Charity-Oriented Myanmar

The Three Millennium Development Goal Fund
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3MDG

Role Of Women & Girls

in Health related Decision Making

Collective Voices on Gender & Health

Australian Aid

EUROPEAN UNION

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Acknowledgements and Disclaimers

We would like to thank the donors contributing to the Three Millennium Development Goal Fund (3MDG) for their kind contributions to improving the health of the poorest and most vulnerable people in Myanmar, particularly women and children.

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Contents

Charity-Oriented Myanmar

Founded in 2005, Charity Oriented Myanmar (COM) is a national youth-led civil society organization dedicated to promoting democratic culture and socio-economic development in Myanmar by empowering youth and women, strengthening political institutions, raising political awareness in the public, participating in the peace building process and working for the development of rural and urban communities.
COM, although established in 2005, became actively involved in the political process of Myanmar in many ways after 2010, which is believed to be a major milestone in the nation's move towards democracy. COM delivers many kinds of training programmes targeting different clients such as youth, women, ethnic youth, all political parties, ethnic political parties, etc. so that they can effectively and efficiently participate in the democratization process. Now, COM has over 800 training alumni,11 Alumni Clubs across the country and 3 Youth Resource Centers in Taunggyi, Mawlamyine and Dawei. COM also holds public forums in many places to mobilize the general public to participate in politics and raise their voice to be heard by duty bearers. Moreover, COM conducts advocacy workshops with both state and non-state actors who are playing a major role at all levels in Myanmar politics. In addition, COM also works for the development of rural communities with the help of international volunteers through the International Voluntary Service Programme. Most importantly, COM runs a social enterprise called Hita San Company for its sustainability. COM's registration number at the Ministry of Home Affairs (MOHA) is 2058.

Social Care Volunteer Group

Social Care Volunteer Group (SCVG) is a local non-profit non-governmental civil society organization working for youth and children in Myanmar since 2007. SCVG has served several thousands of youth

and children in Magway region through its interventions: HIV prevention, youth capacity building, civil society organizations/community-based organizations strengthening and child rights governance and advocacy projects. SCVG is recognized as a leading organization in Magway region and is working with local and international NGOs/CSOs and government ministries on local and national issues.

Development Parami

Development Parami (DP) is a community based organization which has depended on the donation of their members since 2008, after Cyclone Nargis at Labutta Township, Ayeyarwady Region. They have been conducting a range of activities in the community such as blood donation, supporting childbirth for mothers and kids under 5 years in cooperation with Merlin, supporting transportation for emergency patients to the hospital, food and money for the needy, sending mobile Community Development Teams to 16 villages in Pyinsalu from January to April 2009, mobile clinics and sharing information to increase awareness on health issues such as reproductive health, pregnancy for women, health in , children under 5 years, and preventing the flu.

Ayarwaddy Social Development Organization

Ayarwaddy Social Development Organization (ASDO) was founded in January 2014 by self-help groups in 6 townships in Hinthada District. The groups have supported social affairs in their villages. ASDO aims to promote the development of Farmers' and Fishers' affairs, environment issues, education and health issues and the empowerment of youth, women, and child rights. There are 4 sub-offices in Zalun, Myanaung, Kyankhin and Inngapu townships. There are altogether 25 Executive Committee members who have been implementing the activities.

Foreword

As the saying goes “Health is Wealth”, and health plays a vital role for human kind. In every developing country, the health sector should grow together with any other sectors but the gap between urban and rural communities in terms of access to public and private health services remains significant. In Myanmar, according to 2014 Census data, 70 % of the population are living in rural areas. This majority population is facing difficult access to health services in our country.

We, Charity-Oriented Myanmar (COM), with the support of the 3MDG Fund, conducted community meetings in partnership with three local community-based organizations, namely Development Parami, Ayeyarwaddy Social Development Organization and Social Care Volunteer Group, to gain a deeper understanding of rural communities and their access to health services by using participatory methods. Community meetings were held in 30 villages of 3 townships, Myan Aung and Labutta in Ayeyawaddy Region and Magway Region respectively.

