracted labour, ensuring that this change in status complies with the relevant laws.
34. Encourages governments to integrate volunteerism into national development strategies, plans and policies, United Nations Development Assistance Frameworks or equivalent planning frameworks.

Strategic direction 2

All people have equitable access to quality health and care throughout life

Achieving 2030 health-related goals requires new approaches to ensuring equitable access for all, specifically for geographically and socially isolated communities – those most at risk of being "left behind". Those who are socially isolated differ both within and between countries but frequently include ageing populations; the poorest; people who are discriminated against including minority ethnic and religious groups; lesbian, gay, bisexual, transgender, intersex and queer/questioning (LGBTIQ) people; those engaged in criminalized behaviours[35]; migrants; people living in remote or complex settings; people with disabilities or mental health problems or who suffer from isolation or loneliness; people without access to affordable and sustainable services; those affected by disasters and crisis; or those who are not digitally literate or connected. Barriers to access for these populations - whether social, legal, economic, or geographic - need to be understood and responded to. Community-based approaches have the potential to engage isolated groups and individuals and to find new ways to reduce barriers and improve access.

The ability to access quality health services throughout the life course requires a sustainable and resilient health system of connected tertiary, secondary and primary health services together with community-based health activities. Community-based health programmes take many forms ranging from health promotion activities, to demand creation and delivery of health care services - from simple awareness campaigns, to screening, early diagnosis and management of certain illnesses, to ensuring patients follow their treatment regimes, to the more complex and regulated provision of basic health services. Social care is also a growing area of need given increasing social isolation and loneliness and as the number of older people in need of care and support increases.

Communities are the first line of defence and response against disease outbreaks and are key to well-functioning early warning and surveillance systems. Without community cooperation, there is very little chance of ending outbreaks such as Ebola, cholera, polio, Zika and flu epidemics. In emergencies, communities that are already engaged in community-based health approaches are the "eyes and ears" of emergency preparedness, response and recovery efforts. They are not only the first responders, but also the last[36]. In the 2019/20 COVID-19 outbreak, National Society volunteers immediately put their training to work to provide support, accurate messaging and liaison between health officials and vulnerable populations. These actions were launched by volunteers already trained to enable them to respond as needed and in alignment with local MoH guidance for a virus that was being transmitted at the community level.

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35. People who use drugs, engage in sex work or are homosexual in countries where these activities are illegal.
36. Linkages need to be forged with other approaches including DCPRR (early warning, DRR/Climate Change Adaptation (CAA), shelter, etc.) all of which link into and complement health preparedness, response and recovery.

The benefits of community-based health programmes are not confined to certain responses or diseases. Community health volunteers learn and teach basic health literacy about what contributes to people falling sick. The training and skills that go into any response will be used in other types of programmes and the trust developed with the community will be equally transferable. There is a much greater chance of programmes that are "owned by communities", or those where communities have participated in design and delivery, surviving in the long term.

National Societies often provide an important continuum of care, acting as a bridge between home and hospital, acknowledging that the more complex the task, the more important it is that community-based services are closely coordinated with the formal health system, that responsibilities are clearly outlined, and that programme implementers are adequately trained and supported, including through legal frameworks and protections.

In situations of conflict National Societies often have a crucial role in ensuring access to basic health care and protecting health system infrastructure and personnel providing vital services. Their sustained presence within communities enables them to bridge the humanitarian-development nexus - while the context may change communities remain present, engaged and adapting to circumstances.

Goal 3

Reaching geographically and socially isolated communities

- **Focusing on "last mile" communities.** While authorities have the obligation to provide services for all citizens, National Societies are often best placed to find effective pathways to reach more isolated communities, enhancing the work of the formal health system through its community volunteers and focused outreach approach. Building on trusted relationships it can often reach isolated communities to ensure basic health interventions, services and support and in exceptional circumstances substitute the work of authorities, within agreed frameworks. National Societies' active community health role in fragile and conflict settings, in protracted complex emergencies situations and during pandemics is well understood. This role now needs to be extended to those communities that have the potential to experience an "emergency" in poor health outcomes.

  To engage effectively a National Society's approach needs to be open and inclusive. This means recruiting volunteers and staff that reflect the diverse make-up of society including from groups that experience first-hand inequities and lack of inclusion, while establishing the necessary support systems for those volunteers to operate with success. Such an approach accords with the fundamental principles of impartiality, neutrality and humanity.

