www.ifrc.org
Saving lives, changing minds.

Health
Annual Report

International Federation of Red Cross and Red Crescent Societies

MAA00001

30/APR/2013

This report covers the period 01/Jan/12 to 31/Dec/12.

***Mongolia – Chingeltei branch – 2012**: Look how clean our hands are, from kindergarten no. 83 in Chingeltei branch.*

Overview

Working within a four-year long term planning framework (LTPF) 2012-2015, the Federation Secretariat health programme is making solid progress in building its strategic operational framework (SOF) for health that is aligned to the strategic aims and enabling actions of Strategy 2020. Additionally, the health department LTPF and logframe are aligned to the IFRC's Secretary General's objectives and priorities reflected under five business lines.

Over the reporting period, secretariat health staff have continued to support National Societies (NSs) based on the above mentioned global strategic direction, as well as on NSs' expressed needs, strengths, and capacities, and global trends in public health.

Secretariat Health department provided guidance and leadership by supporting NSs technically through guidelines and manuals, tools, and materials. The secretariat health department invested as well actively in capacity building of NSs in the field of health through workshops and trainings and through active knowledge sharing, elearning, online platforms and discussion fora. It supported NSs financially, allowing them to increase their capacity to deliver programmes to beneficiaries. In this process, the secretariat health team ensured programme technical quality and financial accountability.

More specifically, during the reporting period, main achievements include success in working together as a global health team ensuring an organization wide move towards the same goals, steady progress towards a department's research agenda, and the development of various department wide concepts such as a holistic health approach, a behaviour change framework, and a training strategy and plan. The health team has as well initiated a number of cross-technical and/or cross-sectorial health projects to harmonize approaches, address programming gaps and work more effectively.

In addition, the health team continued to promote its global advocacy campaign on eliminating health inequities as well as the adopted resolution on health inequities (resolution 6, 31st International Conference), reaching different internal and external audiences. To promote IFRC's health programmes, the team developed a Health Corporate Folder that includes 14 corporate brochures for the different health subject areas.

Various achievements were made at programme level, *details can be found under the Progress Towards Outcomes section.*

Working in partnership

The health team maintains and further develops a wide range of partnerships. This includes global positioning, coordination, relationship management and technical support in a number of global initiatives, such as the global water and sanitation initiative (GWSI) or the global malaria initiative. In many instances, the team took a leading role in positioning the IFRC within key health partnerships among civil society organization platforms. For example, the IFRC is currently chairing the Alliance for Malaria Prevention partnership and vice-chairing the GAVI civil society constituency. We are also part of the Strategic Advisory Group of the Global WASH Cluster. The Health Department is represented in the Global Health Cluster and its Core Group, in the Global Outbreak Alert and Response Network, and in the International Coordination Group for Meningitis, Yellow Fever and Cholera Vaccines.

In addition to our primary partners comprising Red Cross Red Crescent National Societies as well as our traditional partners such as the World Health Organization, different UN organizations, private sector and various government agencies, the team has initiated and developed partnerships in order to come closer to its strategic operational goals, continue to implement successful health programmes, improve on quality, ensure longer term gains and sustainability, and scale-up health activities. Such new partnerships include the International Federation of Pharmaceutical Manufacturers & Associations (IFPMA), Eli Lilly and Company, the Global Fund to fight AIDS, TB, and Malaria, UNAIDS, UNITAID, the Partnership for Maternal, Newborn and Child Health, the WatSan Inter-agency Group, etc. *More details can be found under the Progress Towards Outcomes section*.

Progress towards outcomes

Business line 1: Raise humanitarian standards **OUTCOME:** *Uplifted thinking that inspires and underpins our services to maintain their relevance in a changing world, along with increased magnitude, quality, and impact.*		
Health outcomes and outputs	**Indicators**	**Progress, achievements, constraints**
Outcome 1.1: National Societies have the technical support and knowledge to implement quality health programmes		
Output 1.1.6: New technologies are tested to ensure continuous improvement of health programming	• A draft research agenda finalised and updated per year • # of research projects which moved from a concept phase to an implementation phase per year • # of research projects finalised per year • # of abstracts and articles in publications per year	The health team continued to conduct operations research activities at programme level. These activities all fed into the health department's research agenda. Main activities include: • In malaria, we supported the roll out of the Rapid Mobile Phone-based (RAMP) surveys via a website and toolkit presenting the methodology and steps for National Societies to roll a survey out with minimal external support. • We developed a proposal and secured funding for a Management Information System (MIS) that allows Red Cross volunteers to submit data by SMS using their own mobile phones. • We developed proposals to transition Burkina Faso and the Kenya RC Home Management of Malaria to Integrated Community Case Management and Mother, Neo-natal and Child Health projects, providing rapid testing for malaria at community level and providing treatment for malaria, pneumonia and diarrhoea, as well as addressing malnutrition. Both projects include operations research. Other malaria operations research activities were conducted in Togo to assess the effectiveness and cost of hang-up activities conducted by Red Cross volunteers; • In Community-Based Health and First Aid (CBHFA), we conducted a desk review and developed a research and learning plan. • In Noncommunicable Diseases (NCDs), we started the

		preparatory work for the noncommunicable disease research plan 2013-2015 by developing a concept paper; • In Water & Sanitation, we secured funding from OFDA for a two year sanitation research and development project which will be an IFRC led consortium with Oxfam GB and WASTE focusing on practical solutions for better emergency sanitation hardware, especially for urban contexts. This fund is linked to Global WASH Cluster strategic thinking and funding streams; • In HIV , we engaged with KRCS on a proposal " Treatment as prevention in Kenya: feasibility and impact of a scalable implementation model in partnership with the University of Manitoba/Canada programme science consortium. • We carried out a review for impact of the Sierra Leone cholera operation to study the causality and relationship of long term CBHFA programmes and the spread of cholera in an outbreak; • We have started to engage with the University of Geneva to get potential support in evaluation & research for MDR TB projects (funded by the Lilly grant) as well as for the preparedness and response to noncommunicable diseases in emergencies. • We work in close partnership with WHO Reproductive Health Research Department to utilize new technologies and pipeline innovations to reduce maternal mortality and to increase neonatal survival in humanitarian settings. • In follow-up of the 2011 General Assembly, an Evidence-Based First Aid network was announced, with the aim to conduct research on different areas in First Aid to ensure RCRC NSs are contributing to science development and to promote RCRC work in First Aid.

