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**FOLLOW-UP TO THE 28<sup>TH</sup> INTERNATIONAL CONFERENCE**

**PART 4:  
Implementation on General Objective 4 of the Agenda for Humanitarian Action:  
Reduce the increased vulnerability to diseases arising from stigma and  
discrimination and from the lack of access to comprehensive prevention, care  
and treatment.**

**Document prepared the International Federation  
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## FOLLOW-UP TO THE 28<sup>TH</sup> INTERNATIONAL CONFERENCE

### PART 4:

#### **Implementation on General Objective 4 of the Agenda for Humanitarian Action: Reduce the increased vulnerability to diseases arising from stigma and discrimination and from the lack of access to comprehensive prevention, care and treatment.**

The aim is to protect human dignity from the devastating consequences of HIV/AIDS and other diseases. In particular, those consequences faced by groups that are stigmatised, discriminated against or socially marginalized because of their situation or circumstances and often lack access to comprehensive prevention, treatment, care and support. To achieve this it is necessary to address legal and policy barriers, as well as underlying societal attitudes, which stigmatise and discriminate against People Living With HIV/AIDS (PLWHA) and other highly vulnerable populations. Equally important will be providing equitable access to prevention, treatment and health care, including psychosocial support, for all people, including displaced persons and other marginalized and vulnerable groups. These groups, including prisoners and detainees, need special attention in order to reduce the impact and further spread of HIV/AIDS and other diseases and promote the enjoyment of the highest attainable standard of health; one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.

Advocacy, and support of stakeholders to fight against discrimination were seen as the major vehicles for Movement work .

A significant development that has come to fruition during the reporting period is the development of the concept of the “Federation of the Future”, a significant reorientation of the way in which the International Federation operates and how it sets its priorities.

Intimately linked to the “Federation of the Future” is The International Federation’s “Global Agenda” which includes four goals: reduction the number of deaths, injuries and impact of disasters and of diseases, building capacity, and fight discrimination and intolerance.

Two of these Goals are closely linked to the outcome of the 28<sup>th</sup> International Conference:

Goal 2: Reduce the number of deaths, illnesses and impact from diseases and public health emergencies.

Goal 4: Promote respect for diversity and human dignity, and reduce intolerance, discrimination and social exclusion.

These objectives are particularly relevant, dealing with both diseases and with the dimension of the attainment of these goals which relate to the ability of individuals to

gain access to prevention, care and treatment services through removal of barriers based on discrimination and stigmatisation.

In order to strengthen its ability to achieve these goals, the International Federation has reformed its approach to implementation away from a centralised model and towards one with more decentralised decision-making, and a greater centrality of the role of the National Society as the primary operational unit of the organisation.

Thus, under this “New Operating Model”, the International Federation endeavours to co-ordinate and integrate activities and programmes at the country level, itself playing the role of a service provider to the participants and support for the National Societies involved, as well as to tackle global efforts to address specific issues (e.g., HIV/AIDS) through “Global Alliances” in which each individual National Society member is able to bring its contribution to bear within in a common framework, whether at the local, national or international level.

Meanwhile, the International Committee of the Red Cross (ICRC) has strengthened its operational response to control HIV and TB among at risk & discriminated groups such as prisoners and victims of conflict and violence.

## 1. Introduction

When the leaders of the world met at the United Nations Millennium Summit in 2000, they made an historic commitment to meet “their collective responsibility to uphold the principles of human dignity, equality and equity at the global level. “As leaders,” they said, “We have a duty to all the world’s people, especially the most vulnerable”. Their goals, especially:

- Goal 3 (to promote gender equality and empower women),
- Goal 4 (to reduce child mortality),
- Goal 5 (to improve maternal health)
- Goal 6 (to combat HIV/AIDS, malaria and other diseases)

While these are goals set by States for States, they are more likely to be achieved with the help of the Red Cross Red Crescent Movement. Where health used to be seen as a side effect to a good economy, there is now a worldwide consensus that health and development are intimately connected. The Movement’s contributions to all the Millennium Development Goals (MDG) and especially these four are made on this basis.

It is clear from their responses to the questionnaire following up the 28<sup>th</sup> International Conference that National Societies and States have made serious attempts to meet the commitments they made. Many have included campaigns such as the “Pass it on” in their strategic planning and have worked in partnership to influence public thinking and attitudes. While there is clearly much work to be done, the enormity of the problem and the rapid spread of the infection, especially among vulnerable groups (women, children, detainees) have resulted in real action by many countries. It has also been a great joy to see National Societies and States offering financial and human assistance to less well-off National Societies and States for work in this area.

**Final goal 4.1: Eradicate the stigma, discrimination and denial faced by populations affected by and living with HIV/AIDS.**

In May 2006, the International Committee of the Red Cross (ICRC) embarked on a two-year transversal process to strengthen its response to HIV and tuberculosis. Their work has three parts:

- Strengthening those areas which already produce direct HIV and TB related outcomes such as blood safety, universal precautions and the provision of treatment for tuberculosis;
- Achieving better indirect outcomes from existing work such as maternal and child health, prevention and treatment of Sexually Transmitted Infections (STI), strengthening primary health care, expanding the IHL dissemination and communication agenda.
- Clarifying specific areas where direct HIV/TB outcomes can be incorporated such as anti-retroviral treatment, Opportunistic Infections (OI) and PMTCT.

The intent is to move towards practical tools to ensure a consistent HIV/TB integration into programmes to maximize opportunities to reduce stigma and discrimination, limit transmission of infection and increase treatment and care, with a view to controlling those diseases among prisoners and other victim of violence. From operational perspectives, the ICRC is integrating more and more HIV/AIDS, TB and Malaria control components into its health activities especially in Africa, as a contribution to foster access to health care for population affected by violence.