Goal 4

Providing evidence-based, quality assured health promotion, disease prevention and health and care at scale - aligning with and complementing health and care systems

- **Delivering community-based health promotion, WASH and disease prevention programmes.** These programmes take many forms, often delivered by volunteers working in low, middle- and high-income countries and across differing contexts, including in rural and urban settings. They range from health promotion, advocacy and awareness campaigns to a focus on risky behaviours and behaviour change strategies, to treatment literacy, and provision of life-saving interventions, for example, immunization programmes or malaria control bed net distribution programmes.

  Communities assessing their own health priorities and engaging themselves in all stages of assessment, planning, priority-setting and delivery lead to well-designed, locally adapted and well-managed programmes, with communities often finding their own solutions to health challenges. Such an approach is essential if programmes are to be delivered "at-scale", including in "hard-to-reach" communities. Discussion and agreement with the MoH and local health authorities and professionals on opportunities for task-sharing, financing and other issues relating to the National Society's auxiliary role in health can support this approach.

- **Providing services that respond to health needs over the life course, including in social care.** National Societies provide a wide range of service and programme support across the life course - ranging from care and support for infants, women in pregnancy, services for adolescents and young people, promoting healthy lifestyles and providing care and support to the aged, including home visiting and home care. Many National Societies engage in direct services, for example hospital-to-home services, community transport, helping with basic screenings or support to navigate the health system, child and maternal health, engaging with palliative care, community mental health and psychological support and social services. While these are roles already being provided by some National Societies, there is an opportunity for further expansion.

- **Working with health providers and advocating for accessible health, social care and WASH services for all.** Improving access to existing services by working alongside service providers in the formal health system is important work for National Societies. Ensuring that access and provision of services are free from stigma and discrimination and are welcoming to all, irrespective of social status, is important in both rural and urban settings. National Societies can work in tandem with service providers at health facility level to help ensure that they are welcoming for all. They can facilitate training and capacity-building of health care providers on community needs and working in partnership, for example, in engaging mobile clinics and outreach services to extend and improve access for "hard-to-reach" communities.

- **Engaging communities in epidemic preparedness and response** is an important focus for National Societies as part of national and local government's emergency response plans. Early warning and community-based surveillance systems are essential elements of epidemic and pandemic preparedness and response, as is active outreach, rapid and early case detection and delivery of appropriate response programmes. Epidemics begin and end in communities. If well prepared, communities can detect, report and contribute to stop epidemics at an early stage. If that fails, localized outbreaks can rapidly transform into a regional or global epidemic, with substantial human, social and financial costs.

  When disease outbreaks occur short-term vertical programming and focused responses may be necessary. These will, however, be more successful if built on foundations that have been laid through comprehensive and enduring community-led approaches to health and care that promote resilience. For these efforts to be effective it will likely require National Society wide planning, training and simulations, ideally carried out jointly with authorities and paying attention to those communities that are not digitally connected. National Societies may need to expand community-based surveillance, linking with facility-based strategies and systems through engagement with MoH, WHO and other actors and providing a two-way dialogue between response actors and communities to build the necessary trust for effective response.

- **Providing high quality, evidence-based programming** is an important factor in the success of programme delivery. Finding the right balance and emphasis between approaches that are at the same time community identified, led, and delivered while maintaining appropriate standards is critically important. Training, supervision and health literacy are important for National Society volunteers and paid staff for delivery of quality programmes.

  Designing evidence-based programmes, developing appropriate monitoring, evaluation and quality assurance and conducting field-based research to contribute to the body of knowledge on how communities change and transform their own health, are all essential if the IFRC is to be in a position to realize its full potential as a leader in community health.

- **Working at scale to improve health outcomes.** At the same time as focusing on isolated and "hard-to-reach" communities National Societies must also work for all. It is not enough to work in some neighbourhoods and not others, to focus on one marginalized group and not others if we are to stand for the principles of the Red Cross Red Crescent Movement. This means working "at scale", across communities, across neighbourhoods and across the nation[37]. Small scale or pilot programmes need to be scaled up and to attract significant funding. It is acknowledged that limitations will exist in terms of financial and human resources; however an ambition for achieving scale as a longer-term ambition is important.

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37. The IFRC WASH programme has had successful experience in developing programmes "at scale". This work could inform scale-up strategies as part of the Strategy implementation plan.

