Health Policy

for International Cooperation

Swiss Red Cross

3rd Edition

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Abbreviations

HIV/AIDS	Human immunodeficiency virus/acquired immunodeficiency syndrome
IC	International Cooperation
IFRC	International Federation of Red Cross and Red Crescent Societies
LMIC	Low- and middle-income country
Movement	International Red Cross and Red Crescent Movement
National Society	National Red Cross / Red Crescent Society
NCD	Non-communicable disease
NGO	Non-governmental organisation
RANAS	Risk, attitude, norm, ability, self-regulation (approach)
SDG	Sustainable Development Goal
SRC	Swiss Red Cross
WASH	Water, sanitation and hygiene
WHO	World Health Organization

1. Introduction

1.1 Rationale and scope

It is the mission of the Swiss Red Cross to foster healthy living and improve the disaster risk management capacities of particularly vulnerable people and communities.

The Health Policy for International Cooperation is the guiding framework for the health programmes of the SRC Department of International Cooperation. It covers the entire spectrum of SRC response, recovery and development programmes and serves as a reference for dialogue with partner organisations, health authorities and other interested institutions.

The Health Policy outlines in detail the guiding principles, objectives, priority approaches and thematic priorities of health programmes carried out as part of the SRC's international cooperation work. Since its inception in 2012, global frameworks have changed and new thematic priorities have arisen. Together with the SRC impact model, which guides the SRC's work in health and disaster risk management, the Health Policy has been revised in the light of those developments and adapted for application along the response, recovery and development nexus. The present Health Policy will apply as of 2020.

1.2 Embedding the Health Policy in the SRC and IFRC policy frameworks

The Health Policy is based on the seven Fundamental Principles of the International Red Cross and Red Crescent Movement – humanity, impartiality, neutrality, independence, voluntary service, unity and universality – and guided by the strategies and policy frameworks of the IFRC and the SRC.

The Health Policy is aligned with the ***IFRC Strategy 2030 – A Platform for Change***[1], which considers health as one of five key global challenges and comprises the following three strategic goals:

- Strategic goal 1: People anticipate, respond to and quickly recover from crisis
- Strategic goal 2: People lead safe, healthy and dignified lives, and have opportunities to thrive
- Strategic goal 3: People mobilise for inclusive and peaceful communities

Health Policy and the ***IFRC's Health and Care Framework***[2] . The latter reflects the IFRC's contribution to Universal Health Coverage in three ways: it presents the collective priorities and programming modalities defining the work of the IFRC health and care network; it illustrates a pathway for National Societies to engage with health authorities as auxiliaries in the fields of health and care; and it links the work of the IFRC health and care network to the global SDG agenda.

SRC programmes are also guided by other IFRC thematic frameworks, such as the *IFRC Framework for Community Resilience*[3], the *IFRC maternal, newborn and child health framework*[4] and *the IFRC Strategic Framework on Gender and Diversity Issues*[5].

The **SRC Strategy 2030** defines health as one of three spheres of action. It refers to the SRC's leading role in health as a humanitarian organisation in Switzerland and as an important player in emergency response and development cooperation abroad. The SRC recognises that health is a human right and that good health is a precondition for economic development.

The SRC Strategy 2030 incorporates the **SRC IC vision for 2030**[6], according to which the SRC will follow through on its commitments based on the strength of its past approaches and competencies to reach its beneficiaries effectively and sustainably. In order to further localise its aid agenda, align itself more closely with the strategies and plans of host National Societies and enhance Movement coordination and cooperation, the SRC increasingly works through the National Societies in selected programme countries, engaging in joint action with the host National Society to implement programmes with the Ministry of Health, community-based organisations and NGOs.

