



Annual Global Health Report
Health Department
2014

Table of Contents

Foreword	1
Health Report 2014	2
Annexes	
<i>Annex 1 Community Based Health and First Aid (CBHFA)</i>	15
<i>Annex 2 Noncommunicable Disease (NCDs)</i>	18
<i>Annex 3 Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCAH)</i>	20
<i>Annex 4 Water and Sanitation (WatSan)</i>	23
<i>Annex 5 Emergency Health (EH)</i>	25
<i>Annex 6 HIV</i>	27
<i>Annex 7 Tuberculosis (TB)</i>	29
<i>Annex 8 Malaria</i>	31
<i>Annex 9 Global First Aid Reference Centre</i>	33
<i>Annex 10 Psychosocial Support Reference Centre</i>	36



An elderly man drops a dose of polio vaccine into the mouth of a young girl; he is a volunteer. A young woman holds a needle to the arm of a scared baby boy; she is a volunteer. A nurse bandages a head wound in the hours after an earthquake, holds an IV bag as a woman hit by shrapnel is loaded into an ambulance; they are volunteers.

These images are iconic within the International Red Cross and Red Crescent Movement. They speak to our presence, through National Societies and their volunteers, in communities right around the world. They reflect the critical role that we play in these communities, and the central role that we have played in health since we were founded more than 150 years ago.

They are also iconic images within the wider humanitarian community.

As this annual report notes, a lot of progress has been made over the past 20 years. Global under-five mortality rates have dropped considerably, and the toll of communicable diseases like HIV and AIDS, malaria and polio has also lessened. How much of this could have been done without the Red Cross Red Crescent? How much could have been achieved without the volunteers who took the needle to the arm, who shared information on malaria control and prevention, and who provided health services in the wake of disasters?

Red Cross and Red Crescent volunteers have strengthened and extended community and emergency health systems, bridging the gaps between communities and health services. National Societies have supported governments to strengthen and develop national health policies and country coordination mechanisms, creating environments that are more conducive to meaningful change.

This report summarizes some of the important results achieved through our collective efforts. In 2014, 109 National Societies used the Federation-developed Community-Based health and First Aid approach for their community health programmes. Together, they reached more than 5 million people with health promotion and behaviour change information. With Federation support, Red Cross and Red Crescent volunteers provided direct advocacy and preventative interventions to 70,000 people vulnerable to tuberculosis, and more than 24,000 trained and resourced volunteers were able to engage in malaria prevention and control activities worldwide. Working in partnership with 104 National Societies, we supported the implementation of 450 water and sanitation projects in 80 countries.

But we know that needs are ever increasing and we are committed to do more. In many communities, the threat posed by communicable diseases is now rivalled by the rise of non-communicable or 'lifestyle diseases'. As more and more people move to cities, many now live in informal settlements with poor access to clean water and basic sanitation. The risk of new epidemics remains ever present, as we saw most cruelly with the Ebola outbreak in West Africa. The Ebola outbreak demonstrated the value of the Red Cross and Red Crescent. It was Red Cross volunteers who took on the dangerous but critical task of burying those who had died from Ebola, safely reducing the threat that the highly contagious bodies posed, all the while treating communities and their dead with dignity and respect.

We could do this because we are always there, right where we need to be, alongside communities. Our goal as a Secretariat is to make sure that our National Societies and volunteers have the training, expertise and resources that they need to deliver all that they can, helping communities to become stronger and more resilient in responding to the many challenges they face.

Elhadj As Sy
Secretary General, CEO
International Federation of Red Cross
and Red Crescent Societies



1. SITUATION ANALYSIS

1.1 Health at a glance

- Health has been recognized as central to international development for more than 20 years, and major efforts have been made to reduce morbidity and mortality either universally, or through a focus on specific population sub-groups (e.g., “the poor”, “women and children”).
- The global health landscape looks more optimistic than ever, although progress has been uneven (see Box 1).
- By 2013, **global under-five mortality rate** had decreased by 48 per cent. The 10 countries with the highest child mortality are all in sub-Saharan Africa. This region not only has the highest burden of communicable, neonatal, and nutritional diseases, it also has the highest burden of noncommunicable diseases (NCDs) in young children (e.g., sickle cell disorders, congenital anomalies, epilepsy and asthma). A child born in western sub-Saharan Africa is almost 30 times more likely to die by the age of five than a child born in Western Europe.
- **Maternal mortality** has not shown sufficient progress. It accounts for 9.1 per cent of all deaths among women aged between 15 and 49. In developing regions, only half of pregnant women receive the World Health Organization (WHO)–recommended minimum of four antenatal care visits.
- The general pattern of the **epidemiological transition from communicable disease toward NCDs** has occurred in many regions. Since 1990, the number of deaths resulting from communicable, maternal, neonatal and nutritional causes has decreased by more than a quarter, whereas deaths from NCDs and injuries increased by about 41.8 and 10.7 per cent respectively (See Figure 1).¹

BOX 1: [The Lancet Global Burden of Disease Study 2013](#)²

According to The Lancet:

“Global **life expectancy for both sexes increased** from 65.3 years in 1990 to 71.5 years in 2013, while the number of deaths increased from 47.5 million to 54.9 million over the same interval. Decomposition of global and regional life expectancy showed the prominent role of reductions in age-standardised death rates for cardiovascular diseases and cancers in high-income regions, and

¹ The state of global health in 2014, Jaime Sepúlveda and Christopher Murray.

² [www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(14\)61682-2.pdf](http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(14)61682-2.pdf)

reductions in child deaths from diarrhoea, lower respiratory infections, and neonatal causes in low-income regions.

HIV/AIDS reduced life expectancy in southern sub-Saharan Africa. For most communicable causes of death both numbers of deaths and age-standardised death rates fell whereas for most non-communicable causes, demographic shifts have increased numbers of deaths but decreased age-standardised death rates. Global deaths from injury increased by 10.7%, from 4.3 million deaths in 1990 to 4.8 million in 2013; but age-standardised rates declined over the same period by 21%.

For some causes of more than 100,000 deaths per year in 2013, age-standardised death rates increased between 1990 and 2013, including HIV/AIDS, pancreatic cancer, atrial fibrillation and flutter, drug use disorders, diabetes, chronic kidney disease, and sickle-cell anaemias. **Diarrhoeal diseases, lower respiratory infections, neonatal causes, and malaria are still in the top five causes of death in children younger than 5 years.** The most important pathogens are rotavirus for diarrhoea and pneumococcus for lower respiratory infections. Country-specific probabilities of death over three phases of life were substantially varied between and within regions.

For most countries, the general pattern of reductions in age-sex specific mortality has been associated with a **progressive shift towards a larger share of the remaining deaths caused by non-communicable disease and injuries.**"

Figure 1

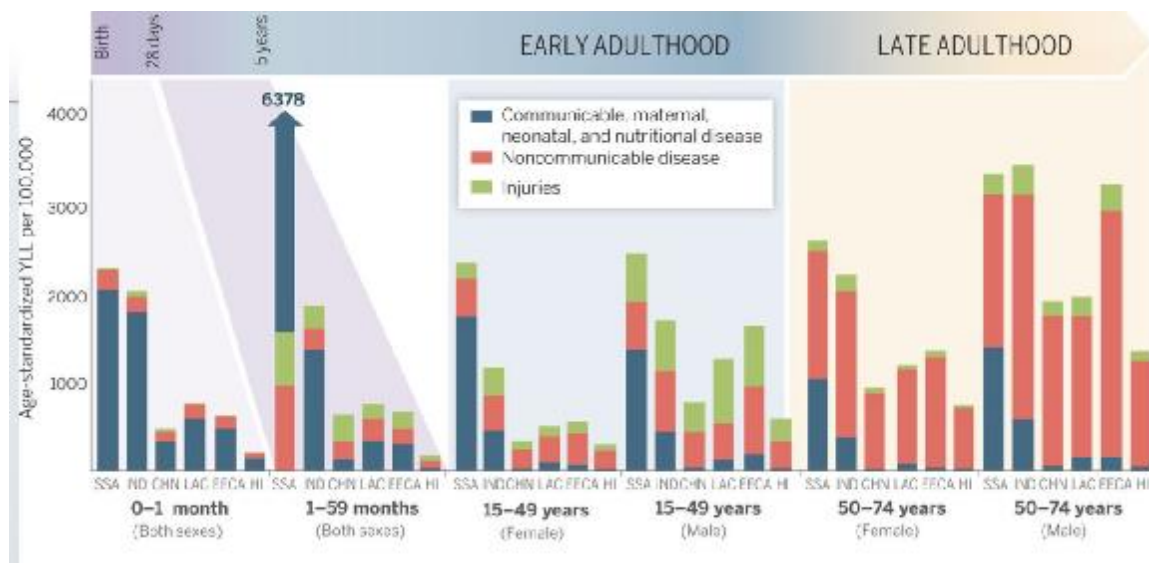


Fig. 1 The burden of disease across various life stages and regions due to specific cause categories, depicted as age-standardized YLL per 100,000 (Source: Jaime Sepúlveda, and Christopher Murray, Science 2014;345:1275-1278)³.

In addition, new health emergencies are affecting health related work, namely the re-emergence of polio in the Middle-East, the Ebola outbreak in West Africa, the emergence of Middle East Respiratory Syndrome Coronavirus and the spread of Chikungunya to the Caribbean and Latin

³ The burden of disease across various life stages and regions due to specific cause categories, depicted as age-standardized YLL per 100,000. These six geographical regions cover most but not all of the world's population, and their selection is intended to show important regional variations: sub-Saharan Africa (SSA); India (IND); China (CHN); Latin America and Caribbean (LAC); Central Europe, Eastern Europe, and Central Asia (EECA); and high income (HI). The burden of communicable, maternal, neonatal and nutritional diseases in SSA exceeds the YLL scale, and ages 5 to 15 and 75+ years are not shown.

America. These are just a few examples of how infectious diseases continue to burden some of the most vulnerable communities, and how unexpectedly severe the impact can be as disease patterns and their geolocations change. Red Cross and Red Crescent National Societies keep responding to these health emergencies; yet new public health and emergency medical needs keep appearing almost by the day as migrants arrive at the shores of Europe, acts of terror kill and maim hundreds of students in an African university, chronic conditions in fragile states worsen and large scale disasters, complex conflicts and movement of people increase (IFRC analysis/own experience).⁴

1.2 A changing and volatile landscape: complex challenges, new opportunities and our response

Science and medicine have made incredible progress, but their benefits are poorly distributed, as highlighted above. The prevention and management of health issues, particularly chronic diseases, are more complex as both require behaviour change, more sophisticated cradle-to-grave health management systems and a holistic approach to health and its determinants. Meanwhile, in richer countries, the appetite for public spending on humanitarian operations and development aid is diminishing amidst growing domestic inequalities. As a result, policymakers are less inclined to support the ever increasing number of disaster-prone, conflict-ridden fragile and failed states.

While the health team is maintaining its focus towards strengthening our response to infectious disease, with increased attention to the top killers, namely malaria, diarrhoeal diseases, tuberculosis and HIV, we are also leading the Movement in expanding to NCDs by integrating NCD prevention and control in the community health approach, and exploring new avenues towards behaviour change. The health team continues to focus on the most vulnerable age groups, namely new born, children and mothers, in an integrated package of interventions, including immunization and strong water, sanitation and hygiene promotion programming, both for acute and chronic contexts. These priorities are based on the health team's analysis of the global trends.⁵

There are nevertheless new opportunities that the health team is seizing to better serve vulnerable communities around the world. These new opportunities are political, financial, conceptual and technological but need to be grounded in proven and tangible evidence-based measurement of impact and sustainability to scale.

A renewed political commitment. Despite mixed results in terms of equity and sustainability, the United Nations Millennium Development Goals (MDGs) have made an impact and contributed to greatly improve maternal, infant and child mortality, increase access to water (although significantly less so to sanitation), and avert millions of deaths from malaria and tuberculosis. Renewed political commitment with the Sustainable Development Goals (SDGs) will pave the way to new and more complex global partnerships and funding mechanisms. Resources will be channelled to **in-country mechanisms or global entities to strengthen national health systems, rather than towards disease-specific projects.** The effectiveness of health systems will be measured in terms of equity and universal access to health services, water and sanitation and improved hygiene.

The health team's constant advocacy for health equity⁶, community health and universal health coverage⁷ has set the stage for greater involvement of National Societies in their countries' health systems. In 2014, the health team has been particularly active in advocating for the role of communities and the community health workforce in improving access to health services in fragile states. It has also actively promoted a shift in approach from responding to isolated outbreaks (for example, of dengue) to investing in long-term, integrated programming, including community initiatives leading to sustainable behaviour change. In areas like the prevention and treatment of

⁴ Additional information on number of people affected by conflicts, who fare the worst in conflict (distinction between IDPs, refugees, and conflict-affected residents), health conditions, vaccination coverage, malnutrition and child deaths can be found in CRED 2013 publication on Humanitarian needs in numbers.

⁵ https://docs.google.com/document/d/1Z416IH5UJHb19aV3DSC9Fmlmx1KIRT7NKL_Si9fnv49s/edit?usp=sharing

⁶ IFRC Health Policy, 2005, International Conference Resolution 6 on Health Inequities, 2011, IFRC Eliminating Health Inequities: Every Woman and Child counts, 2011, and our 2013–2015 communication and advocacy long-term initiative on access to health care.

⁷ IFRC Statements to the World Health Assembly, 2012 and 2013 and IFRC Declaration on the post-2015 Humanitarian Agenda, Sydney 2013.

HIV, malaria and NCDs, the IFRC has been advocating for increased attention to community service delivery systems and for positioning the Red Cross and Red Crescent as a key contributor in strengthening community systems, including in fragile states and situations.