Business Line 2: Grow Red Cross Red Crescent services for vulnerable people.

OUTCOME: *Increased share of consistent and reliable Red Cross Red Crescent action in support of communities affected by disasters and crises.*

Health outcomes and outputs	Indicators	Progress, achievements, constraints
Outcome 1.1: National Societies have the technical support and knowledge to implement quality health programmes		
No specific health output(s) ***NB: Outputs 1.1.3, 1.2.1, 1.2.2, and 1.2.3 included in the LTPF have been moved under Business Line 5.***	No specific health indicator(s)	Over 2012, we have supported communities affected by disasters and crises through the work of our emergency health and WatSan colleagues, and in particular through: • Technical support to emergency operations with field visits for various cholera outbreaks (Lake Chad Basin, West Congo Basin, Lake Tanganyika, Sierra Leone, Horn of Africa); yellow fever outbreaks (Senegal, Ghana, Burkina Faso, Cameroon, and Sudan); polio outbreaks (Cameroon, Kenya) and the Ebola outbreak in Uganda; • Deployment of key EH staff to FACT missions in Jordan (Syrian Refugee Crisis and Sierra Leone (cholera). • Technical support for the Sahel Food Security; • Technical support and quality assurance for various emergency appeals and DREF operations; • Deployments in Madagascar and Burkina Faso with the Rapid Assessment Team (RAT) concept. In terms of tools and materials in support of communities affected by disasters and crises, we: • Developed IFRC cholera guidelines now available for field review; • Revised the influenza component of the Epidemic Control for Volunteers manual and initiated the production of the manual in Haitian Creole; • Developed an overall architecture for an e-learning system in Public Health in Emergencies and finalized module 1 (of some 6-7 modules); • Developed the prototype for a digital version of the IFRC and Johns Hopkins Bloomberg School of Public Health

		publication “Public Health Guide for Emergencies” and initiated the process of the 3rd edition of the guide. • Started to develop a Dengue advocacy paper; • Continued to participate in the Global health cluster and collaborate with WHO on technical research and development of guidelines in the areas of Neglected Tropical Diseases, Sexual and Reproductive health in emergencies, and communication in epidemics; • Continued to collaborate with the Food Security team and developed a terms of reference for a Nutrition strategy; • Secured funding, in partnership with the shelter department, to produce a disability and shelter in emergencies guideline in collaboration with Handicap International and the Christian Blind Mission (CBM); • Produced a concept note, in collaboration with the shelter department, to review emergency stove and lighting options for relief. This is to ensure improved indoor air pollution contamination, reduce risk of injury from fire, and reduce gender based violence. Our emergency health training support included, among other activities: • Support to ERU trainings in five NS for technical input, quality assurance and representation of the IFRC; • Support to a lessons learned workshop in public health in emergencies in MENA Zone for NS affected by the Arab spring; • The development of an online version of the Emergency Health Mission Assistant, now available for use. Some other activities included: • Represented the IFRC in various meetings, including the expert consultation on the Health Emergency Risk Management Framework (HERMF) and improving Public Health Preparedness in collaboration with WHO as well as an expert consultation on Foreign Medical Team guidelines arranged by WHO;

		• Lectured in Public Health in Emergencies in Ecole des Hautes Etudes en Santé Publique in Paris; • Continued to advance the use of digital data gathering in emergencies for use in assessment monitoring and disease surveillance; • Conducted ad hoc communications and media activities on a wide range of issues or crises, including a press conference on the cholera outbreak and the Red Cross Red Crescent engagement in the response organized with WHO.

Business Line 3: Strengthen the specific Red Cross Red Crescent contribution to development

OUTCOME: *Appropriate capacities built to address the upheavals created by global economic, social, and demographic transitions that create gaps and vulnerabilities, and challenge the values of our common humanity.*

Health outcomes and outputs	Indicators	Progress, achievements, constraints
Outcome 1.1: National Societies have the technical support and knowledge to implement quality health programmes		
Output 1.1.1: Relevant and evidence-based tools, guidelines, and information are available.	• A draft Holistic health approach (new or updated) per year • A draft Need analysis (new or updated) per year • A draft needs analysis for Behavioural change capacity building project developed and updated per year • A draft strategic plan for behaviour change capacity building developed and updated per year • % of existing tools updated per year • # of position papers on technical areas per year	During 2012, our team members worked on a number of department wide concepts including a holistic health approach, a draft behaviour change framework, and a position paper on task shifting. We have as well revised the latest draft of the Strategic Operational Framework for health to include additional analysis and background. Additionally, we continued to provide National Societies with evidence-based tools, guidelines, and information: • Finalized a Noncommunicable Disease framework; • Finalized the Maternal, Newborn, and Child Health framework disseminated in web and non-web format. We also developed an MNCH and immunization global interactive mapping tool and disseminated it across IFRC Zone offices; • Developed minimum standards in volunteering in the Elderly programme with the Europe Zone office and Austrian RC;

