



Health and Care Forum, Thursday 10 May 2007

**Pakistan WATSAN and Gender Equality and Community Participation
Programme**

Speakers: Dr Ali Warsi, Pakistan Red Crescent Society (PRCS)
Charity Sikamo, the WATSAN delegate for the IFRC
Moderator: Dr Mukesh Kapila, Actign Director, Policy and Planning Division

Abbreviations: PRCS (Pakistan Red Crescent Society); ERUs (Emergency Response Units); CBFA (Community Based First Aid); ERRA (Earthquake Reconstruction and Rehabilitation Authority); PHAST (Participatory Hygiene and Sanitation Transformation)

Presentation 1

Dr Ali Warsi of the Pakistan Red Crescent Society (PRCS) opened the session with a **summary of the response of the PRCS to the earthquake of 2005.**

This disaster led to extensive destruction of the physical infrastructure; in the worst hit areas 51% of houses, water and sanitation systems and 70% of health facilities were destroyed. Working as part of a coordinated approach with the national government, other humanitarian agencies and local communities, the PRCS focused on setting up Emergency Response Units (ERUs), the provision of water and sanitation facilities and hygiene programmes, mobile clinics, mental health support, and improving maternal and child health.

As well as succeeding in encouraging a high level of community participation, the PRCS programme has led to some longer term benefits; increased capacity building, improved access to health care in communities who previously had none and new areas of health care work, such as Community Based First Aid (CBFA), Safe Motherhood, Primary Health Care, avian influenza, malaria prevention and HIV/AIDS.

Dr Warsi outlined some of the challenges faced by the programme: these included gaps in human resources, low pay for PRCS workers, communication and coordination problems, gender issues resulting from cultural and religious restrictions for women, lack of qualified staff (especially women), competition between NGOs and lack of national media coverage.

Presentation 2

Charity Sikamo, the WATSAN delegate for the IFRC, then addressed the conference on some of the challenges faced by the PRCS with particular reference to **gender equality and community participation in the WATSAN programme.**

Communities affected by the earthquake were experiencing serious health problems as a result of lack of access to safe drinking water, poor hygiene awareness and restrictions on the use of emergency sanitation facilities by women on cultural and religious grounds.

Working alongside government policy on reconstruction (the 'hardware'), established by the Earthquake Reconstruction and Rehabilitation Authority (ERRA) the PRCS aimed to provide the 'software'; promoting active community involvement, improving hygiene practices and providing sanitation facilities, particularly so that they could be used by women.

The key components of the programme included:

- Establishing a multidisciplinary WATSAN team.
- Building partnership with key stakeholders.
- Setting up a system for monitoring achievements.
- The gradual introduction of community participation.
- Passing from the emergency phase through transition to the recovery phase.
- Mainstreaming gender issues.

At the core of these components were sustainability, capacity building and a developing participatory approach.

In total 68% of the population of the Banian Union Council were beneficiaries of the activities of the PRCS WATSAN programme. In addition to the provision of sanitation and hygiene facilities or equipment, 173 community volunteers were trained in Participatory Hygiene and Sanitation Transformation (PHAST) of whom 83 were female.

Moving forwards, the PRCS plans to develop the PHAST process as a community-based management tool for health programmes and the integration of hygiene promotion in the Primary Health Care community-based programmes.

Attendees were then invited to submit their questions and comments on the presentations given. A key issue concerned strategies to attract women to work as volunteers within the prevailing cultural and religious restrictions. Extensive lobbying and talking to leaders of the community about some of the important responsibilities that women have in the home convinced them of the need to engage female as well as male hygiene promoters, particularly as it is not acceptable for female workers to work with men and vice versa.

Dr **Mukesh Kapila**, Acting Director of the Policy and Planning Division, then summed up some lessons that should be learned from the experience of the PRCS earthquake response

relating particularly to gender issues. He emphasised the importance of having access to meaningful disaggregated data and understanding cultural constraints but also working to find a way to overcome issues that prevent women from moving forwards.

He stressed that there was a need to define the Federation's contribution in addressing violence of different forms – such as urban and youth violence and most importantly gender-based violence.

Dr Kapila stated that although the Federation have had a gender policy since 1999 this needs to be updated. The Secretariat is currently recommending guidelines for all Federation operations and appeals for individual staff responsibility. Nevertheless, there is a need for investment in gender equality and a more efficient mainstreaming approach. In 2007 the following outputs are expected:

- An updated policy
- The integration of a gender perspective into the key global agenda
- Policies and practical approaches
- The zero tolerance implementation within the Federation.

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Health and Care Forum, Thursday 10 May 2007

How does Health and Care programming links with the Federation Health and Care strategy?

Speakers: **Evelina Milusheva, Bulgarian Red Cross**
Ingele Holmetz, Head of Health and Social Welfare Department, Swedish Red Cross
Carlos Mirete Valmala, Spanish Red Cross
Bernard Simon, French Red Cross

Moderator: **Rose Tamsin**

Abbreviations: NS (National Society), Spanish Red Cross (SRC), CRF (Croix-Rouge Française), HCP (Home Care Program)

Case study 1:

Bulgarian Red Cross: Home Care Program,

The Bulgarian Red Cross has 6 centres caring for 350 beneficiaries. The program's goal is to address the issue of insufficient homecare available to vulnerable and disabled people.

The centres provide such services as hygiene care, food, and shopping, health care and social support. Some of the project's outcomes for the elderly have been reduced social isolation, life-long learning, high quality community-based services by involving older people in the organization of the program.