(Field examples are available from Tunisia, Mauritania, Burundi, Ivory Coast, Guinea Conakry, Democratic Republic of Congo, Rwanda, Uganda, Georgia, Armenia, Azerbaijan, Haiti, Afghanistan, Kyrgyzstan and Peru. See also 4.2)

In 2006, the International Federation launched the HIV Global Alliance approach with Southern Africa as the first region to release detailed plans for scaling up. The Global Alliance platform seeks to enable country and regional programmes to meet 10% of HIV-related needs in the community and to at least double the Red Cross Red Crescent (RCRC) contribution by 2010.

In his statement to the United Nations General Assembly Special Session on HIV in 2006, the then Secretary General, Mr. Kofi Annan, of the United Nations was clearly worried that the reform of the legislative process throughout the world in this regard was too slow. While civil society, frequently involving the relevant National Society, is involved in the legislative process in many

4.1.1 States, in fulfilment of the commitments made in the Declaration of Commitment adopted by the United Nations General Assembly Special Session on HIV/AIDS (UNGASS), should eliminate any laws, policies and practices that adversely discriminate against people living with HIV/AIDS (PLWHA), with special attention to women and girls and highly vulnerable groups.

countries (cf Bolivia, Solomon Islands), the primary responsibility for legislation resides with the State Parties to this Declaration and many replies do indicate some progress towards, if not complete, elimination of discriminatory legislation. This can be measured both in terms of reporting on this Agenda for Humanitarian Action and on the pledges made at the 28<sup>th</sup> International Conference. Some legislation is comprehensive, covering all forms of discrimination. At an even higher level, some

States indicated that any such practice would contravene their national constitution (cf Finland, Cyprus).

It was pleasing to see examples of legislation that specifically eliminate discrimination against people suffering from infectious diseases including HIV/AIDS (cf Japan, El Salvador, Guatemala).

Increasingly, States (cf Norway) include a requirement for the inclusion of the gender perspective in all applications for public grants. This is sometimes coupled with plans to establish networks for women living with HIV, including a special focus on the needs of immigrant women. In addition to working within their own country, national governments and National Societies are encouraging the elimination of laws, policies and practices that adversely discriminate against people living with HIV/AIDS with special attention to those affecting women and girls in those countries where they offer aid and assistance (cf Australian Red Cross' Regional Stigma and Discrimination Project conducted in Mongolia, Cambodia and Indonesia).

The introduction of provider-initiated HIV testing in countries with high prevalence and low testing rates has raised concern because of the frequently documented high rates of discrimination in medical settings. It can also be seen as an opportunity to reinforce principles such as pre-test counselling and informed consent. The World Health Organization Ethical Guidelines for health care providers set out the duty to treat, to provide the best medical care, confidentiality and to do no harm. It is critical that HIV testing is an empowering process, especially given the high level of motivation needed by people living with the virus who will have to take anti-retroviral drugs for the rest of the lives.

There was ample evidence of the steady inclusion of people living with HIV/AIDS especially in policy making, programme design and implementation and peer education. A significant number of RCRC leaders have publicly acknowledged the humanitarian contribution of PLHIV<sup>1</sup>, calling for and role-modelling inclusion. However it is an area where the International Federation has admitted that it still has work to do to eliminate stigma and discrimination even within its own organization. This is a process requiring continuous improvement and PLHIV organizations are working with UNAIDS to develop and define indicators.

4.1.2 States undertake to adopt appropriate and effective measures aimed at enforcing policies and strategies aimed at eradicating HIV/AIDS-related stigma and discrimination, with specific attention paid to the gender implications of HIV/AIDS, and an emphasis on the social inclusion of people affected by and living with HIV/AIDS and other vulnerable groups, notably by ensuring the full enjoyment of their human rights and fundamental freedoms.

Many States have now given priority to HIV/AIDS and sexual and reproductive health, not only in their own work but also in

4.1.3 States, assisted by National Societies, are urged to undertake operational measures, with special emphasis on empowering women and addressing the gender balance to promote the widespread availability of and equitable access to comprehensive prevention, care and treatment, improved and enhanced sexual and reproductive health care.

<sup>1</sup> Primarily because of the development of anti-retroviral and other drugs for the treatment of the virus, there has been a worldwide move from using the abbreviation PLWHA to PLHIV. Where a quote is used in this paper, the original has been maintained. Other wise PLHIV has been used to reflect current practice.)

development work (cf the Netherlands, Belgium RC, French RC,) There is increasing use by States and National Societies, in partnership (Polish RC/Poland Government) or separately, of mass media (Solomon Islands RC) and of peer educators (cf Austria, Azerbaijan RC, Bosnia/Herzegovina RC, Chile RC, Czech Red Cross Youth, Estonia, Slovakia RC Youth ) to mount campaigns to empower young people, especially young women, using themes such as HIV prevention, the effects of substance abuse, contraception and family planning. These programmes can extend to work with indigenous people (Guyana RC) and with people living on the streets, often associated with information tailored for use with injecting drug users (cf Greece).

The International Federation, working through its member National Societies, is committed to improve the health of mothers and children particularly by reducing their vulnerability to disease. Nevertheless, the United Nations Office of Drugs and Crime (UNODC) is particularly concerned, stating that services for women hardly exist in most countries. One of the main reasons they say that HIV prevention and care services are not reaching particularly vulnerable groups of women, especially women who inject drugs, is that most of these services are designed for men.

States and National Societies, especially in Latin America, have a strong emphasis on implementing programmes to limit the transmission of HIV from mother to child ( cf El Salvador, Colombia, French RC, Trinidad and Tobago RC ) The British RC are supporting research into the prevention of mother to child transmission in Lesotho. Regrettably the care of victims of female genital mutilation continues to be needed (cf Mali) despite international efforts to limit this practice.

