Health Policy
for International Cooperation

Swiss Red Cross
Edition

Swiss Red Cross
International Cooperation
iz@redcross.ch
www.redcross.ch
PC 30-4200-3
Design and print
graphic-print

Berne, August 2016

Picture cover page:
Mali ©SRK, Caspar Martig

Pictures last page:
Bulgaria © SRK, Alfred Mikus
Sierra Leone © IFRC, Katherine Mueller
Haiti © SRK, Florian Kopp
Nepal © SRK, Stefan Maurer
Contents

1. Introduction  5
   1.1 Rationale and scope  5
   1.2 Embedding the Health Policy in the SRC and IFRC policy frameworks  5
   1.3 Recognising international policy frameworks  7
   1.4 Evolution of the Health Policy over time  8

2. Context and challenges  9

3. The stakeholder model  12

4. Objectives of the SRC’s engagement for health  13
   4.1 Goal  13
   4.2 Outcomes  13

5. Thematic priorities  14

6. Priority approaches  16

7. Quality management  20
   7.1 Relevance and impact  20
   7.2 Monitoring, evaluation and learning  21
   7.3 Thematic and methodological advice  21

Annex I: Health Policy synopsis  22
Annex II: Impact model health  23
Annex III: “Must-have” key indicators  24
Endnotes  26

List of figures and tables

Figures
1   The SRC policy framework  7
2   The SRC health stakeholder model  12
3   Health Policy priority approaches  16

Tables
1   SRC thematic priorities in health  15
### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV/AIDS</td>
<td>Human immunodeficiency virus/acquired immunodeficiency syndrome</td>
</tr>
<tr>
<td>IFRC</td>
<td>International Federation of Red Cross and Red Crescent Societies</td>
</tr>
<tr>
<td>LMIC</td>
<td>Low- and middle-income country</td>
</tr>
<tr>
<td>NCD</td>
<td>Non-communicable disease</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-governmental organization</td>
</tr>
<tr>
<td>SDG</td>
<td>Sustainable Development Goal</td>
</tr>
<tr>
<td>SRC</td>
<td>Swiss Red Cross</td>
</tr>
<tr>
<td>WASH</td>
<td>Water, sanitation and hygiene</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
1. Introduction

1.1 Rationale and scope

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

The Health Policy is the guiding framework for the health programmes of the 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 for International Cooperation 2012–2017 outlines in detail for the first time 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, global frameworks have changed and new thematic priorities have arisen. The SRC impact model, which guides the SRC’s work in health and disaster risk management, has been revised and adapted for application in the response, recovery and development continuum. The Health Policy 2012–2017 has been revised in the light of those developments. The present new policy will apply as of 2017. A synopsis is presented in a diagram in Annex I.

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

The SRC 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 International Federation of Red Cross and Red Crescent Societies (IFRC) and the SRC.

The IFRC Strategy 2020, saving lives, changing minds,1 renews the IFRC’s commitment to humanitarian aid and calls for more action to prevent and reduce the underlying causes of vulnerability. It focuses on three strategic aims for the next decade:

- Strategic aim 1: Save lives, protect livelihoods, and strengthen recovery from disasters and crises
- Strategic aim 2: Enable healthy and safe living
- Strategic aim 3: Promote social inclusion and a culture of non-violence and peace

The IFRC Framework for Community Resilience2 defines health as an important characteristic of resilience, acknowledging not only that a resilient individual is healthy, but also that health is key to resilience. SRC programmes are also guided by other IFRC thematic frameworks, such as the IFRC maternal, newborn and child health framework3 and the IFRC Strategic Framework on Gender and Diversity Issues4.
The SRC Strategy 2020 addresses health in two of its four core business areas. 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 generates added humanitarian value for vulnerable people by:

- supporting the implementation of services in the SRC’s three core areas of intervention (response, recovery and development), focusing on prevention, health promotion and access to quality care;
- facilitating a process whereby people and communities are empowered to engage in dialogue with the authorities and claim their right to health;
- advocating for and influencing local policy dialogue;
- building the capacities of local partners (National Societies, local and national authorities, Non-Governmental Organizations [NGOs]);
- spreading knowledge of the Fundamental Principles and international humanitarian law.

