Integrating gender and diversity into community health
Guidance note

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Cover photo: Post-Cyclone Sidr, the public health in emergency programme implemented in Bangladesh focused not only on providing first aid training to volunteers to assist in the immediate aftermath of disasters but also raised awareness about common diseases. Volunteers have further disseminated this knowledge by conducting health sessions and providing basic healthcare in their communities. Graham Crouch/IFRC
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Introduction

To strengthen community resilience and eliminate health inequities it is necessary to actively involve women, girls, boys and men of all ages and forms of diversity in planning, decision-making, and resource allocation.

Mother, newborn and child health (MNCH), noncommunicable diseases (NCDs), urban health, ageing population, a peaking AIDS epidemic coupled with sexual and gender-based violence (SGBV), limited resources, rapid urbanization, environmental degradation, uncertainty of climate change and poverty are some of the many problems facing communities around the world. In order to mitigate these challenges and reduce impact, communities must be empowered and their resilience strengthened.

Women, girls, boys and men of all ages play different roles in society and have different healthcare needs. In addition, older persons, lesbian, gay, bi-sexual, transgender and intersex (LGBTI) people, people living with HIV (PLHIV) and persons with disabilities, among others, also have distinct healthcare needs and often encounter discrimination, which may manifest itself in violence and the lack of equal access to appropriate healthcare. Integrating a gender and diversity perspective in community health programming will ensure that everyone’s specific healthcare and psychosocial needs are addressed in the broader context of their culture, age, sexual orientation, gender identity, ethnicity and religion. This in turn will lead to equitable, more effective and efficient programming and reach at community level.

In line with the IFRC Strategic Framework on Gender and Diversity Issues 2013–2020, this note provides guidance on how to integrate gender and diversity considerations when applying the community-based health and first aid (CBHFA) approach particularly in regard to health promotion and disease prevention, MNCH, NCDs, violence prevention and urban health programmes.
Target audience

The case studies and practical guidance presented here will enable Red Cross and Red Crescent programme managers, staff and volunteers to draw on lessons learnt and advocate for integrating gender and diversity in community health programmes.

The checklist will aid programme managers and staff to design, implement and evaluate community health programmes that are gender- and diversity-sensitive. Doing so will contribute to reducing health inequities and create healthier and more resilient communities.

Gender inequality leads to disparities in health status

Gender equality and respect for diversity exist when women, girls, boys and men of all ages and with all their forms of diversity are able to share the distribution of power and influence equally. It does not mean that everyone is the same but that their rights, responsibilities and opportunities do not depend on their sex, age or any form of difference.

Gender is often incorrectly used as a synonym to refer to issues only related to women and girls. In fact, gender refers to the social differences between females and males throughout their life cycle. Although deeply rooted in every culture, the social differences are changeable over time and are different both within and between cultures.

Sex refers to biological and physical characteristics.

Diversity means acceptance and respect for all forms of differences that may be based on age, class, nationality, ethnicity, sexual orientation and gender identity (LGBTI), HIV status, and disability.

Gender inequality and lack of respect for diversity leads to unequal decision-making power, employment opportunities and income, education, housing, nutrition, individual behaviours and psychosocial well-being which in turn undermines resilience.

Health inequities are “unfair and avoidable differences in health status seen within and between countries.” These differences, in turn have an impact on health outcomes.

Gender and diversity influence health status in terms of:

- risk and vulnerability
- severity or frequency of health problems
- health seeking behaviour
- access to and use of healthcare services
- ability to follow treatment
- psychosocial well-being, long-term psychological, social and health consequences.
The distinct roles and relations of women, girls, men, boys of different ages and forms of diversity in a given culture, may bring about differences and give rise to inequalities that result in inequities in health and access to and use of health-care services, especially for women and girls. For example:

- women and girls do not receive the required healthcare because cultural and or religious norms prevent them from travelling alone to a clinic or seeing a male doctor;
- men and boys engage in high-risk behaviours as a result of trying to live up to their peers’ expectations. They are more likely to engage in drugs and alcohol abuse and have multiple sex partners;
- women, girls, men, boys and LGBTI people may be deterred from seeking or receiving medical services due to cultural and social stigma associated with sex and sexuality. This is especially true in the case of adolescent girls and boys who are expected not to be sexually active and thus assumed not to need sexual and reproductive health services;
- PLHIV often do not seek health services because of fear of stigma and discrimination;
- older women and men may have difficulty to come forward and access healthcare for different reasons. In a given society, restrictions placed on women’s power and autonomy results in more hindrances in accessing healthcare. On the other hand, for a condition like mental health problems, prevalent gender norms may make it more difficult for men to come forward and seek the required healthcare.
- women and girls may consume inadequate nutrition due to their low status and prioritization of other household members. Poor nutrition can lead to poor development of girls and render them more vulnerable to infection during their lifetime.