	• # of new tools meeting the criteria per year	• Completed and disseminated the Rapid Mobile Phone Based Survey (RAMP) toolkit and RAMP communications report; • In First Aid, we have started to develop the concept of "One FA" with the ICRC. Also, the International First Aid Guideline was translated into Arabic, French, Spanish and Chinese; • Finalized and disseminated a collection of Community Based Health and First Aid case studies 2012, CBHFA mapping for 2011, , and a CBHFA introduction presentation; • Finalized and disseminated a publication on multi-drug-resistant Tuberculosis, including lessons learned and recommendations; • Initiated work on a guidance manual on best practices in the provision of HIV/TB testing for drug users and migrants in low-threshold services, to be published with the Italian Red Cross; • Issued a Practical guide to collaborate with National Celebrities, in cooperation with the WHO and the Stop TB Partnership, with the aim to support country level TB advocacy; • Developed a guidance note for Gender in Water, Sanitation, and Hygiene Promotion; • Printed and disseminated the HIV/TB Prevention and Care guidelines in Russian; • Started the development of new RCRC cholera guidance documents; • Malaria toolkit translated into Spanish and Portuguese; • Developed a knowledge sharing report on how the Kenya Red Cross Society became Principal Recipient of Round 10 HIV/AIDS Global Fund grant and prepared for grant implementation; • In collaboration with WHO and the IAWG RH, developed a policy brief on Sexual and Reproductive Health in emergencies; • In collaboration with WHO, developing guidelines on Communication in epidemics; • Conducted a mapping of the different initiatives that use modern technology in First Aid education and drafting a report capturing RCRC experiences in this field. • The Masambo Fund (MF) granting system had been restructured and new guidelines for NS developed together

		with a business plan on the future of the MF under IFRC Secretariat umbrella for consideration by IFRC senior management.
Output 1.1.2: A relevant and consistent set of trainings, workshops, seminars, as well as direct technical support enables National Societies to improve their health programmes.	• A draft training need analysis (new or updated) per year • A draft training strategy and plan new or updated) per year • % of existing trainings updated according plan and HHA) per year • # of new trainings meeting the criteria per year • # of new online trainings and discussion fora which meet the criteria of HHA per year • # of NS participants in training and workshops per year	During 2012, we have conducted a department wide training review and analysis and developed a training strategy and plan. We have developed a number of tools and materials to support National Societies' capacity building, including: • Due to an increased need to scale-up, harmonize, and standardize key learning materials, reach more staff and volunteers, and eventually reduce the cost of trainings, we have worked on a series of online trainings: - Four CBHFA e-learning modules (general introduction, and modules for volunteers, facilitators and programme managers) were developed and posted on the IFRC Learning Platform - Emergency Health e-learning (in its final stages) - First Aid e-learning report (under development) - First Aid application with support of GDPC. • Generic CBHFA Master Facilitator guide and lessons learnt • Drafting Healthy Life Style Module (to address NCDs) • With support from Canadian RC, drafting Violence Prevention Module using CBHFA approach. • Finalized the French version of the HIV Prevention, care, treatment and support training package for community volunteers; • Produced and dispatched the Gender and HIV training module in English, with French and Spanish versions under development; • Issued version 2.0 of the LLIN mass distribution toolkit for the Alliance for Malaria Prevention; • Finalized and disseminated the RAMP training manuals. At programme level, we continued to support National Societies through various activities, including: • Facilitated and provided technical assistance to various ERU

		trainings (Spanish, Norwegian, German, and French RC); • Conducted a training for country level TB advocates with the Stop TB Partnership; • Conducted/facilitated various CBHFA trainings and lessons learnt workshops, mainly a CBHFA delegate's training in Sweden (June 2012), CBHFA delegate's training in Australia (November 2012), a CBHFA Master Facilitator workshop for Palestinian RC with emphasis on linking community health and emergency health in Jordan (June 2012), CBHFA lessons learnt workshop in Africa (April 2012), Asia Pacific (October 2012), Global (November 2012) and Americas (December 2012) • Provided support to the Swedish and British RC Mass Sanitation training (September 2012) • Conducted Harm Reduction training for Latvia and Lithuania RC (December 2012), in cooperation with Italian RC. • Malaria programme provided direct technical support to Kenya, Burkina Faso, Nigeria, Togo, Angola, Namibia.
Output 1.1.4: Sets of tools and guidelines common across technical health areas are available.	• # of cross technical (health)projects based on a joint work plan initiated per year • # of cross technical (health)projects based on a joint work plan finalised per year	Over 2012, we have initiated a number of cross technical health projects to harmonize approaches, address programming gaps and work more effectively: • Developed a discussion paper on integrating CBHFA and Participatory Hygiene and Sanitation Transformation (PHAST); • CBHFA/EH: review for impact of the Sierra Leone operation to study the causality and relationship of long term CBHFA programmes and the spread of cholera in an epidemic; • Through the CBHFA e-learning, collaborated on linking the e-learning with other health programmes; • Initiated discussions with water and sanitation as to community prevention of emerging infectious diseases (EID) at the animal-human ecosystem interface (zoonoses) and maternal, newborn and child health (MNCH).