The SRC Strategy 2020 for International Cooperation defines health and disaster as the core spheres of international cooperation activity, in line with the mission to “foster healthy living and improved disaster management capacities among particularly vulnerable people and communities”. SRC international cooperation activities are also guided by the Fundamental Principles of the Red Cross and Red Crescent Movement and bound by the following overarching principles of action:

- focus on particularly vulnerable and deprived groups of people;
- empower communities and individuals to take self-determined action and reinforce their self-help capacity;
- promote gender equality;
- promote voluntary work;
- emphasise relevance and effectiveness;
- cooperate in partnerships;
- promote alliances and participate in networks;
- do no harm and take conflict-sensitive action.

In line with the SRC Concept Partnership in International Cooperation, the National Red Cross and Red Crescent Societies are the SRC’s preferred partners for cooperation in response, recovery and development. In the wake of major disasters, the SRC usually acts under the coordination of the IFRC; during and in the aftermath of violent conflicts, with the International Committee of the Red Cross.

It may, in specific instances, cooperate directly with community-based organisations and NGOs. Programmes to strengthen the health system usually require a contractual cooperation arrangement with the country’s Ministry of Health and/or other government entities, the National Society, a community-based organisation and the SRC.

Figure 1 shows the Health Policy embedded in the SRC policy framework.
In addition to the IFRC and SRC policy frameworks, the SRC recognises the United Nations 2030 Agenda for Sustainable Development and the Sustainable Development Goals (SDGs).

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 World Health Organization (WHO) and other United Nations agencies, the policy strategies and frameworks of the countries in which the SRC implements its programmes, and the Swiss Health Foreign Policy.
1.4  Evolution of the Health Policy over time

Global developments and the lessons it has learnt from its health programmes in the past four years have prompted the SRC to include several new priorities for its health programmes.

Contributing to the SDGs
The SRC furthers achievement of the SDGs by emphasising the need to strengthen the building blocks of local health systems and by empowering people and communities to realise their right to health. SRC programmes endeavour to leave no one behind, meeting the needs of girls and boys, women and men with different abilities and of all ages living in rural and urban areas.

Working for universal outcomes
Health programmes in response, recovery and development work towards one goal: improvement of the health status of all, in particular for vulnerable people, groups and communities. Three outcomes are key: enhanced quality, improved access to health and changed health behaviour.

Emphasising a life-course approach
SRC programmes 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. Involving youth is essential to shape healthy lifestyle and future decisions and choices. Furthermore, demographic changes require a focus on elderly people in low- and middle-income countries (LMICs). Age-friendly environments, active ageing and long-term integrated care have become significantly more important, and “ageing and health” has thus been determined to be an additional thematic priority of the SRC’s work.

Encouraging partners to engage in policy dialogue and advocacy
The SRC will continue to heighten Swiss public awareness of the interrelations between health, development and poverty reduction. Besides engaging in policy dialogue on global health with the Swiss government, the SRC intends to facilitate and strengthen its partners’ efforts to engage in local policy dialogue with the respective authorities in the programme countries. Policy dialogue in SRC programme countries 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.
2. Context and challenges

Rigorous implementation of the Millennium Development Goals resulted in major health gains by the end of 2015. The global under-five mortality rate declined by more than half, dropping from 90 to 43 deaths per 1,000 live births between 1990 and 2015. In the same time span, the maternal mortality ratio declined by 45 per cent worldwide. By June 2014, 13.6 million people living with HIV were receiving antiretroviral therapy globally, an immense increase from just 800,000 in 2003. Worldwide, 2.1 billion people gained access to improved sanitation, and the proportion of people practicing open defecation had fallen by almost half since 1990. However, 400 million people still have no access to basic health care and unacceptable gaps remain in equal access to health between and within countries.