At the same time, many States were at pains to explain that all men and women have equal access to prevention, treatment and care including sexual and reproductive health services (cf Congo, Cyprus, Germany, Armenia), sometimes working in partnership with National Societies ( Lithuania RC, Turkmenistan RC). Others incorporate support and information into women-specific programmes (Japan) or encourage the establishment of networks of women, especially migrant women and women living with HIV(Norway). Health care and assistance to irregular migrants particularly those living with HIV and/or tuberculosis is a special project of the Swedish RC. It is pleasing to see a growing inclusion of gender issues in the strategic plans of National Societies ( Liberian RC) and an encouraging number of gender awareness programmes for men (cf Norway).

Several National Societies continue to run clinics and hospitals offering medical care at no cost or at nominal prices either in their own countries (Egypt RC) or in developing countries (Italian RC in Eritrea, Mozambique, Iran,) while others have moved to home-based care where there is a special emphasis on women as the primary caregivers (Mozambique, Namibia, Lesotho, Malawi, South Africa, Ukraine RC). Often these programmes are mounted with international support (cf German RC, Icelandic RC. Specific EU programmes mentioned included "AIDS and mobility", concerned with the dissemination of HIV/AIDS information to migrant communities with a special emphasis on migrant women, and "TAMER: Trans-national AIDS/STDs prevention among migrants and prostitutes".

The “HIV Prevention, Treatment, Care and Support” training modules developed by the International federation in conjunction with the World Health organization (WHO) included a module “Care of the Carers” to address the needs of volunteers providing palliative care at home. This highlights the importance of ensuring that these carers (often female) are not overburdened, especially where formal health systems are weak, and the need to fund training, supervision and support systems for this important part of the care chain. At least one National Society reported that these guidelines had been most useful.

4.1.4 States are urged to ensure that a wide range of prevention programmes which take account of local circumstances, ethics and cultural values, is available in all countries, particularly the most affected countries, including information, education and communication, in languages most understood by communities and respectful of cultures, aimed at reducing risk-taking behaviour and encouraging responsible sexual behaviour, including: abstinence and fidelity; expanded access to essential commodities, including male and female condoms and sterile injecting equipment; harm reduction efforts related to drug use; expanded access to voluntary and confidential counselling and testing; safe blood supplies; and early and effective treatment of sexually transmittable infections.

UNAIDS has reported very low rates of access to prevention services by the key vulnerable populations, underscoring how little progress has actually been made towards universal access to prevention messages and

commodities. Given that we cannot treat our way out of this epidemic, the current rate of new HIV infection is unsustainable. Cultural values have sometimes been used as a reason to deny the need to address the epidemic rather than as a way to engage creatively and ensure cultural adaptation and even survival. It is important that all the strategies that have been proven to work are used to match the epidemic in particular cultural contexts.

At the same time, there was evidence that some States and National Societies are endeavouring to reach out to at-risk communities in appropriate and acceptable ways (Belgium, The Congo, Iceland, Japan, Mexico, and Nicaragua). Some Ministries of Education are seeking to reduce risk-taking behaviour through specific components of their school health programmes (Cyprus). As a WHO Collaborating Centre, Germany staged a major international conference in November 2006 on youth sex education in a multicultural Europe where a priority issue was the identification of appropriate approaches and communication strategies and an analysis of the 16 Country Papers revealed a growing awareness of gender-sensitive address forms and strategies.

Examples of other efforts being made include:

- the Netherlands Government which is very active in supporting programmes geared to behavioural change and integrates sexual and reproductive health rights (SRHR) and HIV/AIDS in its policy messages and operational support to health systems in developing countries.
- the Austrian Development Agency which is sponsoring a project for integrated youth development and HIV/AIDS interventions in the Southern Nations, Nationalities' and Peoples' Region (SNNPR) and in Ethiopia.
- the Egyptian RC programme which trains young women as “health guides” for their own communities.



- the Macedonian RC 3 year programme for information change and information sharing between transport workers, sex workers, rural communities and socially marginalized groups for the promotion of voluntary confidential counselling and treatment for HIV as an entry point for health services and treatment.
- the highly successful taxi-driver training campaign developed and used by several Latin American National Societies.)

Not only are States working effectively with the components of the Movement, in this area but they are also working together on a regional basis. Examples given from Europe were the European Aids Treatment Group and the European Community Advisory Group. This cooperative work is mirrored by the comprehensive activity of European Red Cross/Red Crescent Network on HIV, AIDS and Tuberculosis (ERNA), which has a current membership of more than forty National Societies.

#### 4.1.5

States, assisted and supported as appropriate by components of the Movement, should undertake operational measures aimed at ensuring continuous progress in the availability of treatment and care for people living with HIV/AIDS, with an emphasis on reaching marginalized groups that do not have ready access to such treatment and care, in order to protect their dignity, lives and livelihoods and prevent the transmission of HIV.

The International Federation has clarified the contribution volunteer systems can make in creating demand for treatment and in supporting people living with HIV successfully. It believes that the mobilization of volunteers and the empowerment of PLHIV are essential to minimize the development and spread of drug-resistant HIV and to ensure that universal access to care and treatment is a reality. Support groups for PLHIV and home-based care programmes are being underpinned by technical guidelines on service delivery for care and anti-retroviral therapy. A generic training package for community-based volunteers, developed with the World Health Organisation (WHO) and SafAIDS is being adapted at country level with Ministries of Health so that volunteers and Ministry staff are trained together.