Output 1.1.5: Sets of cross-sectoral tools and guidelines are available.	• # of cross sectorial projects based on a joint work plan initiated per year • # of cross sectorial projects based on a joint work plan finalised per year	We have as well worked on a number of cross sectorial projects, mainly: • Addressed Gender in our newly developed Gender and HIV training module in English and French • Addressed Gender in the Water, Sanitation and Hygiene Promotion guidance note. • Worked in a cross departmental task team to expand the IFRC's collaboration with the Global Fund to fight AIDS, TB, and Malaria, and particularly in support of a Round 10 TB grant in Niger. • Developed a concept for the engagement of men and boys in HIV and sexual reproductive health (SRH), maternal, newborn, and child health (MNCH), and prevention of gender based violence (GBV). Unfortunately, funding did not materialize to take this concept further. • Worked jointly across Emergency Health (EH), MNCH and CBHFA programmes around a Nutrition capacity analysis and training, all in parallel to ongoing discussions between EH and Food Security; • EH and Shelter worked together to produce disability and shelter in emergencies guideline (in collaboration with Handicap International and CBM) • EH and Shelter produced a concept note to review emergency stove and lighting options for relief. • Collaboration between the EH and malaria teams to support the roll out of an emergency health focused RAMP survey in Sierra Leone.

Business Line 4: Heighten Red Cross Red Crescent influence and support for our work

OUTCOME: *Evidence-based humanitarian diplomacy conducted to draw attention to the causes and consequences of vulnerability, giving voice to vulnerable people, and demonstrating the value of Red Cross Red Crescent humanitarian work and leadership.*

Health outcomes and outputs	Indicators	Progress, achievements, constraints
Health Outcome 2.1: Key global health issues are influenced in accordance with RC RC mandate.		
Output 2.1.1: Key global health issues in accordance with RCRC mandate are addressed in international fora.	• Draft communication and advocacy strategy and plan for health by year • # of discussions on advocacy theme (video, ted roundtable) per year • # participants in the advocacy online fora per year • # of visitors to online discussion per year	Over the past two years, we have taken a more strategic approach to global advocacy. Members of our team have continued to reach various audiences with our global advocacy campaign on inequitable access to health and continued disseminating the advocacy report around health inequities (Eliminating health inequities) and the related resolution from the 31st International Conference of the Red Cross and Red Crescent (Resolution 6: Health inequities: reducing burden on women and children). We have worked together to develop a Health Corporate Folder that includes 14 corporate brochures for the different health subject areas. Additionally, we have developed a Health Corporate Presentation that is in line with the corporate folder. We participated in various International events, and organized/co-organized, when relevant, side events/discussions, mainly: • One Health Summit in Davos (Feb 2012); • World Water Forum in Marseilles (March 2012), panel on the humanitarian reform process, in addition to the WASH cluster meeting and event for World Water Day where we issued a web story and video; • World Malaria Day event at the EU Parliament in Brussels (April 2012) - co-hosted by RBM, Norwegian RC, IFRC, Malaria Consortium, PATH MVI and Malaria No More; • World Immunisation Week (WIW): The GAVI Civil Society Organisation (CSO) Constituency, in which IFRC is vice-chair and communication focal point of the steering committee (SC), produced a WIW statement; • During the World Health Assembly (WHA) convened in Geneva (May 2012), we represented the IFRC and delivered a plenary statement on Universal Health Coverage and statements on agenda items pertaining to NCDs, the Global Vaccine Action Plan (GVAP), Nutrition, and Polio Eradication. • At the request of the Partnership in Maternal, Newborn and

		Child Health (PMNCH), we joined speakers during the WHA, at the Born too Soon side event, to highlight the key role of the community and its leaders, in particular men, and RCRC volunteers in addressing maternal and children health against a backdrop of prematurity as the leading cause of neonatal deaths and the second cause of death after pneumonia in under five year old children worldwide. • On behalf of the IFRC, we co-hosted the WHA side event focusing on the role of civil society in operationalizing the GVAP, with WHO,UNICEF, the GAVI Alliance, Decade of Vaccines Collaboration(DoVC),Save the Children and GAVI Civil Society Organisation (CSO) Constituency and launched a video highlighting this key role. • Nuclear preparedness conference in Tokyo (May 2012) • The GAVI Civil Society Organisation (CSO) Constituency Steering Committee bi-annual meeting (June 2012) was hosted at the American Red Cross and chaired by IFRC bringing together representatives from organisations in India, Nigeria, Pakistan, Ethiopia, Malawi, Ghana, Cameroon, Uganda and including international NGOs such as Save the Children, Médecins sans Frontières (MSF) and Catholic Relief Services (CRS). • On behalf of IFRC, we co-hosted the Maternal, Newborn and Child Health (MNCH) Roundtable with Global Health and Diplomacy (GHD), Women Deliver and Management Sciences for Health (MSH) (June 2012); • Coalition for Cholera Prevention and Control Inception Meeting in Atlanta, Georgia; • Organized a Meeting with UNODC (June 2012) to follow-up on the MoU signed between IFRC and UNODC in May 2011 and discuss potential joint activities; • IFRC, Canadian Red Cross and GAVI CSO Steering Committee colleagues (June 2012) joined the Civil Society Forum convened at Family Health International (FHI 360) in events focusing on strategies for ending preventable child deaths. • IFRC joined the MNCH panel with the Canadian Red Cross