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.

Nutrition – the key to health
Malnutrition is one of the greatest threats to health, particularly in vulnerable groups and communities. About 800 million people go to bed hungry every night. 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 non-communicable diseases (NCDs) like cardiovascular disease and diabetes.

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. 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 Water Sanitation and Hygiene (WASH) and nutrition, are the leading causes of illness and death in small children. There are 37 million people living with Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (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. Nearly 500,000 people died of malaria in 2014, 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.
The vicious cycle of poverty and illness
In 2015, approximately 702 million people, or 9.6 per cent of the global population, lived below the newly defined international poverty line of United States dollars 1.90 a day.\(^\text{17}\) 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 healthcare.\(^\text{18}\) 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.\(^\text{19}\) 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.

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 far below 5 per cent of gross domestic product to health,\(^\text{20}\) despite having signed the Abuja Declaration.\(^\text{21}\) The lack of doctors, midwives 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.\(^\text{22}\) 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.

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.\(^\text{23}\)

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 %).\(^\text{24}\) 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.
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. 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.

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 by going the last mile. 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. With only four countries investing more than 10 per cent of their gross domestic product in public health spending, health and development cooperation must be predicated more than ever on aid effectiveness, alignment and harmonisation, multi-stakeholder collaboration models and new as well as 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 stakeholder model

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 also a vital resource for social and economic development. Good health enables people to engage in economic activities, to generate household income and to sustain livelihoods. 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. Health is key to resilience.

The SRC is determined to save lives, alleviate suffering and protect and improve the health of vulnerable people at all points in their lives. Improved health requires joint efforts and alliances at all levels of society and among all sectors, from the individual to the community, from country to global level. SRC activities are intended to bring about behavioural change in individuals and communities, and structural changes spearheaded by local and national governments, civil society and the business sector.

In pursuing a holistic approach to health development, SRC programmes aim to build bridges between health service providers and communities by enhancing quality, improving access and changing health behaviour. They strengthen the interfaces between the various actors and stakeholders of local health systems, irrespective of the entry point (see Figure 2).
4. Objectives of the SRC’s engagement for health

4.1 Goal

Informed by the global challenges, oriented by the SRC Strategy 2020 and guided by the overarching principles of action defined in the SRC Strategy 2020 for International Cooperation (see chapter 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

The following three outcomes apply for SRC projects in response, recovery and development.

**Quality is improved**

In order to obtain better health outcomes, SRC programmes focus on improving the quality of services, care and goods. This encompasses improved technical, behavioural and managerial skills and processes at all levels of the health care system and addressing determinants of health.

**Access is increased**

SRC health projects endeavour to improve equitable access to health services and to goods and services that determine health by working on the interface between the health provider and the “customer” on the demand side of health services. Barriers to access are carefully assessed from the point of view of both supply and demand, and addressed by helping the partners step in for, restore or support the local health system and act on determinants of health.

**Health behaviour is changed**

SRC projects promote healthy living and encourage healthy lifestyles and timely health-seeking behaviour. The SRC advocates and facilitates an environment that encourages people to change their health behaviour and enables them to make health-conscious choices.

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

The SRC’s health policy has eight thematic priorities and corresponding intervention strategies (see Table 1). Operational strategies relating to the thematic priorities are defined in the specific thematic concept papers (see Figure 1 in chapter 1).

The SRC’s priority is primary health care and the sustainable reinforcement of health systems. Comprehensive people-centred and integrated health care, health promotion, community empowerment and a strong emphasis on prevention rather than cure are the cornerstones of its primary health care approach. The SRC focuses on reproductive health, which includes maternal, neonatal, child and adolescent health and sexual and reproductive health and rights, and disease control, targeting communicable as well as non-communicable diseases.

In terms of determinants of health, SRC programmes focus on two thematic priorities: WASH and nutrition.