In order to create healthy and resilient communities, it is therefore imperative that gender and diversity issues along with psychosocial support are taken into account when designing and implementing community health programmes.

Gender analysis is a tool for understanding the local context and promoting gender equality.

What to consider when carrying out gender analysis?

- To understand the gender relations, division of labour and assess who has access to and control over resources and decision-making power consult with community members;
- Work together with community members to identify the different health needs and recognize capacities of women, girls, boys and men of different ages and forms of diversity;
- Collaborate with communities to identify and seek solutions to cultural and religious barriers that may restrict women, girls, boys and men of different ages and forms of diversity in accessing and using healthcare;
- Increase ownership by presenting women, girls, boys and men of different ages and forms of diversity with equal opportunities to participate in discussions around identifying their health priorities and making decisions.

Refer to the checklist for designing gender- and diversity-sensitive community health intervention on page 17 for further details.
BOX 1 – Afghanistan: Grandmothers committee facilitate women’s access to health services

Afghanistan has the highest maternal mortality in the world. It ranks second highest for under-five mortality. Poor and improper nutrition among women of reproductive age leads to pregnancy-related complications. There is an acute shortage of health facilities and trained staff (particularly female staff). Access to antenatal care and essential medicine is limited. Furthermore, the vast majority of the population lacks access to basic health and sanitation services. A major contributing factor to maternal morbidity and mortality is lack of trained female healthcare providers.

To overcome cultural barriers and address the challenges of MNCH in remote regions of the country, the Afghan Red Crescent Society has introduced an innovative way to access women and engage them in community health by creating ‘grandmothers committee’ and training female volunteers.

Given that grandmothers are considered influential figures not only in their own families, but also in the rural communities at large, they play an important role in encouraging health-seeking behaviours. They are able to convince otherwise conservative husbands and fathers to let their wives and daughters seek health services and undergo medical treatment in the nearest health facility as and when needed.

The Afghan Red Crescent Society has engaged with and sensitized the Village Health Committee in Balkh province on the key role grandmothers can play in reducing health risks related to pregnant women and mothers.

In agreement with the Village Health Committee, the National Society provided 20 grandmothers with a five-day training on key reproductive health issues that included safe motherhood, antenatal, postnatal, safe delivery as well as tetanus toxoid vaccines, hygiene promotion and behavioural change activities.

In addition to the grandmothers committee, female volunteers are also being trained and empowered at the local level to raise awareness around health-seeking behaviours and contribute towards reducing maternal mortality. Female trainers, working on the condition that they are accompanied by their male relatives, travel to remote regions of the country to sensitize community leaders about the benefits of involving women in health promotion.

One of the main challenges faced in training volunteers has been a high illiteracy rate. To ensure that the volunteers learn the key health messages accurately, the Red Crescent trainers are using simple visual aids adapted to the local context to promote behavioural change in health, first aid and safety practices.

The Afghan Red Crescent Society has 25 male and 11 female CBHFA master trainers and some 22,000 trained volunteers, including more than 2,000 women, in 34 provinces.

Communities are benefitting from the key health messages that are being delivered by the grandmothers and female volunteers. Women living in remote villages are being trained in performing simple health-related activities – such as diarrhoea treatment with oral rehydration solution. Both grandmothers and volunteers are referring women to health clinics for antenatal care, prenatal care and family planning.

Using culturally-sensitive approaches and addressing gender-specific barriers, the National Society has not only been able to develop grandmothers and women’s confidence and recognition within their communities but also to encourage them to seek healthcare regularly.

LESSONS LEARNED

- Adapting to cultural contexts to reach the most vulnerable is at the core of facilitating change at grassroots level.
- Applying a gender-sensitive approach to CBHFA and capacity-building at community level contributes towards reducing morbidity and mortality and developing a sustainable health system.
- Empowering women and engaging men by actively involving them in planning and training of health service delivery is essential to ensure that women, girls, boys and men have equal access to health services.
The CBHFA approach seeks to create healthy and resilient communities by empowering volunteers and communities to take charge of their health. CBHFA goes beyond first aid and promotes health and disease prevention, addresses health needs such as MNCH, NCDs, urban health risks, malaria, water sanitation, hygiene promotion, violence prevention and psychosocial support among others.

When working with communities to highlight their health needs it is pertinent to understand and address existing gender and diversity related inequalities. Gender awareness, sensitization on psychosocial support and social inclusion enables volunteers to apply innovative and culturally-appropriate ways to work towards transforming existing beliefs, attitudes and social norms that negatively impact the health status and limit women, girls, boys, men of all ages and forms of diversity to access and/or use healthcare services. Without a gender and diversity perspective, the effectiveness of community health activities can be compromised and inequities in health reinforced at best and increased at worst.