New funding approaches. Demand for greater transparency and accountability to a greater number of stakeholders (including better informed citizens and a fragmented civil society) is pressuring traditional donors toward providing fewer subsidies and more **results-based funding**. Likewise, the corporate sector and private foundations are increasing their contribution by investing in social and economic impact (social impact investing) rather than increasing their corporate social responsibility donations. **They will invest in scalable systems that demonstrate long-term sustainable impact as opposed to subsidising small scale projects and “pilots”.**

The health team recognizes the fact that scale and sustainability are more likely to be achieved by demand-driven approaches that empower people rather than by technocratic top-down supply-driven programmes that give little thought to human motivations and incentives.

The Global Water and Sanitation Initiative (GWSI) is one successful example of scalable and sustainable approaches. Launched in 2005, GWSI was originally planned to target five million people over 10 years, but will triple its target by 2015 with 15 million people reached in 80 countries with water, sanitation and hygiene promotion services at scale where demand is greatest. GWSI is setting standards in data-driven mapping of needs and programmatic outcomes.

The Health and Legal departments, in close coordination with some National Societies, are also exploring innovative funding mechanisms (social impact investing) to implement the [IFRC Framework for Community Resilience](#) and rapidly scale up Red Cross Red Crescent programmes. The rationale is eloquently expressed in the Cali [One Billion Coalition](#) for Resilience: “We call on partners from the private sector to invest in communities beyond your immediate stakeholders, acknowledging that the resilience of communities directly impacts your business”. One candidate programme is Community-based health and first aid (CBHFA) in Prison.⁸ The health team is already partnering with private global leaders, like Nestlé, Land Rover, Cartier, Procter & Gamble and Eli Lilly. We will continue to diversify and increase our funding from the private sector.

New conceptual thinking. The IFRC Framework for Community Resilience stipulates that strengthening community resilience requires a demand-driven people-centred approach. It embraces the complexity of communities and human behaviour, and champions the empowerment of volunteers in their communities because volunteers are most likely to understand the complexity of their context. The Framework promotes a holistic systems approach in line with current thinking in health, i.e. the realization that we need to integrate and strengthen national health systems and community health systems.⁹ The health team is promoting the systems approach with realist evaluations as a means to understand what works, for whom, in which contexts and why.¹⁰ It is through this approach that the IFRC, with its academic partners, can build the evidence base for Red Cross Red Crescent programmes and services.¹¹

It is also moving towards strengthening systems by reviewing IFRC’s CBHFA approach to focus on community health volunteer motivation and performance, and behaviour change. It is also seeking to emphasize the health systems strengthening components of IFRC’s framework for Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCAH) programming. These efforts will continue throughout 2015.

New technology. Digital technology is transforming the humanitarian landscape in the same way it revolutionized media, banking, retail, transportation, i.e. every sector of human activity. This is a

⁸ IFRC Impact Investment and the IFRC – background paper, Geneva 2014

⁹ WHO Systems Thinking for Health Systems Strengthening, Geneva 2009

¹⁰ Pawson and Tilley, Realist evaluations, 2004

¹¹ Vareilles G. et al. Understanding the motivation and performance of community health volunteers involved in the delivery of health programmes: a realist evaluation protocol, BMJ online 2014

global **cultural revolution** with profound consequences: for the first time in the history of humanity, youth are more empowered than their elders, and people more powerful than governments. Digital technology can and will empower people in the most vulnerable communities, connecting them among themselves as well as to Red Cross Red Crescent branches, thus creating a truly global humanitarian network that will change the way we work. The health team is experimenting, with the technical support of Google, the healthy lifestyle Massive Open Online Community (MOOC) and the Lean Startup approach to project design and management. We are also developing mHealth approaches to project management, building on National Societies' experience with mobile phone-based surveys (RAMP).

2. OUR STRATEGIC APPROACH: RESULTS

2.1 Strategic Operational Framework for health

The Strategic Operational Framework (SOF) for health specifies the vision, mission and goals of the Global Health Team.¹²

Vision (Strategy 2020): 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.

Mission: We will work on a systematic basis to build capacity in, and support, National Societies in their health programmes, encouraging them to innovate, adapt and learn from examples of good practice elsewhere. We will promote an increase in the scale and quality of programmes, ensuring sustainable improvement in health services, while at the same time addressing resilience, health inequities and emerging trends in global health. We aim to achieve a harmonized Federation-wide approach to planning, performance management and accountability in health programming.

The SOF defines two goals and five operational directions:

Goals

- Build further upon National Society capacity to enable safe and healthy living and to respond appropriately to health emergencies and crises, by reducing vulnerabilities and building resilient communities
- Position Red Cross Red Crescent as a leading strategic partner to improve global health

To meet these goals, the health team has set **five operational directions:**

1. Improve programming quality
2. Scale up programming
3. Work holistically as a Federation
4. Improve communication and advocacy
5. Maintain existing business and create new, actively seeking alliances and partnerships

Operational direction 1: Improve programming quality

Ensure integrated, holistic programming: In Burkina Faso the RMNCAH programme implemented by the Burkinabe Red Cross Society with support from the IFRC and the Norwegian Red Cross aims at bridging the gap between health facilities and communities with a specific focus on access and strengthening local community health systems. The community health programme focuses on health promotion for pregnant women, women of childbearing age and children under five years. The aim is to promote behavioural and social change in relation to preventive and curative health

¹² IFRC Strategic Operational Framework for Health, 2012

care, while supporting the efforts of the Ministry of Health. Community engagement and social mobilization are core components of the programme. Expanding the use of mobile data collection tools for monitoring and evaluation will ensure quality implementation and give a more cost-effective means to monitor the whole project cycle.

Encourage partnerships: Tuberculosis (TB) diagnosis and access to appropriate treatment of multidrug-resistant TB (MDR-TB) remains a challenge, particularly in Eastern European countries. The IFRC, with the support of Eli Lilly Foundation is addressing this issue through a multi-country grant which is supporting over 700 most vulnerable MDR-TB patients on a daily basis. In Georgia for example, in collaboration with the Ministry of Labour, Health and Social Affairs and the National Centre for Disease Control and Public Health, the Georgia Red Cross Society complements the work of the formal health system by providing support and care to those suffering from MDR-TB and their families. Community health workers are not only delivering care, support and monitoring treatment adherence at dispensaries but also, and crucially, beyond the dispensary door, in patients' homes.

Monitoring and evaluation: Rapid mobile phone-based methodology (RAMP): We have used the [RAMP methodology](#) as part of our community health programmes, including for RMNCH baseline data collection in Burkina Faso. The RAMP user guide for RMNCH includes a comprehensive set of indicators, sample questionnaires, and survey guidance. The user guide suggests household sampling approaches that use available administrative population data (often limited and outdated in rural contexts) and complements them with a household census and/or the use of Google Earth imagery and GPS coordinates for village and household mapping in order to select a truly representative sample of households for a survey that is free from bias. A similar exercise will be conducted as part of the GWSI programmes in early 2015. We plan to develop standard RAMP monitoring and evaluation tools with defined water, sanitation and hygiene promotion indicators.

In addition, the CBHFA approach to monitoring and evaluation has informed an increasing number of evaluations and researches in the last few years, including 21 programme evaluations, 34 baseline and 18 end line surveys using the updated CBHFA Planning, Monitoring, Evaluation and Reporting methodology.

Mappings and data quality: defining quality data collection needs: We have designed an online survey questionnaire for National Societies to provide information on their domestic health programmes. The aim was to have a global picture of the health activities of National Societies, priorities and needs, as well as their financial and human resources. A response was received from 108 National Societies and once analysed, a good overview of their activities in the health sector was formed. Similarly, the CBHFA global 2014 mapping includes data from 109 National Societies that use the CBHFA approach in their community health programmes.

After analysing responses further and comparing our mappings with other sources of data, we have identified a number of issues related to data quality, particularly in relation to the estimated number of people reached and how numbers are aggregated, among other issues. We have highlighted a series of recommendations that will be shared early in 2015 and will inform our data management systems.

Systemic research and learning: Uganda and Ethiopia realist evaluations: An effective programme requires context-specific plans and designs. We need to understand what works, where and for whom, since contexts are different depending on various influences. For example an RMNCH evaluation conducted in Ethiopia showed the need for a stronger data management system and supported the requirement to learn about volunteers' motivation and to upgrade volunteer management systems.

Operational direction 2: Health programmes at scale

Scaling up in fragile states: Since 2013, the IFRC, Ministries of Health and the Global Fund to Fight AIDS, Malaria and Tuberculosis have worked together to address malaria, HIV and TB in two very

challenging environments, Central African Republic and Niger. This collaboration is paving the way to the expansion of Red Cross Red Crescent work in addressing these three diseases at scale in fragile states. The programme is being used as an opportunity for strengthening National Society capacity to deliver in complex humanitarian situations.

In Central African Republic, despite the near total collapse of the health system in 2014 due to internal conflict, the IFRC supported the Ministry of Health and partners to distribute more than 500,000 malaria nets and more than 450,000 ACT treatments for malaria through 371 health facilities within the country. At the same time, the IFRC Reference Centre for Psychosocial Support provided support to Red Cross volunteers engaged in dead body management.

Example of the Global Water and Sanitation Initiative: Zimbabwe Red Cross Society, with support from IFRC and British and Finnish Red Cross, is entering the final year of eight years of water, sanitation and hygiene promotion developmental programming under GWSI. Over 200,000 people will have improved their access to water, sanitation and better hygiene by the end of 2015 and the Zimbabwe Red Cross Society is a partner of choice in the sector as a result. This is only one country of the over 80 who have benefited from the GWSI support.

Operational direction 3: Working holistically as a Federation

Framework for Community Resilience: the health team actively participated in authoring the framework for community resilience adopted in Cali in November 2014 and endorsed by the Governing Board immediately after. The resilience framework will guide the revision of CBHFA to ensure it meets the principles of community systems strengthening and demand-driven, people-centred, health programmes as domestic services managed by empowered branch and community volunteers. We expect this successful example of cross-sectoral collaboration will continue in the coming years as the resilience framework broadens its scope to health crises and epidemic preparedness, moving away from its original natural disaster focus.

Examples from the work of Reference Centres: the Global First Aid Reference Centre, hosted by French Red Cross in Paris, is coordinating with a number of National Societies on the development of the First Aid and Resuscitation Guidelines for 2015. The Red Cross Red Crescent Evidence Based Group, and the leadership and guidance of the reference centre is also collaborating with the Centre for Evidence-Based Practices and the International Liaison Committee on Resuscitation

The IFRC Reference Centre for Psychosocial Support, hosted by the Danish Red Cross in Copenhagen, enables and supports National Societies on issues related to psychosocial support. PSS remains a crucial component of many health and emergency health programmes, for example the Ebola operation in West Africa.

Red Cross Red Crescent health networks: between November 2013 and early 2014, the health team commissioned a mapping of internal health networks to better understand the conditions under which networks function, with the ultimate aim of improving the relevance and availability of expert networks and groups to respond to various National Society needs. There were diverse opinions on the measures of effectiveness of networks despite the fact that they all have a common purpose: to extend access to expertise and improve the capacity of National Societies to meet health needs. The mapping report also highlighted critical success factors and several recommendations for the health team.

Learning strategy: the health team reflected on how it could become a more effective learning entity. With the help of an organizational learning expert and Prof. Karen Watkins of the University of Georgia, the health team identified and tested a wide range of simple and low cost ways of

enhancing informal learning and performance. The learning strategy will guide our learning objectives for 2015.¹³

Operational direction 4: Improve communication and advocacy

Communication and advocacy strategy: The health team endorsed the 2014–2015 communication and advocacy strategy and plan, focusing on the overarching “access to health services” initiative.

As part of the 2014 plan, the IFRC co-hosted and participated in three high level events during the [2014 World Health Assembly](#), together with strategic partners and donors. The events on fragile states, NCDs and community health care represented a key opportunity to position the work of Somali Red Crescent Society, Maldivian Red Crescent and Sierra Leone Red Cross Society. Leaders from National Societies spoke on behalf of the Movement and advocated for equitable access to health and the role of community health volunteers. The participation of the health team in [the International AIDS conference](#) in July was also an occasion to position the Red Cross Red Crescent as a key contributor in strengthening community service delivery systems, including in fragile states and situations, and advocate for the recognition, protection and support of health volunteers as key to accelerate progress towards universal access to HIV testing and treatment services.

Dengue advocacy report: [Denque: Turning up the volume on a silent disaster](#) was launched as part of the “silent disaster” and “access to health” long-term initiatives. The report advocates for a complete shift in approach from responding to isolated outbreaks to investing in long-term programming, including highlighting the role of health volunteers in strengthening access to health preventive and care services. The combined effort of zones, regions and National Societies has amplified our communication outreach and demonstrated the power of our communication efforts (more than 300 media hits).

Global First Aid Initiative 2015–2020: the health team developed, in consultation with nine National Societies, a communication and advocacy strategy and plan to roll out a global initiative to enhance, expand and improve first aid trainings worldwide as a key component of the health and resilience approach. The strategy will inform the development of the One Billion Initiative.

Research seminars and publications: the health team organized three research seminars on volunteer motivation and performance in community health. The first focused on the realist evaluation approach, the method of inquiry identified to address the complexity of community health interventions and human motivations. The second seminar presented the realist evaluation protocol for the Uganda Red Cross evaluation of volunteer motivation and performance in a CBHFA project in Kampala. The third seminar presented findings and recommendations from the Kampala study and other research on volunteer motivation. The Uganda study protocol was published in [BMJ online](#)¹⁴ and the results should be published in 2015.

Operational directions 5: Alliances and partnerships

Google partnership: [Healthy Lifestyles Community](#) (HLC) is a free, interactive online platform for users to help their friends, family and communities reduce their risks of developing NCDs by changing risky habits. HLC was developed in partnership with Google. The HLC English version was launched in June 2014 and the Spanish version in January 2015 (Comunidad Vida Saludable). With around 10,000 visitors to the English and Spanish platforms to date, HLC is

¹³ Sadki, Reda, Learning to learn better and faster: A strategy for the IFRC Global Health Team to strengthen learning culture and performance in the Red Cross Red Crescent context, Geneva, March 2015

¹⁴ Protocol submitted in 2014: Gaëlle Vareilles et al, Understanding the motivation and performance of community health volunteers involved in the delivery of health programmes in Kampala, Uganda: a realist evaluation protocol, BMJ online, 2015

already a tremendous success. The HLC initiative won the [Google Research award](#) in November 2014. The award supports cutting-edge research in computer science, engineering and related fields including online education and social networks. The USD 50,000 award will help IFRC to further develop this project in 2015.