Furthermore, the SRC has many years of experience and expertise in specialised fields and medical services. Over the past decade, the SRC has positioned itself in the fields of home-based care and assistance and active ageing. Ageing and health has thus become a new thematic priority. Eye care, blood safety and health in emergencies remain high on the agenda. The SRC provides support to its partners, often health ministries, at local, regional and national level to increase the availability of quality services and improve quality management, and advises them on policy issues. In its responses to disasters worldwide, health in emergencies will continue to be a priority.

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.

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 of 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.

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

<table>
<thead>
<tr>
<th>Thematic priority</th>
<th>SRC interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reproductive Health</td>
<td>• Maternal health and safe motherhood</td>
</tr>
<tr>
<td></td>
<td>• New-born and child health</td>
</tr>
<tr>
<td></td>
<td>• Adolescent health</td>
</tr>
<tr>
<td></td>
<td>• Family planning and contraceptive choice and safety</td>
</tr>
<tr>
<td></td>
<td>• Prevention of sexual and gender-based violence and abuse</td>
</tr>
<tr>
<td></td>
<td>• Promoting healthy sexuality and sexual rights</td>
</tr>
<tr>
<td>Disease control</td>
<td>• Prevention, care and treatment of the infectious diseases most prevalent locally,</td>
</tr>
<tr>
<td></td>
<td>such as sexually transmitted infections, HIV/AIDS, malaria, tuberculosis, diarrhoea,</td>
</tr>
<tr>
<td></td>
<td>pneumonia, chagas disease, dengue, chikungunya, zika</td>
</tr>
<tr>
<td></td>
<td>• Institutional preparedness to react to sudden epidemics or a changing context</td>
</tr>
<tr>
<td></td>
<td>• Promotion of healthy living to prevent NCDs</td>
</tr>
<tr>
<td>WASH</td>
<td>• Access to safe drinking water and sanitation</td>
</tr>
<tr>
<td></td>
<td>• Hygiene promotion</td>
</tr>
<tr>
<td></td>
<td>• Embedding WASH in wider environmental health, e.g. waste management, particularly</td>
</tr>
<tr>
<td></td>
<td>in urban areas</td>
</tr>
<tr>
<td></td>
<td>• Integrated water resource management</td>
</tr>
<tr>
<td>Nutrition</td>
<td>• Direct nutritional action to reduce malnourishment (under- and over-nutrition)</td>
</tr>
<tr>
<td></td>
<td>in children and vulnerable groups</td>
</tr>
<tr>
<td></td>
<td>• Food aid</td>
</tr>
<tr>
<td></td>
<td>• During emergencies, multi-sectoral action to ensure food security</td>
</tr>
<tr>
<td></td>
<td>• Health education and promotion of healthy lifestyles</td>
</tr>
<tr>
<td>Ageing and health</td>
<td>• Promoting age-friendly environments</td>
</tr>
<tr>
<td></td>
<td>• Integrated medico-social home-care services and assistance for elderly, chronically</td>
</tr>
<tr>
<td></td>
<td>ill and disabled persons</td>
</tr>
<tr>
<td></td>
<td>• Healthy and active ageing</td>
</tr>
<tr>
<td>Health in emergencies</td>
<td>• Deployment of expatriate nurses, physicians, midwives, laboratory technicians and</td>
</tr>
<tr>
<td></td>
<td>public health experts in multilateral Emergency Response Units and bilateral</td>
</tr>
<tr>
<td></td>
<td>Emergency Response Teams</td>
</tr>
<tr>
<td></td>
<td>• Provision of care, drugs and medical commodities</td>
</tr>
<tr>
<td></td>
<td>• Reconstruction of health infrastructure, including service, water and sanitation</td>
</tr>
<tr>
<td></td>
<td>facilities</td>
</tr>
<tr>
<td></td>
<td>• Control of epidemics, such as cholera and other water-borne diseases</td>
</tr>
<tr>
<td>Blood safety</td>
<td>• Technical assistance for national blood safety programmes and blood transfusion</td>
</tr>
<tr>
<td></td>
<td>services</td>
</tr>
<tr>
<td></td>
<td>• Support to develop blood safety policies</td>
</tr>
<tr>
<td></td>
<td>• Capacity-building at national and local level for quality services, including</td>
</tr>
<tr>
<td></td>
<td>certification</td>
</tr>
<tr>
<td></td>
<td>• Partner capacity-building in recruitment of voluntary non-remunerated blood donors</td>
</tr>
<tr>
<td>Eye care</td>
<td>• Prevention and treatment of eye diseases</td>
</tr>
<tr>
<td></td>
<td>• Strengthening of regional and local eye care systems</td>
</tr>
<tr>
<td></td>
<td>• Integration of eye care into primary health care</td>
</tr>
</tbody>
</table>