		chaired by PAHO at the November Canadian Conference on Global Health highlighting RCRC work in MNCH globally, with focus in the Americas • XIX International AIDS Conference where six events were organised: (1) live talk show on TB/HIV affected women and children jointly organised with Stop TB Partnership, (2) session on decriminalisation of drug users jointly organised with harm reduction International (3) HIV stigma and discrimination in the workplace in partnership with RCRC+, UN+ and IPPF+, (4) HIV in emergencies in partnership with UNAIDS, (5) HIV and Ageing and (6) HIV and vulnerable youth in partnership with American Red Cross. • Hosted and facilitated the Global WASH Cluster annual meeting in Nairobi, with over 80 emergency WASH practitioners and donors. • Hosted the Steering Committee Meeting of the Global Outbreak Alert and Response Network (GOARN)
Output 2.1.2: Reference materials for effective advocacy on health issues are available.	• # of advocacy reports per year	In 2012, we worked on the following advocacy reports/articles: • Continued to disseminate the health inequities report. • Launched the advocacy report: "Getting the balance right" between sanitation, hygiene and water. • Published an MNCH article "1000 critical days" in Global Healh and Diplomacy • Started the development of a Dengue advocacy paper (in cooperation with Climate Centre and Asia Pacific Zone, to be finalized in 2013) • Launched a Practical guide to collaborate with National Celebrities, in partnership with WHO and Stop TB Partnership. • Developed and disseminated the "Fighting Malaria with Bed nets: The driver for universal coverage in Cross River State Nigeria" report. • Prepared and disseminated a World AIDS Day communication package, including concept paper, audio-visual materials and key messages, internal IFRC event and material focusing on stigma and discrimination issues, RCRC+ Network and

		Masambo fund. • Launched an internal photo competition for World Toilet Day in October, and received an inspiring number of responses, photos, comments, and votes, demonstrating the dignity that a toilet provided by a RCRC programme can ensure. • RAMP communication report launched, profiling the roll out of 4 RAMP surveys to communicate ease of use, low cost and rapid results achieved during survey implementation. • Published TB Advocacy Report together with stop TB Partnership.
Health Outcome 2.2: RCRC 's work is recognized in International for a		
Output 2.2.1: National Societies' individual work is recognized in scope, scale, and quality.	• # of presentations on of NS program per year in international conferences • # of case studies published per year	In addition to technical support, we have as well attempted to promote the exceptional work that is conducted by National Societies through various means, including: • The production of a collection of CBHFA case studies 2012 where we showcased the individual work of 14 NSs. In the CBHFA mapping, we highlighted the work of 97 NSs in community health ; • During the XIX Inter-American Conference (March 2012), the Canadian Red Cross and IFRC America zone convened for a MNCH panel on Eliminating Health Inequities. IFRC health moderated deliberations between PAHO, and Canadian, Guatemalan, Columbian, and Bolivian Red Cross Societies; • During World Immunization Week (April 2012), and through a health communications web story, we highlighted the partnership between IFRC, eight National Societies, the Ministry of Preventative and Public Health, PAHO and national actors in conducting Haiti's integrated National vaccination campaign for all children (2.8 million) and women of reproductive age.
Output 2.2.2: The RCRC's collective work is recognized	• # of plenary appearances per year • # of abstracts and articles in publications per year • # of presentations on international	At Global level, we have intended to highlight RCRC work and show our contribution to different MDGs through various groups, networks, and global reports: • A UN Water annual mapping document (GLAAS) was released

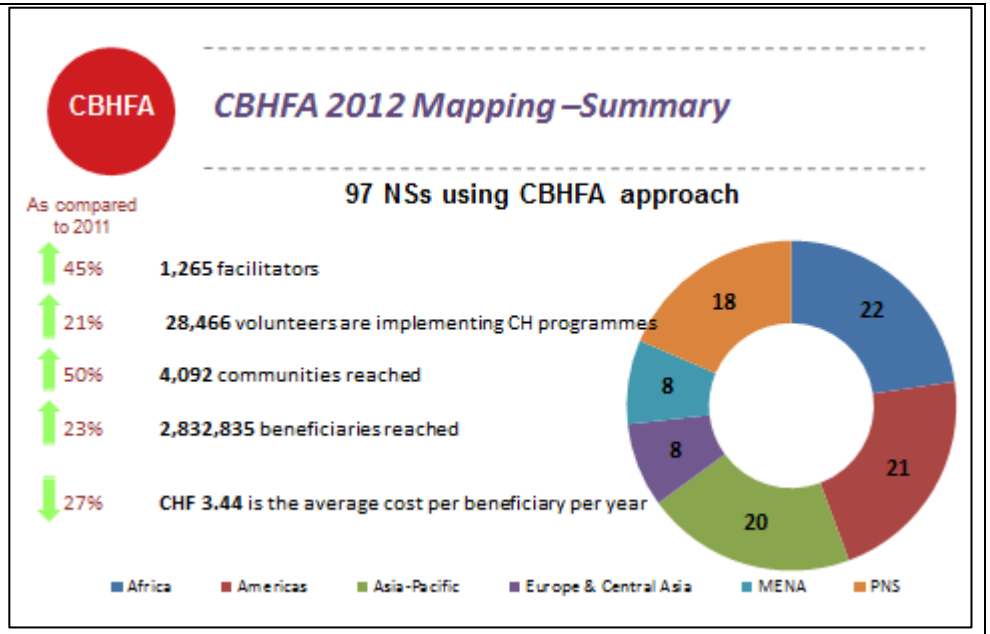
	conferences • # of visitors to online courses and events per year	that included significant mapping of Global Water and Sanitation Initiative (GWSI) projects worldwide, underlining IFRC & RCRC efforts in contributing to MDG targets; • IFRC was re-elected, unopposed, to the Strategic Advisory Group of the Global WASH cluster; • IFRC is part of the Core Group of the Global Health Cluster; • IFRC continues as Partner in the Global Polio Eradication Initiative (GPEI), Global Polio Partners Group, and the Measles & Rubella Initiative (M&RI); • IFRC holds vice-chairmanship and communication focal point roles in the GAVI Civil Society Constituency Steering Committee and an advisory role to the GAVI Board civil society representative;. • IFRC is a member of the expert group developing the WHO Guidelines on Management of Substance Abuse during Pregnancy; • Through our MNCH and CBHFA focal points, we are members of the CCM inter-agency Task Force. We continued to collaborate with the Canadian RC with regard to task shifting, as expert member of the WHO Recommendations on Optimizing the Delivery of Key Maternal and Newborn Health Interventions to attain MDGs 4 & 5 (Optimize4MNH). • At the invitation of Global Health and Diplomacy, IFRC penned the article titled maternal and child health article '1000 Critical Days' which was published in the summer edition "The Last Generation". This was shared at both the Child Survival and Rio+20 Summits (June 2012) and is available online. • Child Survival Summit and global Call to Action (June 2012) was convened by the governments of the United States, Ethiopia and India in collaboration with UNICEF. IFRC colleagues from health and humanitarian values and diplomacy, Standing Committee member from Mali, Canadian Red Cross, American Red Cross colleagues were invited to join over 80 countries' government representatives and partners from multilateral organisations, private sector, and civil society for a Call to Action to reduce global under five year old child mortality (deaths per 1000 live births) to 20 or less by 2035