Impact investment for the Red Cross Red Crescent: Sustainable funding requires us to improve our reporting on outcomes and impact. Community health, water and sanitation, RMNCH, etc. are all designed around logical frameworks that guide M&E. As data management systems improve, we will be able to systematically collect data for well informed and responsive health projects, measuring improvements in health outcomes and mobilizing resources from a wider range of sources, including the private sector in the shape of impact investments, social franchises and social bonds. In 2014, the health team explored these alternative approaches to scaling up and sustaining programmes. Prospective proofs of concept include CBHFA in prisons, an accreditation system for civil society partnerships, moto-ambulance services for RMNCH, RAMP as a data management system for responsive project management, etc.

2.2 National Societies and their branches at the centre of health

What did we learn from the mappings (Global Health, CBHFA, and water and sanitation)?

The [Global Health mapping](#) provided essential information about more than a hundred National Society domestic health activities in 2013, including expenditure, staff and volunteers working on health, as well as National Society expectations of the health team's role. Unsurprisingly, National Societies reported first aid (100 per cent) and blood services (79 per cent) as their core health activities. Many National Societies reported HIV and psychosocial support activities, while fewer than half reported malaria and MNCH activities. Responses provided insight on other activities not currently supported by the health team, like mental health, facility management, and ambulance services.

We also analysed data to evaluate the relevance of the Strategic Operational Framework for Health as well as our programming in relation to the national burden of disease. Malaria and HIV data were used as examples for further analysis. Findings confirmed the relevance of HIV and malaria programming. Gaps, however, remain, suggesting outstanding opportunities for National Societies to engage, as long as they are provided with adequate resources.

Other sources of data related to National Society health programming included the CBHFA Global Mapping survey, the GWSI project database, and the FDRS database. Unfortunately, there were many variations in figures reported (e.g., number of people reached), suggesting that more guidance is needed on reporting of "reach".

Our accountability to National Societies and people: nothing for "National Societies without National Societies"

The health team provides services to National Societies, by reinforcing (1) the National Society auxiliary role in the national health system, (2) building capacity at branch level to best serve vulnerable populations and ensure sustainable health outcomes, and (3) advocating on key issues of concern and positioning the work of National Societies as partners of choice in health.

The Health department builds National Society capacity in different ways. It designs projects and prepares grant proposals with and for selected National Societies. It conducts evaluations and look-back studies on selected programmes to inform the design of new projects. It is designing and testing data systems to improve programme quality and responsiveness (RAMP) and provides support to analyse baseline and end line surveys.

The health team also develops tools, trainings, provides technical guidance and organizes regional and global workshops for the health staff of National Societies, such as the global and regional community health workshops focusing on CBHFA, NCDs and RMNCH, water, sanitation and hygiene promotion.

During key strategic meetings and fora (e.g., World Health Assembly), the health team documents the work and supports the engagement of National Societies as key speakers on behalf of the Movement.

In 2014, our ambition to work more closely with National Societies has been somewhat hindered by a complex decentralization structure.

2.3 Our systemic approach: how do we improve and sustain health for people?

The health team is responsible for knowledge management, systems design, coordination and facilitation.

Community health systems

Our tools and trainings inform the delivery of the community health initiatives of National Societies. Among others, we completed the [Healthy lifestyle toolkit](#) with the NCDs prevention module (CBHFA module 8). The module builds on the existing CBHFA tools, incorporating behaviour change methods to increase knowledge and equip communities and individuals with the tools to make healthier lifestyle choices. We also launched the CBHFA e-learning in English, Spanish and French with around 6,000 registrations by the end of 2014 (74 per cent increase from 2013).

Global learning workshops complemented our online learning platforms (i.e. CBHFA delegate training, CBHFA in prisons, CBHFA and RMNCH master facilitator workshops).

The CBHFA approach needs to be updated to increase relevance, usability, sustainability and scalability of the tools and approach. IFRC, in close consultation with National Societies, is working on evolving its CBHFA approach so that it becomes a platform for health and resilience, better addresses the key lessons and challenges from the last ten years of implementation and focuses on the new post-2015 sustainable development agenda. A background paper on facts and trends affecting community health and a discussion paper outlining the key concepts on upgrading the IFRC community-based approach in 2016 were developed and shared with National Societies for feedback and input. In addition, a discussion paper on NCDs and a vision outlining the direction of the IFRC and National Societies in NCDs prevention and control were developed.

Emergency health systems

The experience from the Ebola response in West Africa has shown, once again, what remarkable human and material resources the Red Cross Red Crescent membership can mobilize if our systems to manage and deploy international surge are adapted to be more inclusive and coordinated. In particular, response to large scale epidemics and to slow-onset crises requires non-traditional dynamics between disaster management professionals and health specialists inside the IFRC, and between the IFRC and its membership. Global response tools such as the Emergency Response Units (ERU) and Field Assessment Coordination Teams (FACT) have a role to play in all types of disasters. Making these tools increasingly flexible will only increase their relevance and applicability in different crisis settings.

During 2014, performance gaps have been identified and lessons learnt and documented through evaluations and National Society feedback. There is clearly a capacity building need that has emerged during the Ebola response. Due to limited funding, the training on public health in emergencies is no longer offered on a regular basis, leading to a very limited number of technical training opportunities in that area, and to a short supply of delegates who can perform reliably and predictably in the most complex humanitarian and disaster settings, providing analysis, technical assistance and leadership to the Membership.

In emergencies our primary tool is our capacity to rapidly analyse and think creatively. There is no cookie-cutter response or decision-making process within the core framework of public health. Training before field missions is absolutely necessary. However, resources available to support traditional trainings based on classroom attendance are becoming more and more limited. The discrepancy between training in western, stable, affluent clinical settings (the supply) and the reality of humanitarian public health and health risk management (the need) results in a widening

of the performance gap in complex aid operations. The health team is, therefore, paying particular attention to delivering online learning through the IFRC Learning Platform and connecting every training initiative to a Competency Framework for public health professionals and clinicians.

Training time for ERU and FACT teams, two important target audiences for the health team training activities, is very limited. It has to cover numerous topics and therefore does not allow the development of analytical skills required for effective public health in emergency contexts. Health staff in development contexts do not necessarily have access to this type or level of training.

The experience from the Ebola response in West Africa and the pre-deployment courses provided for all deployed clinical staff has shown how the health team has a key role in rapidly rolling out specific sub-specialty trainings that respond to the needs arising in a changing environment.

Health systems strengthening

Fragile state: The IFRC work in Central African Republic as principal Global Fund recipient aimed at supporting CAR's fragile health system. We supported the Ministry of Health to move from a disease reporting system on the brink of collapsing to a mobile phone-based reporting system that is currently, for malaria, achieving 60 per cent on time and complete reporting on a monthly basis. It is currently working on achieving the same for HIV and TB.

Malaria campaigns: IFRC supported the Sierra Leone Red Cross Society to conduct social mobilization activities in support of the country maternal and child health week campaign, reaching a total population of over 1.5 million people in four districts.

Immunization campaigns: The role of the health team is also to build knowledge and guide National Societies by answering complex questions on the demand side and in working with health systems. This will assist in developing better programme drivers in scaling up immunization and reaching the most vulnerable. A complex set of interrelated activities including training, logistics, planning, supervision and communication between health service providers and the public enables/ensures wider outreach and delivery. Red Cross Red Crescent has been an important partner in social mobilization activities during campaigns and routine immunization. In 2015 and beyond the IFRC will expand the immunization portfolio by: (1) increasing community demand for eligible women and children in every community, (2) improving immunization and injection safety, and (3) supporting strengthening systems in routine immunization and in emergencies (both outbreaks and crisis-affected communities). The Centers for Disease Control (CDC) has recently seconded an expert to IFRC secretariat to support the above in developing the immunization portfolio.

First aid: the Global First Aid Reference Centre (GFARC) supported National Societies to roll out mass first aid education activities around World First Aid Day (WFAD). This year's theme highlighted the need for "first aid heroes" in daily emergencies and disasters. Around 600,000 volunteers or staff members were involved and 11 million people were trained in first aid and/or received educational information on first aid. In 2014 the GFARC and the Global Disaster Preparedness Center (GDPC), hosted by the American Red Cross, continued their collaboration through the Universal First Aid App Program. In response to the Ebola outbreak, GDPC rolled out the application in West Africa, with a specific Ebola-related content developed with the health team, and in close consultation with GFARC.

Some key figures on the use of the application in 2014:

- over 1 million downloads in total worldwide
- 48 first aid apps developed
- 15 multi-hazard apps developed
- 13 apps with Ebola-specific messaging for countries in West Africa

3. OUR REFLECTIONS ON THE WAY FORWARD

While we attempted to fulfil our objectives as best we could and worked with colleagues, partners, and most importantly member National Societies, we have learnt a great deal in 2014.

Preparations in view of the new Plan and Budget 2016—2020 process will provide an opportunity to initiate much needed discussion around secretariat priorities, guided by a number of high level documents and guidance, particularly Strategy 2020, the Framework for Community Resilience, and the Strategic Operational Framework for Health, and help us improve our effectiveness to deliver relevant technical and strategic support together as a global health team and in consultation with National Societies.

We are set to review our community-based health approach in 2015. We will aim to design future community health projects that are responsive, scalable, sustainable, and that empower National Society staff and volunteers, and most importantly, the people we serve. We will take into account real community priorities and complexity issues, and contribute to community resilience and sustainable development goals.

Different trends in health, ageing, technology, education, financing, migration, protection, gender and social inclusion, urbanization and global priorities will challenge the way we implement community health initiatives worldwide. There will also be new opportunities to better manage emerging needs at the community level. Addressing the challenges and taking advantage of the opportunities require flexible, continuous learning and open-minded leadership.

In time of rapidly changing technology and needs, new strategies are required. Our strategies should balance traditional, evolutionary and revolutionary solutions to meet the challenges ahead of us. Being comfortable with our traditional ways of working should not influence our understanding of the trends and our focus on the right priorities.

A well-integrated health programme incorporating both demand and supply, with strong community links through a strengthened and motivated workforce of volunteers is vital for the implementation of any community health plan at country level. Coordinated community-based and population-based approaches rather than stand-alone vertical interventions will contribute towards a greater reach of individuals in communities. Implementation strategies should be based on the context and may be different in each case. Strategies may include traditional approaches (e.g., through face-to-face community mobilization activities), innovative approaches (e.g., mHealth/eHealth), advocacy for policy change, research to better inform the approach, and innovative partnerships to make things happen.

Our country-wide role as primary recipient of the Global Fund in CAR has profiled the IFRC as an important player in Health Systems Strengthening. Yet the Ebola virus disease crisis has crippled even more health systems of countries in West Africa. We still need to think how to leverage the auxiliary role of National Societies so that they are key actors in the strengthening of health systems in their countries.

IFRC Geneva is playing a critical role as a knowledge powerhouse to provide services to National Societies and the global health community in research and learning, development of evidence-based tools, and advocacy. We provide technical support and capacity building to our member National Societies so that they can play a vital role in disease prevention and management at community level, building healthier and more resilient communities.

But we cannot afford to be complacent. The past few years have demonstrated increasingly complex humanitarian operations, with multiple actors involved, new and ever changing standards and guidelines, new terminologies, new products, new coordination platforms, changing donor roles, and challenges in accessing populations in need, leaving communities more vulnerable than ever. Key questions arise: how to use the full potential of our knowledge and experience to develop strategies and initiatives for large scale disaster response and public health crises; how to adapt

plans to the changing global situation exacerbated by the current economic austerity and insecurity, globalization, urbanization, and environmental factors; and, how to build international and country capacities towards self-reliance and improved preparedness. All these issues are high on the agenda and must be tackled over the coming months.



ANNEX 1: 2014 Community-Based Health and First Aid (CBHFA)

1. Key achievements

In 2014, 109 National Societies implemented community health programmes using the [CBHFA approach](#) (36 per cent increase from previous year). Nearly 1,000 (983) active master facilitators and 33,885 active volunteers (36 per cent increase from previous year) supported 5,052,477 community members world-wide on health promotion and behaviour change (45 per cent increase). IFRC and 18 partnering National Societies provided technical and financial support to make these global efforts to build healthier and resilient communities a reality.

1.1 Research and learning

- Research using the realist approach was conducted in Uganda and Ethiopia with the focus on volunteer capacity building and motivation. An academic paper describing the protocol to be used was published in the [BMJ](#) on understanding the motivation and performance of community health volunteers. The results will be published early in 2015.
- CBHFA global mapping was conducted to better understand the status of implementation, the trends and lessons learnt and challenges.
- To improve programme quality, an increasing number of evaluations and researches has been conducted over the last few years including 21 programme evaluations, 34 baseline and 18 end line surveys using the updated CBHFA Planning, Monitoring, Evaluation and Reporting (PMER) toolkit.

1.2 Development of evidence-based tools

- A [background paper](#) on facts and trends affecting community health and a [discussion paper](#) outlining the key concepts on upgrading the IFRC community-based approach in 2016 were developed.
- The CBHFA [eLearning](#) in Spanish and French was finalized and launched and the English version further disseminated. In total there were around 6,000 registrations by the end of 2014 (74 per cent increase from the previous year).
- CBHFA PMER toolkit was translated into the IFRC official languages and disseminated. A CBHFA baseline questionnaire was also added to the Rapid Mobile Phone-based (RAMP) toolkit.
- [Healthy lifestyle and NCDs tools](#) (CBHFA module 8) was developed to support the implementation of primary and secondary prevention at the community level and the [Healthy Lifestyles Community \(HLC\)](#), a free, interactive online platform for users to help their friends, family and communities reduce their risks of developing NCDs by changing risky habits was established.
- A violence prevention module (CBHFA module 9) was implemented by approximately 14 National Societies. The module addresses child protection and gender-based

violence prevention in development and emergency contexts. The module was translated and made available in Arabic, English, French, and Spanish.