By using simple tools adapted to local context, CBHFA empowers communities to address their priority health needs. Integrating gender and diversity considerations into community health is necessary for a positive impact on health outcomes.

Gender and maternal, newborn and child health

Many of the world’s most vulnerable women and children die because of unequal access to information, prevention, treatment and services to meet their most basic needs. In many countries, women and girls’ access to health, nutrition, education and income is influenced by social and behavioural norms that often restrict their use of health services. Gender inequality and lack of empowerment has an impact on access to information and services leading to adverse reproductive health outcomes, including high maternal and child mortality.¹⁰
BOX 2 – Honduran Red Cross: Engaging men in promoting maternal, newborn and child health

The Honduran Red Cross implemented the MNCH project called REDES (meaning “Networks”), in partnership with the Honduran Ministry of Health and municipal organizations between 2006 and 2012. Together, they worked towards achieving Millennium Development Goals 4 and 5, to reduce child mortality and improve maternal health. Through the project, Red Cross volunteers, health personnel, and community leaders were trained to educate community members on health and nutrition of children, and encourage healthy practices such as exclusive breastfeeding, and how to prevent diseases, such as diarrhoea. Communities were also educated on recognizing the danger signs for mother and child during pregnancy and childbirth, after birth, and children under five-years old.

In Honduras, there are large disparities in the health status of people living in urban and rural settings. In remote areas, women and children are particularly vulnerable. The lack of health services and information in these communities reduces the likelihood that women will seek medical attention during pregnancy, childbirth and after giving birth. Traditional norms vis-à-vis women and men’s roles assign women the responsibility of caring for their family’s health but do not give them the power to make decisions. The unequal status of men and women also means that women often do not have the resources to access the services needed to assure their own good health, and that of their children.

Recognizing the correlation between unequal gender relationships and health, the REDES project aimed to strengthen community and government networks for improving MNCH, while promoting equal practices and behaviours between men and women in support of family health. In order to do this, the project developed a strategy to encourage men to take part in MNCH initiatives. Support groups for men were developed to provide them with the education they need to promote their family’s health, and make informed health-related decisions.

In the rural communities of Copán and Santa Bárbara that participated in the REDES project, many men have started taking on new roles as active and engaged advocates of MNCH. Don Ramon is one of these men. In his rural village in Copán, Don Ramon volunteers as a traditional birth attendant and monitor for the Integrated Community Child Healthcare strategy. After his sister died giving birth, he raised her daughter as his own. When Don Ramon’s wife gave birth to their children, the option of going to a birthing clinic was non-existent and so he learned to assist during home delivery. Don Ramon is challenging the views on gender roles held by most people in his community. His leadership has made him a role model for other men. He is trusted among the women and men in the surrounding villages as a knowledgeable person in matters of pregnancy, birth and postpartum issues.

He communicates key messages presented in workshops in the form of songs. In his village, he composes and recites songs to promote gender equality and health. The REDES project has recorded 16 of these songs on a CD and invited him to perform at health-fares with his group, “The Eagles”.

Neria Evora is another dedicated volunteer with the REDES Project. Through the REDES project, she was trained in the areas of gender and health. Neria says, “In our communities, the father’s attitude can determine the life of the woman, the future of a child. Here, we see women and children die because of the patriarchal tradition that characterizes our culture. Working with gender is fundamental to decreasing maternal mortality, teenage pregnancy, in changing the role of men and in reducing female subordination.” She goes on to add that when male partners are involved in pregnancy related-matters, women are more likely to seek institutionalized healthcare, which is key part of reducing maternal and child mortality and morbidity.

Neria and Don Ramon’s stories show the vital role of Red Cross volunteers in building bridges between the families living in remote communities with local health services.

LESSONS LEARNED

• Targeted fatherhood programmes encourage men to participate more actively in the care and support of their children.

• Actively engaging men in MNCH contributes to the reduction of maternal morbidity and mortality and improves birth outcomes and child health and well-being.