The National Society is an active partner with the State in the national policy of deinstitutionalization.

The Age Awareness and Advocacy project is geared toward community involvement.

The continuing challenge is sustainability. A sense of ownership, fundraising campaigns and income generated activities such as training can support towards a more sustainable programme.

Case Study 2:

Swedish Red Cross: Health as a Human Right does it apply to everyone?

Illegal migrants are excluded and discriminated against in the Swedish national health care system. The Swedish Red Cross has taken an initiative to support this vulnerable population in accessing health care. The National Society believes everyone should have a right to health conventions.

Supported by a network of volunteers who liaise the health needs of these immigrants with hospitals and other health services. This includes advocacy in the media to raise awareness on the right of this group and a discussion on a legal framework addressing their health needs. This has received public attention and facilitated dialogue with politicians. Swedish Red Cross understands advocacy effort in order to make changes will demand a long term approach.

Case study 3:

Spanish Red Cross: Program for the Elderly,

The Spanish Red Cross has a well-established and extensive program for the elderly. This includes a telephone-based triage service, home based care, a support system for care givers, day or night care centres, transportation for disabled persons and emergency services. These services are provided by a network of 150,000 volunteers.

This programme also provides a wide range of social activities for the ageing population. The Spanish Red Cross works closely with the government.

Case study 4:

Les Actions Sociales et Sanitaires Nationales de la Croix Rouge Française.

The French Red Cross enjoys a strong and successful partnership with the French Government. Its health programmes includes running retirement homes, centres for the disabled, training schools, rescue services, ambulance services, emergency housing, programmes for refugee and migrants and counselling services.

The National Society monitors its activities by an internal auditing department. Each programme uses its own indicators. The National Society believes in quality programmes and activities

must be measurable. The National Society should be proactive proposing solutions and discuss them with the relevant ministries.

Summary of the discussion:-

Ensuring our community-based health programmes met the needs of our beneficiaries

- Beneficiaries and volunteers should be actively involved in identifying their own needs.
- Community design its own project, manages and evaluates its progress and success. Community should be an equal partner.

Increasing our advocacy effort with the most vulnerable

- Effective advocacy involves all stakeholders from beneficiaries at community to leaders at the political level.
- Engaging celebrities and government officials enhances changes.
- National Societies need to share their experiences in advocacy and learn from one another.
- Advocacy should be evidence based.
- Partnering with other agencies with same advocacy agenda can give a 'louder voice' to the most vulnerable.

Mobilising volunteers and community groups more effectively

- National Society need to show passion in what they do with a focus on actions and respect for volunteers.
- Volunteers should be involved at the decision making in the National Society.
- Volunteer management needs to be flexible according to the volunteers' lifestyle and availability.
- Volunteers need to have their expenses reimbursed.

Learning about the strategy and implementing it in the National Society

- Disseminate and discuss with others about the strategy and its directions.
- Increase advocacy effort in partnership.
- Implementing the strategic directions consistent with local needs.
- Foster partnership with other local community groups and committees.
- Increase social mobilisation in health.



Health and Care Forum, Wednesday 9 May 2007

Implementation of the Health and Care Strategy

Speakers: Lois Hue, Jamaican Red Cross
Enkhtuya Byambasuren, Mongolian Red Cross
Monique Mayala Ngaralbaye, National Director for Gender and Development of the Chad Red Cross
Dr. Magda El Sherbiny, Egyptian Red Crescent

Moderator: Ilona Kickbusch, external consultant

Abbreviations: AI (avian influenza), FGM (female genital mutilation), JRC (Jamaican Red Cross), MRCS (Mongolian Red Cross Society), NS (National Society), GO (governmental organisations)

Ilona Kickbusch on implementation of the Health and Care Strategy:

- Establishing a cycle of continuous process improvement with defined tasks of strategic management identified through mission and strategic vision.
- Setting measurable objectives and crafting, implementing and executing the strategy. Evaluating performance
- Identifying project inputs, activities, intended outputs and outcomes.

The purpose of the day's sessions was to examine *how* to implement and *how* to measure a successful programme at the national society level.

Key elements to consider:

- The unique culture, organisational capacities, support systems, etc of every National Society and country with are key factors in successful programme implementation
- The unique nature of the International Federation of the Red Cross and Red Crescent Societies as a learning organisation comprised of volunteers, requiring a tailored management approach different to standard organisations or companies.

Case Study 1:

Jamaican Red Cross: HIV & AIDS Programming, presented by Ms. Lois Hue

The Jamaican Red Cross programme faced significant social obstacles regarding local attitudes both about HIV/AIDS and the stigma attached to various "at risk" social groups. In

Jamaica, some 25,000 people are infected with HIV and 11,000 have AIDS. AIDS has a significant negative impact on the most productive sector of society, with 65% of all AIDS cases in Jamaica are with the 20-44 year-old age group.

The Jamaican Red Cross implemented seven approaches:

- "Together We Can" youth campaign,
- "Faces" - poster and billboard campaign adopted from Red Cross societies from Central America, adjusted to Jamaican demographic context;
- anti-stigma campaign,
- voluntary testing and counselling program,
- social marketing and mobilization programme,
- home-based care initiative
- strategic alliances.

The case study highlighted the creative initiatives that could be taken to create programming that is more relevant to specific social and cultural contexts. Example: a mobile AIDS testing programme which initially met with much resistance. In Jamaica it is common practice for preachers to preach to passengers on public busses. The Jamaican RC took this approach and introduced a free ride on a bus - in return for listening to a specific message.