COM is proud of the work done in a collective effort by various stakeholders with close and regular cooperation with UNOPS and the 3MDG Fund. We would like to express our thanks to the 3MDG Fund and UNOPS for their technical and financial support. Our gratitude goes to Dr. Than Tun Sein for his great facilitation in Stage -1 of our Collective Voices project. We really appreciate the effort of our consultation team; Dr. Aung Htike Min and U Kyi Soe Thu and the team of facilitators who worked hard and smart on the ground. Our deepest thanks are to the communities from Myan Aung, Labutta and Magway for their participation in various ways: inviting and organizing participants, hosting our facilitator team, participating in meetings

and any sort of help given to us. Last but not least, COM hereby recognizes our partners; Development Parami, Ayeyarwaddy Social Development Organization and Social Care Volunteer Group for their marvelous cooperation.

Chan Nyein Aung
President
Charity- Oriented Myanmar

Initial Participatory Techniques

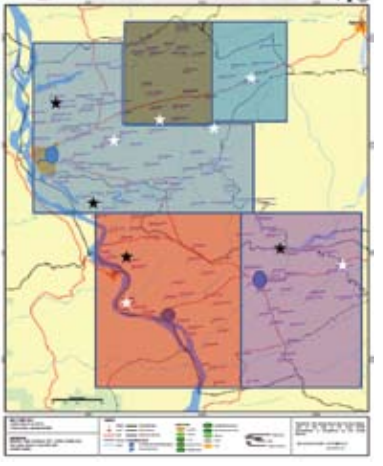
Capacity Building for Community Facilitators

15 people from the local community were selected by 3 implementing partners and trained to become facilitators by COM. They received training on facilitation concepts and skills, participatory learning action (PLA) tools, gender awareness and basic public health knowledge from a two-week training session including pilot field practice in a village near Yangon.

They also received computer skills for data entry and timely mentoring with corrective action throughout the process of community meetings.

Community Selection

For community selection, COM and 3 partner organizations agreed to select 30 sample communities for this study. Accordingly, we selected 10 villages in each township by using a simple random sampling method. In Magway, though we selected the community randomly, most of them were quite close to the township and did not represent the whole township population. Thus, we used a stratified random sampling method based on the presence of the nearest hospital.



"It is convenient to conduct village meetings, organize the villagers and get permission from the local authority and local leader because of the background of the organization." Voice from facilitator in Labutta Township.

Participant Selection

In each community, we asked for help from the community leaders and asked them to invite 25-30 girls, women and men from different areas of the community. Selected community members were different ages from different parts of the village and from different backgrounds in terms of livelihood living standard, education etc... Moreover, the participants for community meetings were carefully selected so as not to include health service providers, nurses, mid wives, duty bearers, and influential members. The numbers of community members selected from each community are as follows;

Category	Number
Girls	5-8
Women	8-10
Men	8-10

Participatory Learning Action

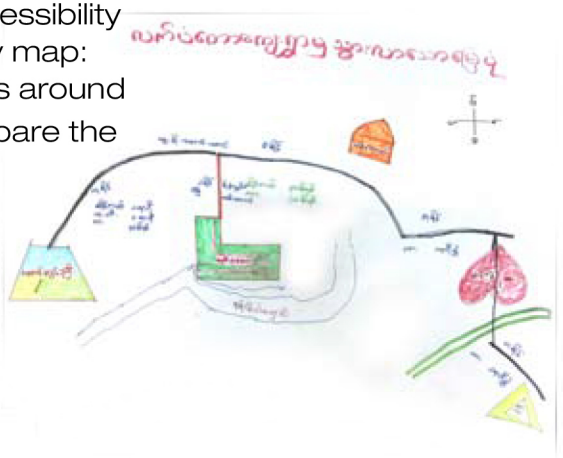
Tools	Male	Female	Girl	Number
1. Village Health Service Mapping	Heterogeneous			1
2. External Health Service Accessibility Mapping	Heterogeneous			1
3. Significant Health Event Historical Timeline	Homogeneous	Homogeneous		2
4. Seasonal Disease Diagram	Homogeneous	Homogeneous		2
5. Daily Time Use	Homogeneous	Homogeneous	Homogeneous	3
6. Venn Diagram		Homogeneous	Homogeneous	2
7. Transect Walk	Large Group			1

Village health service mapping: to discover the overall situation of each village and **internal health services** available in the community.

External health services accessibility mapping by using mobility map: to assess the health services around the community and to compare the **degree** of

accessibility,
cost,
responsiveness
and feedback mechanism

of each service.