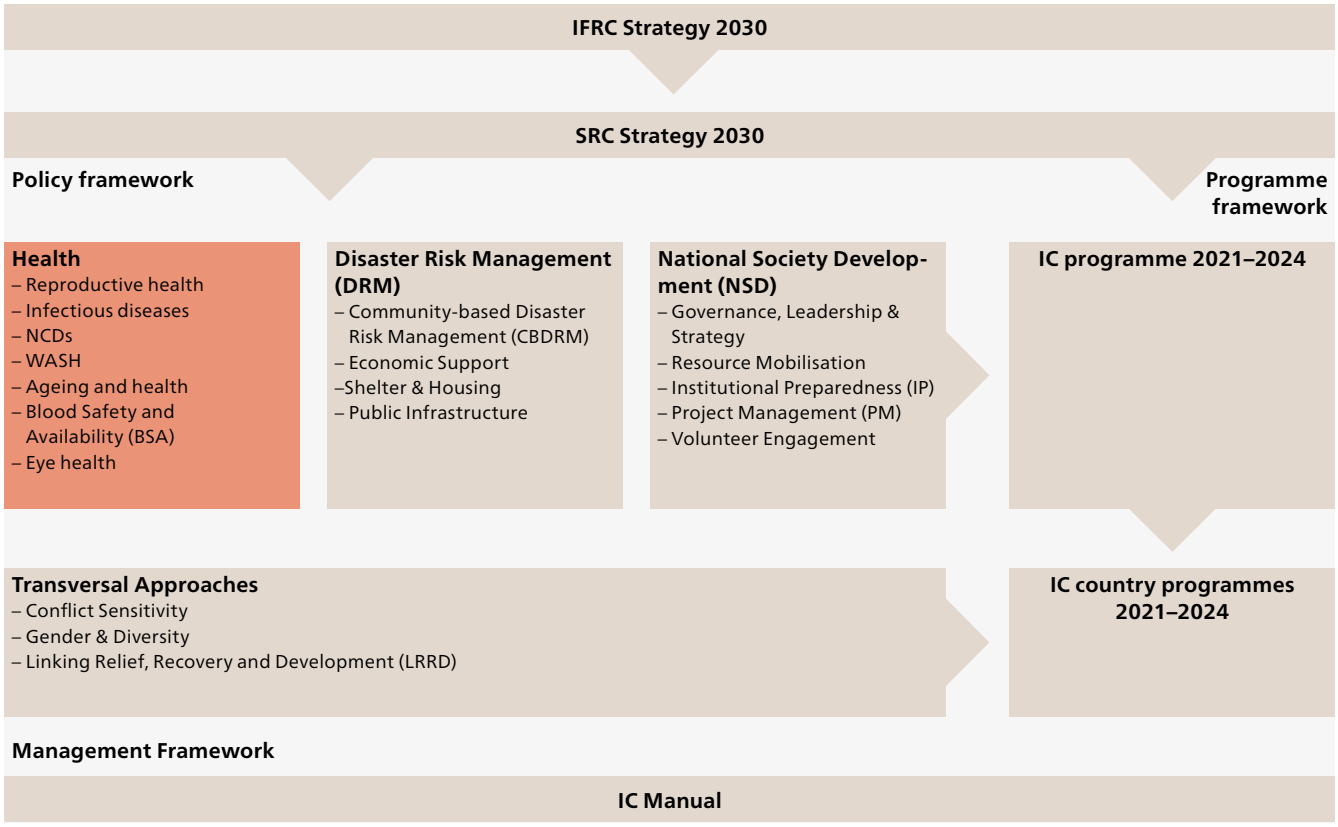


Figure 1: SRC health policy within the SRC policy framework

SRC international cooperation activities are bound by the following overarching guiding principles (cf. International Cooperation Programme 2021–2024 [7], Healthy people in resilient communities, *chapter 3.2*):

- Social, economic and environmental sustainability;
- Focus on vulnerable people and communities;
- Community empowerment;
- Volunteering;
- Partnership and localisation;
- Accountability;
- Policy dialogue;
- Alignment;

1.3 Recognising international policy frameworks

In addition to the IFRC and SRC policy frameworks, the SRC recognises the United Nations 2030 Agenda for Sustainable Development and the related SDGs[8]. All its health programmes contribute to achievement of the SDGs, in particular:

- Goal 2, to end hunger, achieve food security and improved nutrition and promote sustainable agriculture;
- Goal 3, to ensure healthy lives and promote well-being for all at all ages;
- Goal 5, to achieve gender equality and empower all women and girls;
- Goal 6, to ensure availability and sustainable management of water and sanitation for all.

The SRC's work is also guided by the health strategies and frameworks of WHO and other United Nations agencies, the policies, strategies and frameworks of the countries in which the SRC implements its programmes, and the Swiss Health Foreign Policy[9].

2. Context and challenges

Health is central to the 2030 Agenda for Sustainable Development. The aim is not only to eradicate disease, but also to **ensure equal access to health and care.** In order to successfully address health gaps and inequities, the global health trends and context need to be taken into account. The SRC considers it particularly relevant to address the global health trends and challenges described below.

Non-communicable diseases and epidemics on the rise

Almost two thirds of all deaths worldwide are due to NCDs caused by smoking, poor diet, physical inactivity and harmful use of alcohol.[10] Cancers, diabetes, chronic respiratory illness and cardiovascular disease are on the rise not only in high- and middle-income countries, but also in low-income countries. At the same time, infectious diseases continue to take a heavy toll – indeed, they result in a double disease burden – among people and communities in many areas of the world. Pneumonia and diarrhoea, caused by poor quality WASH and nutrition, are the leading causes of illness and death in small children. There are 37 million people living with HIV/AIDS worldwide, 71 per cent of them in sub-Saharan Africa, with around 50 per cent of HIV/AIDS patients have access to care and treatment.[11] Nearly 500,000 people died of malaria in 2014,[12] and 10 million are diagnosed with tuberculosis annually. Next to these infectious diseases, viruses such as Ebola, Zika, dengue, chikungunya and yellow fever are causing a magnitude of fast-spreading epidemics that are difficult to control and require a well-prepared health system and good intersectoral collaboration.

Ageing societies

In many regions of the world, improved living conditions and the successful prevention and treatment of infectious diseases have dramatically increased life expectancy. In Europe, South America and parts of Asia, where fertility rates have sharply decreased, demographic change has far-reaching implications for health systems and people's health needs. In Europe's transition countries, for example, where social services have deteriorated and extended family networks are falling apart, elderly people require new approaches of community support and home care. These will have to be extended to LMICs, which it is estimated will be home to 80 per cent of the world's older people by 2050.[13]

Urbanisation

Over half of the world's people live in urban areas. In low-income countries, 2.5 billion people live in urban slums, suffering from crowded housing, poor water, sanitation and hygiene, food shortages, and the absence of basic health services. The situation is especially critical in the cities of sub-Saharan Africa, where 62 per cent of the urban population lives in slums, followed by South (35%) and South-East Asia (31%).[14] In the slums, violence, often in relation to organised crime, is an urgent life and health concern for the inhabitants. At regional level, Latin America in particular has seen a large increase in urban violence in recent years.

Increasing health inequities: the vicious cycle of poverty and illness

According to recent estimates, in 2015, 10 per cent of the world's population lived on less than US$1.90 a day, the internationally defined poverty line. While nearly 1.1 billion fewer people are living in extreme poverty than in 1990, the decline in poverty levels has been uneven. More than half of the extreme poor live in sub-Saharan Africa and the majority of the global poor live in rural areas, are poorly educated, employed in the agricultural sector and under 18 years of age.[15] There is ample evidence that the lower an individual's socio-economic position, the higher their risk of poor health. Indeed, poverty is both a cause and a consequence of poor

health. Poverty creates ill-health because it forces people to live in environments that make them sick, without decent shelter, clean water or adequate sanitation. Likewise, ill-health exacerbates impoverishment. WHO estimates that 100 million people are pushed into poverty every year because they have to pay for health care.[16] Millions of people are deprived of basic health care because they cannot afford to pay for it. Children from rural and poorer households remain disproportionately affected: those from the poorest households (rural and urban) are nearly twice as likely to die before their fifth birthday as those children who count among the richest 20 per cent.[17] Reducing out-of-pocket payments and introducing social health protection schemes is high on the agenda of LMICs and outlined in their respective Poverty Reduction Strategy Papers. The challenge is implementation, despite the fact that bilateral and multilateral donors have scaled up their efforts to promote and invest in universal health coverage, which also includes better protection of the population from catastrophic health expenditure and impoverishment.

Living in an environment of conflict and fragility

Working in humanitarian settings and fragile context is gaining increased attention in development policies and programmes. Armed conflicts have become deadlier and more protracted, forcing almost 60 million people into displacement globally. An estimated 1.4 billion people are living in fragile contexts.[18] Conflict-affected populations and migrant groups are particularly vulnerable, as they lack access to basic health services, water and sanitation, and are vulnerable to violence and abuse. They have physical health needs, but also require psychosocial support.