- “Integrating gender and diversity into community health” [guidance note](#) was translated into the IFRC official languages.

1.3 Action (advocacy, technical support and capacity building)

- [World Health Day](#) – Dengue Advocacy Report (silent disaster)
- [World Health Assembly](#) – National Society representatives from Sierra Leone, Somalia and Maldives participated in side events co-organized by IFRC on community health, fragile state and NCDs with WHO and different global partners.
- [Healthy Means campaign](#) in partnership with Devex, an online conversation advancing the discussion around future challenges and opportunities in global health.
- Further dissemination of CBHFA advocacy and promotion videos: [Irish Red Cross Society](#) (CBHFA in Prison), [East Timor](#) (working in rural communities) and development of a new one, [Cambodia](#) (harmonized approach to community health).
- Development of harmonized approach to community health case study based on Cambodian Red Cross experience in CBHFA and WatSan.
- Development of community health catalogues to present the key IFRC tools in CBHFA.
- Coordination and support of different zonal and global learning workshops (CBHFA delegate training, Finland, February 2014; CBHFA in Prison, Ireland, June 2014; CBHFA and RMNCH master facilitator workshop in French, Congo, July 2014; CBHFA Africa meeting, Malawi, October 2014; CBHFA and RMNCH global meeting, November 2014)
- Creation of [CBHFA](#) Facebook group for networking, knowledge-sharing, discussion of key relevant issues, and crowd-sourcing the support needed by National Societies.
- See figure 1 below summarizing the key CBHFA actions in 2014.

Figure 1. Mind-map: Summary of IFRC Geneva CBHFA in 2014



2. Key partners

- Key partners that provide technical and financial support to CBHFA global work include Finnish Red Cross, Norwegian Red Cross, Danish Red Cross, American Red Cross, IFPMA and Google.
- The University of Geneva and University of Antwerp have provided research support and Devex has collaborated in an advocacy campaign.

3. Key challenges

- More National Societies are interested and using the CBHFA tools which increases the demand on IFRC support. Further funding and partnership options are required and IFRC should increase its technical human resources capacity in Geneva.
- Developing CBHFA+ in 2016 requires strong leadership from the IFRC health department and the field. The position of the head of the health department in Geneva was vacant for several months and there are a number of key vacant health positions in the field in addition.
- Emergency needs and actions can easily take attention from the long-term development and prevention work in the field. Vertical disease intervention is still a focus of different donors whereas we promote integrated health programmes based on community needs and the building up of the community and health systems.

4. Key lessons

- The CBHFA approach needs to be updated to increase relevance, usability, sustainability and scalability of the tools and approach. National Societies still need support in setting-up monitoring and evaluation systems and increasing programme quality and scale.

5. Next steps/forward plans

- IFRC is working on evolving its CBHFA+ approach to become a platform for health and resilience, better to address the key lessons and challenges from the last ten years of implementation and address the new post-2015 sustainable development agenda. See figure 2 below for more information on the next steps.

Figure 2. Mind-map: IFRC Geneva CBHFA plan 2015—2016





ANNEX 2. Noncommunicable Diseases (NCDs)

1. Key achievements

1.1 Research and learning

- Use of Lean Start-up approach to develop online tools for NCDs in partnership with Google.
- Research on how to enhance behavioural change through online tools, partnered with University of Geneva.
- Research project coordinated by Danish Red Cross on Youth and NCDs in partnership with Copenhagen University. This research will inform the development of NCD tools for children and youth.
- A research project with Australian Red Cross on task-shifting has begun. This examines the role of volunteers in healthcare provision for vulnerable populations. This project is still at early stage.

1.2 Development of evidence-based tools

- Finalization of [4HealthyHabits](#), a Healthy Lifestyle and NCDs prevention module. The module builds on the existing [CBHFA](#) tools, incorporating behaviour change methods to increase knowledge and equip communities and individuals with the tools to make healthier lifestyle choices. Thus far, the tools have gone through piloting in different regions and through eight drafts. The materials are to be translated into Arabic, French, Spanish, Indonesian, German, Armenian, Russian and other languages.
- Development of NCDs [discussion paper](#) and [vision](#) to outline the IFRC and National Societies' direction in NCDs prevention and control
- Launch of the online [Healthy Lifestyles Community \(HLC\)](#), a free, interactive online platform for users to help their friends, family and communities reduce their risks of developing NCDs by changing risky habits. The achievements of HLC were recognized in November 2014 with the Google [Research award](#).
- Draft of NCDs guideline for children and youth.

1.3 Action (advocacy, technical support and capacity building)

- Staff and volunteers from 64 National Societies and different IFRC offices were trained on the new NCDs tools.
- Healthy Lifestyle Master Facilitator Workshops were conducted at zonal levels including Asia Pacific (Kuala Lumpur, April 2014), Europe and Central Asia (Istanbul, May 2014), Americas (Guatemala, September 2014) and Russian speaking National Societies (Belarus, December 2014).
- NCDs global meeting in Istanbul (November 2014) was conducted to share experiences, obtain updates, and create actionable plans for moving forward.
- World Health Assembly 2014 [4HealthyHabits side event](#) with NCD Child, WHO, University of Geneva, Maldivian Red Crescent and IFPMA.
- Case studies of National Societies conducting NCD-related activities from [Cook Islands](#), [Tuvalu](#), [Sri Lanka](#), [Armenia](#), and the [Maldives](#).

- [Healthy Means campaign](#) in partnership with Devex, an online conversation advancing the discussion around future challenges and opportunities in global health.
- Interviews and articles with Devex about the [work of National Societies](#), [partnerships](#), and similar [campaigns to prevent and treat NCDs](#).
- Development of [4HealthyHabits video](#).
- Development of community health catalogues to present the key IFRC tools for NCDs.
- Facebook group for [NCDs](#) to discuss key relevant issues, share experiences and crowd-source the support needed by National Societies.

2. Key partners

- Key partners providing technical and financial support to global work for NCDs include Norwegian Red Cross, Danish Red Cross, IFPMA, and Google.
- The University of Geneva has provided four applied psychology masters students conducting research in collaboration with the IFRC health department, most notably on the healthy lifestyle module.

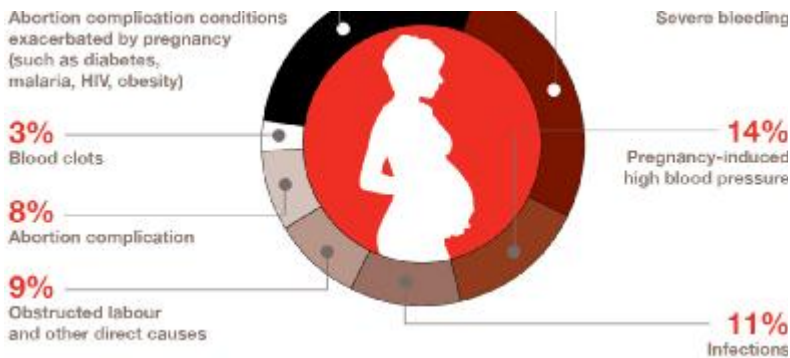
3. Key challenges

- More National Societies are interested and using the NCDs tools which increases the demand for IFRC support. Further funding and partnership options are required and IFRC should increase its technical human resources capacity in Geneva.
- Currently, NCDs receive little funding, particularly compared to the major portion of burden of disease associated with these health issues. NCDs receive less than 1.2 per cent of global development assistance for health. There are gaps between donor funding and disease burden in most regions. Change in the funding situation will slowly start after the Sustainable Development Goals approval in September 2015.
- Lack of human resources for health in MENA zone prevented IFRC from implementing a healthy lifestyle workshop in Arabic in that region. Working with other zones/regions could be a challenge due to different focus and analysis of the priorities.

4. Next steps/forward plans

In addition to advocacy and capacity building around the existing healthy lifestyle module and tools, IFRC has new projects to advance its NCDs agenda including:

- Establishment of **Global Working Group** for NCDs.
- Scaling-up the implementation of **4HealthyHabit** (Healthy Lifestyle tools) at the community level.
- Update the IFRC **vision and framework** on NCDs.
- Scaling-up the outreach and learning from the online **Healthy lifestyle community**.
- **Healthy Lifestyle at Work (HL@W) Initiative:** This initiative is aimed at both creating an enabling environment and empowering staff and volunteers to improve health in the workplace. Thus far we have developed a concept paper, 2015 work plan, and promotional PowerPoint explaining the initiative. We officially launched the HL@W pilot among IFRC and National Society offices in February 2015.
- **NCD Children and Youth:** In collaboration with the Danish Red Cross, we are developing an “Implementation Guide for Children and Youth NCD Programming” tool and aim to roll-out programming on NCD Youth from 2015 onwards.
- **Ageing:** We have partnered with Pfizer to develop and test evidence-based tools to support healthy and active ageing at the community level and jointly advocate for NCDs prevention and control and healthy and active ageing.
- **NCDs in emergencies:** Over the next two years, IFRC aims to develop a framework for NCDs in emergencies, identify global gaps, determine which gaps the IFRC is best suited to address and how to achieve their closure, identify potential partners, assessment tools, mechanisms and platforms for advocacy and prevention, and needed research.
- **Mental Health:** finalize the mental health framework.



ANNEX 3: Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCAH), Including Immunization

1. Key achievements

1.1 RMNCAH today

- Reviewed, analysed and developed compendium of 10 unique interventions in different contexts and developed recommendations for the way forward.
- Compendium translated into French, English and Spanish and disseminated to National Societies within the five zones.
- Global mapping was conducted to better understand the status of implementation of all RMNCAH projects, trends, lessons learnt and challenges.

1.2 Used “Lean Startup” model in Burkina Faso, for programme implementation and advocacy

- Provided technical support to National Society in RMNCAH programme and advocacy.
- Presentation of design, implementation and lessons learnt at fora with IFRC, zones and GlaxoSmithKline.

1.3 Provided technical input on RMNCAH to WHO on World Blood Donor Day 2014 with the theme “Give blood for those who give life”

- Organized session on strategy development and represented IFRC at the global event in Colombo, June 2014.

1.4 Developed “RAMP in RMNCH”, a user guide for undertaking surveys and evaluations via mobile phones

- Developed comprehensive RMNCH questionnaire as part of RAMP.

1.5 Training and workshops on RMNCH using the community health platform in Africa and Central America for 33 National Societies

- Congo, July 2014.
- Guatemala, September 2014.

1.6 Evaluation and compilation of lessons learnt

- In Ethiopia, undertook a project evaluation including volunteer motivation using a comprehensive approach (IFRC protocol along with realist approach).
- Developed supplement/note on using the Realist Approach in programmes, complementary to the conventional approach.

1.7 Global advocacy. Discussions took place on inputs to influence UN global strategy on RMNCAH

- Conducted global meeting, November 2014, focusing on strategic level and next steps.
- Ensured inclusion of civil society viewpoints in GAVI, the Vaccine Alliance's upcoming 2016—2020 strategy, including the inclusion of “community ownership” as a guiding principle.
- Through involvement with GAVI, secured Civil Society Organization (CSO) representation to WHO Strategic Advisory Group of Experts on Immunization (SAGE).
- Work on developing the Abu Dhabi “declaration and commitments to action” for 2015
- Advocacy to place developmental and humanitarian settings at the heart of the new global strategy for Every Woman Every Child everywhere, to address health and well-being for life, to strengthen health systems and services across development and humanitarian contexts, to inculcate accountability and recognize innate resilience.

1.8 Strategic alliances

- Promoted IFRC at strategic alliances and worked along with global actors in RMNCAH on shared values and efforts so that fewer people fall through the net (e.g., WHO, UNICEF, UNFPA, GAVI, PMNCH, Save The Children, USAID, etc.).
- London, February 2014 - Reinstating and diversifying the RMNCAH Technical Group in Red Cross Red Crescent, bringing together Red Cross Red Crescent partners and potential external partners to form alliances that focus on programme delivery and link this with resource mobilization.
- Establish shared goals with different programmes at IFRC.

2. Key partners

- Norwegian Red Cross, British Red Cross, Finnish Red Cross, The Netherlands Red Cross and Swiss Red Cross.
- GAVI, the Vaccine Alliance. IFRC continues to coordinate the CSO Constituency and Steering Committee of GAVI. This involves representing these bodies at high-level immunization and health systems fora and ensuring that communities and community actors are represented in key decision-making processes related to global immunization initiatives.

3. Key challenges

- Measuring our work in Red Cross Red Crescent by its impact on the poorest and most vulnerable populations, not simply by national averages.
- Vertical disease intervention is still a focus of many donors and global health initiatives. We promote integrated health programmes based on community needs and the building up of the community and health systems.
- More National Societies are interested in RMNCAH implementation in developmental and humanitarian contexts. This leads to increased demand for IFRC support. To go to scale and meet specific needs requires further funding and partnership options in Geneva.

4. Key Lessons

- Promoting gender equality by empowering women and adolescent girls and engaging men and adolescent boys is fundamental to improving sexual and reproductive health and RMNCAH outcomes.
- No intervention in RMNCH can be implemented in isolation. Clinicians and the community must work together. Linking interventions is imperative since it not only reduces costs by allowing greater efficiency but also increases uptake.
- Moving from coordination to collaboration with as many actors in the area should be explored. Essentially, a formal method of engagement with structures in the Ministry of Health and other actors working in health and water, sanitation and hygiene promotion is critical for sustaining the achievements and developing further.

- Communicating clearly at global and regional fora about what IFRC and National Societies do in RMNCH, including immunization, is both challenging and important. Organizations and potential partners should learn more about our programmes and approaches by being shown concrete examples.