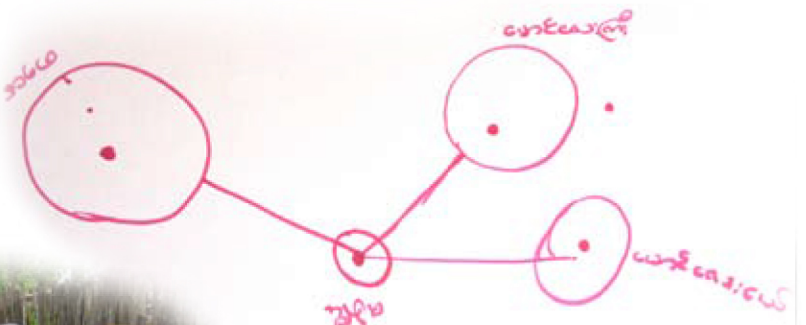
Gender disaggregated historical timelines: to identify history of **major health issues** in targeted areas and who did what.

Seasonal calendar: to find out **seasonal diseases** and who does what.

" We used to have water supply but because of climate change and the shortage of water, we don't have enough water in the rainy season.So,we can't plant crops well. "
Voice from seasonal calendar session in Thabyu Kone Village.

Daily time use: to **disaggregate** how girls, women and men spend time on a daily basis and how this links with health related decision making.

Venn Diagram: to address **women's power & relations** with their **household heads/ husbands/ brothers/ fathers/ uncles** in health issues.



For the purpose of data **confirmation and triangulation,** the study finally visited around the village and held discussions with key people from the village. The transect walk tool was used for this activity.

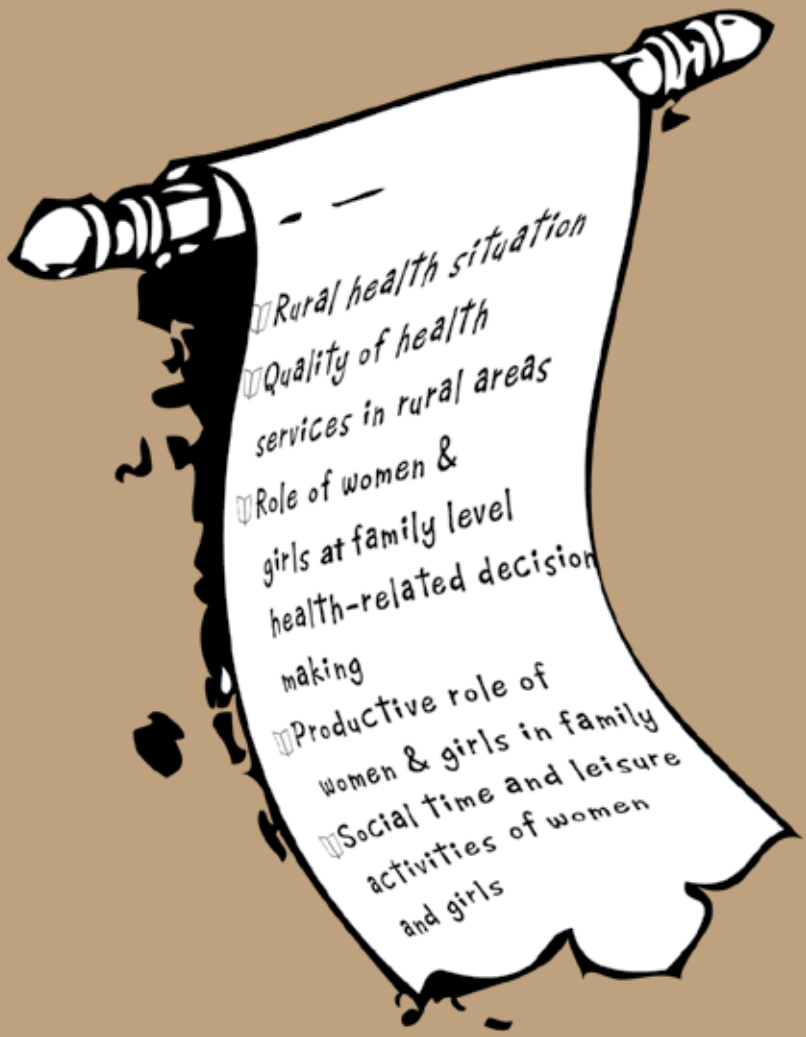
Target Population Reached

No	Township	Male	Female	Total
1	Myan Aung	82	116	198
2	Labutta	81	148	229
3	Magway	83	141	224
Total		246	405	651

Participatory Reflection Workshop

After the community meetings, COM organized a participatory reflection workshop in Magway with the field facilitators and two consultants. The consultants designed the workshop with a participatory approach by introducing analytical thinking skills and letting them analyse the findings from the community meetings by themselves through teamwork.