Coping with climate change and disasters

Similarly, natural hazards such as earthquakes, floods, droughts and cyclones have a sudden devastating impact on the lives and health of communities and on their infrastructure. Often the public health system is unable to cope with the emergency health needs of the people concerned and requires external assistance. A quickly changing environment calls for institutional preparedness and project/programme adaptations in order to stay engaged throughout the response, recovery and development continuum. Experience shows that, as in fragile contexts, women and children, marginalised and poor groups are particularly exposed to loss, suffering and gender-based violence and require special attention after a disaster.

Environmental threats to health

According to WHO, poor environmental conditions are responsible for 25 per cent of the global burden of disease. In urban areas, the main environmental factors for disease are air pollution, poorly managed waste disposal and water contamination; in poor rural areas, where people use solid fuel for cooking and heating, indoor air pollution is a major health hazard, and exposure to lead and toxic waste associated with poor chemical management in industries contributes significantly to mortality and disability.[19]

Nutrition – a key to health

Malnutrition is one of the greatest threats to health, particularly in vulnerable groups and communities.[20] About 800 million people go to bed hungry every night.[21] While stunting rates in children have declined over the past 25 years, from 39.6 to 23.8 per cent, wasting has increased to an alarming 7.4 per cent globally. Every second child that dies before the age of 5 is malnourished. At the same time, 1.5 billion people, including 40 million children, are overweight and obese, and thus at risk of contracting NCDs like cardiovascular disease and diabetes.[22]

Poorly functioning public health care systems

Chronic underfunding of primary health care systems and a shortage of health workers are some of the main contributors to poorly functioning public health care systems in many LMICs. Most LMICs allocate less than 6 per cent of gross domestic product to health,[23] despite having signed the Abuja Declaration.[24] The lack of doctors, midwifes and nurses is particularly acute where people need them most. In 2013, the global shortage of health care workers stood at 7.2 million, a number that the Global Health Workforce Alliance estimates will increase to 12.9 million by 2035. Not addressing this shortage and its underlying causes, such as health workforce migration, will have serious implications for the health of billions of people across all regions of the world. Forty-four per cent of the world's countries have a density of skilled health professionals of less than 22.8 per 10,000 inhabitants.[25] Additional issues are accessibility, acceptability and quality of the health care systems. Where public services are struggling for resources, the private health care sector is growing, providing quality health care against fees-for-service and thereby perpetuating the poverty cycle for those who cannot afford to pay.

Changing the global architecture for health development and financing

The 2030 Agenda for Sustainable Development establishes a new paradigm for holistic global development in all countries. Rather than targeting specific diseases, it aims to strengthen health systems and ensure universal health coverage for all in a holistic manner, taking health and social determinants into account. All national and development efforts are geared towards «leaving no one behind» and reaching the most vulnerable. This requires substantial investments. Economists calculate the costs for implementing the SDGs in trillions of US dollars per year, and yet, although development assistance for health increased by 11.3 per cent annually between 2000 and 2010, there has been no substantial increase since then.[26] With only ten countries investing more than 10 per cent of their gross domestic product in public health spending[27] – with most of these small-island states – health and development cooperation must be predicated more than ever on aid effectiveness, alignment and harmonisation, multi-stakeholder collaboration models and innovative finance models. In this context, civil society organisations have an important role to play as watchdogs and stakeholders in policy dialogue at national and global level.

3. The SRC IC conceptual framework for health

Health is more than the absence of illness. The SRC considers health, as defined by WHO, as a state of physical, mental and social well-being that embraces fundamental properties of life such as vitality, self-determination, happiness, dignity, freedom and security. Health is a resource for social and economic development and thus a key element of resilient communities. Good health frees resources for investments other than health care. Being healthy allows people to access education and information and to realise their political and human rights. The SRC uses «health» as an umbrella term covering the broad spectrum of health, social and WASH activities.

SRC programmes focus on primary health care and on bridging the gap between the health care system and the community. In order to leave no one behind and to achieve universal health coverage, the SRC approach is people-centred, promotes integrated health care and community empowerment, and places prevention rather than cure at the centre of its health projects. With its **goal** of an improved health status for all, the SRC aims to achieve three **outcomes**: behaviour change, improved access to health, and enhanced service quality. These are described in section 4.