5. Next steps/forward plans

2015 will consolidate the progress we have made so far in 2014 and contribute to evolution of CBHFA to CBHFA+, with the following plans:

- IFRC RMNCAH Guidance for Programme Managers
- IFRC Strategy on Health System Strengthening
- Supplement to the RMNCAH Guidance on Nutrition for integrated programming
- Work in developing Red Cross Red Crescent capacities for handling **RMNCAH health emergencies** and **RMNCAH interventions in emergencies/crisis situations**
- Development of a concept paper and plan for how RMNCAH fits in the context
- Work on draft guidance and pilot this in selected contexts, for example in a health emergency such as obstetric haemorrhage and as an intervention package in emergencies
- Knowledge management. Develop case studies, videos and stories to appear on IFRC website and on FedNet and other common platforms in the health department for communication and advocacy (developmental and in crisis)
- Focus on access, developing data management systems, research and evaluations
- Discuss with GAVI expanding IFRC's coordination role to the regional level with regards to CSO engagement (currently the focus is on global coordination)
- Develop a stronger and more reliant **data system** from the field level that informs National Societies from the outset of the project to its end, is easy to use and keeps up with technological advancements
- Use the community health platform to leverage RMNCAH activities. This includes determining when to scale up RMNCAH initiatives in places where public health systems are weak (population-based approach), and when to target specific communities and people (community-based approach).
- Dissemination of the strategy, guidance, nutrition guide and framework and advocacy videos
- mHealth tools for referral and advancing health literacy



ANNEX 4.

Water, Sanitation and Hygiene Promotion Programme (WatSan)

1. Key achievements

1.1 Global Water and Sanitation Initiative (GWSI)

- A GWSI mapping process took place, bringing together inputs and updated data worldwide on developmental WatSan efforts, demonstrating that the programme has reached and surpassed its goals. By direct contact with National Societies (at headquarters and country level), key field staff and GWSI project managers' data were collected. Analysis of the raw data led to a final set of data which was published for World Water Day and other WatSan related events during 2014. Further efforts to roll out more "Look Back" studies as evidence based research led to studies being completed in Kenya and East Timor. GWSI publications were revised and published. GWSI resource mobilization led to a new five year partnership with Nestlé and a new three year partnership with Cartier. These partnerships provide funding for long-term projects in Côte d'Ivoire, Ghana Myanmar and Cambodia.

1.2 Emergency Operations

- The Philippines Typhoon Haiyan operation has transitioned to recovery water and sanitation programming. A Water and Sanitation Module 40 was deployed to South Sudan in response to a cholera outbreak. Support in training and to field staff was provided to the Ebola Virus Disease outbreak response.

1.3 Emergency Sanitation Project (ESP)

- The IFRC continued research and development on new equipment for sanitation in difficult environments (including urban and peri urban settings). New equipment was developed for sludge removal and hand-washing. Field testing for sludge disposal was carried out in Malawi, with additional trials planned in Côte d'Ivoire and India. Results of the Emergency Sanitation Project were presented at Stockholm World Water Week.

1.4 Unit core costs

- The Nestlé partnership provides funds to meet some core costs in Geneva. British Red Cross continued its support to the WatSan/EH Unit and increased its financial commitment to a full time staff on loan (SOL) position. British Red Cross also supported a SOL rotational position.

1.5 Global WASH Cluster

- IFRC was re-elected to the Strategic Advisory Group of the Cluster and was chosen to lead an evolution of the Cluster Field Support Team (still under negotiation) for 2015—2016.

2. Key partners

Internally, the Strategic partnerships and International Relations team are very supportive, especially in relationships with the corporate sector (Nestlé, Cartier, Procter & Gamble). Externally, we maintain constant interaction and working relationships with the EU/ECHO, OFDA/USAID, DFID, DFAT, Oxfam, ACTED, ACF, UNICEF, NCA, SI, WVI, CARE and others to a lesser extent.

The Emergency Sanitation Project is a consortium of agencies including Oxfam and Waste, with Netherlands Red Cross expected to increase their collaboration with the ESP.

3. Key challenges

Health overall, including WatSan/EH, does not receive adequate financial support for core positions but is, however, expected to deliver core functions, especially in the disaster management area, but also in developmental contexts on a regular basis. This is stressful when we are recognized as a key delivery mechanism but struggle to maintain staffing levels and capacity to deliver. The working relationship between Geneva and the zones remains a crucial area of concern. Roles and responsibilities that may be unclear lead to duplication of efforts, increased and inefficient management layers and a loss of coherent planning, programming and vision throughout the Secretariat. This results in a loss of credibility with our membership and reduced resource mobilization and IFRC positioning internally and externally.

4. Key lessons

Although our efforts to increase evidence based information and operational research to better inform strategic and programmatic planning are well advanced, there are limited resources to go further. Donors, both Red Cross Red Crescent partners and external are increasingly demanding a higher level of reporting, monitoring and evaluation and if we cannot provide this we lose ground to our competitors.

5. Next steps/forward plans

- Further application and use of mobile phone technology for full project cycle management (ongoing in GWSI).
- Increased operational research (“Look Back Studies”, Emergency Sanitation Project).
- Further evolution of GWSI criteria and strategic direction to match Sustainable Development Goals by the end of 2015.
- Increased flexibility of WatSan ERUs.
- Scale up Hygiene Promotion technical capacity.
- Expanded ESP partnership.
- If practical further engagement with the WASH Cluster.
- Increased resource mobilization.
- Increased internal and external marketing.
- Increased partnership development.



ANNEX 5: Emergency Health (EH)

1. Key achievements

- The new Community Health training for emergencies was first piloted in Norway, making use of problem-based learning and linking the learning outcomes to the Competency Matrix for Humanitarian Health workers.
- The IFRC continued to represent the Membership in interagency fora such as the Global Health Cluster, Foreign Medical Teams Working Group, International Coordination Group for Yellow Fever, Meningitis and Oral Cholera Vaccine, Cholera Task Force.
- Two staff rotations from a partner National Society to the Emergency Health Team during the year provided a learning opportunity to the staff members and supported the work of the Secretariat.
- The annual ERU technical working group took place in Washington DC.
- The Emergency Health Team dedicated most of its time in 2014 to the West Africa Ebola outbreak, supporting the operation both in the field through staff deployment, and through technical assistance and interagency coordination in Geneva.
- Close to 250 healthcare staff were trained in a series of two-day Ebola Pre-deployment courses in Geneva.

2. Key partners

- Academic partners: Johns Hopkins Bloomberg School of Public Health, University of Geneva, Swedish Red Cross University College of Nursing.
- Movement partners: Spanish Red Cross, Norwegian Red Cross, British Red Cross, Canadian Red Cross, Australian Red Cross, Icelandic Red Cross.

3. Key challenges

- The West Africa Ebola outbreak showed the organization how different the needs are in management, resource allocation and planning in a large scale epidemic outbreak, compared to traditional sudden onset natural disaster operation management. The organization had to review its approach to epidemic response in particular and to Health Emergency Risk Management in general.
- The Membership continues to struggle with a short supply of two important segments in the humanitarian health workforce: leaders and public health specialists.
- The Emergency Health Learning System must be brought to completion and made available for the whole Membership.

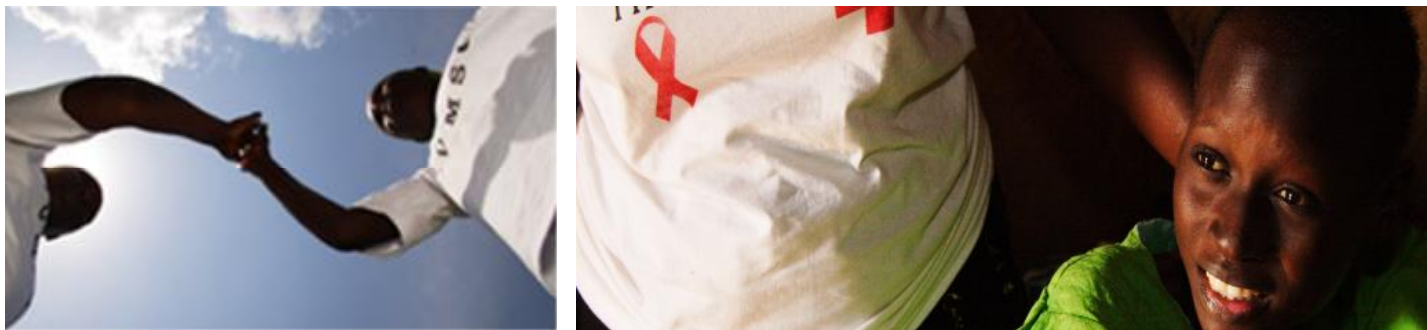
4. Key lessons

- We wish to increase our efforts to educate a generation of public health specialists and health professionals with leadership skills and coordinating capacity so that the Membership can perform in the most complex L3-type (severe) humanitarian emergencies.

- We acknowledge the extraordinary need for humanitarian health capacity building in the MENA region due to several protracted crises and wish to increase collaboration in this respect.

5. Next steps/forward plans

- Competency framework to be finalized in June 2015.
- Community Health in Emergencies Stage 2 training in June 2015
- Emergency Health eLearning, three additional modules produced this year.
- Public Health Pre-deployment Course piloted in third quarter of 2015.



ANNEX 6: HIV/AIDS Global Programme (HIV)

1. Key achievements

1.1 Relevant tools to support IFRC and National Societies developed

- The Community-based service delivery model (CBSDM) has been developed in conjunction with the Global Alliance Evaluation, translated into four languages and disseminated to 60 National Societies in the five zones.
- In conjunction with UNAIDS, a template has been developed to enable data collection at country level to check on the costing of the CBSDM. The costing exercise will take place in Burkina Faso, Côte d'Ivoire, Kenya and South Africa.

1.2 Technical support and advocacy to zones and National Societies provided

- A visit took place to the Africa zone and specifically to Kenya and Nigeria to support the ongoing programme in Kenya and the discussion between the Nigerian Red Cross Society, UNAIDS and the National Aids Control Agency.
- HIV programming mapping: starting in October 2014, the mapping exercise of HIV programming in Africa zone is now completed and is available for consultation. It will further serve to tailor our technical support.
- Presentation of the CBSDM to stakeholders in Nigeria and Côte d'Ivoire (October to November 2014).
- Support to the Global Fund Programme Management Unit in Central African Republic (CAR):
 - Two field visits to present the programme to in-country stakeholders and to prepare documents for selection of sub-recipients.
 - Development of the IFRC strategy for the Global Fund programme in CAR, including the mapping of the health facilities (functionality).
 - Revision of the consolidated HIV/Aids and TB work plan.
 - Revision of the Global Fund performance framework.
 - Revision of the Global Fund M&E Plan and Budget.
 - Revision of the Global Fund PSM plan.
 - Participation in the Global Fund grant negotiation.

1.3 Communication around Red Cross Red Crescent HIV programming and achievements World Aids Day 2015 (WAD) was the main vessel for communication, with the following outcomes:

- Official message on the “Close the Gap Campaign” was shared within the Federation along with a press release
- Small size grants were allocated to National Societies to support their communication activities during WAD (Namibia, Malawi, Zambia, Thailand, Vietnam, Kyrgyzstan, Kazakhstan, Tajikistan).
- Support was provided to the Adam's Love Campaign in Asia Pacific (aiming to scale-up routine HIV testing, promote safe sexual behaviour and build positive self-image

among key populations such as men who have sex with men and the transgender population).

2. Key partners

- Joint initiatives with International Aids Alliance on HIV in fragile states (discussions are under way to select a country to implement a model of intervention based on contingency planning, perhaps Haiti, South Sudan or Côte d'Ivoire).
- Participation in the IATT meetings to discuss HIV in emergencies (UNAIDS, UNFPA, UNHCR, Save the Children, UNICEF, WHO, etc.).
- Several meetings with UNAIDS to discuss the support IFRC could provide in achieving the Global Fast-Track Strategy targets (continuous process).

3. Key challenges

- Long absence due to ill health of key member of the HIV/AIDS team.
- The inability to hire staff on loan for the position of HIV Officer.
- The late disbursement of the programme income in June 2014 had a heavy impact on the pace of delivery of activities and the absorption rate of the budget.
- Significant amount of money carried over for use in 2015.

4. Key lessons

- Smart reprogramming, proactivity and good communication with the Norwegian Red Cross was key to the successful utilization of the unspent balance from 2014.

5. Next steps/forward plans

For 2015, priority will be given to:

- The promotion of the CBSD and subsequent advocacy to support the UNAIDS Fast-Track Strategy Targets.
- Costing of the CBSDM.
- The development of the CBSD training curriculum.
- Development of a Monitoring and Reporting System to support the implementation of the CBSD.
- Development of the Red Cross Red Crescent Guidelines and assessment tools for HIV in emergency settings.



ANNEX 7: TB and Harm Reduction Programme (TB)

1. Key achievements

1.1 Tuberculosis

- The Global Tuberculosis and Harm Reduction Programmes continued to support Red Cross Red Crescent health workers and volunteers to improve the detection and treatment of tuberculosis, provide care and support to drug users, promote the harm reduction approach, and participate in advocacy and partnership with key allies.
- Under the United Way Worldwide (UWW)/Lilly project we covered 37 communities with direct advocacy and preventive interventions, reaching 70,000 community members through Red Cross Red Crescent volunteers and giving daily support to 770 patients with MDR-TB via trained nurses and community health workers.
- Programme evaluation has been conducted in six countries. The TB programme evaluation took place in China, Honduras and the Russian Federation. This is the second phase of programme review under UWW/Lilly global MDR-TB Programme. Findings demonstrated the importance of supporting communities affected by the problem in TB control, not just patients but their families and the environment, and the requirement to design each individual project based on local needs and local reality at the same time as applying internationally recommended strategies and policies.
- Technical support is provided to Global Fund-supported activities in Niger and Central African Republic for the HIV and TB grant.