Case Study 2:

Mongolian Red Cross: Social Care Programme, presented by Ms. Enkhtuya Byambasuren

Increased migration to the capital city, Ulaanbaatar,

creates pressure on the city's infrastructure and services. Many migrants who moved to the city do not have any relatives there and experience. Older people, single-households headed by women, as well as disables suffer particularly from lack of socialization and support.

Mongolian Red Cross Society developed a programme to help the 2,500 most vulnerable residents of the city through Homecare and Social Care programme, in co-operation with GOs and NGOs.

The case study highlighted the successful outputs, including 1,000 trained volunteers, 10 Social Centres established and 60 beneficiaries' situation improved that they no longer need project support. The programme improved networks with GOs and NGOs, Red Cross branch volunteers increased, volunteer management improved and the Mongolian Red Cross Society benefited from an increase in public image.

Case study 3:
Chad Red Cross: Fighting against Female Genital Mutilation in Chad, presented by Ms. Monique Mayala Ngaralbaye

The Chad Red Cross initiated a campaign against female genital mutilation (FGM), a traditional initiation rite in the country that has been declared illegal. The Chad Red Cross decided to target four regions for their intervention, focusing on the following activities: general population information campaign, sensitisation of influential figures, training, setting-up advocacy network amongst the village chiefs and micro-projects to generate revenue for former FGM practitioners who have been retrained to carry out other professions.

The programme relies on motivated volunteers, through activities that include educating of population through theatre shows or radio programmes (Chad has an illiteracy rate of about 80%). The HIV/AIDS awareness raising programme also contributed to the battle against FGM, as people become more wary of the danger of infection during the excision itself, and the increased risk of infection afterwards.

Constraints include the slow implementation of law banning FGM, financial problems, and the lack of infrastructure to accommodate endangered women. The programme has been contributing towards breaking the taboo of talking about FGM. An alternative initiation rite is now being considered by local chiefs, slowly contributing towards complete elimination of FGM practice from Chad.

Case Study 4:
Egyptian Red Crescent: Avian Influenza preparedness mitigation and response, presented by Dr. Magda El Sherbiny

Egyptian RC presented the impact of avian influenza (AI) on Egypt's population. Poultry, especially farmed in backyards, has traditionally been a cheap source of protein and an important source of income for poor families. The overall goal of the Egyptian RC programme is to provide vulnerable communities with support and assistance in dealing with AI outbreaks, as well as to prepare for human influenza pandemic.

Implemented in strong co-operation with government and NGOs, the programme focuses on community empowerment, especially of young people, and on enhancing health and hygiene education.

Conclusions

Ilona Kickbusch summarised that all four programmes related well to the Global Health and Care Strategy. She also stressed the motivation of volunteers as the main strength of the International Federation of the Red Cross, a point that had been emphasised in all presentations.

Key elements for successful implementation of the strategies:

- good planning, with set priorities according to the needs of the countries and the vulnerable beneficiaries
- community participation
- clearly defined scientific indicators to measure success, impact and sustainability
- creating partnerships with other organisations and governments (which has seen a significant increase over the last ten years)
- links to the Global Health and Care Strategy formulated by the International Federation of Red Cross and Red Crescent Societies
- financial sustainability and continuity to achieve a lasting impact.
- A move from project-based to long-term activities
- A compromise between standardised programmes and adaptation to each National Society's specific situation was imperative.
- While the International Federation of the Red Cross has to speak a common

language in order to facilitate learning
between NS, standardisation should not

reduce diversity or stifle innovation.

Summary of the discussions:

Capacity building:

- Strengthen volunteer base to increase operational capacity
- Improve quality and performance of volunteers through training and accreditation
- Using existing well established programme for strengthening the capacity of the NS – such as CBFA (Community Based First Aid), as this programme is a vehicle for other programmes as well
- Adapt the existing programmes with new methodologies
- Ensure M& E tools are up to date and disseminated to the National Societies
- Identify focal points in each NS responsible for M&E ensuring continuity in using M&E
- Partnering between different national Societies on technical support and training
- Use of IT tools such as pod casts, chat room, other online tools
- Develop a common strategic plan integrating Health and Care and DM programmes
- Better coordination of recruitment, training and retention of quality professionals
- Secretariat to provide guidelines on standardised appraisal
- Recruit from the pool of volunteers and train them to become professionals
- Maintain web groups or inter-regional database of health professionals
- Establish strategic alliances with universities focusing on their role to critically evaluate programme

Social mobilisation:

- First important to evaluate, monitor and share lessons concerning volunteer mobilisation
- Develop best practice manuals with experiences of dealing with outbreaks such as malaria
- Programme beneficiaries or donors (eg. Blood donors) could become volunteers, thus this may be a way to increase social mobilisation network
- Provide interesting work for volunteers to retain the volunteer pool; involve women and young people
- Create gender/age segregated database to help create a marketing strategy for volunteer recruitment for the members
- Indicators: “number of rigorous evaluation studies of volunteer effectiveness planned and implemented” and “percentage of best studies written for publication”, “number of active national societies included in specific national coordination meetings as key stakeholders” and “number of National Societies recognised in country plans”.

Partnerships:

- Create an advisory group focusing on developing future partnerships; also tasked to track ethical issues concerning the partnerships
- Encourage better coordination and partnerships between the National Societies
- Global alliances, networks and operational partnerships with the private sector – how to measure the impact of these partnerships in relation to MDGs
- Some of the ‘global alliances’ directed by the Secretariat are far too global and insufficiently adapted to country realities
- There is a major lack of recognition of the governments of the auxiliary role of Red Cross/Red Crescent; RC/RC also perceived as an emergency relief wealthy organisation rather than community-based health organisations
- Advocacy towards the Ministries of health required
- Need to measure the effectiveness of RC/RC – vs the funding received from donors

Health in Emergencies:

- Closer integration of National Societies with government and regional planning and response organizations.