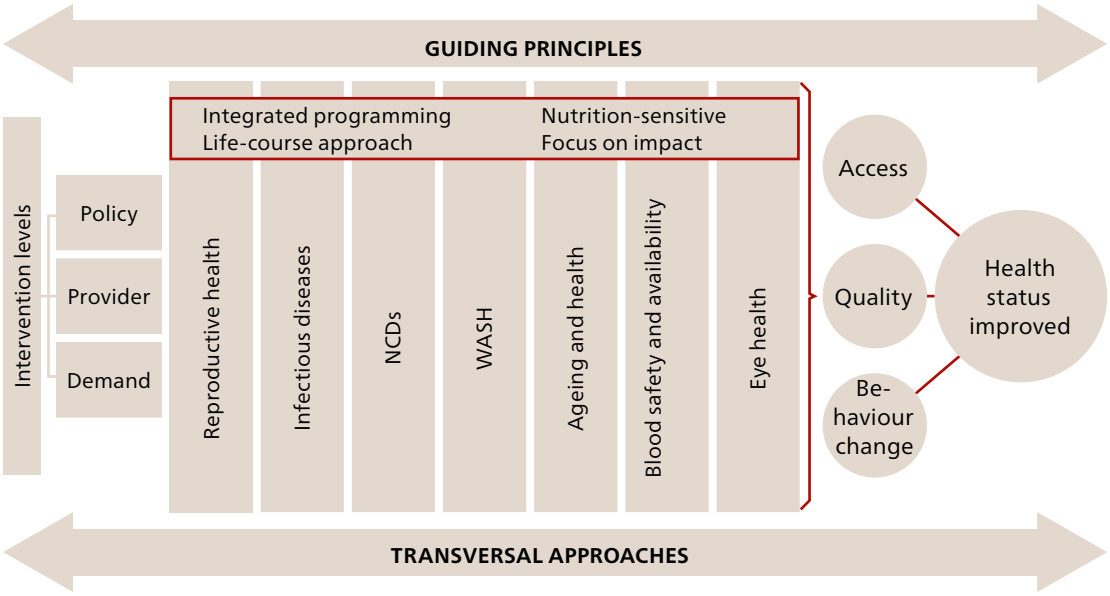


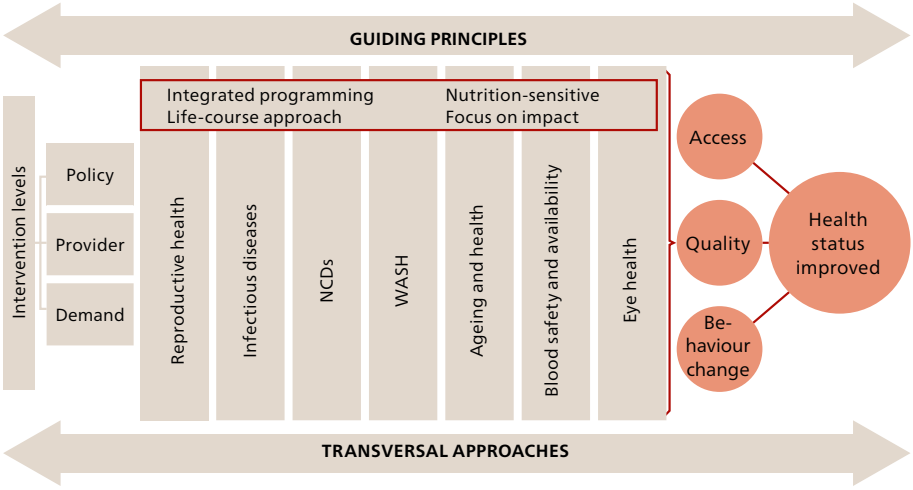
Figure 2: The SRC IC conceptual framework for health

The SRC works in the following **seven thematic health priorities**: reproductive health, infectious diseases, NCDs, WASH, ageing and health, blood safety and availability, and eye health (see Figure 2). These thematic fields and the four priority approaches applied to tackle them – integrated programming, nutrition-sensitive programming, life-course approach and focus on impact – are described in detail in section 5.

Across the seven thematic health priorities, SRC programmes address both **demand/beneficiary** and **provider** concerns, and aim to influence health policies. By building bridges between communities and health service providers, and by creating and reinforcing inter-linkages between the different stakeholders of local health systems, the SRC helps improve the ability of health systems to deliver accessible and affordable quality health care. Health promotion and disease prevention require communities, the government, civil society and the private sector to work together to foster healthy lifestyles in an environment that is conducive to an improved health status for the entire population. The SRC facilitates and strengthens its partners' efforts to engage in local **policy dialogue** with the respective authorities. Policy dialogue can range from putting local policies into practice to influencing national health policies. Scaling up interventions to increase impact and visibility, along with documenting and sharing best practice evidence, are important vehicles for policy dialogue. The SRC stakeholder model is in section 6.

SRC health programmes apply the SRC **guiding principles** (see section 1.2) and the **transversal approaches** of gender and diversity, conflict sensitivity, and linking relief, rehabilitation and development.

4. Objectives of the SRC's engagement for health



4.1 Goal

Informed by the global challenges, oriented by the SRC Strategy 2030 and guided by the SRC IC vision for 2030 (see section 1.2), the goal of SRC health programmes is to:

Improve the health status of all, in particular for vulnerable people, groups and communities

4.2 Outcomes

SRC projects in response, recovery and development are intended to have three outcomes.

Behaviour change is practiced

SRC programmes encourage healthy lifestyles and improved health-seeking behaviour. A variety of health promotion and health education approaches are applied at the community and individual level to promote healthy behaviour and lay the groundwork for healthy lives. SRC programmes work together with stakeholders in different sectors to advocate for policies that create the framework for an enabling environment for behaviour change.

Access is increased

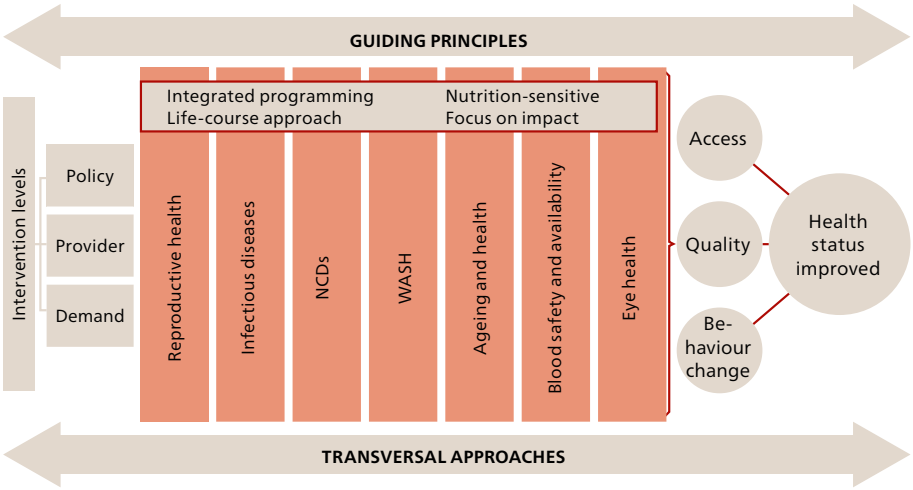
SRC programmes aim to improve equitable access to health care by working on the interface between the supply of and demand for health services. On the supply side, the SRC, together with its partners, helps the local health system address access gaps, in particular in connection with the achievement of universal health coverage. On the demand side, the SRC empowers local communities to claim their right to health and establish community-managed systems that enhance access (local transport, community financing, etc.). SRC projects also act on health determinants, above all access to safe drinking water and sanitary facilities, community hygiene and good nutrition.

Quality is improved

In order to obtain better health outcomes, SRC programmes focus on improving the quality of health services. Good-quality service provision increases demand and enhances access, and good-quality health promotion results in behaviour change. To that end, the SRC concentrates on the health system components of service delivery, the health workforce, and information and technology. Well-founded health management information analyses foster reflection on quality and are a prerequisite for services that respond adequately to the population's needs. WHO and other internationally accredited guidelines, clinical pathways and reference documents are benchmarks for quality improvement in all SRC thematic priorities. When it comes to the quality of water supply systems, context-specific solutions, local technologies and sustainable maintenance systems are in-built to ensure long-term quality and use.

These outcomes apply to all the thematic priorities outlined in the next section. They are reflected in the impact model in Annex I.

5. Thematic priorities



The Health Policy has seven thematic priorities and suggests a series of possible intervention strategies (see Table 1 below). Operational strategies relating to the different thematic priorities are defined in the specific thematic concept papers (see Figure 1).