1.2 Harm Reduction

- Support was provided to the Secretariat of the Red Cross Red Crescent partnership on substance abuse to develop the strategy document and promotional material. A visual identity for the Drug Abuse Partnership was developed, including a promotional leaflet. Two steering committee meetings were organized. In 2014, two training sessions were organized and facilitated at Villa Maraini in partnership with Italian Red Cross.
- A special side event on harm reduction was organized during the Europe Regional Conference in Florence, June 2014.
- Support and input was provided to the organizing committee during the preparation for the Moscow HIV conference for East Europe/Central Asian countries together with the IFRC Office in Moscow. The IFRC team participated in the event (11–14 May) together with USG, American Red Cross, The Russian Red Cross Society and IFRC Moscow office with a number of interventions, presentations and sessions.

2. Key partners

- In TB programmes IFRC is increasingly working in collaboration with Lilly MDR-TB Partnership, UWW, Global Fund and USAID to address TB and support activities. UWW/Lilly/IFRC MDR-TB Initiative, launched in October 2012 is a multi-country grant support from the Eli Lilly Foundation. The initiative provides funds for nine projects.
- Since 2013 IFRC and Global Fund have started to work together to address TB in two very challenging environments, Central African Republic and Niger.

- We have worked with WHO and other partners on the following initiatives:
 - WHO guide to TB low incidence countries on TB elimination plan (completed and published).
 - Multi-agency framework on TB in complex emergencies (draft prepared)
 - European End TB Plan 2015—2020 (completed)
 - Joint monitoring mission in Myanmar organized by WHO and Ministry of Health of Myanmar
- We are working with Stop TB Partnership and other stakeholders on tools to strengthen the role of communities and civil society in TB programmes, specifically supported by the Global Fund, with a key objective to support community systems and affected communities to be central to, and active members of, country coordination mechanisms.
- We have worked with Project Hope and Global Fund on the regional proposal addressing TB and migration in Central Asia.
- We are working with Europe Harm Reduction Association supporting the revision of the harm reduction training curricula.
- Together with Austrian Red Cross and Red Cross Red Crescent Partnership on Substance Abuse, we organized a side event during the Commission on Narcotic Drugs (CND) meeting of the United Nations Office on Drugs and Crime (UNODC) in Vienna in March 2014.
- A meeting has been organized between the Chair of the Red Cross Red Crescent Partnership on Substance Abuse and United Nations Secretary General's envoy for TB and HIV. Joint activities are planned in relation to advocacy on harm reduction.

3. Key challenges

- More work needs to be done at country level to promote activities by National Societies in TB and harm reduction programmes. It is important to incorporate National Society activities in national responses to TB or drug addiction programmes to ensure efficient resource mobilization.
- Working with drug users is still a problematic area for many National Societies worldwide.
- Resource mobilization for harm reduction programmes is challenging.

4. Key lessons

- The IFRC's way of addressing TB and harm reduction is built through active partnerships that include the private sector. Working closely with the Stop TB Global Partnership, WHO offices, UNODC, Global Fund, Harm Reduction International and patient organizations is essential.
- High level influence is vital. IFRC is a member of Stop TB partnership, on several working groups and different selecting committees influencing proposals, and is a member of the technical advisory group of WHO, working closely with UNODC on drug related issues.

5. Next steps/forward plans

- Active consultation with National Societies and partners on IFRC TB and harm reduction agendas.
- Manage the 2015—2016 grant with Lilly and UWW.
- TB programme evaluation in South Africa and China.
- Support the Red Cross Red Crescent Partnership on Substance Abuse.
- Continue to contribute to global partners in fighting TB and addressing drug abuse-related problems.



ANNEX 8: Malaria

1. Key achievements

- To address the burden of malaria, the Red Cross Red Crescent, through its network of volunteers, works to extend the reach of health services and bring prevention, diagnosis, care and treatment closer to the most vulnerable members of the population. In 2014, more than 24,000 Red Cross Red Crescent community-based volunteers engaged in malaria prevention and control activities worldwide. Through them, we are able to reach millions of households in the most vulnerable communities, empowering them to respond comprehensively to malaria and thus strengthening community resilience.
- Mass distribution of long lasting insecticide-treated nets (LLINs) for malaria prevention has been shown to reduce malaria incidence by 50 per cent and child mortality by 20 per cent, and continues to be a pillar of IFRC's malaria programming. In the last 10 years over one billion nets have been delivered worldwide with support from the Alliance for Malaria Prevention (AMP), chaired by IFRC. Reductions in malaria deaths have contributed substantially to progress towards achieving the target for Millennium Development Goal (MDG) 4 to reduce by two thirds the under-five mortality rate by 2015. The malaria-specific MDG (6 target C) to have halted by 2015 and begun to reverse the incidence of malaria has already been met.
- In 2014, IFRC provided financial and technical support to the Sierra Leone Red Cross Society and its partners to deliver over 3.5 million LLINs to cover the entire population of Sierra Leone. It was critical that the country distributed LLINs prior to the peak of the Ebola outbreak, in particular to ensure that the population was not exposed to a double burden of disease. The aim was to avert malaria deaths through the increased ownership and usage of LLINs which was successfully achieved through the national LLIN distribution campaign.
- Ongoing conflict in the Central African Republic (CAR), has rendered more than half the population of 2.7 million people in need of urgent humanitarian assistance and led to near total collapse of the already weakened health system. These factors make it harder to combat malaria which accounted for 64 per cent of all fevers in February 2015. IFRC is the Principal Recipient of the Global Fund malaria grant which allows the Central African Red Cross Society to distribute rapid diagnostic testing kits, malaria drugs for treatment, and mobile smartphones for data collection to all health facilities country wide. IFRC is also carrying out prevention activities under this same grant which includes the distribution of over 2.2 million LLINs to the entire population of CAR to achieve universal coverage.
- Support from IFRC and partners has also seen CAR's fragile health system move a disease reporting system on the brink of collapse to a mobile phone-based reporting system that is currently achieving 60 per cent of malaria reporting on time and complete on a monthly basis.

2. Key partners

- Successful malaria elimination programmes are built on strong partnerships, better coordination and commitment to sound programme delivery. At the global level, IFRC

is committed to strengthening the Red Cross Red Crescent role in the global malaria community through partnership coordination and technical assistance to countries. The IFRC chairs AMP, a partnership of more than 40 government, business, faith-based and humanitarian organizations which focuses on responding to country-driven requests for technical support in the planning, delivery and follow-up of malaria prevention activities. In 2014, the malaria programme has also sustained its existing partnerships with USAID, the Norwegian Red Cross, the United Nations Foundation and the Y's Men International who have continued to fund IFRC malaria activities. The IFRC has also continued to work on its engagement with new partners such as the Global Fund. Since 2013, IFRC is the Principal Recipient on the RD8 Phase II Malaria Grant in Central Africa Republic.

- At the country level Red Cross Red Crescent malaria activities are coordinated by the National Society in close partnership with the Ministry of Health structures at central, regional, district and health facility level.

3. Key challenges

- The greatest challenge to global malaria activities in particular is lack of stable, sustainable funding in malaria-endemic countries.

4. Key lessons

- In 2014, the IFRC malaria programme has conducted support to projects in very challenging environments, from the distribution of LLINs in Ebola-stricken Sierra Leone, to addressing the malaria burden in conflict-riddled Central African Republic. These experiences have shown that the Red Cross Red Crescent operational approach is flexible and adaptable enough to deliver projects in complex emergencies, and continues to reach the most vulnerable populations.

5. Next steps/forward plans

- Roll out Rapid Mobile Phone-based programme (RAMP) for project management for community volunteer programmes.
- Roll out Rectal Artesunate Suppositories (RAS) as a pre-referral treatment for children with severe malaria.
- Document lessons learnt in complex operating environments (Central African Republic and Niger).



ANNEX 9. Global First Aid Reference Centre

Introduction

The IFRC Global First Aid Reference Centre (GFARC) was created in December 2012. Its main mission is to serve as the IFRC's hub of technical expertise and to help Red Cross and Red Crescent National Societies around the world to expand and improve their first aid education programmes. The GFARC had its first global meeting on 15th October 2014.

Following the results of the global survey on first aid education carried out in 2013, which helped pointing out the issues to focus on, the activity of the GFARC in 2014 was concentrated on the three following areas.

Technical support and capacity building

Scientific guidelines

The next international scientific guidelines on first aid and resuscitation will be published in October 2015. The GFARC takes part in the review of science through the ILCOR (International Liaison Committee On Resuscitation) process at 3 different levels: first as a member of the ILCOR first aid task-force, second as a member of the Scientific Advisory Council of the American Red Cross and third as a member of the European Resuscitation Council: participation in the annual Congress (15-17 May in Bilbao, Spain) as well as the two sessions of the General Assembly.

IFRC international first aid and resuscitation guidelines

After the scientific guidelines are published, an adaptation to the RC/RC context will be available in early 2016. The work has already started with the IFRC Evidence-Based Group: divided into 4 sub-groups (First aid / Education / Resuscitation / General Care) the group met twice in 2014: in London (March 2014) and in Paris (October 2014) to prepare the future reference document to which every RC/RC National Society should refer to update their first aid education programme.

Communication

GFARC informative leaflet

The document is available in the four official languages on Fed Net. Please click on [the link](#) to access the document.

World First Aid Day

World First Aid Day (WFAD) takes place every year on the second Saturday of September. In 2014 it was on Saturday, September, 13.

The Red Cross Red Crescent believes that first aid is more than just learning a series of techniques; it is an act of humanity. It empowers volunteers and communities to save lives without discrimination. With 90 per cent of lives saved after a disaster done so by local people, first aid

training is for anyone who has ever been – or will be – a bystander.

This year's theme highlighted the need for 'first aid heroes' in daily emergencies and disasters.

National Red Cross and Red Crescent Societies were encouraged to host initiatives highlighting the theme and to spread the message loud and clear that neither a cape nor superpowers are needed to be a hero:

The communication tool kit designed by IFRC to help National Societies around the world promote the event was available on Fed Net (<https://fednet.ifrc.org/en/resources/health/first-aid/world-first-aid-day-2014>). Tools could be translated and adapted to national context as National Societies could add their own logo and information.

As a result around 600,000 volunteers or staff members were involved in celebrating WFAD and 11 million people were trained in first aid and/or received educational information on first aid. Global activity report is available on Fed Net.

Global first aid initiative

In 2014 the IFRC Secretariat proposed in collaboration with the GFARC to launch a global long-term first aid initiative 2014-2020 to ensure a growing number of people and communities, anywhere, are prepared and equipped to save lives when a disaster or an emergency occurs.

In September 2014 a group of National Societies first met to discuss the initiative and the way they could be part of it.

Since then the IFRC Governing Board, on proposal of the Global Community Resilience Forum (Cali, Colombia – November 2014), approved the **One Billion Coalition for Resilience** as a new initiative to scale up community and civic action on resilience. To avoid launching two parallel campaigns, it was decided that the Global First Aid initiative will be part of the resilience initiative: first aid should be seen a pillar of the resilience effort.

Building strategic partnerships for first aid

In collaboration with the IFRC Secretariat and one consultant, the GFARC established a strategy for seeking partners; those can be sister NS, companies from private sector, organizations from public area. As basis for the implementation of the strategy, a number of projects has been identified and described (see below).

Collaboration with other components of the FICR

Global Disaster Preparedness Center

In 2014 the GFARC and the Global Disaster Preparedness Center (GDPC) hosted by the American Red Cross continued their collaboration through the Universal First Aid App Program: whereas the GDPC endorses the technical development and the relationship with the National Society, the GFARC coordinates the clinical review of the first aid app.

In addition to the core first aid guidance that is in the apps and to respond to the Ebola outbreak, the GDPC also decided to build first aid apps for West African countries currently responding to or preparing for Ebola. As French is the main common language spoken in some of these countries the GDPC also requested support GFARC's assistance in translating the protective measures for Ebola prevention to be included to the app.

Some highlights during 2014:

- Over 1 million downloads total worldwide.
- 48 First Aid apps developed.
- 15 multi-hazard apps developed

- 13 apps with Ebola specific messaging for countries in West Africa

In January 2015, there were **56 live First Aid apps**.

Other reference Centres

- Collaboration with the Centre for Evidence-Based Practice of the Belgian Red Cross-Flanders on the next IFRC first aid and resuscitation guidelines.
- Participation to the third annual meeting of the RC/RC reference centres on 29-30th April 2014 in Barbados.

IFRC Secretariat, IFRC Zone Offices

- Regular meetings in Geneva to discuss technical or strategy issues with the different partners of the GFARC: meeting with USG Walter Cotte, discussion and working sessions with the different departments: health, communication or legal departments
- 03-06 June: participation to the 9th European Regional RC/RC Conference in Florence, Italy.
- Regular telephone conferences with Health and First Aid coordinators of the different IFRC zone offices.

Next steps: five key projects for 2015-16

In 2015-16, the Global First Aid Reference Centre aims at undertaking five projects as first steps to scale up first aid training globally:

Expanding the supply of first aid trainers: Develop and deploy an international curriculum for training people to teach first aid skills, helping Red Cross and Red Crescent National Societies cascade training more rapidly and effectively.

Knowledge-sharing: Create a virtual collaborative workspace where Red Cross and Red Crescent National Societies can build capacity by sharing first aid knowledge, experience and tools, and creating common projects.

Global standards: Establish an International First Aid Certificate, adopted throughout the global network of Red Cross and Red Crescent societies.

Research: Conduct research projects on the real-world use of first aid techniques, to enhance first aid training, and how first aid can act as a preventive tool, encouraging people to take preventive measures, increasing community resilience.

Public awareness: Conduct a web-festival '24 Hours on Earth', using a website and social media to share video, reports and testimony from people around the world highlighting the importance of first aid.

The implementation of these projects will be subject to availability of resources.



ANNEX 10: Reference Centre for Psychosocial Support Programme

Context and introduction

The year 2014 was characterized by an unusually high number of serious crises and disasters world-wide. Violent conflicts in Syria, Ukraine, the Central African Republic, Gaza, Libya and South Sudan have caused widespread human suffering and are contributing to the highest number of refugees globally since the Second World War. Responding to the needs in conflict affected countries and in the countries receiving refugees includes the provision of psychosocial support to beneficiaries, staff and volunteers. While not all the affected National Societies have had strong psychosocial support capacity to begin with, all have made substantial efforts to boost existing capacities or build new capacity.