Strategic direction 3

Community level experience informs policy makers

It is well known that community or grassroots informed policies, strategies and programmes are more likely to have impact and to affect sustainable change. The IFRC, through its local and global engagements, is well placed to influence policy and strategies required for the new decade. Being both locally based and auxiliary to the public authorities, National Societies are well positioned to strengthen the links between public health policy, communities and the health systems that serve them. Some National Societies will need to do more to inhabit this space if they are to play the role required of them in delivering S2030 and this community health strategy.

Equally, the IFRC and its secretariat have a crucial role to play in bringing grass roots experience of its member National Societies to policy, planning and technical fora at global and regional levels, creating opportunities for community voices to be directly heard. Importantly the IFRC secretariat and National Societies' staff and volunteers bring not just technical knowledge, but that of the lived experience of people across the world, and the communities that they call home – whether it is those living in stable settings, the millions of displaced people living long term in camp environments, communities ravaged by on-going conflict, those affected by pandemics, by long-term drought and heat stress or the socially disenfranchized in our cities across the globe. These situations and the lived experienced of their inhabitants need to be fully understood by policy makers at the global, regional, national and local level. The IFRC and National Societies have a responsibility to bring community voices to policy fora and advocate for their needs.

Goal 5

Leveraging influence at global, national and local level

- **Bringing grassroots and community informed experience to policy fora, strategy development and technical working groups** is a key role for National Societies as they actively engage with MoH and other national and local level authorities. Leveraging its unique position as a trusted dialogue partner through its auxiliary role, National Societies can contribute to national policies and strategies and advocate for the necessary investment to meet the needs of both vulnerable communities and the wider population. Ideally this can lead to the inclusion of Red Cross Red Crescent strategies and plans in national disease control frameworks, including the potential of financing a National Society's work. This may require investment in information management and reporting capabilities in order for National Societies to demonstrate their contributions to achieving global health agendas.

- **Utilizing National Societies' convening power and voice to set agendas and build partnerships** is an opportunity to be taken in the coming decade**.** National Societies and the IFRC, both individually and collectively, have substantial convening power, able to draw the attention and interest of NGOs, governments and UN agencies. Focusing humanitarian diplomacy efforts towards better coverage, access and equity in health service provision and advocating for adequate health budgets are important roles for National Societies.

Goal 6

Developing and leveraging partnerships for service delivery, financing, research and programme development

- **Engaging in coordination platforms, technical working groups, financing mechanisms** and other fora at global and national level, the IFRC secretariat and National Societies can draw on their technical skills and community experience to advocate for increased and better targeted funding for sustainable health outcomes in communities. Flexible funding allocations are needed, for example, during health emergencies to support community structures and to enable course correction following community feedback. Some National Societies will also be able to be a voice "to hold governments to account" in delivering on global and national policy and financing commitments, without compromising their position as a critical partner.

- **Brokering and expanding partnerships for service delivery, research and programme development.** Partnerships between WHO, health focused NGOs, MoH and the National Societies to focus on agreed priorities, for example, geographically and socially isolated communities, could have a major impact on lives while contributing to achieving UHC and other global health goals. Similarly, partnerships of mutual benefit could be developed with UNICEF, GAVI, WHO, Global Fund, Country Co-ordinating Mechanisms (CCMs) and with other actors. Strong linkages between the IFRC and these partners at the global and regional level is essential in helping to position National Societies as central actors in national dialogue - inform them of global debates and opportunities to be an effective partner of government. The secretariat can create spaces for National Societies to engage effectively at all levels - be that global, regional or at country level.

  Building academic partnerships at the national and international level to contribute to community-based research and to provide academic rigour in programme design, monitoring and evaluation and in documenting lessons learnt can contribute to better community health programmes and to global learning.

- Engaging with global financing mechanisms and country level financing platforms of Gavi, Global Fund, Global Financing Facility (GFF), World Bank etc. Financial resources for health are increasingly being devolved from western capitals to national level funding mechanisms. National

Societies, and the IFRC secretariat in particular, need to adjust to these shifts. Knowledge of how these funding mechanisms work at the country level is required to enable National Societies to position themselves for funding and to develop the technical, partnership and contract management skills required of grant recipients. National Societies are encouraged to participate in those national platforms where large grants are discussed, ensuring that they remain responsive to community need. National Society community health programmes could earn grants from vertical diseases (e.g. TB, HIV, malaria - Global Fund), for specific preventive programmes (e.g. immunization - GAVI) and also for health system strengthening interventions (e.g. World Bank, Global Fund). Strengthening technical support to National Societies and empowering staff to participate fully in these national level platforms is required.