• Constructive engagement of men in sexual and reproductive health and rights has a positive effect on their own health and the health of their wives or partners and adolescent girls and boys.
Statistics reveal that:

• An estimated 800 women die every day during pregnancy and childbirth mainly due to poor access to effective interventions.\textsuperscript{11}

• Globally, over 10 per cent of all women do not have access to or are not using an effective method of contraception. It is estimated that family planning alone could reduce the number of maternal deaths by almost a third.\textsuperscript{12}

• Female genital mutilation (FGM) is also one of the major reasons for complications associated with pregnancy, childbirth and the postpartum period. It is estimated that in Africa alone an additional 10 to 20 babies die per 1,000 deliveries as a result of FGM.\textsuperscript{13}

• Approximately seven million children under the age of five, including three million within the first month of life die annually. Pneumonia, diarrhoea and malaria account for 36 per cent of these deaths; 14 per cent are due to prematurity.\textsuperscript{14}

• In 2010, women and girls accounted for more than half of all people living with HIV (about 52 per cent). Women are more susceptible to acquire HIV than men due to physiological, gender-based and socio-cultural factors.\textsuperscript{15}

• Women and adolescent girls are more likely than men to receive blood transfusion because of higher rates of anaemia and complications during childbirth. More than 90 per cent of children living with HIV contract the virus through mother-to-child transmission either during pregnancy, at birth or through breastfeeding.\textsuperscript{16}

Most interventions related to MNCH and sexual and reproductive health focus primarily on improving women and adolescent girls’ knowledge of and practices on MNCH issues. However, in most societies, men often control household income and hold the decision-making powers in matters that affect MNCH – whether it is access to social services or reproductive and contraceptive choices. Interventions that aim to build communities’ resilience and achieve improvements in MNCH need to involve older persons (both men and women), religious leaders and more specifically men and boys given their familial and social roles within communities in order to improve MNCH outcomes.

In order to address health inequities in a holistic way, it is necessary to ensure that men and boys understand how their attitudes and experiences impact them as well as women and girls and how they can contribute to transforming the situation.

Gender and noncommunicable diseases

The increase in and prevalence of NCDs, i.e. cardiovascular diseases, cancer, diabetes and chronic respiratory diseases represents a global health crisis. NCDs account for almost two-thirds of all deaths globally, with 80 per cent of these deaths occurring in low- and middle-income countries.\textsuperscript{18} Sixty-three per cent of all deaths in 2008 – 36 million people – were caused by NCDs.\textsuperscript{19}

The inter-linkages between MNCH and the development of NCDs are becoming increasingly clear.\textsuperscript{20} NCDs are the leading cause of death among women worldwide, particularly during childbearing years. One-third of the poorest two quintiles in the developing world die prematurely from preventable NCDs.\textsuperscript{21} Although on average women live longer than men, they suffer from poor health for many of those years as a result of NCDs.
NCDs are a leading threat to health and development. Yet these diseases are preventable. The global NCD crisis is not only a health but also a gender issue. Gender roles, biases and social marginalization expose women and men to different risks factors that lead to NCDs. The four main NCD risk factors for women and men are:

- unhealthy diet
- physical inactivity
- tobacco use and
- excessive use of alcohol

It is estimated that these risk factors are behind the deaths of a staggering 100,000 people every day. By eliminating shared risk factors, approximately 80 per cent of heart disease, stroke and type two diabetes and more than one-third of all cancers could be prevented.

In general men’s mortality rates from cancer are 30 to 50 per cent higher than women’s. Lung, stomach, liver, colon and prostrate cancers are the major killers for men while women suffer from and succumb to breast, lung, colon, liver and cervical cancers. Tobacco smoking has traditionally been associated with men, leading to high lung cancer mortality. However, female lung cancer deaths are on the rise since cigarette manufacturers have been successfully able to advertise smoking as a way of improving women’s social and political status, possibly causing more young women to take up smoking.

Since death rates from heart diseases are often higher among men than women at specific ages, there is a tendency to associate cardiovascular diseases as a male problem. As a result of this misconception there remains a significant gap between perceived and actual risk of cardiovascular diseases in women. Very few women perceive it as an actual threat to their health. In fact heart diseases is the leading cause of death among women. Among men and women 60-years and older, death rates from cardiovascular diseases are approximately the same.

Gender and diversity equality is an integral component for NCD strategies and policies to be successful as well as for universal access to prevention and treatment of NCDs.
The poorer segment of society are more vulnerable to NCDs and carry double the brunt as most of the care is covered through out-of-pocket payments. This leads to catastrophic medical expenditures further exacerbating their social and economic situations dramatically.\(^{30}\) Sixty per cent of the world’s poor are women, twice as many women as men suffer from malnutrition, and two-thirds of illiterate adults are women. These underlying determinants put women and girls at a disadvantage in their capacity to protect themselves from the main NCD risk factors.\(^{31}\)

Attitudes towards seeking healthcare can influence men and boys’ likelihood of early diagnosis. While prevalent cultural norms not only reduce women’s opportunities to decision-making but also accessing and using healthcare services for NCD treatment. For example, if a household has money available for healthcare, the funds are often spent on men’s health needs further marginalizing women.\(^{32}\) As the principal caregivers, women and girls educational and income-earning opportunities are also interrupted since they need to care for the sick family member.