Table 1:
SRC thematic priorities in health
6. Priority approaches

SRC programmes apply different health approaches at individual, community and health system level. They include action to:

1. Consolidate the health capacities of local communities and individuals
2. Strengthen health care systems with a view to access for all
3. Promote healthy living conditions (determinants of health)
4. Engage in advocacy and local policy dialogue for health

Health programmes are most effective if action is taken using all four approaches simultaneously. SRC programmes do not necessarily implement all approaches themselves, but use multi-stakeholder partnerships and alliances to engage in subsidiary and complementary action. The programmes collaborate with communities and with the existing health system, strengthening them to reach out to and meet the needs of the most vulnerable.

* The health priority approaches are aligned with those of the Disaster Risk Management Policy: emphasising the community and system level, promoting wider, underlying determinants and integrating advocacy and policy dialogue

Figure 3: Health Policy priority approaches
**Priority approach 1:**
**Strengthening the health capacities of local communities and individuals**

The SRC’s experience and international studies show that community-based health interventions can make a significant difference to people’s health. Programmes generally rest on the following pillars of intervention:

**Community action for health and Community Based Health and First Aid:**
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 promoting healthy living, building, increasing and retaining community health capacity and enabling individuals to make healthy choices.

**Community empowerment**
SRC programmes facilitate the establishment of and work with community-based organisations, local initiative groups, associations, village/community committees and health facility boards. 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.

**Community health workers and volunteers**
SRC programmes strengthen 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 (such as the Community Based Health and First Aid; Home Helper manual etc.) developed by the IFRC and other NGOs. Well-trained, well-equipped and well-supervised community health workers and volunteers are important agents who can bridge the gap between community needs and the formal health system.

**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.

**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.

**Updated to e-community-based health and first aid in 2016.**
Priority approach 2:  
Strengthening health care systems with a view to access for all

Health system strengthening addresses all activities whose primary purpose is to promote, restore and maintain health, and to prevent household poverty due to illness. 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) 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.

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. Furthermore, SRC projects target barriers to access, with the aim to enhance access in particular for the marginalised and differently abled/disabled persons and groups.
**Priority approach 3:**
**Influencing determinants of health**

The SRC recognizes that a person’s health and well-being are fundamentally influenced by the social, economic and physical environment as well as his/her characteristics and behaviour. Addressing the underlying determinants of health, the SRC acts on WASH and nutrition concerns in different ways.

**Creation of an environment that encourages behaviour change**
In line with national and internationally accredited guidelines, technical designs and context-specific solutions, SRC projects provide, for example, the necessary infrastructure to increase the coverage, quality and sustainability of WASH and nutrition interventions.

**Health education and health promotion**
All SRC projects incorporate health education and health promotion, in order to add to the knowledge of individuals and community groups and stimulate them to turn knowledge into action. In a conducive environment, this will lead to health-conscious choices for healthy living.

**Priority approach 4:**
**Engaging in advocacy and local policy dialogue for health**

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, including the Swiss Agency for Development and Cooperation, 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.
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.\textsuperscript{32, 33, 34} 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 poli-
cies, 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 indi-
cators. 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 II).