Summary table – Strategy directions

Strategy directions 1. National Societies and communities positioned as essential parts of health and systems

Goal 1. Positioning National Societies as recognized actors in health and care systems

- Developing clear frameworks for the National Society's role in community health, as auxiliary to the public authorities
- Positioning National Society volunteers in the health and care system within a clear regulatory framework
- Strengthening the capacity of providers engaged in primary health systems

Goal 2. Positioning communities as recognized contributors to health and care systems

- Engaging community, in all its diversity, to improve health outcomes at the individual and community level

Strategy directions 2. All people have equitable access to quality health and care throughout life

Goal 3 Reaching geographically and socially isolated communities

- Focusing on last-mile communities

Goal 4. Providing evidence-based, quality assured health promotion, disease prevention and health and care at scale - aligning with and complementing health and care systems

- Delivering community-based health promotion, WASH and disease prevention programmes
- Providing services that respond to health needs over the life course including in social care
- Working with health providers and advocating for accessible health, social care and WASH services for all
- Engaging communities in epidemic and pandemic response
- Providing high quality, evidence-based programming; working "at scale" to improve health outcomes

Strategy directions 3. Community level experience informs policy makers

Goal 5. Leveraging influence at global, national and local level

- Bringing grassroots and community informed experience to policy fora, strategy development and technical working groups
- Utilizing National Society's convening power and voice to set agendas and build partnerships

Goal 6. Developing and leveraging partnerships for service delivery, financing, research and programme development

- Engaging in coordination platforms, technical working groups and financing mechanisms
- Brokering and expanding partnerships for service delivery, research and programme development
- Engaging with global financing mechanisms and country level financing platforms

5. IMPLEMENTATION – ACHIEVING FEDERATION-WIDE LEADERSHIP IN COMMUNITY HEALTH

To realize the ambition of this strategy, adjustments will need to be made by all 192 National Societies and the IFRC secretariat - additional expertise developed, new partnerships forged, priorities redefined and a shift of emphasis in day-to-day work. Six areas of focus will be required to achieve this change.

Focus area 1

National Societies skilled-up for community health leadership

- **National Societies leading the implementation of this strategy** by being at the forefront of community-based health interventions. This will require National Societies to:

  a. Develop their own contextualised community health strategies focused on engaging communities in community-based health activities according to national and local priorities.
  b. Strengthen branch capacity in community participatory approaches and in engaging both diverse communities and local health systems.
  c. Recruit branch level volunteers that truly reflect the diversity of local communities, (i.e. migrants, people of different sexual orientations, people with disabilities, minority or excluded groups, youth, etc.).
  d. Develop training programmes for staff and volunteers including adaptation of eCBHFA to the local context and implement within the principles articulated in section 3.
  e. Advocate for the range of national and local actors to respond fully and effectively to community health needs.
  f. Work towards becoming data driven, evidence-based providers.

- **Investing in National Society capacity for leadership in community-based approaches to health** ranging from knowledge and tools for empowering communities to digitalization, mobile health, data science etc. Provision of standardized Federation-wide approaches that can go to scale will be required, spreading investment costs across the membership, if the transformations evoked in S2030 are to be realized.

Focus area 2

Shifting secretariat focus to support National Society community health leadership

- **Focusing the IFRC Health and Care team on supporting National Societies to deliver this strategy** - acting as an enabler, facilitator, promoter, guide and supporter of the 192 National Societies with primary responsibility for seeing the ambition of this strategy realized. The Geneva secretariat and its regional offices need to be at the forefront in:

   a. Acting as a convener and knowledge broker in support of the work of 192 National Societies
   b. Linking the work of National Societies to global health agendas and priorities
   c. Partnering with global health institutions – WHO, GF, GAVI, UNICEF, the private sector
   d. Championing community-led approaches as central to all activities
   e. Developing technical guidance, protocols, tools, service packages, etc.
   f. Facilitating technical assistance, sharing of knowledge and expertise
   g. Developing quality assurance approaches for National Society programmes
   h. Creating a culture that enables and supports innovation
   i. Developing a research agenda for evidence-based community health approaches
   j. Providing a platform for sharing National Society community health achievements and learning

- **Developing an integrated IFRC approach to community preparedness and resilience** that can act as a foundation to more substantive preparedness in health, WASH and disaster response. Such an approach requires shared ownership across secretariat teams – Health and Care; National Society Development; Policy, Strategy and Knowledge; and Disaster and Crisis Prevention, Response and Recovery – while including the cross-cutting issues of community engagement and accountability; protection, gender and inclusion; and importantly a green response. The aim is for one integrated and simplified approach for National Societies to use rather than the various stand-alone tools, assessments, and approaches[38],[39],[40]. This can then be linked with the eCBHFA platform and a joint team approach developed for engaging National Societies in community and institutional preparedness.