Reproductive health encompasses maternal, neonatal, child and adolescent health, and sexual and reproductive health. The SRC helps lower maternal and neonatal mortality and morbidity rates by improving access to good-quality pre-, intra- and post-partum services and neonatal care, including early and exclusive breastfeeding. SRC programmes also aim to enhance sexual and reproductive health and rights through increased use of family planning methods and the prevention of teenage pregnancies.

SRC programmes aim to improve prevention, early detection, care and treatment of HIV/AIDS, malaria, dengue and other **infectious diseases**. SRC programmes also target **NCDs**, fostering healthy lifestyles and creating enabling environments so as to reduce NCD-related mortality and morbidity.

WASH programmes promote equitable access to clean water and sanitation. Particular attention is given to handwashing, nutrition, and personal and environmental hygiene.

The SRC has many years of experience and expertise in blood safety and availability, eye health, and ageing and health. It works with National Societies and health systems providing integrated care using a patient-centred approach to **ageing and health**. It promotes the scaling up and out of best practices in home-based care and active ageing interventions, creating an age-friendly environment and intergenerational support systems.

In **blood safety and availability**, the SRC supports the promotion and management of voluntary non-remunerated blood donation, blood donor retention and strengthened blood transfusion systems, with a view to ensuring a sufficient supply of safe blood products in a timely manner.

In **eye health**, SRC programmes strengthen health systems in order to prevent visual impairment and avoidable blindness, facilitating a closer link between the host National Society, the government health system and other eye health stakeholders.

Depending on the country context and needs, SRC projects target the beneficiaries' psychological and social well-being with specific activities. Country programmes are encouraged to assess and address the need for psychosocial support and social well-being. These are not, however, considered thematic priorities.

Thematic priority	Potential intervention strategies
Reproductive health	• Maternal health and safe motherhood • New-born and child health • Adolescent health • Family planning and contraceptive choice and safety • Prevention of sexual and gender-based violence and abuse • Promoting healthy sexuality and sexual rights
Infectious diseases	• Prevention, early detection, care and treatment of infectious diseases most prevalent locally, such as sexually transmitted infections, HIV/AIDS, malaria, tuberculosis, diarrhoea, pneumonia, Chagas disease, Dengue, Chikungunya, Zika and others • Institutional preparedness to react to sudden epidemics or a changing context • In emergency context control of epidemics, such as cholera, other water-borne diseases, Ebola, Zika and others
NCDs	• Promotion of healthy living and healthy lifestyle to prevent NCDs • Prevention, early detection, and facilitation of access to treatment and counselling by applying "best buys" to tackle cardiovascular diseases, diabetes, cancers and chronic respiratory diseases • Support a public policy and population-based approach to contribute to a conducive environment in NCD prevention
WASH	• Access to safely managed drinking water and sanitation • Hygiene promotion • Embedding WASH in wider environmental health, e.g. waste management, particularly in urban areas • Integrated water resource management
Ageing and health	• Promoting age-friendly environments • Integrated medico-social home-care services and assistance for elderly, chronically ill and disabled persons • Healthy and active ageing
Blood safety and availability	• Technical assistance for national blood safety and availability programmes and blood transfusion services • Support to develop blood safety and availability policies • Capacity-building at national and local level for quality services, including certification • Partner capacity-building in recruitment of voluntary non-remunerated blood donors
Eye health	• Prevention and treatment of eye diseases • Strengthening of regional and local eye health systems • Integration of eye health into the primary health care systems

Table 1: SRC thematic priorities and intervention strategies in health

At programme and project level, the country programmes work on the thematic priorities in accordance with the criteria below.

Local burden of disease

In response to the diverse health challenges between and within regions and countries, programme themes are selected on the basis of a thorough assessment of the local epidemiological profile and burden of disease. A clear understanding of the local context, policies, needs, vulnerabilities, capacities, resources and stakeholders is pivotal.

Comparative advantages

The Movement's institutional and volunteer network is a key comparative advantage in international cooperation. The SRC builds on the thematic profile of its long-standing partners and engages in thematic alliances, complementing the efforts of other key stakeholders.

Expertise

The SRC has extensive knowledge and experience in health on all continents. Tools and instruments developed or used by the IFRC are applied in a context-specific manner by all Movement partners and thus contribute to increased global expertise.

Priority approaches across health themes

The SRC applies several cross-cutting priority approaches regarding the above thematic priorities (see Figure 2 above).

Integrated programming is an on-going process within the Movement and is defined as «… a holistic approach to addressing the risks and needs faced by the community... [It] is an approach that incorporates key components of the National Society's core programme areas into a holistic programme model, which recognizes the beneficiary/beneficiaries in their totality of needs and rights» (IFRC South Asia 2009, quoted from *Danish Red Cross Integrated Programming Guideline*[28]). For SRC-supported health projects, this means linking the different thematic priorities. For example, NCD activities are linked to ageing and health and to eye health interventions, or a reproductive health project is linked to WASH or NCD interventions.

The SRC also strives to apply an integrated approach to health and disaster risk management, i.e. to realise synergies in the form of increased efficiency and effectiveness in relation to project teams and communities.

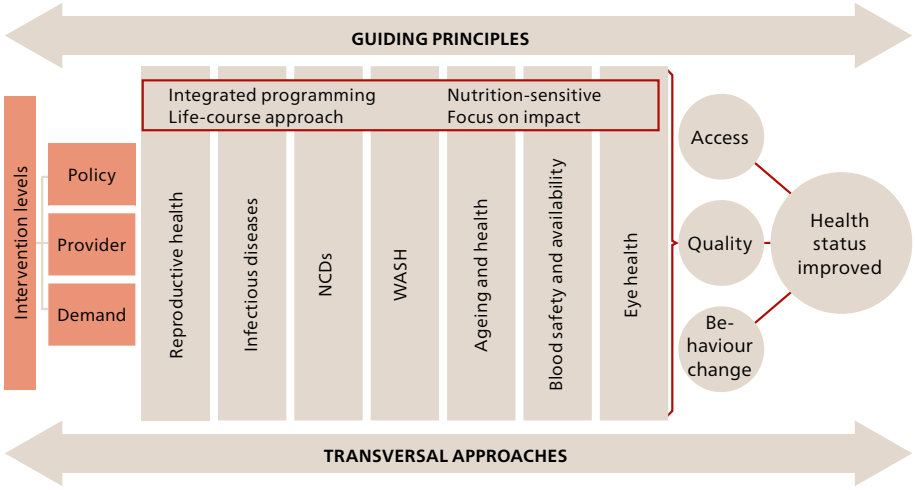
Working in a nutrition-sensitive manner in other thematic priorities has an impact on the nutritional status of the beneficiaries. WASH interventions prevent diarrhoea and other intestinal diseases and are a major contributor to better nutrition. In particular, hand-washing with soap at critical times has an enormous effect. Working in a nutrition-sensitive way is important when it comes to eye care (e.g. Vitamin A distribution), sexual and reproductive health (e.g. exclusive breastfeeding), infectious diseases (e.g. treatment and care of persons living with HIV/AIDS); and nutrition is part and parcel of the fight against NCDs. Projects need to embrace nutrition-sensitive programming and build competences to more systematically plan, describe and monitor effects in terms of and on nutrition.