Women usually access healthcare through the primary care and sexual and reproductive healthcare services. The MNCH continuum of care provides opportunities to prevent, diagnose and treat NCDs among women and girls. Women are vulnerable to a range of NCDs and are disproportionately affected as caregivers. Empowering women by giving them greater means and opportunities to promote healthy lifestyles in their families is the way forward.

Improved disease management can reduce morbidity, disability and death, and contribute to better health outcomes.\(^{33}\) Overall, the National Red Cross Red Crescent Societies have a long history of disease prevention and health promotion, and as such are in a unique position to be pioneers in implementing gender-sensitive NCDs prevention programmes using the CBHFA approach.
According to the last official census conducted in 2010 (Qatar Statistics Authority), 75 per cent of the total population of Qatar is foreign guest workers, mainly men. The majority of the male migrant workers come from South Asia, the Philippines and other Arab countries.

Due to dust and sand in the air respiratory problems are the main health issue in Qatar. Other NCDs, particularly among the workers like hypertension and diabetes are also on the rise.

Qatar’s New Industrial Area is one of several locations in the country that accommodates male labourers, most of who encounter health problems. Roughly 15 per cent are reported to have problems with NCDs such as hypertension, diabetes and occupational asthma. These health problems are mostly connected with lifestyle habits that include tobacco smoking and chewing, poor diet and lack of health-related knowledge. Most workers are also illiterate and live in sub-standard conditions that make them more vulnerable to developing NCDs.

In collaboration with the Qatari Ministry of Health and the Ministry of Labour and selected private companies, the Qatar Red Crescent Society opened the Workers Health Centre in December 2010. The health centre is working towards identifying risk factors and minimizing the number of NCDs through health promotion and education as well as disease prevention. The health centre provides healthcare to all single male migrant workers.

As of July 2011, 12 teams from five private companies have volunteered at the health centre to help workers improve their health-related knowledge and reduce NCDs.

Volunteers attended a three-day seminar on identifying the specific risk factors and health problems in their companies. The three major NCDs identified among the workers were hypertension, diabetes and occupational asthma. Plans focusing on disease prevention and control to reduce NCDs were developed in each company based on the specific occupational ailment the workers were exposed. For example, workers of one cement company were found to have more respiratory problems, while workers at another company, which employs drivers for buses and taxis, suffered from hypertension.

As part of the programme, companies printed leaflets in different languages and conducted separate information seminars for their workers. The health centre staff checks progress by conducting site visits to company premises and confirming if workers’ understanding and knowledge vis-à-vis their health has increased.

With the migrant workers coming from different countries, language has proved to be a major barrier to communication between workers and programme staff. Lack of education among the workers also poses difficulties. The health centre needs to adapt to the different cultures and nationalities in the New Industrial Area. Another challenge for Qatar Red Crescent Society is expanding the project to ensure that the programme reaches all the single male workers in the New Industrial Area. To boost its staff and volunteers capacity, the health centre is planning to expand the volunteer system to a further 10 to 15 companies.

Overall, the volunteer system has shown positive results, with more industrial area male workers now aware of their health status and potential health-risks they face. Further, volunteers are also raising awareness around health issues with their peers.

**LESSONS LEARNED**

- Community-based approach has been used successfully in developing and implementing NCDs prevention programme and promoting healthy lifestyle between male migrant workers.
- Based on the occupational illness they are most likely to be faced with, the male migrant workers receive appropriate information on reducing the risk of NCDs.
- Gender-sensitized and trained volunteers play an important role in community-based NCDs prevention.
- The Qatar Red Crescent Society complements the government’s actions in NCDs and is a key player in changing behaviour to promote healthy lifestyles.
Violence is among the most prominent public health problems we face today. Besides being a leading cause of mortality – particularly among children and young adults – many of the millions of non-fatal injuries result in life-long disabilities. In addition, tens of millions more suffer long-term psychological health effects as a result of an injury or an act of violence.\(^{34}\)

The damaging effects of violence on health include both psychological and physical consequences such as brain injuries, bruises and scalds, chronic pain syndromes.\(^{35}\) It can also contribute as a risk factor for sexual and reproductive health problems such as infertility, pregnancy-related complications, unsafe abortions, pelvic inflammatory disorders, HIV and STDs and unwanted pregnancies among others.\(^{36}\)

A study by the University of Zurich and Dialogai association suggests that young homosexuals are two to five times more likely to attempt suicide than their heterosexual peers.\(^{37}\) The bullying of young people with different sexual orientation often leads to suicide. In many areas of the world, LGBTI are still living on the margins of society, shunned by their families and communities with little or no access to the rights they are entitled to. They are often victims of hate crimes, prejudice, forced outing and violence and lack access to healthcare services.