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38. The existing Community Resilience Framework could guide this exercise.
39. https://media.ifrc.org/ifrc/wp-content/uploads/sites/5/2018/03/IFRC-Framework-for-Community-Resilience-EN-LR.pdf
40. https://media.ifrc.org/ifrc/wp-content/uploads/sites/5/2018/03/1310403-Road-Map-to-Community-Resilience-Final-Version_EN-08.pdf

- **Supporting National Societies strategies to reach marginalized populations and to work more comprehensively in urban communities.** The IFRC Secretariat will need to work with National Societies, compiling National Society-informed guidance focusing on engaging with socially isolated and marginalized groups, including stigmatized populations like homeless people, migrants, undocumented workers and those engaged in criminalized behaviours; developing approaches to external and internalized stigma; compiling guidance on engaging within the complexity of urban setting which pose additional risks, vulnerabilities and challenges; adapting community health programmes to meet the needs of these communities, and other relevant topics.

- **Working with National Societies to co-develop guidance for voluntary service in community health**, enabling volunteers to be not just service providers but agents of change at the local level, able to support sustained behavioural change and community development. Approaches to volunteer management including selection, training, supervision, retention, appraisal and support should be developed; regulatory frameworks and volunteer protection; relationship with paid community health workers and health systems, task shifting, etc. Approaches and guidance will need to be based on the principle of National Society volunteers truly representing the diversity within their communities, including vulnerable and marginalized communities. Also the impracticality of local volunteers being "sectorialized" needs to be understood - accepting that many National Societies and local branches generally have a small number of volunteers working across disaster response, emergency health, community health, social care, activities that are often integrated at the branch level.

- **Extending the scope of eCBHFA as the central platform for community health** and as the "go to" place for National Societies. This will require an expansion of what is already an important tool, both widening its focus and providing greater clarity on its purpose and use. It has the potential to be the depository for all technical standards and guidelines, training materials, job aids and other information across the spectrum of community health topics and approaches, including on community engagement and assessment. It will be important to make clear the link with Disaster Risk Reduction.

- **Rejuvenating the first aid component of eCBHFA** as a foundational cornerstone of the work of National Societies and for the new decade aspiring to have every Red Cross Red Crescent staff member and volunteer the world over being trained in first aid, including psychosocial first aid. Further, governments should be encouraged to enact laws requiring mandatory first aid training in schools and in the workplace and also for drivers before being awarded a driving licence.

National Societies have the potential to be the training provider of choice for government institutions, with commercial first aid being a further opportunity to strengthen both the visibility and the financial resources of National Societies.

- **Linking community health with National Society development** to ensure operational, managerial and governance effectiveness in programme implementation. Developments in community health cannot be viewed in isolation and most often need an all-organization approach. If National Societies are to deliver effective, impactful and resourced community health programmes then governance and management systems will need to be drawn on in terms of oversight and accountability. Strengthening of institutional and programmatic arrangements at both national and branch level is important if National Societies are to fulfil their potential as leaders in community health. Developing linkages with other National Society health services such as pre-hospital care, nursing schools, psychosocial support (PSS) services, commercial first aid will be important to ensure that where appropriate, approaches are unified and integrated.

Focus area 3

Expanding and coordinating Federation-wide learning and knowledge sharing

- **Positioning National Society to National Society learning and knowledge sharing as a central role of the secretariat.** Knowledge and experience of community-based health is spread across the globe, held by different organizations, communities and National Societies and often by those in low- and middle-income settings. While financial resources may be more available to National Societies in high-income countries or generated from these countries (though this is changing and will increasingly do so), the same cannot be said for knowledge. We too often link resources with an ability to play a leadership role in knowledge dissemination and learning. New approaches need to be found to enable those National Societies demonstrating particular skills and experience to be positioned as IFRC knowledge leaders.