The findings presented in the next chapter are the findings that were combined and interpreted by the community facilitators. The role of the consultants was to in the conclusions and recommendations in regard to the findings.



Results of Collective Voices

Rural Health Situation[1]

The most frequently occurring seasonal diseases in study areas are as follows:

	Summer	Rainy	Winner
General	Conjunctivitis, Heat stroke, Diarrhea, Rashes, Excessive sweating, Fatigue/ Lethargy, Skin Infection	Dengue fever, diarrhea, Malaria, Seasonal Flu, Common Cold/ Fever	Running Nose/ Rhinorrhea, Cough, Flu, Malaria
Labutta	Significantly, most of the villages suffered from diarrhea outbreak because of the water shortage after cyclone Nargis.		
Myang Aung	The area is located near the woods and some groves so people are more likely to get malaria and dengue fever all year round compared with other townships.		
Magway	The most common seasonal disease is diarrhea especially in the summers by eating overripe mangoes. Another common disease is dengue fever that mostly occurs among children.		

[1] Meeting notes are written according to participants' wording without any significant modifications. What they mentioned in Myanmar language is translated into English to the best of our efforts. Therefore, COM and its partners bear no responsibility for the technical correctness of any medical terms described here.

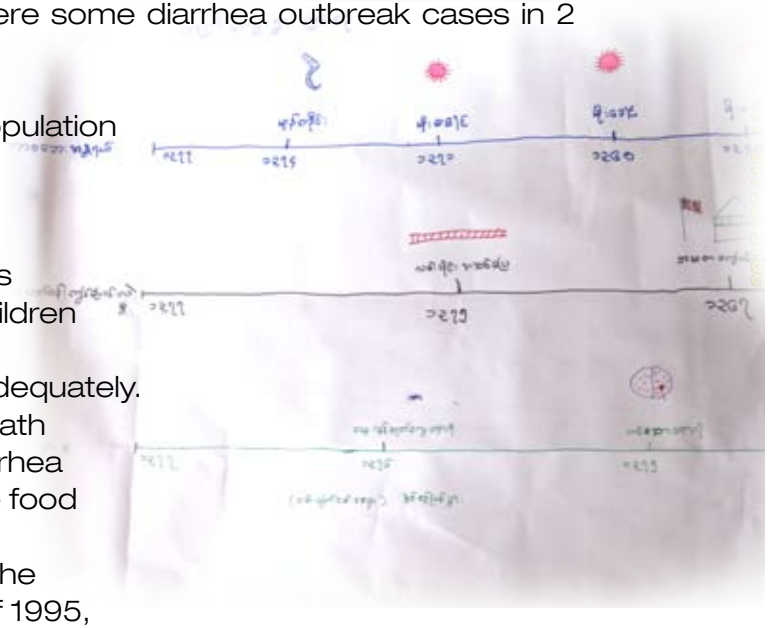
The most frequently occurring diseases in history are

Dengue fever, diarrhea, hypertension, cancers, heart diseases, diabetes, liver related diseases, rheumatic fever, AIDS, mistletoe, jaundice and anemia.

The least frequently occurring diseases in history are

Tuberculosis, cerebral palsy, malaria and German measles. In Labutta, most of the participants mentioned that dengue fever and diarrhea became more frequent after the Nargis Cyclone period. Dengue fever is a more common disease among children. Immediately after Cyclone Nargis, children and elderly death cases were found because of food shortages.

In Myanaung, there were some diarrhea outbreak cases in 2 villages 4 years ago. Exceptionally, as there was a relatively high population and households in Sann village and the respective village health service providers rarely visited , some children and pregnant women were not vaccinated adequately. There was a certain death history because of diarrhea by eating inappropriate food in YinnarTharsi village, Magway Township. In the overheated summer of 1995, the whole village of Thamantaw suffered from terrible diarrhea outbreak probably because of ingestion of inappropriate food.