		through implementation of A Roadmap to Ending Preventable Child Deaths, partnerships and pledges of which IFRC is signatory.

Business Line 5: Deepen our tradition of togetherness through joint working and accountability

OUTCOME: *More effective work among National Societies through modernised cooperation mechanisms and tools, and a greater sense of belonging, ownership, and trust in our International Federation.*

Health outcomes and outputs	Indicators	Progress, achievements, constraints
Health Outcome 1.1: National Societies have the technical support and knowledge to implement quality health programmes		
Output 1.1.3: Relevant quality standards and monitoring frameworks with their implementation and reporting guidelines are available.	• Draft HHA quality standards are defined and updated per year.(see above) • % of existing quality standards updated according to the HHA criteria per year • # of specific technical Quality standards are developed in accordance with the HHA per year	We have collectively finalized a department wide log frame 2012-2015 and programme log frames for 2012. Additionally, we have developed draft department metrics to monitor and demonstrate progress in various strategic areas (to be finalized at the beginning of 2013). Other main activities at programme level included: • A mapping of community health programmes using CBHFA approach in 2012 revealing that 97 NSs are using CBHFA approach, they have 1,265 facilitators *(45% increase compared with 2011)* and 28,466 volunteers *(21% increase compared with 2011*), they reached 4,092 communities *(50% increase compared with 2011)* and 2,832,835 beneficiaries *(23% increase compare with 2011)* with an average cost of CHF 3.44 per beneficiary per year *(27% decrease of cost compared with 2011)*



- We have continued the dissemination of the CBHFA PMER toolkit, developed in 2011 with support from the Planning & Evaluation team. The CBHFA 2012 mapping showed that 67% of NSs use the CBHFA PMER toolkit *(was 43% in 2011),* 69% of NSs have a logframe *(was 61% in 2011),* 62% have a M&E plan for the Community Health programme using CBHFA approach, 57% have a beneficiary / feedback mechanism. Baseline surveys were conducted in 32 NSs *(was 21 in 2011)* and endline surveys in 16 NSs *(was 6 in 2011),* 28% of programmes using CBHFA approach were evaluated during 2012.
- We have introduced a rotation initiative for core Delegates and NS staff within the WatSan/EH Unit. The initiative has proved successful so far and plans to broaden it within the whole health department are underway;
- A mapping of the Global Water and Sanitation Initiative projects revealing that in almost 7 years, the original target of serving five

		million people doubled to over ten million, with the intent to increase this to 15 million beneficiaries by 2015, with over 300 projects in 65 countries worldwide; • We have conducted a more in depth mapping of our emergency work indicating that on average we serve over 2 million beneficiaries per year with emergency water, sanitation and HP services; • We have supported the development and dissemination of a Kenya Red Cross Society and Global Fund report "How KRCS became Principal Recipient and prepared for the task of grant management" that will serve as a model for other National Societies wishing to engage with the GFATM. • The MNCH framework that we developed provides guidance for monitoring implementation of maternal and child health interventions.
• **Health Outcome 1.2:** National Societies have a wider range of partners, donors, and experts to implement relevant and innovative health programmes.		
Output 1.2.1: Strategic partnerships, in particular with governments, enable National Societies to anticipate global trends and emerging health issues.	• Developing and update of draft criteria for functioning partnerships, networks and technical expertise yearly • Draft Map of Global strategic partnerships developed and updated yearly • Draft Global Donor Map developed and updated yearly • # of functioning global strategic partnerships identified – following the criteria per year	We have developed a draft map of global strategic partnerships and emerging funding opportunities, to be updated on a regular basis. Additionally, a draft global donor map identifying global funding initiatives was initiated during December 2012, to be reviewed and improved during the first half of 2013. We have continued to maintain successful partnerships and developed new partnerships in various health areas such as: • Continued to chair the Alliance for Malaria Prevention partnership and currently hosting the Roll Back Malaria Central and Southern Africa region focal points. • Continued as vice-chair of the GAVI Civil Society Organization and host of their Communications Focal Point and Advisor to the board. • Re-elected unopposed to serve a further two years on the Global WASH Cluster advisory group. • Continued the collaboration with the World Bank through its Health, Nutrition, and Population Civil Society Group and participation in face to face meetings and teleconferences. • Continued to be part of the Toward a Safer World initiative from the UN System Influenza coordination (UNSIC).