Many States have made a commitment to the availability of treatment and care for PLHIV (Iceland, Japan) with some States making these services free of charge (cf Norway, San Marino, Mali, the Congo, Cyprus, Cuba, Germany (if they have health insurance) and Greece (including assistance to undocumented migrants). The Republic of Korea enables PLWHA to receive subsidies for medical treatment and nursing care based on their "National Basic Livelihood Security Act". Others offer financial assistance to developing countries for this purpose (Greece/ Zambia, Zimbabwe, Malawi, the Netherlands). Only a few States were explicit about the scope and content of their programmes particularly access to retroviral therapy. Georgia, for instance, includes free diagnostic and treatment services, including antiretroviral therapy for all PLHIV, and, with the assistance of the World Health Organisation (WHO), has developed first- and second- level regimens. As ever, the availability and sustainability of treatment and care very often depends mainly on financing (Armenia).

The pledge made during the 28<sup>th</sup> conference by the Italian Red Cross to "eliminate the stigma, discrimination and denial faced by populations affected by and living with HIV/AIDS" has been carried through with vigour. In addition to hosting two high-level

meetings on drug policy (“Rome Consensus 2005 and 2007”), they have provided assistance, human and financial, to almost a dozen countries and have shared their expertise generously. They can be seen as the leading National Society in harm reduction in the field of injecting drug use.

Croatia RC is one of the National Societies that have benefited from the expertise of the Italian Red Cross in developing a comprehensive harm reduction programme for injecting drug users. It is a member of the national body for fighting HIV/AIDS and actively cooperates with the Croatian association of PLHIV

Through their membership of ERNA, chaired by the Swedish RC since 2003, an increasing number of National Societies have built considerable capacity in the area of harm reduction.

As has often happened in the RCRC tradition, it is the youth section of National Societies that is most active (cf Ecuador). Bulgarian Red Cross Youth participate in campaigns for consulting rooms and anonymous free HIV testing; Czech Red Cross Youth organize seminars, forums and promotion. Alongside information programmes for young people, the Liberia RC is working with the Kaliningrad RC on two projects “I can have another lifestyle – what about you?” and “Keep the promise”, the latter for infected people and their integration into society,

There is still a long way to go before access to treatment and care is universal. Efforts must continue to ensure that treatment and care reach those people who are most vulnerable and most marginalized within their societies. Following RCRC principles, those people who are the hardest to reach and may be most in need should not be left to last.

Several States have made considerable progress with implementing legislation (cf Sweden, Liberia, Norway) while others promote tolerance through health education. The Ministry of Foreign Affairs of the Netherlands has implemented a workplace programme for all its relevant embassies. In Cyprus, the Council of Ministers have decreed that seropositive people with low professional and education skills have priority in employment on a number of positions in the government sector. Responses from Latin American States also indicate progress in this area.

4.1.6 States are urged to adopt and implement legislative measures to eradicate discrimination against people living with HIV/AIDS in the workplace. In close cooperation with states, civil society organizations and international organizations, the components of the Movement will carry out awareness and education activities aimed at creating positive, socially inclusive workplace environments for staff, volunteers and beneficiaries, and will provide support and assistance for other organizations wishing to implement workplace initiatives to eradicate stigma and discrimination against people living with HIV/AIDS.

The International Federation’s (Secretary General) HIV Workplace Directive has been revised and disseminated. In December 2006, the Secretary General made a commitment to ensure access to treatment, care and support for Secretariat staff living with HIV regardless of where they are employed. All National Society requests to date for financial support for anti-retroviral (ARV) treatment for RCRC staff and volunteers living with HIV have been met through the International Federation’s Masambo Fund and places are still available. Nevertheless, there is concern that the majority of both staff and volunteers needing ARV are still not on treatment.

A best practice publication highlighting the work of the Kenya RC in HIV Workplace Initiatives was developed and disseminated during 2004.

The ICRC is aware of the significant impact of the HIV/AIDS pandemic on its national and expatriate employees and their dependents. Therefore, the ICRC developed an institutional policy named: "HIV/AIDS workplace policy for ICRC, national and expatriate employees", to ensure that all ICRC employees working at headquarters or in the field, whether national or expatriate, and their dependents have full access to effective HIV/AIDS preventive care and medical treatment (antiretroviral drugs). This policy is based on the International Labour Organization's Code of Practice on HIV/AIDS. Since 2004, the ICRC settles this policy provides fair employment practices and confidentiality, education, awareness raising and prevention, care and treatment, in 21 countries, especially in Africa. The ICRC plans to implement the workplace programme worldwide

This recognition has taken many and varied forms, some of which will be discussed further in the forthcoming international meetings where the topic of "auxiliary to the public authorities in the humanitarian field" has been highlighted.

Throughout the responses to the questionnaire, States and National Societies listed shared membership of relevant national councils and committees as well as examples of regional and local collaboration. While there was not specific listing of other civil society representation, it was clear that, in the majority of cases, representation of PLHIV was also achieved.

4.1.7 States, recognizing the importance of the independent and auxiliary role of National Societies with respect to the public authorities in providing humanitarian services in the field of health and care should negotiate clearly defined roles and responsibilities with their respective National Societies in public health, development and social activities. This could include representation of National Societies on relevant national policy and coordination bodies. States should also take specific legal and policy measures to support and assist National Societies in building sustainable volunteer and community capacity in the area of HIV/AIDS and health promotion and [disease] prevention activities.

The adaptation by individual countries of the International Federation's "HIV Prevention, Treatment, Care and Support" training modules has helped to build relationships and clarify roles between their National Society, Ministry of Health and other stakeholders, and has contributed to improved appreciation of volunteers.