- **Developing technical knowledge hubs** by linking those National Societies with expertise together so that they can further develop knowhow, expertise and learning to benefit the collective of 192 National Societies is another approach to be explored. This exists to some extent with the current reference centres, however there is an opportunity to develop a much broader and more dynamic approach by linking those National Societies with specific thematic expertise within different contexts, to become "virtual" hubs of learning. The secretariat, acting as an enabler and facilitator, creating institutional linkages and frameworks would enable knowledge to be available to all National Societies, including through digital platforms. Consideration could be given to extending these platforms beyond the IFRC, broadening the approach and linking other actors including NGOs, donors and governments to, for example, Cholera Platforms, WASH Clusters, Health Fora, etc.

- **Investing in technology and innovations for better health predictions, analysis and solutions.** In the near future, digital technology will be an important and integrated part of community health information systems. IFRC will need to transform into a data driven, evidence-based digital network, as described in Strategy 2030. National disease surveillance systems registering events at community level and reporting these to community-linked facilities and governmental services that monitor changing needs are now being developed. IFRC will need to continue to invest in integrating emerging technology, skills and digital culture into its ways of working and could take a lead in how this technology is rolled out and impacts at the community level. It will need to build data and digital literacy, forming purposeful partnerships with a wide range of actors; ensuring that there is an organizational culture and structure that supports a focus on digital transformation, with agile experimentation across the IFRC; evidence that insights and analysis from digital technologies and innovations are utilized for strategic and operational decision-making; that local branches are digitally connected and contributing to a global network and that staff and volunteers in all National Societies significantly enhanced their skills and capacities in digital solutions.

Focus area 4

Measuring quality and impact

- **Measuring impact and developing appropriate indicators** will be critical in demonstrating National Societies' contributions to both community health and to global health outcomes. Measures will need to be developed with clear indicators for demonstrating change and progress. This will require investment in an IFRC-wide data repository and capacity development in IT, data collection, digital innovation and communications.

- **Demonstrating quality through rigorous monitoring frameworks, indicators and measurement**[41] will involve adapting existing guidance (Community engagement and accountability (CEA), Project/Programme planning (PPP) guide, M&E guide etc.) and designing mechanisms for accountability - how much was done? (quantity); how well was it done? (quality); what behaviours were changed (behaviour change focused); have the most vulnerable and marginalized been reached? and what is the impact on key health indicators? This will require collection of sex, age and disability disaggregated data (SADDD)[42], using traditional and innovative methods and continuous review and reflection on such questions as - have we adapted our programmes to meet community needs, roles and capacities, is there adequate participation of communities in what we do, have we acted to prevent negative effects of what we do? etc.

41. The WASH "Look Back" Study Tool which measures impact and sustainability post implementation is a useful reference.
42. https://www.youtube.com/watch?v=wO1s39hqimE

Trialling and rolling out new ways to measure impact including through tools such as Sensemaker, which prompts community members to tell a story about their health after which they are asked a series of quantitative questions around that story. Evaluative tools such as these enable more reliable and valid evaluation of community health work with community voices being heard and validated as evidence of impact.

Focus area 5

Mobilizing long-term financial resources for delivering this strategy

- **Developing a longer-term funding strategy for community health** will be required to realize the ambition of this strategy. This will be required at both the National Society and secretariat level. Reaching out to national and local government, in-country donors and National Society partners for support in delivering this strategy will be important for the development of a longer-term national funding strategy. For the secretariat a focused resource mobilization plan with financial resources for the different streams of work will be required, and exploring potential synergies and engagement with the internal and external funders so as to secure long-time commitments and engagements with National Societies and to bring sustainability to community programmes and services.

Focus area 6

Operationalizing this strategy

- **Developing implementation plans**. The delivery of this strategy will require more practical implementation plans to be developed by each National Society and by secretariat regional health teams. For National Societies, engaging government and other stakeholders in their own planning processes will be important. These plans will need to be context specific considering the interface with the national health system and opportunities for sustainability from the very beginning of the implementation process. They will also need to consider a number of issues raised by this strategy including:

a. Understanding why previous attempts to position National Society volunteers as community health workers has failed
b. How National Societies can respond "at scale" for example, what would it take for a National Society to move from the traditional two to four-year funded CBHFA project/programme approach to a comprehensive long-term district or national level community health partnership with the MoH? And what implementation model might be required?
c. Developing an investment and sustainability plan for delivering the strategy

d. Managing the inherent tensions between community engagement and participatory decision-making and empowerment on the one hand, and large-scale top-down interventions on the other, including with the MoH.

e. How this community health strategy will link with MOH community health strategies.