		• Member of the consortium (Netherlands RC, IFRC, Oxfam, WASTE) to develop specifications for emergency sanitation equipment with funding received from OFDA. • Continued our engagement as core partner of ICG (International Coordination Group for Yellow Fever and Meningitis vaccines). The mandate of ICG is being expanded to cover the emergency stock of oral cholera vaccine stockpile by end of 2012. • We continue to contribute to ongoing maternal and child health partnership discussions related to MNCH and Immunization such as The Partnership in MNCH (PMNCH), Polio and child survival, social mobilisation and research with UNICEF, MNCH emergency technologies with WHO Reproductive Health and Research (RHR)/HRP, Immunization with International Paediatric Association (IPA) and GAVI CSO Constituency, Inter-Parliamentarian Union (IPU) and increased health equity through maternal and child health. • IFRC and the RCRC+ network were partners for the "Living 2012, Positive Leadership Summit" at the XIX International AIDS conference in Washington and contributed to the development of the "People living with HIV Global advocacy agenda" led by GNP+ (Global Network of PLHIV).
Output 1.2.2: Networks of expertise enable National Societies to anticipate global trends and emerging health issues.	• Draft Map or update of human expertise per year • Draft Map or & update of existing global networks per year • # of functioning global networks and reference centre following the set of criteria per year • # of experts registered following the criteria	The health team continues to closely work with the reference centres for Psychosocial Support and Climate Change. **For details about activities of the Psychosocial Support Centre, please see the PS Centre LTPF annual report 2012 (Annex 1) and the PS Centre financial statements for 2012 (Annex 2).** Very recently, a MoU was signed between the IFRC, Italian Red Cross and Villa Maraini in May 2012 on a Partnership on Research and Training in Harm Reduction. The steering committee was formed with representatives from all three entities to define further steps. IFRC and French Red Cross have signed an agreement to create the IFRC Global First Aid Reference Centre. This centre of excellence, originally a European reference centre, will develop first aid training in accordance with the Movement's recommendations and international

		scientific guidelines. Other areas of focus will include supporting National Societies in domestic training and network-wide information sharing, assuring quality management of first aid and supporting first aid harmonization within the Movement. The health team is as well developing and regularly updating online platforms for information sharing and discussion fora. Communities of practice, under FedNet, have been created for various health sectors and networks such as prehospital care, RCRC+ network, etc.
Output 1.2.3: Existing donors increase their support and new donors develop interest in funding health programmes.	• Draft Fundraising strategy new or updated per year • CHF available for funding for Global health per year • CHF available for NS through the global health per year	Key Partner National Societies have continued to support IFRC global health activities through financial and technical support, including Norwegian, Finnish, Swedish, British, American, Danish, Japanese, Swiss, Belgian-Flanders, Australian, German, and Canadian Red Cross Societies (among others). While the health team is working on a global donor mapping and fundraising strategy, various partnerships were successful and resulted in significant financial support to health programmes. These include, but are not limited to: • A cross divisional team project to expand collaboration with the Global Fund to fight AIDS, TB, and Malaria resulted in the IFRC being selected as the Principle Recipient on Round 10 TB treatment funds in Niger, with an approved budget of EUR 31 million (over five years) approximately; • Land Rover partnership has raised 1 million UK Pounds and will raise more for GWSI in Uganda; • OFDA funding secured through the IFRC led consortium for a two year sanitation research and development project. • Negotiations with Lilly Foundation led to additional two year financial support for implementation of MDR TB projects in seven countries as well as activities globally. Additionally, we have engaged with other potential donors such as: • UNITAID: An IFRC/Kenya RC Letter of Intent on Treatment as prevention was developed and submitted to UNITAID for the

		development of the US$ 34 million proposal; • IFPMA: At the end of 2012, we had ongoing discussions for a NCDs related partnership and planned to sign a MoU in the 1st quarter of 2013; • Several meetings, discussions concept papers were conducted and submitted to identify partnerships for NCDs (e.g. IOC, Special Olympics, Metronic, pharmaceutical companies). • USAID: Discussions regarding the existing standing agreement with IFRC and potential for expansion in next phase of grant – (ongoing); • AusAid: Submitted a GWSI funding package, with 4 countries in Africa and 6 countries in Asia/Pacific; • Coca Cola and DFID: engaged in GWSI negotiations for further scaling-up RCRC efforts; • Hansaplast: developed a concept paper to discuss the possibility for a global partnership in First Aid; • IFRC is signatory to Road map to Ending Preventable Child Deaths and its pledge. Discussions with partner signatories to be explored further; • UNF/Nothing But Nets: through the Alliance for Malaria Prevention, IFRC has benefited from a contribution to support LLIN scale up and will continue its engagement with UNF going forward.

Stakeholder participation and feedback

The key stakeholders in the global IFRC health activities are the global health team (including secretariat health staff in Geneva and Zones, and representatives from various IFRC reference centres) as well as National Societies. To ensure coordination and harmonization of approaches, various meetings and teleconferences are held on a regular basis, surveys and feedback is collected from National Societies. Over the past period, the global health team had gone through a long participatory process to develop its strategic operational framework for health. The latest draft was revised during the last quarter of 2012 to include additional analysis and background. The document is expected to be finalized during 2013.

We are planning to collect stakeholder feedback on a department wide level for the year 2013, as part of a "level of satisfaction" study through collecting feedback from a reference group of NSs and other stakeholders with regards to the different tools and materials developed and disseminated, the different trainings and technical support provided, as well as the various advocacy and communication activities we conduct. This "level of satisfaction" will be part of department metrics compiled and analysed to monitor and demonstrate progress in different strategic health areas.

Additional details of engagement and feedback covered by the various health programmes and initiatives can be found under the Progress Towards Outcomes section (programme evaluations outcomes).