7.2 Monitoring, evaluation and learning

The outcomes of SRC health projects are measured regularly using the monitoring and evalua-
tion procedures of the quality management system adopted by the SRC Department of Inter-
national 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 III. 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 find-
ings 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

## Health Policy synopsis

<table>
<thead>
<tr>
<th>Goal</th>
<th>Outcomes</th>
<th>Priority Approaches</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve the health status of all, particularly for vulnerable people, groups and communities</td>
<td>Quality enhanced</td>
<td>Reproductive health</td>
</tr>
<tr>
<td></td>
<td>Access increased</td>
<td>Disease control</td>
</tr>
<tr>
<td></td>
<td>Behaviour changed</td>
<td>WASH</td>
</tr>
</tbody>
</table>

**Priority Themes**

- Reproductive health
- Disease control
- WASH
- Nutrition
- Aging and health
- Health in emergencies
- Blood safety
- Eye care
Annex II
Impact model health

Sphere of activity Health

Facility/infrastructure improved and equipped
Services provided
Traditional systems included
Financing and human resources secured
Staff and authorities sensitized, trained, linked
Community workers & volunteers trained, linked
Local committees formed, trained, linked
Communities sensitized

Service delivery enhanced
Facilities sustainably managed
Quality enhanced
(Local) decision-making and policy influenced
Access increased
Communities empowered for health actions
Behavior changed
Knowledge of individuals improved

Facilities sustainably managed
Quality enhanced
(Local) decision-making and policy influenced
Access increased
Communities empowered for health actions
Behavior changed
Knowledge of individuals improved

Health status improved

Healthy living and improved disaster management capacities among vulnerable groups and communities
Annex III
“Must-have” key indicators

The indicators below are taken from the SRC indicator toolboxes. Each project has to choose at least one “must-have” indicator for outcome measurement. The “must-have” indicators are selected depending on the results of the project assessment, context and country needs.