At the international level, the International Federation participated as a permanent observer in UNAIDS Programme Coordinating Board (PCB) meetings and civil society PCB pre-meetings and addressed the United Nations General Assembly Special Sessions (UNGASS) on HIV/AIDS in 2005 and 2006. It is currently hosting the NGO Code of Good Practice. . It continues to

4.1.8 States should facilitate civil society participation in planning and implementing through participation in processes such as the Country Coordinating Mechanisms of the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) This would ensure that disease responses benefit from the unique perspectives, capacities and reach of civil society, and, in particular, the voice and contribution of affected communities. This includes developing and utilizing the full potential of the network of National Society volunteers to reach vulnerable populations at the community and household levels.

provide strategic and operational guidance to National Societies on how to reach people in particularly vulnerable populations such as injecting drug users, men who have sex with men (most recently in China and Mongolia), and uniformed service personnel. The Federation presentation to the Commission on Narcotic Dugs at their annual meeting in Vienna in 2007 was received with acclamation.

At the global level, the Secretariat of the International Federation participates in the support group for the GFATM Board Member for Developed Country non-governmental organisations (NGO) and country and regional delegations have represented the Federation on coordinating mechanisms of the GFTAM. While there were expressions of gratitude for funding received from that source, other National Societies, along with civil society in general, have reported difficulties accessing GFATM processes and HIV-funding at the national level. This has improved over time as the GFTMA Board has clarified standards for civil society participation and Ministries have come to appreciate that it is in their interests to use the money rather than hold on to it so that their country meets the GFATM performance standards.

ICRC is providing technical assistance to facilitate prison health services having access to GFTMA grants through the country coordination mechanisms (example in Georgia, Rwanda, Azerbaijan, Kirghistan and Uganda)

National Societies also play an important role in the planning and coordination of their national malaria, measles and polio campaigns. Many National Societies are standing members of their Inter-Country Coordinating Committees, and actively participate in their national malaria control programmes or cross-border polio partnerships.

The Federation's Global Malaria Programme which is delivered in close cooperation with National Societies to develop sustainable, long-term "Keep Up" programmes which follow mass bed net distribution campaigns, usually integrated into national measles campaigns, is one example of pooling resources to maximize coverage for beneficiaries.

Other partnerships such as the highly successful Measles Initiative are other good examples of where National Societies have been involved in national policy and coordination bodies. The American Red Cross, a founding member of the Measles Initiative, and the Federation work to support National Societies in their key role in planning, coordinating, implementing and following up their national measles vaccination campaigns. The phenomenal success of the Measles Initiative since its founding in 2001, with the reduction of global measles mortality by 60% and in Africa by 75% by 2005, can be traced to the success of the partnership, working closely with host national governments and providing the critical social mobilization component to increase vaccination coverage.

Effective and strong systems for the recruitment, training, supervision and retention of volunteers have yet to be developed in many countries, meaning that this resource is under-developed, under-utilised and vulnerable to short-term exploitation. Much work is required if the potential of volunteers at the community level is understood and broadly supported. This does not replace the need to scale up and retain health workers in the current health workforce crisis or the need to invest in strengthening health services. A strong health system will exhibit the effective contribution and commitment of both its staff and community people.

Once again, the responses from both National Societies and States

4.1.9 States and National Societies are urged to provide in conformity with paragraph seven of the Declaration, including through international cooperation, the necessary human and financial resources and institutional support needed to reduce the risk and impact of diseases.

revealed a wide range of examples of cooperation and collaboration especially in comprehensive partnerships in the traditional model between “participating” National Societies (PNS) and “operating” National Societies (ONS), often with government funding being channelled through the Red Cross Red Crescent network. Replies provided a wealth of information, giving details of a whole variety of relationships such as with “back donors” (Solomon Islands RC), with sources of international aid such as the Global Fund, the Soros Foundation, United Kingdom Department for International Development (DFID), coupled with many examples of international cooperation.

The International Federation, using the HIV Global Alliance approach, to enable National Societies to reposition themselves to meet 10% of the HIV-related needs in each country, launched the “Rising to the Challenge”.

In all, two-thirds of all National Societies participated in some way in the RCRC global anti-stigma campaigns - “The Truth about AIDS, Pass It On”, “Stamps” and “Come Closer”.

While some National Societies limited their activities to the “Pass it on” campaign (Bosnia and Herzegovina RC; Ecuador RC), others used it as part of the regular activities (Croatia RC, Czech RC; Dominican Republic; Egyptian RC; Finland). The EU project “Come closer” had extraordinary publicity especially during Eurovision Song Contest in Athens 2006 while Italian Red Cross Youth developed a campaign entitled “Learn the

4.1.10 National Societies will continue to implement the global campaign against AIDS-related stigma and discrimination (“The truth about AIDS . . . Pass it on”) and, in cooperation with States, will prioritise and scale up efforts to strengthen sustainable capacity and improve the effectiveness of health and HIV/AIDS awareness and advocacy activities at the local and national level, with an emphasis on building effective and inclusive partnerships with people affected by and living with HIV/AIDS and other populations that are vulnerable owing to poverty, marginalisation, social exclusion and discrimination.

ABC (A=Abstinence, B=Be faithful, C=use a Condom). Innovative approaches came from the British RC poetry and drama projects and a special slot in British RC Education on the Web on HIV/AIDS, and from Japan which funded some innovative research into HIV/AIDS communication strategy.

The International Federation has further developed the global campaign against HIV-related stigma and discrimination through a global campaign with country level adaptation in partnership with PLHIV where possible. The “Leading by example: a toolkit for the reduction of HIV-related stigma” was issued in 2006 to collate three years of campaigning materials into one package. A second phase of the PassitOn e-forum, developed with Health Development Network (HDN) has been used to foster discussion among RCRC staff and volunteers, and to promote and share strategies to discuss HIV-related stigma and discrimination. The Federation has promoted and supported National Society partnerships with PLHIV networks at the national level, and partnership with regional networks of PLHIV and Federation regional delegations. In three regions, partnership positions were created for PLHIV to support regional networks and to support partnership activities between National Societies and national networks.