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- Stronger participation of National Societies in Country Coordination Mechanisms (CCMs) or Interagency Coordinating Committees (ICCs).
 - How many national planning documents refer to the National Society and its role.
 - Ensure integration of health issues, especially psycho-social issues, gender and reproductive health concerns, and HIV/AIDS intervention, with disaster management issues at the National Society-level, Secretariat should develop a plan for ensuring that the roles, especially leadership roles, were clear in such integrated groups.
 - Teams that respond to disasters should be composed of disaster management and health personnel who would conduct vulnerability and capacity assessments together; checklists should be created to ensure that all health issues are covered in initial post-disaster assessments.
 - More health training for disaster management on all levels, including at the regional and Federation-level to ensure effective and comprehensive responses to emergencies.
 - Federation global training standards required, but with flexibility to adapt training to National-Society needs
 - Training should be made less costly (fewer trips to Headquarters, fewer trainers brought in), use existing training tools and strategic partners to assist with training.
 - Secretariat had a role in training, particularly in the setting of minimum standards, collecting and disseminating best practices between and among National Societies and regional groups.
 - National Societies, which are closer to the issues that effect the countries in which they work should be responsible for self-assessment of their own competency to respond to an emergency or epidemic, using the self-assessment tools created by the Secretariat.

Advocacy:

- Notion of 'advocacy' hold different meanings
- To advocate for most vulnerable people, first the assessment needs to be made on who actually are the most vulnerable groups in a society – to allow better engagement with these groups to form networks.
- Creating a broader survey of vulnerable groups would also allow the Secretariat to compile a global database, from which global advocacy tools could be designed to support and guide NS's advocacy efforts
- *"People aren't vulnerable; they just find themselves in vulnerable situations, situations which can be changed. We should involve these people in all activities that may help them"*. Empower those vulnerable groups by involving them in the process.
- National Societies must address all relevant parties from influential positions at the government and institutional level, to individuals and groups at the community level.
- Creating and maintaining relationships with external organisations is important and using channels created by these relationships can contribute to better access to existing resources and distribution options. Creating these networks allow for effective advocacy work that is consistent with the objectives of involving vulnerable groups in the advocacy programs that concern them.
- Publications and media-attention, education and training workshops important for advocacy. 'Sensitisation', whereby individuals and groups are exposed to information about vulnerable groups that is designed to encourage their participation and inspire them to further advocate

Community Empowerment:

- Important to empower community committees and groups with a well-developed community-based tools, such as Community Based First Aid Program (CBFA).
 - Community empowerment should be supported on all levels – National, Regional and Secretariat.
 - Support "Train the Trainer" initiative in which trainers would be trained on participatory methodology and knowledge sharing with local communities
 - Continue or encourage the involvement and training of effective community committees and groups. For example in 'surveillance' initiative someone from the community will inform the NS representative on detecting a case of a disease outbreak, prompting actions to be put in motion.
 - Health promotion and community development partnerships and networks at the community level via potential interest groups.
 - In order to empower communities it is crucial to get their participation – teach them and they will help themselves through training and education.
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Health and Care Forum, Friday 11 May 2007

**Cooperation between WHO, MoH and Red Cross and Red Crescent Societies in
community health**

Speakers: **Dr Ala Alwan, Assistant Director General of Head of Health Action in Crises, WHO**
Mark Grabowsky, Malaria Program Manager at the Global Fund
Dr Jo Kreysler (expert, WHO/Health Action in Crisis)
Dr. Howard Njoo, Public Health Agency of Canada and Dan Shropshire, Canadian RC
Eduard Tschan, International Federation of the Red Cross, New York

Moderators: **Lady Keith and Jo Kreysler**

Abbreviations: SARS (Severe Acute Respiratory Syndrome), BSE (Bovine Spongiform Encephalacy), IFRC (International Federation of Red Cross and Red Crescent Societies), MoH (Ministries of Health), ITN (Insecticide Treated Nets); African Red Cross/Red Crescent Health Initiative (ARCHI)

Lady Keith opened the third day of the Forum by emphasizing the importance of co-operation in delivering health services at the community level.

Dr. **Ala Alwan**, Assistant Director-General of "Health Action in Crises" WHO made a speech about the first meeting of its kind between Ministries of Health, Red Cross and Red Crescent Societies and the World Health Organization (WHO) to exchange ideas on promoting greater partnership and steps to implementing the WHO-IFRC Joint Letter of Cooperation.

Dr. **Bruce Eshaya-Chauvin**, IFRC Head of the Health and Care Department, welcomed the delegates to the third and final day of the Forum.

Speech by Mark Grabowsky, Malaria Program Manager at the Global Fund

"When National Societies, the Federation and governments work in partnership, astonishing things can happen." Mr Grabowsky stressed the great importance of partnership in delivering health services especially in the world's most vulnerable areas.

Public health was characterized as currently being in its 'golden age':

- public awareness and political involvement in addressing poverty and disease are unprecedented.

- effective and affordable tools such as drugs to treat AIDS, bed nets for the prevention of malaria and drugs for its treatment are now available.
- the existence of effective policies on issues, such as HIV/AIDS treatment and malaria

- control, has proven a great success in combating the diseases.
- Partnerships are a key denominator for working effectively in public health.

