Gender and Human Rights

Group-3

Facility based treatment

Including EHO posts

Proper history taking

- Language barrier between provider and clients
- Educational and social barriers

- **Solution: Prescription aids to be developed (decentralization in community engagement)**

Use of ethnic language

- No information about the ethnic literacy (they can speak well but have limited literacy) in use of local languages when developing the printed IEC and tools: **(1) to decentralize to ethnic organizations and agencies to develop ethnic health messaging and tools and (2) use of social media and audio visual aids**
- **Limited participations of female groups in ethnic areas**

Pregnancy and lactating mothers

- Many facilities not so friendly to beast feeding mothers (privacy)

Gender barrier during provider-patient communication

- Some cultural barriers for personal communication/contact between provider and clients of different sex/gender. Start with clients to overcome such cultural barriers to increase openness during provider-client communication.
- Need more HE. Let clients know about rights to question/disclose to providers.
- Need to consider vulnerable populations (e.g LGBTQIA, young girls, under 5, persons with disabilities, migrants and camp populations, etc..)

- **Disability friendly services:** Facility staff to follow dedicated outreach
- **Diversity and social inclusion:** BHS limited knowledge that special care is necessary
- **Pregnancy and malaria care:** BHS limited knowledge that special care is necessary
- **Awareness (about free services) and readiness (BHS at all facilities with continuous supplies, both drugs and LLINs)** are identified to be barriers for effective referral services.

LLIN

- LLIN size- not so applicable in some ethnic families: **To introduce insecticide retreatment (IRT) in special zones**
- LLIN distribution: micro planning when doing quantification by household to have proper quota for each family (i.e, two LLINs to two people if the male client is forest goer and there are some social considerations)

Male_ poor compliance

- Drug compliance is poor among male clients due to
  - Their occupational/migration patterns
  - Not accessible mobile network when moving to forest for follow-up
  - Attitude to complete treatment
  - Use of alcohol Vs PQ compliance

Hard to reach and conflict affected areas

- To develop forest-goer kits (including self-testing, treatment and education kits)