High crime rates and unemployment also leave girls and boys of all ages vulnerable to violence and exploitation. Women in urban slums are particularly vulnerable because they often have less education, control over resources and ability to make decisions than men.\(^{38}\)
According to a WHO study, sexual abuse, a form of violence, experienced during childhood accounts for serious health problems in the general population, i.e. 27 per cent of post-traumatic stress disorders, 10 per cent of panic disorders, 8 per cent of suicide attempts, 6 per cent of cases of depression, alcohol misuse, and illicit drug abuse.\textsuperscript{39}

**BOX 4 – Ireland: Volunteer inmates use the community-based health and first aid approach to prevent violence in state prisons**

In June 2009, Ireland became the first country in the world to introduce the CBHFA approach in a prison setting in Dublin. Today, the programme runs in ten of 14 prisons in Ireland, by a small cadre of special-status Irish Red Cross volunteers\textsuperscript{40} who have changed the lives of troubled men, transformed prison culture, reduced violence and improved the physical and psychological health of inmates.

The real beauty of the programme is that the volunteers do not come from outside the prison. “The local community in a prison is the prisoners themselves,” says Graham Betts-Symonds, CBHFA programme manager for the Irish Prison Service. “So what we needed was something that created action and empowerment within that community.” Volunteer inmates were empowered by enrolling in and completing an intensive course in CBHFA.

Volunteer inmates have led successful projects on raising awareness on hygiene, tuberculosis prevention, HIV and AIDS awareness, winter vomiting bug, seasonal flu, smoking cessation, heart diseases and strokes. The volunteers use images, symbols and colour coding to communicate with peers whose language or learning skills mean that they are unable to easily understand English.

But “the most important and challenging project that the volunteers got involved in was the weapons amnesty,” says Irish Red Cross volunteer John.\textsuperscript{41} At Wheatfield prison, there had been a major problem with inmates cutting each other using handmade knives. “There was a cutting happening nearly every two weeks. One fellow nearly died.”

John and other volunteers arranged meetings with inmates and prison authorities to figure out what to do. Eventually, they agreed on a weapons amnesty in which inmates could hand in weapons anonymously. Since the weapons amnesty was introduced, the percentage of fights involving handmade blades has gone down from 97 per cent to 10 per cent in one year – the prison is virtually free of fights. “And that’s something for the Irish Red Cross to be proud of because that never happened in the jail before. They are saving the time of emergency medical staff and saving people from going to the hospital. It’s a massive savings in terms of the budget,” adds John.

CBHFA and volunteering has provided a unique opportunity to develop and implement innovative healthcare projects and prevent violence in prisons.

**LESSONS LEARNED**

- Introduction of the CBHFA approach has benefitted 3,273 prisoners directly and 9,819 indirectly including staff and the families of the prisoners.
- There is a marked improvement in personal, in-cell and prison hygiene. Volunteer inmates provide instructions on good hand washing techniques and in many prisons a colour coded bucket and mop system has been introduced thus contributing to cleanliness and the prevention and control of disease.
- CBHFA has led to a reduction of violence in Irish prisons and an improvement in the quality of life for both inmates and staff.
- Hygiene promotion, violence prevention and other health-related awareness raising sessions carried out by volunteer inmates has reduced the number of prisoners needing to be escorted to hospital for accident and emergencies or long-term in-patient care. This has had a direct impact in reducing healthcare costs.
Checklist for designing gender- and diversity-sensitive community health programmes

The purpose of this checklist is to guide Red Cross and Red Crescent programme managers, community health staff and volunteers to identify and analyse the main gender and diversity issues and design and implement gender- and diversity-sensitive community health programmes.

Accurate information and in-depth understanding of needs, social norms, roles, responsibilities and constraints faced by women, girls, boys, men of all ages and forms of diversity is fundamental to changing health knowledge, behaviour, and attitudes. To ensure that the health programme is gender- and diversity-sensitive, it is necessary to work with the community to assess and analyse their health priorities. This can be done by:

- Collecting data disaggregated by sex, age, LGBTI population, persons living with disability and/or chronic diseases
- Collecting information on mortality, morbidity, disability and determinants of health
- Ensuring the assessment team has an appropriate balance of female and male representation
- Maintaining a balance in the number of women, girls, boys, men of all ages and forms of diversity when identifying their health needs. Depending on the cultural and or religious context, it may be necessary to initiate separate focus group discussions with women and girls; boys and men to identify the needs and capacities of each group
- Identifying female-, male- and child-headed households
- Considering differences in access to healthcare and health status between women, girls, boys, men of all ages and other forms of diversity
- Being sensitive to social structures, including positions of authority and influence, and roles and responsibilities of women, girls, boys, men of all ages and other forms of diversity
- Identifying the factors affecting the health and resilience of women, girls, boys, men of all ages and other forms of diversity and the health and psychosocial needs of each, e.g. differences between women and men in degree of autonomy over their own bodies, cultural practices, division of labour, workload, etc.