The International Federation works to strengthen National Societies' capacity to implement HIV and community health programmes through participatory development and dissemination of tools and technical guidance, provision of training, technical advice and capacity building support, strengthening evaluation systems, mobilizing resources for programme implementation,

4.1.11 The International Federation will support the efforts of National Societies to strengthen their capacity to implement HIV/AIDS and community health interventions through continued knowledge sharing on best practices, resource mobilization and advocacy on stigma and discrimination issues with States and the international community.

support to regional HIV networks, fostering partnership between the Federation, National Societies and networks of PLWHA and the global anti-stigma campaign. This assistance has been much appreciated and effective.<sup>2</sup>

Some National Societies were in a position to contribute financially to the Federation's programme (Iceland RC, the Netherlands RC, Swedish RC) and the British RC supported the International Federation in the development of toolkits and guidelines in HIV(ongoing) and tuberculosis (revised 2007).

A recent discussion with the Federation Regional Delegation in Beijing, China, on 30 May 2007 motivated the Korean RC and other participants to review the real situation of PLWHA and the work of other partners in this area of work.

The International Federation completed this commitment in 2006. Three annual reports and a final report were published and recommendations made to UNAIDS. GNP+ has been going through a redevelopment process and should soon be able to indicate what it expects from its partnership with the International Federation.

4.1.12 The Movement will cooperate closely with UNAIDS and its co-sponsors at all levels. National Societies will contribute to and strengthen the International Federation's status as a UNAIDS Collaborating Centre and its partnership with the Global Network of PLWHA (GNP+) for the elimination of stigma and discrimination, through the mobilization of volunteers at the national, regional and international levels.

In 2006 the International Federation undertook some advocacy work with donors as there was a need for them to acknowledge that organizations of PLHIV need some core funding to function.

National Societies reporting participation at various levels in meetings with UNAIDS and GNP+ included Armenia RC, Bolivian RC, Bosnia and Herzegovina RC, Colombian RC, Congo RC, Croatia, Ecuador RC, Egyptian RC, Georgian RC, Guatemalan RC, Honduras RC, Liberian RC, Nicaraguan RC, Panama RC, Solomon Islands RC, Turkmenistan RC. ). Barbados RC commented that, while cooperation with UNAIDS and other UN agencies had been good, it needed to be more sustainable. Overall the relationship with GNP+ was somewhat variable with some

<sup>2</sup> Indications of appreciation came from many National Societies including Bolivia RC, Bosnia and Herzegovina RC, Bulgaria RC, Chad RC, Congo RC, Croatia RC, Dominican Republic RC, Egyptian RC, Georgian RC, Guatemalan RC, Guyana RC, Liberia RC, Solomon Islands RC, Tajikistan RC, Macedonian RC, Turkmenistan RC, Ukraine RC.

National Societies having no linkage and others commented that the national GNP+ network is not very active and the partnership is not a steady one. The Swedish RC contributed financially to the translation and printing of the GNP+ training manual into Russian in the spirit of partnership. GNP+ has been represented at all meetings of ERNA and their representatives participated in a joint workshop with the Federation at the International AIDS Conference in Canada.

When the 15<sup>th</sup> General Assembly of the International Federation was held in Seoul in 2005, Stu Flavell, the former executive Director of GNP+, was given the Henry Davidson Medal in recognition of his contribution to building the Federation's partnership with PLHIV. This gave him the opportunity to speak to the Assembly on behalf of all those who are in this highly vulnerable group of people.

**Final goal 4.2: Reduce the risk of and vulnerability to HIV/AIDS and other diseases faced by people who suffer most as defined in paragraph seven of the Declaration and other marginalized groups such as prisoners and detainees. Because of their legal status or circumstances, such people have limited access to health education, promotion and care, treatment and disease prevention.**

This is an area where the ICRC has been increasingly active, extending the activities of national HIV/AIDS and tuberculosis programmes into prisons (cf in Mauritania, Tunisia, Democratic Republic of Congo, Rwanda, Georgia (since 1997), Armenia (since 1998), Azerbaijan (since 1995), Haiti, Kyrgyzstan, Uganda and Peru. Their work with detainees, especially in conflict areas, continues unabated. ICRC mobilises and support an inter sectoral awareness among key stakeholders such as Ministries of Health, Justice and/or interior; RC NS, NGOs, Global Fund (GFTMA) and development aid (such as EC or GTZ)

Following the increased international momentum surrounding health and prisons over the past few years and the commitment of the Movement to this issue, the International Federation, in close coordination with the ICRC, launched the Health and Prisons Project at the end of 2006. The main objective of the project is to review specific public health (particularly HIV and tuberculosis) and psychosocial support work of National Societies with prisoners and former detainees when they return to their communities. In addition to outlining the present situation, one of the project's objectives is to share examples of good practice within the Movement. It also fits into a wider context as part of the Federation's contribution to a platform of common interests within the Movement and to increase institutional cooperation in the area of health.

Law reform to deal with discrimination with particular reference to people living with HIV was one the actions States agreed to at the Special Session of the United Nations General Assembly (UNGASS) on HIV in 2001. Implementation was not reported on at subsequent sessions in 2005 and 2006.

4.2.1: States are urged, in cooperation with National Societies, to review existing laws and policies in order to promote the enjoyment of the highest attainable standard of health as one of the fundamental rights of every human being without distinction of race, religion, political belief.