"When the mango flowers blossom, the diseases can happen in the village. When it starts blossom the traditional practitioners warn us to take care of our health." Voice from Loon Chaung Village

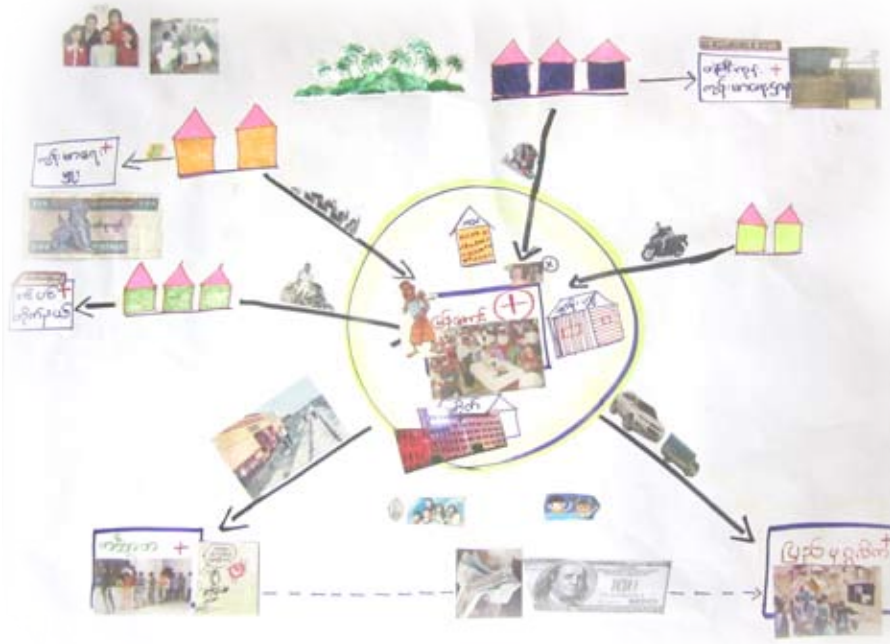
Quality of Health Services in Rural Areas

Myan Aung

Almost all of the studied villages have **no** basic health staff for their village but they have access to some extent to health services from nearby village midwives. Sann Village is a hard to reach area among others. Exceptionally, the people from that village rarely receive health services even from nearby midwives. Generally, all the people from the study area rely on Myan Aung General Hospital.

For the small cases,

- Lae Kwin, Sann and Kan Gyi villages rely on In Pin Station Hospital.
- Zayit Htu and A Lae Kone villages rely on a Health Assistant from A Nauk Kone village
- Sae Ywar, Kyo Kone and Chan Kone villages rely on Tarkhwa TaeGyi Rural Health Center
- Pan Nyo Kwin and Pyi Sin Kwin villages rely on Myan Aung General Hospital



One significant finding is that all the people from the study area rely on a Hinthada private clinic for eye cases and Pyay private clinics for emergency cases. Thus, according to the villagers, health services in Myan Aung Township are not very reliable for emergency and special cases.

The villagers from Sae Ywar and Pyae Sin Kwin village mostly rely on two local authorized practitioners and they mostly rely on only one of these two because the other one is considered to be less responsive in providing services and does not discuss health concerns with patients..

There is Myan Aung Hospital, Ein Pin Taing Hospital and Tarkhwa Tae Gyi Kone rural health centre and among these, the villagers mostly go to Myan Aung Hospital because they feel it has sufficient doctors, facilities, equipment and better accessibility to drugs although they also only experience a limited chance for interactive discussion. The villagers feel that there are insufficient doctors in In Pin Taing village but the expenses are cheaper there.

Magway

In Magway, available internal health services of the 10 studied villages are
as follows:

Rural health center, Health Assistant, Traditional Practitioner	4 villages
Rural health center	1 village
Auxiliary midwife	3 villages
Auxiliary midwife and Quack	2 villages

For external health services, people mostly go to Magway General Hospital and also to the Teaching Hospital of the University of Medicine, Magway

- People from Myitnartharsi and Pahtanago villages go to Min Hla Township Hospital that is located on the other side of the river.
- People from Lapadaw village and Yin Nar Tharsi village go to Taung Dwin Gyi Hospital.
- People from only Kyaw Kan village go to Nat Mauk Hospital

and Nyaung Kan Station Hospital.