The Global Fund to Fight AIDS, TB and Malaria, a funding agency which receives, evaluates and funds proposals as well as monitors the progress of the grants to ensure success, conducts some revolutionary work.

Civil society presents the highest as well as the poorest performing grantees which indicates that civil society though effective, also presents a great risk.

With regard to the difficulties presented in Africa, two solutions were discussed:

- the facility-based model, which puts the responsibility on the patient to obtain health services at the local clinic.
- the community-based model which is characterized by volunteers' awareness of community needs, their role in bringing commodities to the community and their participation in education and monitoring. This

model transfers the responsibility from the patient to clinic volunteers.

Examples of successes with the community-based model include: 2.2 million nets distributed in Niger, 875,000 nets in Sierra Leone and other campaigns in Kenya, Angola and Rwanda. In sub-Saharan Africa this method is the most common for bed nets delivery. Community volunteers are responsible for visiting families and demonstrating proper use of bed nets.

Donors present challenges by establishing funding channels and in turn creating antagonism between government and health care providers. The Global Fund's strategy to combat this issue has been to recommend future proposals contain partnership between government and non-government recipients, referred to as "dual track" financing, so as to create cooperation instead of competition.

Partnership in a national program and a firm commitment to working in partnership are requirements to access funds. So is willingness to take risks and the existence of a comparative advantage not just limited to volunteer capacity.

The importance of civil society and the "last mile" are clearly the most important issues in public health delivery. "Given the new partners, new tools, new strategies, and new resources, combined with your personal commitment; there is no doubt that you will achieve change".

Dr. Jo Kreysler (expert, WHO/Health Action in Crisis)

Dr. Jo Kreysler focused on the collaboration between the WHO and the IFRC, two organizations of different cultures. The current situation worst case scenarios are not being talked about but it is extremely important for governments to be able to imagine such situations and integrate them into their policy. The following issues were covered:

- Development work: In Africa, the total expenditures for development work top 25 billion dollars although until 2007 no real plan has been drawn up about how this amount should be spent.
- Public health: although many promises have been made by foreign NGOs, there are few access strategies and no provisions for the poorest. On the other hand financing is at its peak and between 1996 and 1999 public health has focused on neglected diseases, spending 80 million dollars on them. However, HIV is still a huge problem in poor countries.

- "Brain draining" from southern countries to countries like the United Kingdom or the United States of America is another problem.
- In conclusion, the focus should be on the interface between the WHO and the IFRC as well as on civil society action and that the practical complementarities of both systems should result in an effective collaboration.

Case study 1: Health Emergency Management in Canada: an Integrated Perspective, presented by Dr. Howard Njoo, Public Health Agency of Canada and Dan Shropshire, Canadian RC.

2003 was a challenging year for Canadian public health officials: the apparition of SARS cases in Canada created an unprecedented public health emergency. During the same year Canada documented its first cases of BSE and West Nile Virus. In order to better respond to large scale health emergencies, the government acted to revamp the national emergency health system. An integral part of this strategy involved the capabilities and resources of the Red Cross and other NGOs and volunteer agencies in implementing intervention and services at the community level.

A key learning point from the SARS episode were that no one agency could handle an emergency of national scope and that partnerships were formed at all levels of society (including health care professionals, the Mental Health Support Network of Canada, the Canadian Red Cross and the private sector.) With regard to the Red Cross, guidelines for collaboration were produced as well as research into capacity building and best practices.

- Some key indicators taken into consideration included: the number of registered charities in Canada, the number of other incorporated organizations, the number of citizen who volunteer for charitable and non-profit organizations, the aggregate number of volunteer hours per year, as well as statistics on informal care-giving networks for senior citizens.
- Outputs for the strategy involved community response plans (with defined roles for key stakeholders), enhanced collaboration networks of stakeholders, community awareness and education with emphasis given to pandemic influenza response plans.

Case Study 2: Addressing the Human Resources for Health crisis in Africa:

Integrating Community Health Workers and Red Cross/Red Crescent Volunteers to scale up health service delivery (feasibility study for Kenya, Mali and Mozambique), presented by Eduard Tschan, IFRC, New York. This study was jointly undertaken by the Columbia Earth Institute, UNDP MDG Support Group and the IFRC.

With the current shortage of healthcare workers in industrial countries, healthcare professionals from African nations have been immigrating, creating serious problems in national health care systems. In response to this crisis, the International Federation of the Red Cross and Red Crescent investigated about the feasibility of extending Red Cross networks to fill this void in three countries: Kenya, Mali and Mozambique.

- the actual impact on the health service sector had to be quantified in each country, as well as the potential replacement capabilities in the private sector, NGOs and the Red Cross/Red Crescent. Close collaboration between all stakeholders is absolutely essential. Among these partners, the Red Cross is uniquely positioned to respond to the shortage. However, attention needs to be paid to the increasing demands on volunteers and the importance of motivation and appropriate reward schemes.

Case study 3: Flood Response: The KRCS Experience, presented by Dr James Kisia

In December 2006 and the beginning of 2007, Kenya experienced the worst flooding in 20 years. Over 700,000 people were affected. Entire villages were submerged, with infrastructure, cattle, potable water supply and health facilities in remote areas severely compromised. This emergency presented a significant challenge for the Kenyan Red Cross. Immediate problems identified included the remoteness of the worst affected locations, lack of sanitation, increased disease risk (water born, mosquito born, etc), inadequate personnel to cope with medical demand and threatening refugee situations from neighbouring countries. The Kenyan Red Cross Society's goals were to reduce disease and death rates caused by the disaster, build capacities to provide basic health care, ease transition into the rehabilitation phase of the disaster, community empowerment and capacity building for refugees.