The complexity and dangers of the crises mentioned above have put staff and volunteers under considerable stress. Fortunately, this is recognized by more National Societies than ever, and there has been a high interest from National Societies in building systems to care for and support volunteers better. In the wake of many armed conflicts it is common to see an increase in instances of sexual and gender-based violence (SGBV). SGBV is often associated with religious and cultural taboos making it very difficult to discuss, let alone address, openly. A scoping study showed that many Red Cross Red Crescent volunteers meet survivors of SGBV and often find it difficult to know how best to support.

In March the Ebola virus disease was first diagnosed in Guinea in West Africa, and the disease quickly spread to the neighbouring countries Sierra Leone and Liberia causing the largest outbreak of Ebola in history. Very early in the operation, psychosocial support was identified as one of the main priorities. Fear, stigma and rampant rumours were serious barriers to persuading patients to seek medical support, to get populations to take appropriate and reasonable measures to limit contamination and to practice safe burials. Being infected not only means a high risk of dying; for many patients it also means high risk of infecting loved ones, loss of livelihood, loss of possessions due to disinfection procedures and being ostracized by the community.

Mental health and psychosocial support was high on the agenda in nearly all disasters and crises world-wide. All members of the IASC Reference Group for Psychosocial Support report that as a result of the growing awareness and demands, their staff is under unusual amounts of stress; and that their human resource capacity is stretched to the limit. This view echoes the difficulties there have been in 2014 in the Movement to recruit enough, sufficiently trained staff and delegates for psychosocial support programmes in emergencies.

Psychosocial support and the PS Centre

The IFRC Reference Centre for Psychosocial Support (PS Centre) is a centre of excellence and functions as a decentralised unit of the IFRC Health Department. The PS Centre is hosted by the Danish Red Cross in Copenhagen and mandated to support, promote, and advocate for the awareness and implementation of psychosocial support through the IFRC Psychosocial Support

Programme.

The most important partners of the PS Centre are the National Societies and the Centre continues to respond to requests from a large number of National Societies from around the world. Being part of the IFRC Global Health team involves close collaboration with the Secretariat, Zone and Regional offices. A good flow of communication and information between the health department unit, zones and regions fosters collaboration and a common ground to reach good results.

The PS Centre strives to uphold a small secretariat with key positions, which are considered the mini-mum resource to deliver on the agreement with the IFRC. In addition, a roster of psychosocial professionals who can be deployed as staff or consultants is continuously developed and maintained. The PS Centre is part of and coordinates closely with the IFRC Global Health Team.

The Centre continues to strengthen and expand its cooperation with other colleagues and departments in the zonal and regional delegations and colleagues and departments in the Secretariat in Geneva, as well as a productive working relationship with the ICRC. Psychosocial support is generally defined as a process of facilitating resilience within individuals, families and communities with “resilience” understood as: The ability of individuals, communities, organisations, or countries exposed to disasters and crises and underlying vulnerabilities to anticipate, reduce the impact of, cope with, and recover from the effects of adversity without compromising their long-term prospects.

Strengthening Psychosocial Support Programming



The 2004 Indian Ocean tsunami called attention to the acute need for psychosocial support in post-catastrophe situations and helped make psychosocial support a priority in humanitarian responses. During the tsunami operation, psychosocial support was an important part of the response and recovery in all affected countries. Following the disaster, a handbook on psychosocial support interventions was developed in close collaboration between the National Societies and the PS Centre. In 2012 it was decided to take the opportunity to learn from the post-tsunami interventions a step further with the “Strengthening Psychosocial Support Programming” project. The project sought to build on past experience to create an improved platform for psychosocial support in the region and globally. It would do so by strengthening the capacities of the National Societies to develop relevant PS programmes as well as by developing a tool to strengthen the link between psychosocial support and Restoring Family Links.

The project was finalised in 2014, and the tangible results were the Restoring Family Links and Psychosocial Support e-learning tool; a field guide and training manual on providing psychosocial support to people separated from family members and the book “Strengthening Resilience: A global compilation of psychosocial support interventions”, and finally a workshop for all the National Societies involved in the project, the Asia Pacific Zone and the PS Centre.

Psychosocial support can be centred on promotion or prevention. Promotion focuses on the notion of psychosocial well-being as a positive attribute, rather than merely the absence of psychosocial or mental health problems. Prevention can focus on preventing psychosocial problems from arising in the first place or preventing mild problems from developing into more severe or persistent mental health problems. These two aspects of psychosocial support contribute to the building of resilience in the face of new crisis or other distressing life circumstances.

Red Cross and Red Crescent National Societies implement community-based psychosocial support interventions that focus on strengthening the social bonds of people in affected communities, by improving the psychosocial well-being of individuals and of communities as whole entities. This approach is based on the idea that if people are empowered to care for themselves and others, their individual and communal self-confidence and resources will improve. This, in turn, will encourage positive recovery and strengthen the ability to deal with challenges.

Progress towards outcomes

The PS Centre serves to promote and enable psycho-social wellbeing of beneficiaries, humanitarian staff and volunteers, thereby contributing to the realization of the main aims of the IFRC Strategy 2020. This is achieved through four strategic approaches laid out in the PS Centre 2011-2015 Strategic Operational Framework:

- Technical and operational support.
- Capacity building of National Societies and competence development of staff and volunteers.
- Knowledge generation and knowledge sharing.
- Advocacy and communication.

Strategic Approach 1: Technical and Operational Support

The PS Centre continually receives various requests for support from National Societies and regional and zonal offices. Request include questions about how to integrate PSS in new or existing programmes, tools on monitoring and assessment, ideas for activities and much more. Often the answers to the re-quests can be found in the material published by the PS Centre or by referring to other relevant literature or partners. Sometimes requests result in trainings or consultancies. Requests also include briefing of delegates and assistance in identifying and recruiting suitable candidates for PSS delegate positions.

The PS Centre remains in close contact with Inter-national Federation PSS delegates providing ad hoc technical and operational support and in return receiving valuable input from the field.

Psychosocial Support in Emergencies

Since 2013 the focus of the PS Centre in relation to emergencies has been broadened. The PS Centre continues to play an active role in the maintenance and development of the PSS component of the ERU, working closely together with the ERU deploying National Societies. Adjacent to the ERU system there is a need for the National Societies to have their own capacity for providing psychosocial support in emergencies to supplement the ERUs in larger disasters and to be able to respond to disasters with less outside assistance.

Caring for the volunteers – a central activity in emergencies

Syria, Ukraine and the Central African Republic. Three emergencies, in which Red Cross and Red Crescent volunteers were on the spot to help those in need at great personal risk – and too often also at great personal cost. The challenges in the emergencies were different, but one thing was the same: An understanding on management levels that supporting and caring for the volunteers must be highly prioritized.

In Syria and neighbouring countries several “Caring for Volunteers” workshops were conducted by the National Societies, and demand for the “Caring for volunteers: A Psychosocial Support toolkit” has been so great that it has been necessary to reprint the Arabic version.

In the Central African Republic the security situation was so tense that only a handful of delegates were allowed in the country at a time. Still, admitting a psychosocial support delegate was prioritized to support the CARC. In Ukraine Red Cross asked for assistance in supporting the volunteers who were providing first aid services during the clashes in Kiev. Throughout the year, the National Society has rapidly built a large capacity for psychosocial support training staff and volunteers in numerous branches in caring for volunteers a community based psychosocial support.

Ebola virus disease

The outbreak of Ebola in West Africa is one of the most difficult emergency operations to date. There was very little experience in the humanitarian sector in providing psychosocial support in the context of a disease which is as dangerous and contagious as Ebola, and the provision of psychosocial support was further complicated by the fact that it was necessary to rethink many basic methods of providing the support when people either had to keep physical distance or be ensconced in multiple layers of protective clothing, including goggles and face masks. The fear and stigma surrounding the disease not only made it difficult to provide health care and psychosocial support to the affected people. It also made it unusually difficult to recruit delegates who were sufficiently experienced and willing and available for deployment to this exceptional situation.

In the Ebola affected countries, volunteers (working with community out-reach and safe and dignified burials) were trained in psychological first aid and psychosocial support, affected families were offered counselling, local staff in the IFRC hospital in Kenema, Sierra Leone were supported and a range of anti-stigma and anti-fear messages were developed. Among the steps taken by the PS Centre to enable the National Societies to provide psychosocial support to the affected population, staff, volunteers and delegates were:

- a range of measures to identify suitable delegates and preparing them for deployment, including wide searches in networks, screening of delegates, briefings and answering questions, and development of informational material for friends and families of delegates.
- Training, briefing and ongoing technical support to staff and delegates in the field.
- On-going collection of experiences and lessons learned from the field and other organizations in order to improve the quality and level of support to the field.
- Development, collection and adaptation of psychosocial support tools to fit the specific context of Ebola – particularly with regards to the constraints in physical closeness and the severity of the situation.

Central African Republic (CAR)

Since late 2013 the Central African Republic has experienced extremely violent clashes between militia groups. Central African Red Cross (CARC) provided different types of support to the affected population. The director of the Health Department of CARC and a CARC staff member were trained in community-based psychosocial support in Yaoundé, Cameroon in 2012, at a training of trainers arranged by the PS Centre. As a direct result of this they were able to train 281

CARC volunteers in psychosocial support in November 2013. So when the violence broke out on 5 December, a great deal of volunteers already had some background in psychosocial support. It soon became clear that the volunteers were under tremendous stress. Especially those whose job was to go into the streets of Bangui after violent clashes and recover the bodies, many of which were mutilated, were under extreme stress. The management of CARC asked the IFRC for further support. In January, support was provided to CARC to assist in formulating a plan of action for providing psychosocial support to the most severely affected by the crisis and an initial training for 250 volunteers was held, conveying basic information on how to provide psychosocial support.

Ukraine

The civil unrest in the Ukrainian capital of Kiev, which had been oscillating between calm and violence since November 2013, became more severe during the last weeks of February 2014. More than 100 people died during clashes between anti-government protesters and police. Since then, unrest and violence has spread from Kiev to other parts of the Ukraine, especially to its south-eastern regions.

In order to assist those affected by the violence, the Ukraine Red Cross Society (URCS) immediately mobilized all its first aid rapid response teams, providing first aid and evacuating wounded people. Five URCS volunteers were wounded while on duty. Because of the dangerous and demanding work, the URCS quickly decided to increase their capacity in caring for volunteers.

A matter of life and death

Most of the time, when people think about psychosocial support, they think that it is not really a priority. But in the context of Ebola it is actually a life and death matter. To give an example: Working at the front with the safe and dignified burials is very stressful. And we know that when people are stressed or they are under the influence of alcohol they can put their lives at risk. Helping them managing their stress, taking good care of themselves and having appropriate peer support is a life and death matter in the Ebola context.

Eliza Cheung, Psychosocial Support delegate, Hong Kong Red Cross, deployed in July and August to Liberia to support Liberian Red cross Society in their fight against Ebola. The full interview with Ms. Cheung can be viewed on www.youtube.com, by searching "Psychosocial support during an outbreak of Ebola Virus Disease"

Typhoon Haiyan, Philippines

After the typhoon Haiyan in the Philippines the PSS component of the ERU was deployed with two ERUs. The evaluation, focused on both the organisational and the psychosocial sides of the operation. The evaluation has resulted in a list of recommendations for improvement for both the PS Centre and the deploying National Societies, which are being worked into action sheets for follow-up in early 2015.

During the response to typhoon Haiyan 13 PSS delegates were attached to the Health ERU teams over three rotations. With local PRC volunteers trained in basic psychosocial skills they were able to provide PS activities in child-friendly spaces, psychological first aid (PFA) for children, adults, and volunteers within the clinic base and in outreach. One ERU Health team integrated Violence Prevention and included VP delegates who worked on training, awareness raising and protection issues related to VP in Ormoc and Tacloban.

Two psychosocial support delegates from Belarus, who had participated in the 2013 regional PSS training in Moscow, were deployed to Ukraine to help set up support systems and conduct trainings with the support of the PS Centre. Ukraine Red Cross Society has prioritized psychosocial support highly and throughout 2014 there has been a steady increase in psychosocial support capacity, supported by the two Belarussian delegates, several PS Centre Roster members, IFRC and Danish Red Cross.

As a positive spin off, the involvement of the two Belarussian delegates has sparked interest in Belarus Red Cross to increase its psychosocial support capacity.

Syria crisis

The ongoing armed conflict and refugee crisis in Syria and surrounding countries continued in 2014. The Syrian crisis presents a big challenge. The needs are enormous and the unstable situation both in terms of security and funding makes the much needed capacity building difficult. In Syria, a major concern is supporting and caring for the Syrian Arab Red Crescent staff and volunteers while in the neighbouring countries efforts to provide psychosocial support to the many refugees are ongoing. Caring for staff and volunteers and sexual and gender-based violence against both men and women has been singled out by the National Societies as areas of special concern, and the PS Centre has worked intensively with this during 2014. The National Societies in Syria, Lebanon, Jordan and Turkey are providing psychosocial support activities in community centres and refugee camps to adults and children. Many European countries that are experiencing unprecedented influx of Syrian refugees have also increased their capacity in order to provide psycho-social support to the refugees, many of whom have a very long and perilous journey behind them.

Strategic Approach 2: Capacity building of National Societies and competence development of staff and volunteers

Training is a powerful tool for building capacity in psychosocial support. There is evidence that training enhances capacity for delivering PSS and that it is in fact an obligation to train staff and volunteers well to ensure strengthening resilience and the do no harm principles¹⁵.

In 2014 the PS Centre has focused on the development and testing of new specialised trainings and on trainings for specific capacity building purposes, such as enabling Kenya Red Cross volunteers to implement specific activities for children in informal settlements in Nairobi.