Even though women are usually in charge of food and nutrition in the family, SRC projects endeavour to train and empower both women and men in food production, preparation and allocation. Once men are equally aware of the importance of healthy and balanced nutrition, they are more likely to become engaged in food production and to distribute food equitably to all household members.

SRC programmes emphasise **a life-course approach**. They engage with people from early life until old age and death, recognising critical periods of growth and development and attempting to minimise people's exposure to health risks. They involve young people to shape healthy lifestyles and future decisions and choices. They also focus on the elderly, in the light of global demographic changes. SRC programmes strive to meet the changes in people's health needs over a lifetime.

SRC programmes **focus on impact** and report on outcomes. In order to maximise impact and have the best possible health outcomes, projects/programmes need to implement a bundled intervention approach. This is achieved by forming partnerships, joining alliances and having a geographical cluster approach.

6. Stakeholder engagement



In pursuing a holistic approach to health development, SRC programmes work on three intervention levels, i.e. demand, provider and policy with the aim to build bridges between health service providers and communities (demand side) by changing health behaviour, improving access and enhancing quality. They strengthen the interfaces between the various actors and stakeholders of local health systems, irrespective of the entry point and strengthen them to reach out to and meet the needs of the most vulnerable (see Figure 3 below). In their engagement with stakeholders on different intervention levels, SRC programmes emphasise strengthening the demand side, provider side and engagement in policy dialogue.

6.1 Health capacities of local communities and individuals are strengthened (demand side)

The SRC's experience and international studies show that community-based health interventions can make a significant difference to people's health. SRC programmes are therefore conducted through a local partner National Society and generally rest on the pillars of intervention described below.

Community-based health and first aid, and community action for health

The SRC provides support to its partners at local, regional and national level, promoting and using the IFRC Community-based Health and First Aid (*eCBHFA*) approach. This involves supporting and facilitating community-based action that enables the local population to improve health by identifying its own needs and developing and implementing solutions. Health promotion, health education, empowerment and self-help activities are key means of healthy living, building, increasing and retaining community health capacity and enabling individuals to make healthy choices.

Community empowerment

Local communities are informed about their right to health and entitlements under local health policies. They are strengthened and empowered to engage in decentralized health planning, budgeting and decision-making. Their management and leadership capacities are boosted so that they can act as sustainable partners for the local authorities.

Volunteers and community health workers

Well-trained, well-equipped and properly supervised volunteers and community health workers are important agents who can bridge the gap between community needs and the formal health system. SRC programmes strengthen volunteers and community health worker schemes for community mobilisation, health promotion, health education, first aid and home care. Health worker training and skills are based on field-tested methods and manuals developed by the IFRC and other NGOs.

Local partner capacity-building

The capacity of the local partner organisation to understand and use community-based approaches and to take over a facilitation role in the community is bolstered. Partner organisations are enabled to facilitate an empowerment and solution-oriented process, applying a human rights-based approach. This implies that partner organisations move away from a charity approach and instead draw on the potential and resources of the community and other local stakeholders.

6.2 Health care systems are strengthened with a view to access for all (provider side)

Health system strengthening addresses all activities whose primary purpose is to promote, restore and maintain health, and to prevent household poverty due to illness29. Health systems provide access to prevention and care, improve the health status of communities, protect the population from health threats and enable the users to participate in decision-making. The SRC's efforts are geared towards reinforcing the public health system by strengthening and facilitating the interfaces between the government system, civil society and the private sector in a number of ways.

Health system building blocks

SRC projects aim to strengthen partners so that they can step in for, restore or support the local health system for as long as local needs require. Projects provide context-specific support to different health system building blocks (particularly service delivery, medicines and technologies, financing, health workforce and information)[30] so as to enable the health system to meet the beneficiaries' health needs.

Universal health coverage

SRC programmes strive to help countries increase coverage of the population for equitable access, service coverage for quality health services and sustainable financial coverage for social health protection.

Traditional health providers

In many regions, traditional healers and birth attendants play an important role in the provision of community-based primary care. The SRC promotes intercultural health systems, in which recognised complementary approaches to health care are linked with the formal health system and referrals to the formal health system are functional. In emergencies and fragile contexts, local health organisations and traditional health providers can be critical partners for delivering aid and primary services to the most vulnerable.

Intersectoral collaboration and integration

The public health system does not work in isolation. The SRC facilitates the collaboration and integration of services with other public sectors and ministries. For example, the integrated care approach requires cooperation between the health and social ministries and sustainable health education requires the involvement of the education sector.

Inclusion and diversity

The SRC promotes intercultural health systems, in which recognised complementary approaches in health care are linked with the formal health system. SRC projects target barriers to access, with the aim to enhance access in particular for the marginalised and differently abled/disabled persons and groups.

6.3 Advocacy and local policy dialogue for health is taken forward

The SRC is guided by its mission to advocate for the health of the most vulnerable communities both in Switzerland and abroad.

Policy dialogue in programme countries

SRC programmes engage in policy dialogue in various manners. Firstly, SRC programmes aim to transform local policy into practice. Local communities, community-based organisations and health providers are informed about their rights and entitlements and empowered to hold duty bearers accountable. The SRC builds their capacity and helps them engage in policy dialogue with health authorities at different levels. Secondly, SRC projects apply innovative measures and pilot new approaches on a small scale, in order to inform and influence local policy. The capacity of partner organisations is boosted so that they are able to engage in local policy dialogue and leverage innovations to scale. Thirdly, alliances with other partners, enhance policy dialogue at national level.