Those States that reported progress in this follow up to the 28<sup>th</sup> International Conference are doing so mostly in terms of their legislation regarding notifiable diseases (cf El Salvador), sometimes using the rubric of the Quarantine Law (cf Cyprus) or sometimes Health Insurance Law (cf Croatia). Others linked this work to their work under Action 4.1.1 where work has been done on legislation relating to non-discrimination and patients' rights. Norway is reviewing their criminal law relating to the intentional or negligent transfer of infectious diseases to ensure compliance with international guidelines.

While some States are able to implement laws that "promote the highest standard for health for every human being" (cf Iceland) or have similar provisions in their Constitution (cf Mexico), others show how the link between human rights in poverty stricken nations remains a challenge.



First aid and health training in the community, the standardization of training and equipment and supplies, and the monitoring of standards and performance have all contributed to the implementation of socially inclusive prevention and health care programmes for displaced and marginalized populations. The International Federation has provided training, technical advice and capacity building support for prevention and health care programmes implemented by National Societies through their volunteer networks

4.2.2: States, in close cooperation with the components of the Movement and vulnerable populations, should implement socially inclusive prevention and health care interventions appropriate for displaced and marginalized populations. This implies moving beyond emergency needs to integrate physical and mental health and social well-being into programming.

As societies become more diverse, States and National Societies are working to adjust their programmes to address the needs of minority groups (cf Cyprus) and it is obvious that some National Societies are taking very seriously their responsibility to promote health amongst many other specific groups of vulnerable people especially people who are elderly, who are migrants or who come from ethnic minority groups (cf Chile RC). A shining example is the 'Save-a-Mate' programme of the Australian Red Cross that extends its care to a wide range of groups such as prisoners, drug users, gay, lesbian and transsexual people. National Societies in Norway, Laos, Thailand and Namibia host PLWHA groups within their own organization. The Norwegian RC also hosts a transgender group.

Since 2003 the National Society of Azerbaijan, like many other National Societies, has been working with internally displaced persons (IDP) and people in refugee camps (see also Chad RC, Macedonian RC, Greek RC, Kazakhstan RC). In Bosnia and Herzegovina, the National Society has been providing urgent aid and small household repairs to recent returnees and elderly people. The National Society of the Republic of Korea is providing psychological support and a social adaptation programme for people from North Korea who have settled in South Korea.

The National Society of Armenia provides food, hygiene supplies, sterile syringes, condoms, clothes, finance and counselling as well as language and vocational courses to help displaced and marginalized people in their communities. Some National Societies have designed services to meet the physical and mental health of asylum seekers(cf Belgian RC),

The specific needs of Roma people have attracted the attention of several National Societies and some States. The National Society of Bosnia and Herzegovina has a Home Care programme, a Population Movement Programme and a Participatory Community Development Programme. The Ministry of Health and Social Solidarity in Greece operates 50 medical centres and two mobile units.

In cooperation with their Department of Disabled Affairs, the National Society of Lithuania implements a programme of social integration of people with disabilities. The National Society of Iceland has been in the forefront in advocating for the rights of people who have mental handicap. It operates six centres, working either alone or in cooperation with the respective municipalities. They also run a centre for homeless women. The public authorities in Greece ( both central and local government) have recently adopted several Declarations on mental health, de-stigmatising and community psychiatric care. The Government of the Netherlands is providing support to specific non-governmental organisations working on post-traumatic stress.

The National Society of Egypt has conducted some limited projects for identifying and caring for children and young women at risk and for combating child labour. The World Bank through the National Council sponsored some of these projects for Childhood & Motherhood and some by UNICEF. The integration of people with disabilities is one of the activities of the local Branches of the Czech Republic RC. This National Society also provides material support to people without shelter following a disaster. Others combine disaster relief with the promotion of international humanitarian law and family links programmes (cf Liberia).

A sad footnote to the reports of all this activity is the evidence that, despite the international urgency to control the incidence of HIV, some countries lack the financial means to implement appropriate programmes in this important area. (cf the Czech Republic)

The International Federation and the ICRC have contributed to the development and application of technical standards outlined in the Sphere project and inter-agency guidelines on HIV and AIDS in emergencies, reproductive health, sexual and gender-based violence, as well as psychological support programmes (PSP). The Federation has provided training in public health in emergencies and epidemic control and has identified epidemic control as a key area for volunteer development. More than one hundred health focal people from National Societies have been trained during this period. Since 2006 when "Health Emergency Response Units" (ERU) was created, there have been more than 88 ERU deployments in health, water and sanitation. Special attention had been given by the ICRC and partners to the physical and psychological support of victims of sexual violence in conflict settings such as DRC, Darfur and Uganda through the entry point of primary health care and STI control.

4.2.3: States and the components of the Movement, with other relevant partners, are called upon to address, in a multi-sectoral and coordinated manner, the problems associated with HIV/AIDS and other diseases in armed conflicts, disasters and emergencies, recognizing the special vulnerability and capacity of displaced populations, host communities, military and peace keeping personnel.

The majority of States and National Societies reporting did so within the context of National Disaster Plans.

In response to the commitment made by National Societies attending the Pan African Conference in 2004 to contribute significantly to the reduction of food insecurity (as a consequence of weakened livelihoods) of populations made vulnerable by HIV and AIDS, the International

4.2.4: States, in cooperation with the components of the Movement, are urged to address the special needs and vulnerability of people affected by HIV and AIDS in emergency situations with special attention to food security.

Federation developed a good practice document in 2006 which provided information and strategies for National Societies on HIV and livelihoods in Africa. Training, technical advice and capacity building support have enabled the integration of food security/livelihoods and HIV/health programmes into National Society programmes

(cf Swaziland, Lesotho, Mozambique, Zimbabwe). The National Society of Finland is providing support to food security programmes for the families of PLWHA in Southern Africa. The German Red Cross has been involved with the ICRC in food security programmes in Pakistan.