Together with the regional psychosocial support delegate, the PS Centre developed a tailored regional training in Phnom Penh, Cambodia on psychosocial support in emergencies. Experience from this training was used to develop the PSSIE training curriculum, which was launched at a training in Copenhagen later in the year.¹⁵

Altogether, the PS Centre facilitated and co-facilitated 15 trainings at global, regional or national (HQ) level in 2015. The picture below shows the countries from which participants came to the trainings (dark red). These trainings are only the tip of the iceberg as National Societies are conducting numerous trainings without the assistance of the PS Centre.

¹⁵ Henderson, Silje: Psychosocial interventions after natural disasters- an analysis of evidence and recommendations for practice, 2013

Capacity building matters

In March 2014, the Maldives Red Crescent (MRC) and the PS Centre conducted a Community-based psychosocial support training of trainers for 27 MRC staff and volunteers. In December a fire broke out in the Maldives Water and Sewerage Company (MWSC)'s Generator Unit, disrupting Male' City's water supply for several days. 10 days after the fire, the PS Centre received an email from one of the participants at the training:

"We mobilized over 750 volunteers to help with the distribution of water to the people. Working around the clock for almost eight days we realized the need for PSS not just in the operation center but for the community and the staff of MWSC. A group of us had some meetings and decided to come up with some structured de-briefing and PFA sessions. We used the materials you provided as a guide. After the initial plan, we met with 22 volunteers (who had some PSS background) to have a refresher session on PFA and stress and coping and the debriefing. Several people from various organizations (both government and private offices) agreed to go as Maldivian Red Crescent volunteers to provide PSS to the people. On this session we held last Friday, we did an induction session of the Movement and got them to sign as volunteers. Yesterday we had our first session with the staff of MWSC and we feel that it was a success. It was voluntary and 24 participants were there. Today we are having another session for the next group."

Developing the PS Academy

The PS Academy is the collective term for the psychosocial support trainings offered to the National Societies. The idea behind the PS Academy is to offer a wide range of trainings, from a basic introduction to community-based psychosocial support, over shorter, specialized trainings to training of trainers for more experienced psychosocial support providers. The PS Centre strongly encourages that each training is adapted to fit the specific context and needs. In 2014 four new trainings were developed:

- Psychosocial support in emergencies
- Broken Links. Psychosocial support to people separated from family members
- Caring for Volunteers
- Psychosocial support to people affected by sexual and gender-based violence. (See box on page 11)

Roster

The PS Centre continuously updates the roster of PSS experts and trainers. This has been done in order to better respond to training requests as well as to harmonize trainings and expectations. A roster of experienced staff and delegates were able to take on shorter term missions (1-2 weeks) adds to the strength and ability of the Centre to provide capacity building and technical and operational support. The following are examples of work done by roster members in 2014:

- facilitated or co-facilitated trainings,
- were deployed to the Central African Republic and Ukraine to help set up support systems for volunteers in the two National Societies,
- were a strong advocate for psychosocial support in the Healthcare in Danger workshops and this work will continue in 2015,
- were deployed to West Africa, training volunteers and helping the National Societies developing plans of action and setting up psychosocial support for beneficiaries and staff and volunteers in the Ebola response,
- supported the development of important guide-lines such as HID guidelines and the development of monitoring and evaluation tools.

In December, most of the Roster members met in Copenhagen for a two-day workshop on psychosocial support in emergencies, learning from each other's experiences in recent emergencies and discussing how responses can be improved in the future. A session aimed at

ensuring that the roster members are up-to date with important emergency tools.

PS Centre tool box – production and rollout

The development of more specialized manuals and training materials means that the PS Centre is increasingly able to comply with requests by providing more in depth support not only to emergency response or disaster preparedness programmes, but also to development programmes. The tools are developed in cooperation with and on the request of National Societies and enable them to respond better, and in a more timely manner, to psychosocial needs.

Additionally the PS Centre has developed smaller publications responding to ad hoc needs, such as the briefing note and briefing package about providing psychosocial support to people affected by Ebola, a brochure on Psychosocial support during epidemics, and a brochure in collaboration with the IFRC Staff Health Unit with information to families and friends of delegates deployed to the Ebola operation. The PS Centre regularly provides input to guidelines, policies and tools developed by National Societies, other IFRC operational units and important partners in academia and the international mental health and psychosocial support community.

All developed materials are available in both electronic and hard copies. It is also available for down-load on www.pscentre.org

Strategic Approach 3: Knowledge Generation and Knowledge Sharing

Interventions and methodologies are requested in an increasing number of National Societies and IFRC operational units. New areas of interventions and new ways of combining psychosocial support with other types of humanitarian interventions are continuously emerging. At the same time, universities and applied research institutions produce large amounts of research and knowledge about new interventions and target groups. As the area of expertise and the number of requests grow, the need for new knowledge, tools and methodologies increase in order to base interventions on best practice and research.

With strong ties to both the practical implementation of psychosocial support in the field and the research in academia, the PS Centre is uniquely placed to bridge the gap between the two and work towards better generating and sharing of knowledge, ultimately resulting in better interventions.

Mapping of psychosocial outreach

Knowledge of the psychosocial support capacity and needs in the National Societies is essential in order to assist them in supporting those affected by disasters and sudden or slowly developing crises. The PS Centre has been in contact with the PSS focal persons of 66 National Societies worldwide in order to map the existing psychosocial support efforts, analyse which tools and materials are being used and to look into the needs for further support. Increasing the number of focal persons in the National Society is a high priority as this greatly increases the reach of the PS Centre and facilitates the sharing of knowledge and experience.

The results from this global communication show that 92% of the participating National Societies that were reached conduct PSS activities or activities with elements of PSS. 85% of these National Societies are using the PS Centre resources including tools and handbooks and 75% have had IFRC psychosocial trainings conducted in their National Society. Furthermore the mapping gives a deeper insight towards where to focus the development of future tools.

Operationalising Psychosocial Support in Crisis, OPSIC

The PS Centre coordinates the EU funded research project, "Operationalising Psychosocial Support in Crisis" (OPSIC). 2014 was the second year of the three yearlong project and the year when the results became tangible. More than 600 international guidelines and handbooks on PSS were analysed, broken down and comprised into 51 action sheet for providing psychosocial support to different target groups, in different stages of response and in a range of different types of events. The action sheets have already proven their usefulness: They were used by Austrian Red Cross when they updated their plan for disaster preparedness in flooding situations and the PS Centre has used the action sheet when asked to provide input to the IFRC guidelines on

chemical, biological, radiological and nuclear events (CBRN). A study on long-term effects of crisis has also been performed in the project showing that the need for psychosocial support is present for much longer time than previously assumed. The results from this study will help guide recommendations for providing psychosocial support in the long-term aftermath of disasters.

	<p>Strengthening Resilience</p>	<p>Strengthening Resilience: A global selection of psychosocial interventions was developed in answer to the growing demand for guidance on how to implement psychosocial support activities. It is designed to provide the practitioner with a range of possibilities when planning psychosocial support activities. Drawing on case studies and programme globally, book presents fundamental methods of providing psychosocial support, including concrete examples of interventions, ideas for activities, and how to modify them to suit specific contexts and groups.</p>
	<p>Psychosocial support in emergencies</p>	<p>Based on problem-based learning, practical exercises and role playing mixed with presentations, this training prepares the experienced psychosocial support staff and volunteers for work in the field during and after emergencies by providing knowledge on how to identify, train and supervise volunteers. The training introduces the delegate to fieldwork by focusing on assessment, implementation, M&E and liaison and coordination. By the end of this training, participants will be able to work according to the standard operational procedures and meet criteria as stated in the IASC Guidelines when setting up the PS component in the vicinity of the ERU.</p>
	<p>Broken Links. Psychosocial support to people separated from family members, field guide and training module</p>	<p>Developed to support staff and volunteers in a wide range of settings where they may come in contact with families who have been separated from their loved ones. The material focuses on the causes and consequences of being separated from family members, the psychosocial impacts of separation, how staff and volunteers can support people in this situation, as well as self-care for staff and volunteers. The one-day training is designed to support staff and volunteers contact with families who have been separated from their loved ones.</p>
	<p>Psychosocial support to people affected by sexual and gender-based violence</p>	<p>SGBV is a major problem in the wake of the conflicts, and it is something that is always difficult to deal with, especially in cultures where matters of sexuality and sexual assault is rarely talked about openly. The training subjects like the definition of SGBV, sensitization, dilemmas and do no supportive communications and referral.</p>
	<p>Caring for volunteers, training</p>	<p>This training prepares participants to facilitate "Caring for Volunteers" workshops built on the "Caring for Volunteers, a Psychosocial Support Toolkit". The participants gain deeper insight in the subjects of the tool kit: understanding of psychosocial support; risks, resilience and protective factors for volunteers' psychosocial well-being; self-care; peer support; Psychological First Aid; setting up psychosocial support systems for volunteers; monitoring and evaluating volunteers' efforts.</p>
	<p>Moving Together: Promoting psychosocial well-being through sport and physical activity</p>	<p>A handbook about delivering psychosocial support programmes in crisis situations. Well-designed sport activities offer a safe and friendly space for expressing and addressing problems and fears and help participants gain resilience, coping skills and hope. The handbook explains the theoretical framework for sport and physical activities in psychosocial support interventions, and how to implement. It includes activity cards that can be adapted to suit different situations.</p>

Strategic Approach 4: Advocacy and Communication

Dialogue and exchange of information, knowledge and views are at the core of the PS Centre's approach to communication and advocacy. Through publications, magazines, newsletters, social media and the website the PS Centre increases its visibility and disseminates information. But the return flow of information – from the field, from partners, from the Secretariat and from the mental health and psycho-social support community at large to the PS Centre is equally important. For this reason there is a strong focus on communication directly with delegates, staff and volunteers in the field, increased presence on social media, a website design, which invites dialogue through commenting and increased collaboration with www.mhpss.net

The magazine Coping with Crisis is a part of the effort to advocate for psychosocial support, to high-light important issues and to showcase the wide spectrum of psychosocial support programming. The first issue focused on the mental health gap and violence. The second issue

focused on the psychosocial consequences of performing dangerous humanitarian work. This issue also featured a brochure on providing psychosocial support in epidemics.

The PS Centre has been able to increase its visibility within and outside the Movement. In addition to sharing magazines, newsletters, updating the PS Facebook site and website regularly, the PS Centre is advocating psychosocial support by being visible and vocal in meetings, networks, conferences, etc. inside and outside the Movement. In 2014 the PS Centre hosted the annual meeting in the IASC Working Group for Mental Health and Psychosocial Support, participated actively in the ICRC led Healthcare in Danger project in order to place psychosocial support high on the agenda. The PS Centre represents IFRC on the board of the online global resource and networking tool www.mhpss.net.

Likewise, visibility is ensured through a generally high level of activity; trainings, development and introduction of new training material and establishment and development of partnerships.

Social media has become increasingly important medium for communication and dialogue within the Red Cross Red Crescent psychosocial community. Making short updates is easy and time-efficient and through the informal nature of the medium, it is possible to show a broad range of the psychosocial support activities in the Red Cross Red Crescent. The outreach on Facebook, measured in “likes” has doubled in 2014.

Financial management

Throughout 2014, the PS Centre has maintained close cooperation with its core group of PNS donors; the National Societies of Denmark, Norway, Canada, Japan, Finland, Iceland and France. Generally, there is increasing interest among National Societies to collaborate and partner with the PS Centre. While the interest in psychosocial support and developing partnerships with the PS Centre increases, it is still a challenge to attract new PNS funding partners. However, new and improved agreements have been negotiated with some of the traditional PNS donors. Expanding and working towards a broader PNS funding base remains a key priority for the PS Centre – as the current situation is vulnerable.

Project based funding, mainly from the European Commission, remains important, especially related to research – and knowledge management projects. The PS Centre participates in three European re-search projects, one of which was kicked off in 2014. At the beginning of 2014 a new financial management set-up was introduced, which has enabled the PS Centre to better plan and manage resources effectively. This has been actively supported by the financial controlling section of the Danish Red Cross.

The total expenditure of the PS Centre mounts to DKK 7.196.301, which is an increase of 19% since 2013. The detailed financial report is included in the PS Centre Financial Statement, which is annexed to this Annual Report.

Looking ahead

The PS Centre will continue to work towards strengthening the IFRC Psychosocial Support Programme following the strategic aims set out in its Strategic Operational Framework, with a special focus on psychosocial support in emergencies, knowledge management and advocacy:

Psychosocial support in emergencies

2014 saw an unusual high number of serious emergencies and there is no sign of a lessening in the number or severity of emergencies in 2015. Coupled with an increased awareness in the field about the importance of psychosocial support there will be a continued need to support National Societies and IFRC operational units in preparing for, implementing and monitoring and evaluating psychosocial support in emergencies. This means that there is an increased demand for the PS Centre to become more operational in its support to National Societies. This need will be met through an increased focus on capacity building and technical support to programming, but also by exploring ways of improved direct field support.

Knowledge management

Over the past few years, there has been an increase in the number of psychosocial support programmes and interventions globally; related to preparedness, emergency relief, recovery and longer term programming, within a wide array of thematic programmes ranging from health, disaster management, migration to resilience programmes. This generates enormous amounts of new learning and knowledge, which needs to be captured, developed and used in order to ensure evolved learning and increased capacities and applicability in the Movement. The PS Centre will work towards strengthening the knowledge base on psychosocial support, with the ambition to strengthen the quality of the technical support and the capacity building available to National Societies. Furthermore, more cost effective ways of sharing knowledge, such as e-learning and web-based solutions will be explored.

Advocacy

There will be a continued effort to advocate for the inclusion and mainstreaming of psychosocial support within the Red Cross Red Crescent Movement, but 2015 and 2016 also offers important opportunities to influence the Movement and the global humanitarian agenda. Focus will be on psychological consequences of armed conflict, which will be addressed at the 32nd International Conference in 2015. The PS Centre will work closely with the Inter-Agency Standing Committee Reference Group on Mental Health and Psychosocial Support on including psychosocial support on the agenda of the World Humanitarian Summit in 2016.

How we work

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

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

Contact information

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