The Kenyan Red Cross Society responded by creating improvised teams of medical personnel (doctors, nurses, pharmacists, medical students, translators and drivers), and two basic health care clinics and mobile clinics were established. Insecticide Treated Nets were distributed. At the

same time, outreach focusing on health education and immunization was put into place. Other activities included water quality initiatives (including training of personnel) and construction of sanitation facilities (latrines etc).

As the disaster subsided, the Kenyan Red Cross Society had treated over 23,000 patients and purified and distributed more than 1.9 million litres of water. The number of major disease outbreaks had decreased in respect to the last major floods. Additionally, the capacity to disaster response was augmented, cooperation with other partners (GO, NGOs, UN etc) was improved and community involvement in outreach and health education was increased.

Panel discussion

Examples of the roles of Red Cross/Red Crescent volunteers in community work in relation to the WHO and national Ministries of Health included the following:

- The importance of a good relationship between the Red Cross as a civilian NGO and national governments. Community-based initiatives are a key factor in empowering the community to take the lead in local activities and the involvement of the community has been key to the success of response to recent disasters.

- Partnership between the Jordanian Red Crescent Society and the Ministry of Health was an example of one that focused on the provision of public health centres, combating disease, dealing with emergency situations and on a major hospital project in Amman. Community volunteers can play a complementary role and need to have a more stable and permanent function.

- An example of good practice between WHO, MoH and the IFRC was the work done in preventing disease spreading among pilgrims returning from the annual Haj and the strategies that had been developed over the years.

- A Memorandum of Understanding established between the MoH and the Red Cross in Mali has resulted several other countries adopting a similar resolution. Community-based approach are a key element in strengthening the effectiveness of health centres, in particular in more remote locations, and to the establishment of training modules to strengthen the skills of volunteers.

- In Mozambique, Global Budget Support made it possible for the National Red Cross Society to be founded in 1981. Some of the Red Cross activities in Mozambique that target the most

vulnerable cover work in rural areas, with women and children and include community-based projects, the provision of social support, water and sanitation facilities, preparedness for natural disasters and HIV/AIDS prevention and treatment – in particular mobilising people to attend voluntary blood tests. The importance of community health workers is recognised by the government in Mozambique, as is the need to be sensitive to their needs and to consider their remuneration.

- In Iran, the focus is on developing the national public health care system and integrating medical education and training into health care systems. The primary health care system started in the 1970s as a joint study which involved cooperation between the WHO, the University of Tehran and the MoH. Gradually the pilot project was expanded throughout the country, with primary health care networks being established

in the mid-1980s and there is now an extensive network of rural and urban public health centres. Medical education and training has been greatly expanded and there are now 41 medical schools in Iran.

Summary of key issues and recommendations,:

- The African Red Cross/Red Crescent Health Initiative (ARCHI) 2010 model of volunteer system illustrates areas where Red Crescent societies need to work with national Ministries of Education and the WHO to develop the recruitment of community volunteers.

- Existing gaps in numbers of village health workers within the Ministry of Health system (with a focus on technical responsibility) could be filled by the Red Cross.

- The importance of the benefits of community level volunteers in terms of reaching out to remote communities and keeping track of individual actions is crucial.

Working Group discussions

Working Group 1

Moderator: Lois Hue of the Jamaican Red Cross.
Reporters: Idriss Jebari and Sophie Gonin

On May 11, 2007 approximately 25 delegates from the IFRC and Ministers of Health (MoH) officials discussed the collaboration of the IFRC and the WHO based on their field experience.

1) Note outstanding examples of successes and challenges of joint collaboration in community health in rapid response, recovery, as well in non-emergency settings.

- Relationship building: the Canadian representative shared the benefits of having relationships with the MoH and other partners before an emergency. As needs arise, the relationship is already in place and provides the potential for maximum efficiency and true teamwork during the emergency. However, the success of the relationship is often dependent on the individuals involved.

- Challenge: the Bangkok delegate pointed out that the National Societies (NS) generally have a strong relationship with the MoH but not with the WHO.

- In some cases the government considers the NS as an auxiliary and a NGO, when in reality the NS is a health-planning partner.

- The importance, and challenge of building an expanded perception of the NS and the role it can play in non emergency situations and preparedness.

- Clear communication is key. An idea presented was a square with two-way communication on four ends: the IFRC and the NS communicate vertically; the IFRC and the WHO communicate horizontally; the WHO and the MOH communicate vertically; the NCR and the MOH communicate horizontally.

- Another outstanding example of success mentioned by the Sierra Leone Red Cross Society was the joint collaboration for the measles campaign. The NS operated with the support of the government with success but the program was followed by some difficulty resulting from competition over who should receive the credit for the success.

- Another challenge is making sure the partnership between the NS and the government is one of equals. Often the government will hand over a program to the NS without providing financial or volunteer support. Should there be a case of HIV transmission in a blood program for example; the NS takes the hit and not the MOH.

- Success story of collaboration: (from the Afghanistan Red Crescent): better efficiency could be reached if there were more partners from different delegations during the development and signing of agreements -- teamwork at its best for future and current opportunities.