Advocacy in Switzerland

The SRC aims to influence Switzerland's contribution to improved health worldwide. To that end, it uses its unique access to international health platforms through its Geneva-based partner organisations, the IFRC and the International Committee of the Red Cross. Supported and encouraged by the excellent standing and reputation of the worldwide Movement to which it belongs, the SRC makes the general public, particularly young people, and the private sector aware of the correlations between global health, development and poverty reduction. It also plays an active role in Swiss networks, particularly Medicus Mundi Switzerland and the Swiss Malaria Group, and engages in health policy dialogue with the relevant Swiss government authorities, such as the Swiss Agency for Development and Cooperation and the Federal Office of Public Health.

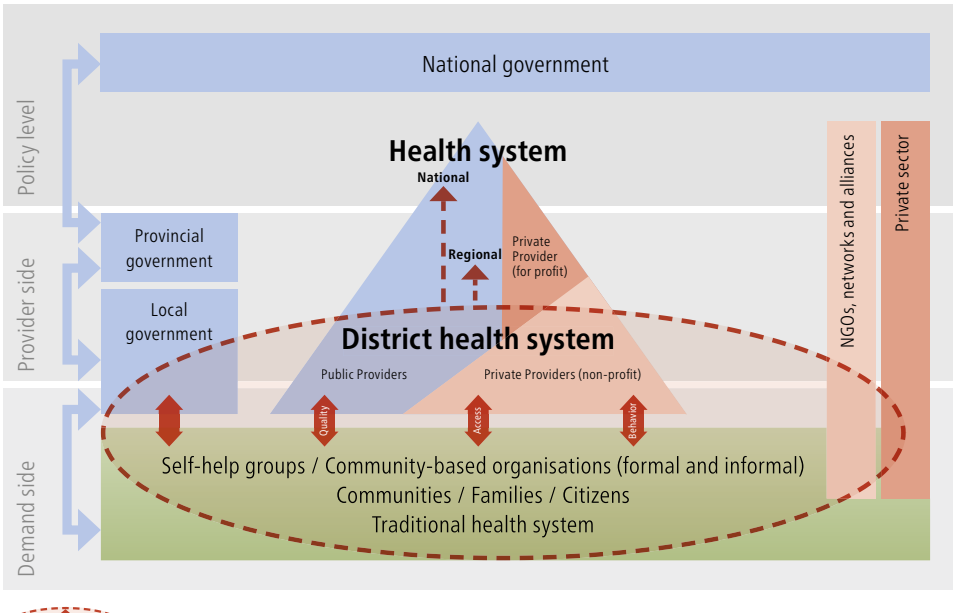


Figure 3: SRC stakeholder engagement model

7. Quality management

The quality management, project cycle management and risk management standards and guidelines of SRC programmes are defined in the quality management manuals for the field and headquarters.[31, 32] The quality criteria below are particularly critical.

7.1 Relevance and impact

SRC programmes relating to response, recovery and development are carried out in such a way that they contribute to relevant local, national and global development goals and policies, reducing the local burden of disease and meeting the health needs of the beneficiaries. In order to achieve the highest possible impact, SRC programmes support and implement health activities that are based on sound evidence as to their efficiency and effectiveness. The SRC understands «impact» to be the contribution programmes make to improve the health of vulnerable groups and communities, measured by internationally recognised health indicators. It is beyond the SRC's scope to assess epidemiological impact indicators. It therefore makes impact hypotheses – evidence-based assumptions – about how its project outcomes are expected to contribute to overall health development goals (see SRC impact model in Annex I).

7.2 Monitoring, evaluation and learning

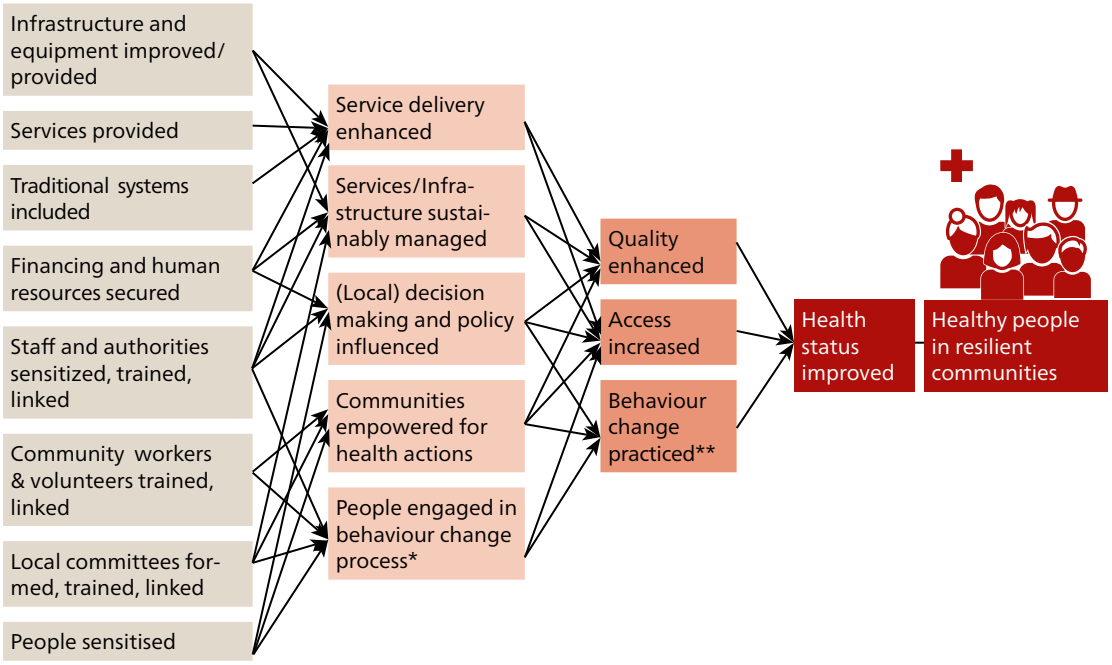
The outcomes of SRC health projects are measured regularly using the monitoring and evaluation procedures of the quality management system adopted by the SRC Department of International Cooperation. Key indicators for each thematic priority are defined in the SRC indicator toolboxes, which comprise internationally recognised indicators, including the SDG targets. SRC key indicators are described in Annex II. Greater use will be made of information and communication technology tools for data collection and management. Regular and timely data collection and analysis serve to track project success and challenges and are used to steer, adapt and learn from individual projects. Operational research will be more systematically embedded in the individual health programmes but also at regional and international level.