- **Secretariat support** - National Societies have indicated that they will require support from the secretariat in the following areas:
  - Developing technical guidance, protocols, tools, including for planning, monitoring, evaluation and reporting (PMER).
  - Facilitating technical assistance, sharing of knowledge and expertise
  - Mobilizing long-term funding resources for sustainable community health
  - Sharing regional best practices
  - Encouraging communication and networking
  - Better alignment of centrally funded projects
  - Strengthening advocacy for involvement in national health plans and programmes.
  - Increased capacity-building for the National Society as well as increased knowledge sharing
  - Engaging National Society leadership in the strategy and providing orientation
  - Ensuring that community health is a foundation for all health programmes

Summary table - Implementing the strategy

Implementing the strategy - Achieving Federation-wide leadership in community health
Focus area 1. National Societies skilled up for community health leadership
• National Societies leading the implementing of this strategy • Investing in National Society capacities for leadership in community-based approaches to health
Focus area 2. Shifting the secretariat focus to support National Society community health leadership
• Focusing the IFRC Health and care team on supporting National Societies to deliver this strategy • Developing an integrated IFRC approach to community preparedness and resilience • Supporting National Society strategies to reach marginalized populations and to work more comprehensively in urban communities • Working with National Societies to co-develop guidance for voluntary service in community health • Extending the scope of eCBHFA as the central platform for community health; rejuvenating the first aid component of eCBHFA • Linking community health with National Society development
Focus area 3. Expanding and coordinating Federation-wide learning and knowledge sharing
• Positioning National Society to National Society learning and knowledge sharing as a central role of the secretariat. • Developing technical knowledge hubs • Investing in technology and innovations for better health predictions, analysis and solutions
Focus area 4. Measuring quality and Impact
• Measuring impact and developing appropriate indicators • Demonstrating quality through rigorous monitoring frameworks, indicators and measurement
Focus area 5. Mobilizing long-term financial resources for delivering this strategy
• Developing a longer-term funding strategy for community health
Focus area 6. Operationalizing this strategy - developing National Society and IFRC regional office context specific implementation plans

DEFINITIONS OF TERMS USED IN THIS STRATEGY

Term	Definition within this document
Communities	By communities we mean groups of people who are connected to each other and who share particular characteristics due to geography, living situations, health challenges, culture, gender, age, religion, identity or sexual orientation. Generally with shared common beliefs and needs. The IFRC Framework for Community Resilience uses the following definition for community: "A community is a group of people who may or may not live within the same area, village or neighbourhood, share a similar culture, habits and resources. Communities are groups of people also exposed to the same threats and risks such as disease, political and economic issues and natural disasters."
Community-based participatory approaches	They include community action in responses to health priorities that are community identified, community led and community driven. Evidence based community-based health and first aid (eCBHFA) is Red Cross Red Crescent's health promotion and health literacy approach which promotes engaging the community in identifying and addressing community issues where they occur using behaviour change principles. eCBHFA is identified as being both: 1) A community approach which involves community interactions and capacity-building THROUGH volunteers from the community: • USING a root-cause analysis approach to IDENTIFY issues that directly or indirectly affect the community's health • IDENTIFYING vulnerable groups to ensure inclusion • DEVELOPING an action plan with the community to address those root causes • IMPLEMENTING activities that address the root causes • LINKING community needs with local health systems • ADJUSTING the activities as needed to IMPROVE the community's health and overall resilience 2) A package of materials in the form of manuals, videos, toolkits and games which are adapted and contextualised for each community served.