2) *Current and future opportunities for RC/RC to contribute to MOH statutory mandate in health and health emergencies.*

- There is a crucial distinction between current and future opportunities: in the short term, the RC/RC should concentrate on handling emergencies, eradicating Polio, and fighting HIV and AIDS, and Malaria; in the long term, the RC/RC objective should be to fulfil the MDG, fight the new tropical diseases and the emerging and re-emerging diseases (i.e. SARS and Avian Flu) and, pay attention to international health security issues.

- Future collaboration opportunities need credibility and unity amongst partners. It is beneficial for partners to share their media platforms and outreach efforts pertaining to similar health initiatives to show the public they are working hand-in-hand on critical issues.

- Training programs provide important opportunities for strengthened collaboration. Successful international joint training programs could and should be applied to regional efforts.

- The criteria for joint collaboration should be based on mandate, priority advantages and resources. Combined with an efficient training program, the Guidebook should be easily accessible to all partners and levels.

- A vision of a global project may look like this: a house that has been built by all the members of the Federation, where the rooms are the smaller projects with each joint action and the windows represent new opportunities for the future. However, with all opportunities, come challenges.

3) *What are the major challenges and constraints for joint action between MOH and RC/RC?*

Challenges:

- The effect of political instability on established collaborations: the NS can build a strong relationship with a MOH, but if that person is replaced, it is difficult and time intensive to re-build a new relationship.

- In some countries, the level of involvement depends more on the personalities of the agency or MOH leaders rather than the function, which is an obstacle for collaboration.

- Lack of information exchange, bureaucracy and a lack of understanding of different roles, responsibilities and mandates calls for a bit of marketing.

- Combination of a lack of political will to assist and a lack of funds. The perception can be that the RC/RC is well funded, when that is not always the case. Based on that assumption, governments often call upon the RC/RC to take on a program without providing any additional funds or volunteer support.

- Lack of collaboration amongst donors in some countries and short funding cycles -- leading to inaccurate perceptions of the RC/RC effect and possibly less engagement from donors in the future.

4) *What proposals would you make for WHO and the Federation to facilitate joint action of MOH and RC/RC?*

Possible solutions covered were:

- Ensure that all agreements are developed and signed at all three levels, develop a plan of action at all three levels and devise a monitoring and evaluation plan.

- The implementation of joint initiatives between the WHO, RC/RC and the MOH and joint trainings of MOH and volunteers.

- Developing marketing and advocacy efforts to help build the understanding of the NS by the MOH and other government representatives thus strengthening the capacity for the RC/RC to become a credible partner.

- Incorporate RC/RC representatives at non-proprietary strategic planning forums pertaining to national health and, vice versa, the RC/RC can incorporate appropriate parties in its forums.

- Send and promote the Global MOU to MOH and NS and that it be communicated to all local levels.

The closing statement encouraged all parties to be strong and to strive to be united so as to be perceived by the public as aligned and credible.

Working Group 2: The practical challenges of the Joint Letter of Cooperation between the IFRC and the WHO.

Reporters: Dominic Keyzer and Calvin Ng

Exactly two years after the signing of the Joint Letter between the International Federation of Red Cross and Red Crescent Societies (IFRC) and the World Health Organization (WHO), delegates agreed that the letter's goals must translate to practical operations that will strengthen cooperation between the two organizations.

- Participants noted that for this to be achieved, bureaucratic interference must be limited so that National Societies can work more efficiently with governments and society as a whole.

Discussion focused on how the Joint Letter could be put into operation. The message was clear that methods must be found that represent the Federation's association with civil society. An important mantra is to emphasize the "public" in public health, especially when dealing with initiatives conducted jointly in collaboration with national governments. While strong relationships

with governments are encouraged, delegates stressed that health initiatives should remain independent, thus ensuring that the interests of society are at the forefront.

Many examples where National Societies collaborated successfully with governments to achieve community health goals: the Spanish Flu epidemic following World War 1 called upon five existing Red Cross Societies to work against the outbreak. This was the first time the Red Cross was active in a non-conflict situation and established its partnership with civil society. This led to the founding of the League of Red Cross Societies, the predecessor to the present Federation.

More recently: in 1995 the Federation raised approximately \$32 million to vaccinate 19 to 49 year olds against Diphtheria in former Soviet countries. Diphtheria infection rates fell dramatically after the immunisation program was introduced.

Participants highlighted how National Red Cross and Red Crescent Societies could step in to assist national governments in carrying out health programmes. It was stressed, however, that collaborations with the WHO and national Ministries of Health should be strengthened to allow ongoing support, rather than *ad hoc* agreements in times of crisis. It was agreed that National Societies could step in and provide services that governments lack resources to provide.

On a regional level, experiences of cooperation between the NS and Ministries of Health included:

- the Pan-American Health Association displayed the diversity of collaborative approaches.

- the Joint Letter manifested existing regional agreements between the IFRC and regional WHO offices for the Americas and Pan-American Health Organization, the Eastern Mediterranean regional office, and the South East Asia regional office and a signing with the African regional office will take place very soon.

- Participants stressed that volunteers are the most important part of this plan. National Societies face the task of creating and managing broad and efficient volunteer bases. When seeing well-managed volunteer bases, governments will more likely see the benefit of including NS to the same degree as international organizations such as WHO.

- Donors must recognize the large monetary requirements of recruiting, training and supervising such large volunteer bases.

- Training volunteers for emergencies, such as in the case of Avian Flu, presents a "unique response capacity" to deal with future health emergencies, as well as training volunteers to work more efficiently in day-to-day work.

- The Joint IFRC-WHO Letter should not only be re-circulated to regional and national offices of both the WHO and the IFRC, but also be accompanied by a comprehensive indication for putting it into practice, such as integrating it into meetings with national ministries of Health, to facilitate more effective dialogue between NS and MoH and minimise competition between NS and other civil organizations for funding and other resources.