It is necessary to actively involve women, girls, boys and men of all ages and forms of diversity in planning, decision-making, and resource allocation for them to become agents of their own health and empowerment. Identify gender- and diversity-related assumptions and risks that could have an impact on the community health programme. The programme design should be flexible as it may need to be adapted in case any gender- and/or diversity-specific issues arise during implementation. This can be done by:
Ensuring gender-balance in volunteers, i.e. proportionate number of women and men from the community are recruited and trained to provide healthcare and psychosocial support services

Ensuring gender-balance in staff when training volunteers

Ensuring that women, girls, boys, men of all ages and other forms of diversity have equal opportunities to access the healthcare and services that are going to be provided

Ensuring that the healthcare delivery strategies and services address the different needs, interests and priorities of women, girls, boys, men of all ages and other forms of diversity

Assessing the structure of the health system, i.e. available resources, prevalent cultural norms, attitudes, number of women and men employed, etc.

SGBV has implications on almost every aspect of health. Women, girls, boys, men and LGBTI people can experience morbidity and mortality due to SGBV. SGBV increases vulnerability to not only HIV but also other reproductive health conditions. It is thus imperative to address SGBV when designing a programme. This can be done by:

- Ensuring specific training for staff and volunteers on psychological first aid and/or counselling as well as about how to deal with SGBV survivors; following-up and caring for staff and volunteers working with affected people should also be taken into consideration

- Ensuring the staff and volunteers are aware that not only women and girls but also boys and men of all ages and other forms of diversity can be victims of SGBV

- Referring survivors of SGBV to government or other organizations that are equipped with mechanisms to ensure protection and confidential services

- Including awareness raising campaigns to prevent SGBV as well as highlight health risks and possible psychological impact associated with it

- Ensuring women, girls, boys, men of all ages and other forms of diversity know how to access 24-hour services to report and seek medical care for SGBV

- Advocating for development and implementation of laws and policies to monitor, prevent and respond to SGBV

Programmes may require women and girls to be more involved; some may emphasize the participation of men and boys; while others may require the LGBTI population to be at the core of implementation activities. To implement community health programmes successfully requires:

- Ensuring women, girls, boys, men of all ages and forms of diversity are involved in decision-making processes

- Establishing beneficiary communication channels
  — Implementing community-based mechanisms to share information about the programme, outcomes and impact

- Training and mobilizing traditional birth attendants (particularly for MNCH initiatives), PLHIV (for HIV-related activities) and people living with disabilities when possible
✓ Actively involve women, girls, boys, men of all ages and other forms of diversity in raising awareness and addressing issues of reproductive health and harmful traditional practices, e.g. FGM, sexual exploitation, abuse of girls and boys

✓ Ensuring privacy during health consultations, examinations and care

✓ Providing a basic health package so that women and men, adolescent girls and boys as well as other vulnerable groups have access to sexual and reproductive services

✓ Ensuring that community health programmes include mechanisms to prevent and respond to violence

Monitor and evaluate activities to measure whether the programme is meeting its objectives by positively changing health-related knowledge, attitudes, and/or health seeking behaviour of women, girls, boys and men of all ages and other forms of diversity. This can be done by:

✓ Reporting against baseline data gathered by sex, age and, if safe to do so, LGBTI population

✓ Reporting on programme outcomes and impact – has there been improvement in overall health status of the community?

✓ Monitoring and evaluating outputs and activities separately for women, girls, boys and men of all ages and other forms of diversity
  — Ask women, girls, boys and men of all ages and other forms of diversity how the health messages and access to and use of healthcare services has brought about change in their life

✓ Applying lessons learnt to further strengthen the programme
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International Federation of Red Cross and Red Crescent Societies
Integrating gender and diversity into community health
Guidance note
Innovative ways of translating the guidance note into action

mHealth
Mobile technology, i.e. mobile phones, tablets, personal digital assistant are increasingly being used as a means to promote health and prevent diseases in communities. In many low- and middle-income countries, mHealth presents an opportunity to increase access to healthcare and save lives. mHealth can improve quality of services by connecting beneficiaries with healthcare providers, enhance data collection, provide diagnostic treatment and support, and facilitate healthcare worker training and communication.