In Magway, there is Magway General Hospital, Kaung Mon Private Hospital, Patharda Hospital, Teaching Hospital, Minbu Eyes Hospital, station Hospitals, Nat Mauk Hospital, Taung Dwin Gyi hospital and Min Hla Hospital.

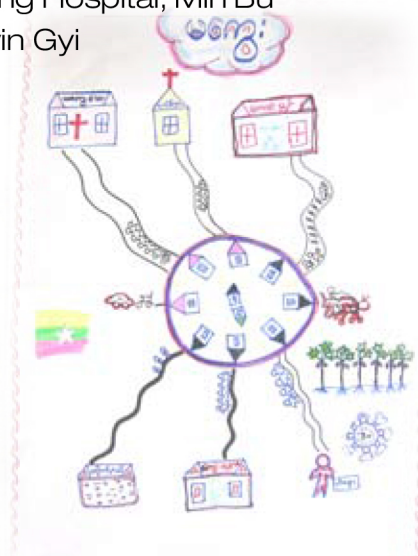
Among them, the poor and vulnerable people usually go to Magway General Hospital and Teaching Hospital for emergency cases. People who can afford it go to private hospitals (Kaung Mon Hospital and Patharda Hospital) because of their reliability and to save time.

Significantly, the poor villagers from those 10 villages go to Min Bu Eyes Clinic located on the other side of the river in Magway. Some people who can afford it go to Patharda Eyes Clinic in Magway city. According to the community meetings from 10 villages, for half of the villages, Kaung Mon Hospital is hard to reach, the responsive service delivery is well recognized in that hospital. The most accessible health services are

at Magway General Hospital, however, the responsiveness is considered to be under satisfactory by the villagers. The feedback acceptability in Magway General Hospital is considered to be moderate by the villagers.

The villagers perceive the Teaching Hospital to have a moderate level of accessibility but the responsiveness is not considered satisfactory and the feedback acceptability is experienced as weak in that hospital.

The health services within the 10 villages are considered overall to be moderate in their responsiveness and in feedback acceptability. Based on this experience, the villagers said that they mostly rely on traditional practitioners and midwives. The rest of the health services are accessed through health service providers, clinics, local unauthorized health service providers, drug stores and medical officers. Among Kaung Mon Hospital, Magway Hospital, Patharda Hospital, Teaching Hospital, Min Bu Eyes Hospital, Nat Mauk Hospital, Taung Twin Gyi Hospital and Min Hla Hospital, Magway Hospital has skilled service providers, advanced technology and easy expense. Thus, people normally go there although it is seen to have low responsiveness and weak on feedback acceptability.



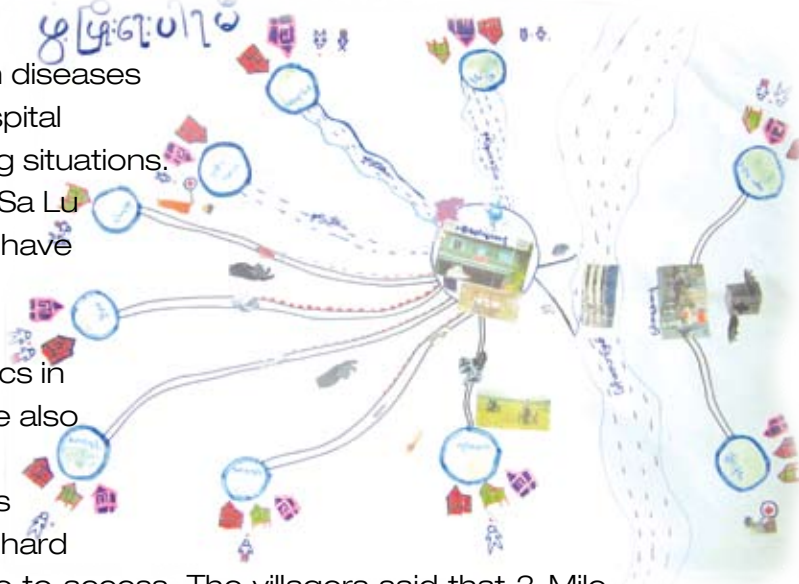
" The auxiliary midwife said we can take pills from her if we are not feeling-good. She gives medicines depending on our disease." Voice from mobility map session in Late Kwin Village