- Participants were asked to explore the opportunities and acknowledge possible challenges that exist in incorporating the Joint Letter into a solid plan of action for NS that includes time frames and indicators of success.

- The importance of regularly reviewing the objectives of the Joint Letter was stressed as was ensuring that the document be kept alive and relevant.

- When discussing how its application could be measured, indicators of success should be results-based, rather than process-based (eg: in one year's time, 50 percent of NS should have collaborations with at least one government body).

The upcoming World Health Assembly will provide the opportunity for IFRC delegates to draw attention to the Letter and reinforce commitment from both sides to the initiative.

Working Group C: WHO/RC/MoH Partnerships

Reporters: Gabriel Ellis and Nina Manocha

The discussions covered the following topics:

- Volunteers. Recent observations revealed a high interest in volunteerism, but that educated volunteers needed better leadership and a superior management system. Volunteers tend to have loyalty to a cause, not an organization.

- Management must adapt to changes in society: e.g new technology has introduced the internet volunteer, volunteers want international experience and may choose to relocate to offer their services and poor sectors of society could be given assistance so that they gain the financial means to be able to volunteer.

- Examples of success and failures in rapid response and recovery of joint collaboration in the past from different National Societies:

- Though the Canadian Red Cross had good collaboration with government on the SARS emergency, they experienced a real challenge regarding how to protect volunteers from possible infection.

- Finland had successful collaboration on the Avian Flu and with blood donors.

- The challenge of partnership in Ghana was overcoming competition between organizations and concentrating on team work.

- France saw success in regard to Lebanon's repatriation that involved 900 volunteers.

- Floods brought good cooperation in Chad between the Red Cross and government but social mobilization came at a high financial cost.

- Support groups for the Tsunami disaster were provided by the Swedish Red Cross.

- The recent challenge in Cambodia was exacerbated by lack of government recognition of helping societies.

- The Red Cross in Mali has participated in aiding in such crisis as floods, Yellow Fever and Meningitis outbreaks.

- Major challenges and constraints for joint action between Ministries of Health and RC/RC include:

- Volunteers are not cost-free: transportation and food come at a cost that must be taken into account. Clearly established contracts for volunteers are needed as well as creating a good environment for professional volunteers. The ongoing challenge regarding volunteers is to recruit, train and maintain.

- There is a need for signed agreements between Red Cross and Ministries and to systematically follow up on memorandums of understanding to tract if partners are keeping to the agreements. E.g: Malawi has no joint planning and only hands over some activities or some country offices deny awareness that a joint partnership even exists.

- Communication is considered a large stumbling block: e.g WHO created a volunteer package for distribution but had trouble sharing this information to country offices because of a language barrier. A proper budget must be prepared and documents translated.

- One question was why solely on the MoH when so many other ministries - Environment, Water, Sanitation and the government as a whole are equally answerable to issues relating

to health. Limits must not be drawn only then can there be success stories.

A few success stories include:

- Settlement of thousands of families in Egypt in their new homes
- Mothers bringing their babies to the clinics in Malawi for immunization against malaria.
- Repatriation of 12,000 migrants from Lebanon to countries of their choices.
- Psychological support teams from Sweden working with families of victims of Tsunami.

Generally, it was felt that MoH work well with the RC in times of emergencies like floods, epidemics and earthquakes. However the social mobilisation of the country is needed to make an impact. This can be achieved by collaboration between WHO, MOH and RC.

WHO is to take the lead into training and be the information provider to the countries since the MoH give it more priority than the RC.

Keeping this as their target goal, recommendations were made for the WHO IFRC partnership implementation.

To WHO:

- Advocacy by WHO with MoH on the added value of volunteerism for public health.
- Proper dissemination of the Joint Letter of cooperation between WHO and IFRC at regional and country levels.
- WHO Geneva to encourage WHO regional bureau to develop regional agreements for cooperation between partners.
- Create a focal point within WHO to deal with volunteerism and health.

To the Federation and its membership.

- Federation to acknowledge RCRC membership contribution to Health.
- Create a reward system to acknowledge successful collaborations at country level.
- Proper dissemination of the joint agreement between partners at regional and country levels.
- Promotion of the RC auxiliary role of the RC to governments with clearly stated responsibilities between partners.
- RC to move from information sharing to evidence based achievements and advocacy with MOH and WHO.

- Federation and NS to strengthen PMER systems.
- RC RC to provide quality professional counterparts.
- RC RC to measure the financial impact of partnership for proper budgeting and implementation.
- RC RC to move beyond informal collaboration with MoH towards more elaborate agreements.
- Volunteer management, recognition of volunteer diversity, and assessment of the costs and time of volunteerism.

- MoH to contribute financially to RC RC community based health programmes.
- MoH to contribute to capacity building of RC RC National Societies.

Joint recommendations to WHO, IFRC and MoH.

- Annual review meetings to monitor implementation of the Joint Letter of cooperation (linked to the sector wide approach to programming)
- Planning and budgeting strategies for implementation.
- Joint resources mobilisation and measurement of impact.

To MoH:

For Block 7:

Reporter: Anna Fabro, Margareta Doubecka, Mary Picard, Emma Greenaway

Editors: Diane Heat, Zoe Smart

Chief Editor: Irene Amodei

For Block 8:

Reporter: Idriss Jebari; Sophie Gonin; Dominic Keyzer; Calvin Ng; Gabriel Ellis; Nina Manocha

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