Term	Definition within this document
Community health	Community health is a branch of public health which focuses on people and their role as determinants of their own and other people's health in contrast to environmental health which focuses on the physical environment and its impact on people's health. Community health approaches are more concerned with the diversity of people and their health across the life course, focusing more on promotion of health, participation and shared responsibility. For the purpose of this strategy community health includes non-emergency WASH programmes, elements of community preparedness, response and resilience related to epidemic and pandemic preparedness and response and community responses to maternal and child health, NCDs, HIV, TB etc.
Formal health system	Government health system, including the state-regulated private sector.
Health promotion	Health promotion is the process of enabling people to increase control over the determinants of health and thereby improve their own health[43]. To reach a state of complete physical mental and social well-being, people and communities must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment.
The IFRC	The International Federation of Red Cross and Red Crescent Societies (the IFRC) is a membership organization established by and comprised of 192 National Societies.
International Federation secretariat	The International Federation of 192 Red Cross and Red Crescent Societies secretariat consists of headquarters based in Geneva, five regional offices and field delegations around the world.
"Last mile" communities	Communities that are not reached by formal health services or by roads, electricity or water supply and risk being left behind. These communities are generally geographically or socially isolated. They may be communities in fragile settings, remote and rural communities, or communities of people who are marginalized, stigmatized, criminalized, socially isolated and/or excluded and often not considered in social, economic, health and education policies.

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43. World *Health* Organization Ottawa Charter 1986.

Term	Definition within this document
Life course approach	Rather than focusing on a single condition at a single life stage, a life course approach considers the critical stages, transitions and settings where large differences can be made in promoting or restoring health and well-being. Adopting the life course approach means identifying key opportunities for minimizing risk factors and enhancing protective factors through evidence-based interventions at key life stages, from preconception to early years and adolescence, working age, and into older age. It is a person-centred rather than a disease-centred approach.
Red Cross Red Crescent Movement	The International Red Cross and Red Crescent Movement[44] is a global humanitarian network of nearly 100 million members, volunteers and supporters in 192 National Societies. It consists of the International Committee of the Red Cross, the International Federation of Red Cross and Red Crescent Societies and the 192 National Red Cross and Red Crescent Societies. Neutral and impartial, it provides protection and assistance to people affected by disasters and conflicts.
Vulnerable communities	Vulnerable populations are groups and communities at a higher risk of poor health as a result of the barriers they experience to social, economic, political and environmental resources, as well as limitations due to illness, chronic health conditions or disability. The definition often includes a wider range of groups depending on context - people who use drugs, migrants, mobile populations, those with HIV, people with disabilities, the urban poor, homeless or older people isolated in their homes with little social support, young children, pregnant and nursing women, youth, female-headed households, populations living in poverty, climate change, disasters or conflicts, those vulnerable to gender identity issues or those without a social safety net or not able to access their "right to health".

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44. The international Red Cross Movement is comprised of The International Committee of the Red Cross (ICRC), The International Federation of Red Cross and Red Crescent Societies (IFRC) and 192 member National Red Cross and Red Crescent Societies. https://www.ifrc.org/en/who-we-are/the-movement/

THE FUNDAMENTAL PRINCIPLES OF THE INTERNATIONAL RED CROSS AND RED CRESCENT MOVEMENT

Humanity   The International Red Cross and Red Crescent Movement, born of a desire to bring assistance without discrimination to the wounded on the battlefield, endeavours, in its international and national capacity, to prevent and alleviate human suffering wherever it may be found. Its purpose is to protect life and health and to ensure respect for the human being. It promotes mutual understanding, friendship, cooperation and lasting peace amongst all peoples.

Impartiality   It makes no discrimination as to nationality, race, religious beliefs, class or political opinions. It endeavours to relieve the suffering of individuals, being guided solely by their needs, and to give priority to the most urgent cases of distress.

Neutrality   In order to enjoy the confidence of all, the Movement may not take sides in hostilities or engage at any time in controversies of a political, racial, religious or ideological nature.

Independence   The Movement is independent. The National Societies, while auxiliaries in the humanitarian services of their governments and subject to the laws of their respective countries, must always maintain their autonomy so that they may be able at all times to act in accordance with the principles of the Movement.

Voluntary service   It is a voluntary relief movement not prompted in any manner by desire for gain.

Unity   There can be only one Red Cross or Red Crescent Society in any one country. It must be open to all. It must carry on its humanitarian work throughout its territory.

Universality   The International Red Cross and Red Crescent Movement, in which all societies have equal status and share equal responsibilities and duties in helping each other, is worldwide.

The International Federation of Red Cross and Red Crescent Societies (IFRC) is the world's largest humanitarian network, with **192 National Red Cross and Red Crescent Societies** and around **14 million volunteers.** Our volunteers are present in communities before, during and after a crisis or disaster. We work in the most hard to reach and complex settings in the world, saving lives and promoting human dignity. We support communities to become stronger and more resilient places where people can live safe and healthy lives, and have opportunities to thrive.