<table>
<thead>
<tr>
<th>Thematic area</th>
<th>Outcome</th>
<th>Indicator</th>
<th>Recommended by</th>
<th>Contributing primarily to SDG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reproductive health</td>
<td>Quality</td>
<td>% of skilled birth attendants using sterile delivery kits and apply clean cord-clamping</td>
<td>WHO</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Standard treatment protocols correctly followed by staff</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>% of women having received a family planning counselling within 6 weeks after childbirth</td>
<td>WHO</td>
<td>3</td>
</tr>
<tr>
<td>Access</td>
<td>% of births attended by skilled birth attendant</td>
<td>WHO</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% of pregnant women having received four or more ante-natal care check-ups during the whole pregnancy</td>
<td>WHO</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% of infants 1-2 years vaccinated three times for Diphtheria, Tetanus and Pertussis and any other additional vaccine (depending on local guidelines)</td>
<td>WHO, UNICEF</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% of women in reproductive age (15-49 years) using any kind of family planning method</td>
<td>WHO</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Behaviour</td>
<td>% of pregnant women reaching health facility in time after danger signs/ complications have occurred</td>
<td>WHO</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% of pregnant women who have a preparedness plan for birth and complication</td>
<td>WHO</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% of infants below 6 months of age exclusively breastfed</td>
<td>WHO, UNICEF</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% of married women of reproductive age who have spaced their births by more than 2 years.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disease control</td>
<td>Quality</td>
<td>% of health staff taking blood pressure routinely at patient admission</td>
<td>WHO</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Standard treatment protocols correctly followed by staff</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Access</td>
<td>% of eligible people receiving drug therapy and counselling to prevent heart attacks and strokes</td>
<td>WHO</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% of children under 5 years of age with suspected pneumonia, dysentery or malaria taken to a health facility</td>
<td>WHO</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Behaviour</td>
<td>Age-standardized prevalence of insufficiently physically active persons aged 18+ years</td>
<td>WHO</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% using a condom during last sexual intercourse with a higher-risk partner</td>
<td>WHO</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% of population sleeping under insecticide-treated bed nets</td>
<td>WHO</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>WASH</td>
<td>Quality</td>
<td>% of water sources that meet international drinking water quality standards</td>
<td>WHO, UNEPA</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>% of households with functional and clean improved sanitary toilet</td>
<td></td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Access</td>
<td>% of households/population using an improved drinking water source</td>
<td>WHO, USAID</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% of the households/ population using improved sanitation facilities</td>
<td>WHO</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Behaviour</td>
<td>% of households adopting safe water handling practices (e.g. cleaning the water carrying container every time before using it; covering the water with lid etc.)</td>
<td>USAID</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% of households with soap and water at the hand washing station commonly used by the family members</td>
<td>USAID, DFID</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Thematic area</td>
<td>Outcome</td>
<td>Indicator</td>
<td>Recommended by</td>
<td>Contributing primarily to SDG</td>
</tr>
<tr>
<td>------------------------</td>
<td>---------</td>
<td>---------------------------------------------------------------------------</td>
<td>---------------------------------------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>Nutrition</td>
<td>Quality</td>
<td>% of severely malnourished children correctly identified and referred to therapeutic feeding centre</td>
<td>WHO, UN standing committee on nutrition</td>
<td>2+3</td>
</tr>
<tr>
<td></td>
<td>Access</td>
<td>% of mothers bringing their children from 0-59 months for monthly check ups and growth monitoring</td>
<td>WHO</td>
<td>2+3</td>
</tr>
<tr>
<td></td>
<td>Behaviour</td>
<td>Exclusive breastfeeding rate in infants 0–6 months of age</td>
<td>WHO, UN standing committee on nutrition</td>
<td>2+3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>% of children 6–23 months of age who receive foods from 4 or more food groups</td>
<td>WHO</td>
<td>2,3+5</td>
</tr>
<tr>
<td>Ageing and Health</td>
<td>Quality</td>
<td>% of the beneficiaries satisfied with the Home Based Care services</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Access</td>
<td>% self-stated inclusion of vulnerable people in the community life</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Behaviour</td>
<td>tbd</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health in emergency</td>
<td>Quality</td>
<td>Time from notification of suspected outbreak until outbreak investigation</td>
<td>Sphere</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Access</td>
<td>% of population affected by an emergency using SRC supported health care facilities</td>
<td>WHO</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Behaviour</td>
<td>% of households treating their water with chlorine before drinking</td>
<td>WHO</td>
<td>3, 6</td>
</tr>
<tr>
<td>Blood safety</td>
<td>Quality</td>
<td>% of blood donations screened for transfusion-transmissible infections</td>
<td>WHO guidelines; country guidelines</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Access</td>
<td>National Blood Transfusion System meets x % of the needs of requested blood products</td>
<td>WHO</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>% of voluntary non-remunerated donation of whole blood and labile blood products</td>
<td>WHO</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Behaviour</td>
<td>% of voluntary non-remunerated low-risk blood donors who donate blood more than one time per year</td>
<td>WHO</td>
<td>3</td>
</tr>
<tr>
<td>Eye care</td>
<td>Quality</td>
<td>% of eyes with good visual acuity after 6 weeks of cataract surgery between 6/6 and 6/18</td>
<td>WHO; Vision 2020</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Access</td>
<td>% of increase of utilisation of the eye care facility from previous year to current year</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Behaviour</td>
<td>% of school children who were given spectacles are wearing them at school</td>
<td></td>
<td>3</td>
</tr>
</tbody>
</table>
3 International Federation of Red Cross and Red Crescent (2013). International Federation of Red Cross and Red Crescent; Maternal, newborn and child health framework. IFRC, Geneva.
33 Swiss Red Cross Quality management Manual Headquarter: https://dms.redcross.ch/sites/iz_sup/QMManualIZ/SitePages/Homepage.aspx