Key Risks or Positive Factors

While there are specific risks and mitigation measures identified by individual health sectors, those listed below are common across all sectors:

Key Risks or Positive Factors	Priority **H**igh **M**edium **L**ow	Recommended Action
Inadequate funds to support key health positions, particularly for HIV/AIDS, MNCH/Immunization, and Voluntary Non-Remunerated Blood Donation.	High	Promote and develop proposals for unearmarked, flexible, and predictable funding, with support from the Strategic Partnerships team.
Aid budgets are increasingly under pressure, and resource mobilization for health is increasingly challenging (various reasons, including global economic crisis, increased bilateralism, etc.).	High	Various actions including: - diversification of donor pool, develop strategic partnerships - reaching out to non-traditional donors, particularly within the corporate sector - investing in operations research for evidence-based results and improved aid effectiveness - investing in advocacy and communication to better position ourselves and our member NSs

Limited adoption and implementation of global policies, tools, guidelines, and materials, as well as compliance with procedures and frameworks	High	Improve consultation process, and appropriate knowledge dissemination
Insufficient human resources due to lack of funding or lack of continuity	High	- Identify and fundraise for institutional global level funding to ensure core positions and support is maintained - Promote staff secondment by PNS - Allow for more flexibility in staff rotation and training

Lessons learned and looking ahead

A very large proportion of IFRC health programmes aim specifically to change behaviours, and some projects demonstrated behaviour change. During 2012, the health department has consolidated IFRC experience in behaviour change in light of recent behaviour change research and best practice both within and outside the movement, and consequently developed a behaviour change framework based on the following:

- Current evidence-based knowledge on behaviour change;
- Best practice in behaviour change both within and outside the movement;
- The very specific institutional context of the Federation and Strategy 2020;
- The very specific needs of all the technical areas and health programmes managed in the health department: HIV/AIDS, TB, malaria, noncommunicable diseases, WatSan/hygiene promotion, emergency health, First Aid, MNCH and immunisation, CBHFA, etc.

Several evaluations were conducted at NS level during the reporting period.

The IFRC developed a desk review to summarize key lessons learnt, challenges and recommendations on using the CBHFA approach based on eight different lessons learnt workshops, ten key evaluations and other related materials which took place during 2009-2011 (in total more than 20 documents). The “desk review” is prepared as a synthesis of key issues based on information gathered during the workshops and lessons learned reports provided by a number of NSs prior to the workshops. Various findings and recommendations were synthesized and can be shared upon request.

We have continued the dissemination of the CBHFA PMER toolkit, developed in 2011 with support from the Planning & Evaluation team. The CBHFA 2012 mapping showed that 67% of NSs use the CBHFA PMER toolkit *(was 43% in 2011),* 69% of NSs have a logframe *(was 61% in 2011),* 62% have a M&E plan for the Community Health programme using CBHFA approach, 57% have a beneficiary / feedback mechanism. Baseline surveys were conducted in 32 NSs *(was 21 in 2011)* and endline surveys in 16 NSs *(was 6 in 2011),* 28% of programmes using CBHFA approach were evaluated during 2012.

Four CBHFA lessons learnt workshops were conducted during 2012: in Africa (April 2012), Asia Pacific (October 2012), Global (November 2012) and Americas (December 2012)

In Water and Sanitation, we have initiated the concepts of “verification missions” and “look back studies” to revisit previous GWSI projects, analyse infrastructural outputs, and further promote post-project measurement of sustainability and impact.

For instance, we conducted with the BRCS a GWSI ‘verification mission’ in Zambia to confirm to the project partners that the infrastructural outputs of the project were completed successfully. Over 200 field sites were visited and indeed did confirm previous reports. More importantly, sustainability was measured as ‘high’ with over 90% of water points and over 80% of sanitation facilities in good working order three years after project completion.

Additionally, the team undertook an in-depth ‘look back’ study in Zimbabwe which was disseminated to RC/RC and external partners with the intent to better feed into and inform future and on-going developmental programming under the Global Water & Sanitation Initiative (GWSI). This process also allows more opportunity for beneficiary feedback and accountability to them and donors and partners.

During the last quarter of 2012, the team conducted an evaluation of the Global Alliance on HIV. Key findings included:

- Substantial contribution with 90 million people reached between 2008-2010 with significant contribution to Community home base Care and support interventions for PLHIV and OVC.
- Repositioned NS with their decentralized network, local reach, and large numbers of volunteers trained
- Effective support by IFRC to build NS technical and managerial capacities and produced documentation and guidance
- Successfully established an HIV performance monitoring system across IFRC.
- The application of the “seven Ones” principles improved coordination of the Secretariat with zone teams, NS and other key HIV actors and had a positive effect on HIV programming through harmonization, coordination and improved managerial processes.

However, lessons learned included:

- Lack of a clear global, regional, and country resource mobilization strategy and resourcing in a global financial crisis left NS’s with unfulfilled expectations and ambitious targets that were not met.
- Limitations of a globally-lead program demonstrated that a vertical, ‘one-size-fits all’ approach does not work.
- Planning, monitoring and evaluation of the Secretariat HIV activities were poorly developed.

Financial situation

Click here to go directly to the financial report (Health Department’s report within wider Programme Services Division Report).

How we work

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

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

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

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

Find out more on www.ifrc.org

Contact information

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

- **In the IFRC Geneva Secretariat Office**
  - Stefan Seebacher, Head of Health Department; stefan.seebacher@ifrc.org; tel. +41 22 730 4435; and fax +41 22 733 0395.
  - Rania Alerksoussi, Officer, Coordination & Planning Support; rania.alerksoussi@ifrc.org; tel. +41 22 730 4610; and fax +41 22 733 0395.