One such Red Cross Red Crescent example is the violence prevention application which is being developed to enable disaster responders to obtain mobile, accessible and practical information to integrate a basic level of violence prevention content into their response activities. For instance, the violence prevention application will include a series of checklists for disaster response teams – health, psychosocial, water and sanitation and livelihoods among others. Women and children form a special group that are subject to violence during disasters. Hence they will be the main focus of the violence prevention application.

Games
Both traditional board games and mobile games can be developed and used to promote gender equality and community health. For example, mobile games like Family Choices, 9-Minutes and Work Attack have been developed and translated into local languages in India and Kenya to bring about social change.

Social media
Social networking sites (Facebook, Google+, Twitter among others) are a part and parcel of the online environment. Due to its potential to reach large populations, social networks and media offer an excellent opportunity for promoting health and preventing disease in an interactive way.

Technology and innovation are major contributing factors to making healthcare better, quicker and more accessible.

Benoit Matsika-Carpentier/IFRC
Further reading

- Canadian Red Cross and IFRC. Case study: Integrating Violence Prevention into CBHFA in Haiti. 2013.
- IFRC. No time for doubt: Tackling urban risks a glance at urban interventions by Red Cross Societies in Latin America and the Caribbean. Geneva, 2011.
- The NCD Alliance. The Millennium Development Goals and Non-Communicable Diseases (NCDs).
- The NCD Alliance. Non-Communicable Diseases: A Priority for Women’s Health and Development.

To become agents of their own health it is essential to actively involve women, girls, boys and men of all ages and forms of diversity in planning and implementing community health programmes.
American Red Cross
Endnotes

2. The overall gender outcomes which form the basis for operationalizing the IFRC Strategic Framework on Gender and Diversity Issues are:
   **Outcome 1**: Systematic incorporation of gender and diversity in all programmes, services and tools (covering the full management cycle from assessment to planning, monitoring, evaluation and reporting)
   **Outcome 2**: Improved gender and diversity composition at all levels (governance, management, staff and volunteers)
   **Outcome 3**: Reduced gender inequality, gender discrimination and gender-based violence (GBV) through the active promotion of fundamental principles and humanitarian values.
8. Ibid.


25. Ibid.


36. Ibid.


40. The Irish Red Cross agrees to have prisoners become special status Irish Red Cross Volunteer Inmates. Should an inmate wish to continue volunteering with the Irish Red Cross upon their release, they must apply in the normal way as any member of the public and comply with all vetting requirements.

41. Name has been changed.

42. Note: You may find that during consultations women and girls may have reduced mobility or time to participate in consultations due to care-giving activities and other household commitments. Similarly, men and boys of working age may be absent for seasonal work during consultation. For increased ownership and success of the initiative look for innovative ways involving all groups in the community.

43. The Half the Sky Movement was funded by USAID to develop and release three mobile phone games in India and Kenya. These games are designed to educate women and girls about essential health issues, increase awareness about gender equality, and empower them to bring about social change in these areas. Further information is available at: http://www.usaid.gov/halfthesky/mobile-games.

44. Family Choices aims to increase the perception of girls’ place in and value to families, with a focus on keeping girls in schools.

45. 9-Minutes introduces players to the key do’s and don’ts of having a healthy pregnancy.

46. Worm Attack! aims to keep girls and boys healthy by defeating the dangerous worms inside their stomachs. Players work to rid themselves and their communities of intestinal worms.
The Fundamental Principles of the International Red Cross and Red Crescent Movement

**Humanity** The International Red Cross and Red Crescent Movement, born of a desire to bring assistance without discrimination to the wounded on the battlefield, endeavours, in its international and national capacity, to prevent and alleviate human suffering wherever it may be found. Its purpose is to protect life and health and to ensure respect for the human being. It promotes mutual understanding, friendship, cooperation and lasting peace amongst all peoples.

**Impartiality** It makes no discrimination as to nationality, race, religious beliefs, class or political opinions. It endeavours to relieve the suffering of individuals, being guided solely by their needs, and to give priority to the most urgent cases of distress.

**Neutrality** In order to enjoy the confidence of all, the Movement may not take sides in hostilities or engage at any time in controversies of a political, racial, religious or ideological nature.

**Independence** The Movement is independent. The National Societies, while auxiliaries in the humanitarian services of their governments and subject to the laws of their respective countries, must always maintain their autonomy so that they may be able at all times to act in accordance with the principles of the Movement.

**Voluntary service** It is a voluntary relief movement not prompted in any manner by desire for gain.

**Unity** There can be only one Red Cross or Red Crescent Society in any one country. It must be open to all. It must carry on its humanitarian work throughout its territory.

**Universality** The International Red Cross and Red Crescent Movement, in which all societies have equal status and share equal responsibilities and duties in helping each other, is worldwide.
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