The SRC engages in continuous individual training and organisational learning on health, both internally and with its partner organisations. Lessons learnt and good practices emanating from evaluations, studies, etc. are shared at regional and headquarters level and incorporated into future SRC programming and strategic development. Reports and studies are also shared with delegates, partnership networks, stakeholder alliances and policy-makers to exchange information, share knowledge and capitalise on learning at all levels of cooperation. The findings are presented at conferences and disseminated in publications, heightening the SRC's visibility and positioning it in the global health arena.

7.3 Thematic and methodological advice

Developing the human resources and organisational capacities of the SRC and its partners are key requirements for the implementation of the Health Policy. Health advisers support the SRC team at headquarters and in the field to put the Health Policy into practice. External experts, consultants and institutions, such as the SRC National Blood Transfusion Service and medical experts from the SRC pool for Emergency Response Teams, provide specific knowledge and technical expertise.

Annex I
Impact model health



* «Engaged in behaviour change»: People are engaged in the first three steps of the IFRC behaviour change model, i.e. Knowledge (1), approval (2), and intention (3). This implies working on risks, attitudes, norms and abilities according to IFRC doer/non-doer analysis (related to RANAS approach)

** «Behaviour change practiced»: People have reached the fourth stage, i.e. practice, of the IFRC behaviour change model. This implies working on self-regulation according to the RANAS model.

Links:
1.IFRC eCBHFA Webpage: *http://ifrc-ecbhfa.org/guides-and-tools/*
2.eCBHFA behaviour change model: *https://drive.google.com/file/d/1DhBQj5EDIKhwN9GmGMjKCykfBgKiayvb/view*
3.eCBHFA doer/non-doer analysis: *https://drive.google.com/file/d/1UzwZilfh9Kppfd5a7ZDdEA58LUcene_k/view*
4.RANAS approach: *https://www.ranasmosler.com/*

Annex II
Standard Outcome Indicators

Each project chooses at least one standard outcome indicator from the SRC indicator toolbox for outcome measurement, depending on the results of the project assessment, context and country needs.

Thematic area	Outcome	Indicator	Recommended by	Contributing primarily to SDG
Reproductive health	Quality	% of skilled health personnel using sterile delivery kits	WHO	3
		% of health personnel correctly following standard treatment protocols	WHO	3
		% of people having received a family planning counselling within 6 weeks after childbirth	WHO	3
	Access	% of births attended by skilled health personnel	WHO	3
		% of women having received four or more ante-natal care check-ups during the last pregnancy	WHO	3
		% of children between 12–23 month vaccinated three times for Diphtheria, Tetanus and Pertussis (DTP 3) and any other additional vaccine (depending on local guidelines)	WHO	3
		% of people who are currently using, or whose sexual partner is using, at least one method of contraception, regardless of the method used (any kind of family planning method)	WHO	3
		% of men accompany their pregnant wifes/partners to at least one ANC check-up	WHO	3+5
		% of children from 0–59 months that appear for regular check ups and growth monitoring	WHO	2+3
	Behaviour	% of pregnant women who have a preparedness plan for birth and complication	WHO	3
		% of Infants < 6 months of age received only breast milk on the previous day	WHO, UNICEF	2+3
		% of people talking about Sexual and Gender Based Violence (SGBV) in the past 6 month	WHO	3+5
		% of children 6–23 months of age who receive foods from 4 or more food groups on the previous day	WHO	2+3
Infectious diseases	Quality	% of health personnel correctly following standard treatment protocols	WHO	3
		Number of hours from notification of suspected outbreak until outbreak investigation	Sphere	3
	Access	% of children < 5 years of age with suspected pneumonia, dysentery or malaria taken to a health care provider	WHO	3
		% of children between 12–23 month vaccinated three times for Diphtheria, Tetanus and Pertussis (DTP 3) and any other additional vaccine (depending on local guidelines)	WHO	3
	Behaviour	% of people sleeping under insecticide-treated nets the previous night	WHO	3
		% of people using a condom during last sexual intercourse with a higher-risk partner	WHO	3
Non-communicable diseases	Quality	% of people who's blood pressure was taken by health facility admission	WHO	3
		% of health personnel correctly following standard treatment protocols	WHO	3
	Access	% of eligible people taking drug therapy and received counselling to prevent heart attacks and strokes	WHO	3
	Behaviour	% in insufficiently physical active people > 18 years of age	WHO	3
		% of children 6–23 months of age who receive foods from 4 or more food groups on the previous day	WHO	2+3

WASH	Quality	% of water sources that meet national drinking water quality standards	WHO, UNEP	6
		% of water committees that have and regularly monitor their water safety plan	UNEP	6
	Access	% of people using an improved drinking water source	WHO, USAID	6
		% of people using safely managed sanitation facilities	WHO	6
	Behaviour	% of people adopting safe water handling practises	WHO	6
		% of people for whom hand washing facilities with water and soap is available on premises	USAID	6
Ageing and Health	Quality	% of health personnel correctly following standard treatment protocols	WHO	3
		% of home care services financed through service agreements, client fees and other domestic sources		3
		Increased self stated integration of older people in the local society	WHO	3
		Proportion of people satisfied with the provision of home based care service		3
	Access	% increase in number of people benefitting from the services		3
		% increase in number of people as group members in active ageing (AA) groups		3
	Behaviour	% of people (AA group members) engaged in social activities		3
		% of people who correctly adhere to their treatment		3
Blood safety and availability	Quality	% of blood donations screened for all transfusion-transmissible infections (TTIs) according to national protocol in the past 12 month	WHO; guidelines; country guidelines	3
	Access	% of the need for blood products met by the blood transfusion service in the past 12 month	WHO	3
		% of voluntary non-remunerated blood donations in the past 12 month	WHO	3
		% of increase of blood donations	WHO	3
	Behaviour	% of voluntary non remunerated blood donors who donated blood more than one time in the past 12 month	WHO	3
Eye health	Quality	% of eyes with good visual acuity after 6 weeks of cataract surgery between 6/6 and 6/18	WHO; Vision 2020	3
		% of health personnel correctly following standard treatment protocols	WHO	3
	Access	% of increase of utilization of the eye care facility from previous year to current year	WHO	3
		Number of cataract surgeries per 1'000'000 population done per year	WHO	3+1
	Behaviour	% of school children who where given spectacles wearing them at school at time of observation	WHO	3+1

Endnotes

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