The Federation supported the Asia Pacific Network of People Living with HIV to undertake a study of how well their needs were met during the Tsunami response. This provided useful feedback on Federation activities while also developing the research capacity of the Network. The Australian Red Cross is awaiting the analysis of the HIV Prevention project in Banda Aceh, a post-emergency HIV project on the effects of the Tsunami on people living with HIV.

States were at pains to explain that inmates in their prisons are entitled to the same medical treatment as the rest of their population (cf Norway). Some went on to detail special services such as voluntary and confidential testing for HIV and other sexually transmitted diseases (STD) (Iceland, Japan, Croatia, Cyprus). In some countries, prison inmates diagnosed as HIV-positive are transferred to special units either at an outside hospital, another prison with advanced

4.2.5: States, in cooperation with the components of the Movement, are urged to implement policies and operational measures in prisons in order to create a safer environment and reduce the risk of transmission of HIV, tuberculosis and other diseases among detainees, prisoners and staff. This includes voluntary and confidential testing for HIV infection, adequate pre- and post- test counselling and awareness programmes.

medical equipment and staff (Japan) or a special unit within the prison hospital. One State (Greece) went to say that this did not constitute segregation but rather of attaining better living conditions for this group of people.

In its "Provider-Initiated Testing" programme, the World Health Organisation (WHO) has recently reminded States and others that all HIV testing should be voluntary, informed and confidential.

At this stage, few National Societies described active work with people in prisons. In countries where prisoners are visited by the ICRC, HIV and TB are systematically assessed and included in a broad protection approach. ICRC provides technical assistance and support to prison health services. ICRC advocates among national and international stakeholders about the need to consider prison public health as a national concern. A major exception was the French Red Cross which has organized programmes and events such as "Et la vie" about sexually transmitted diseases. They are also offering a comprehensive programme for the ongoing care of people coming out of prison. In Finland, the National Society has organized training for volunteers working in prisons to raise their awareness of health problems such as HIV, tuberculosis, sexually transmitted diseases, drug and alcohol abuse. Norwegian Red Cross Youth has visited prisons, giving presentations on "Active Choice".

In the Czech Republic, on the basis of the regulation by the Ministry of the Interior, prisoners who believe that their rights in prison are being violated can turn to their National Society for support and advocacy.

The National Society of Azerbaijan is implementing a pilot project with the ICRC for the ongoing care of people released from prisons. Six nurses are maintaining contact with the released prisoners to encourage them to continue with their treatment, especially directly observed treatments for tuberculosis (DOTS) and also provide health information to them and their families.

While a significant number of National Societies still have major work to do even within their own ranks to change hostile and discriminatory attitudes, it is a joy to see the Federation's Global Health and Care Strategy with its emphasis on community empowerment, participation and partnership, gaining support (The Netherlands RC, Norwegian RC) and being put into action in a number of National Societies. As

4.2.6: National Societies will prioritise and expand efforts to build sustainable capacity and increase their effectiveness in health awareness and advocacy activities at the local and national levels, with an emphasis on building effective and inclusive partnerships with populations that are vulnerable owing to poverty, marginalisation, social exclusion and discrimination.

the National Society of Armenia said so clearly, all RCRC health programmes are aimed at establishing partnerships especially with people in especially vulnerable populations and with recipients of RCRC services (cf Lithuania RC).

Increasingly, National Societies are working closely with networks of PLWHA to address their shared priorities (cf Croatia). Peer education in all its forms is thus very actively practiced (cf The Congo RC, Egyptian RC).

Not surprisingly some of the partnerships in this area are between National Societies in the developed world and those in the developing world (cf Belgian Red Cross (Flanders): Southern and Central Africa and Nepal; Denmark: partner societies in Africa). Others seek alliances with their governments and the private sector (Chile RC). In addition to active intra-Movement partnership, there are also good examples of partnership with international agencies (Macedonian RC with UNHCR).

In the field of community health, National Society capacity has been strengthened through the development and sharing of guidelines and tools on harm reduction, malaria prevention, tuberculosis, community-based first aid, and the toolkit "Making a difference . . . recruiting voluntary non-remunerated blood donations (VNRBO)".

4.2.7: The International Federation will support the efforts of National Societies to strengthen their capacity in the field of community health through the continued sharing of best practices, resources mobilization and advocacy on stigma and discrimination issues with States and the international community.

The Federation has promoted the sharing of best practices of blood safety and of voluntary non-remunerated blood donor recruitment through the Global Advisory Panel (GAP) and Club 25 programmes, and has conducted joint training sessions with the World Health Organization. Best practices in these and other areas have been shared at the annual Global Health Forum and other forums including e-Forums, newsletters such as the quarterly Donor Recruitment International (DRI) and bi-weekly ARCHI newsletters. The Federation has supported the mobilization of funds at the global, regional and local levels for National Societies' community health

responses. The ICRC supports hospital bio security, including sterilisation and blood safe transfusion in over 80 conflict affected referral hospitals.

The assistance and cooperation of the International Federation (cf Croatia RC, Egyptian RC, Georgia RC, Mali RC, Liberia RC) and ICRC (National Society of the Congo) was appreciated by many including those giving examples of direct involvement in the development of policies and strategies of the International Federation (cf Danish RC). Mention was also made of the value of membership in the European Red Cross Red Crescent Network on HIV. AIDS and Tuberculosis (ERNA) and participation in the “Stockholm Group on Health” (Iceland RC)

As one National Society put it “ We are now strong on HIV/AIDS but weak in other areas of community health”(Barbados RC). And therein lies the challenge – how does the Movement, in conjunction with all its partners, learn the lessons of the HIV pandemic and apply them to emerging and recurrent diseases and other public health problems.