Labutta

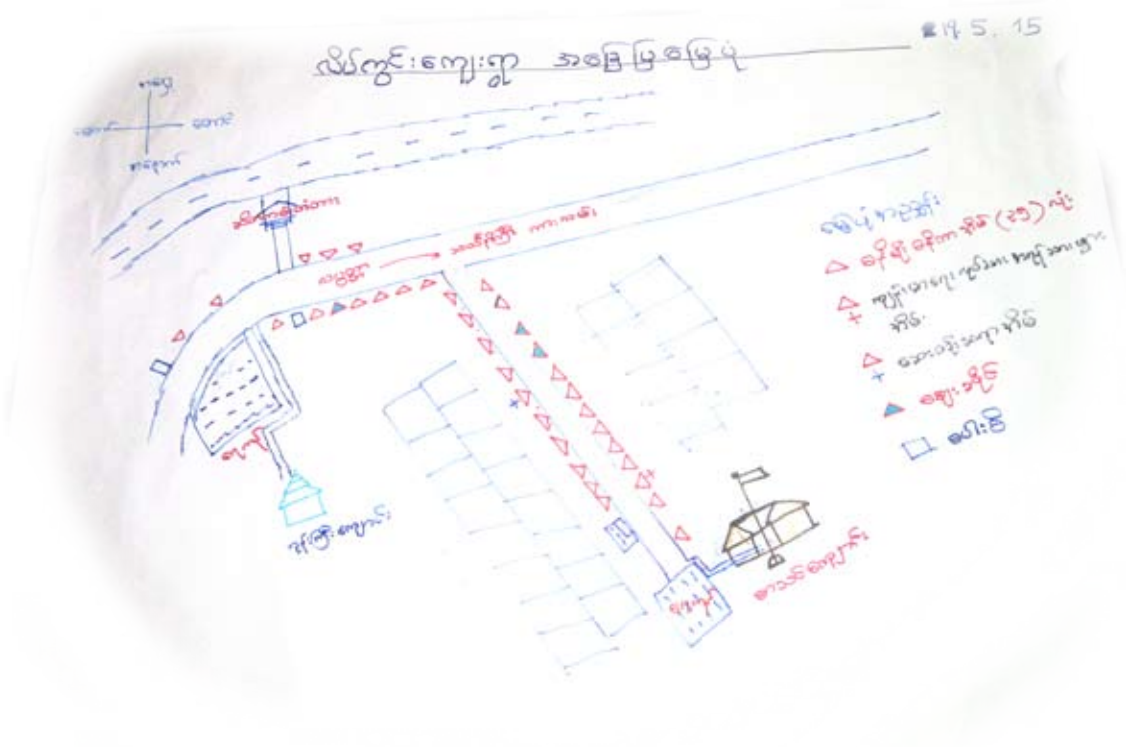
In Labutta, internal health services of the 10 studied villages are as follows:

Auxiliary midwife and health worker	5 villages
Health worker only	2 villages
Auxiliary midwife only	1 villages
Rural health center	2 villages

Almost all villagers go to 3-Mile Hospital beyond the rural area. Among 3-Mile Hospital, Pyin Sa Lu Hospital and other private clinics, people from different walks of life go to 3-Mile Hospital for health problems in Laputta Township. Kyar Chaung village and Kone Gyi village which are on the other side of Pyan Ma Lott river usually go to Pyin Sa Lu District Hospital for common diseases and go to 3-Mile Hospital only in life-threatening situations. This is because Pyin Sa Lu Hospital has seen to have insufficient service providers and other staff. The private clinics in Labutta Township are also expensive and considered to be less effective so they are hard for many rural people to access. The villagers said that 3-Mile Hospital has reliable responsiveness despite the high cost.



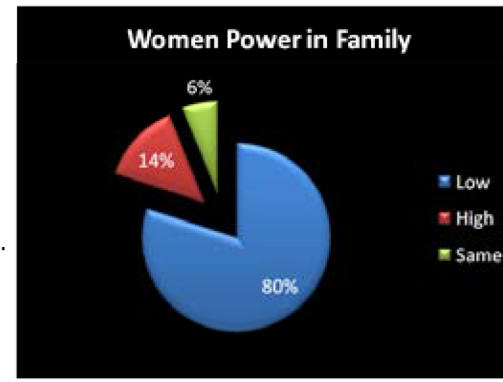
" We have free land to build a health clinic centre but no one can afford to contribute to the expense of a building." Voice from a man in Ka Byo village



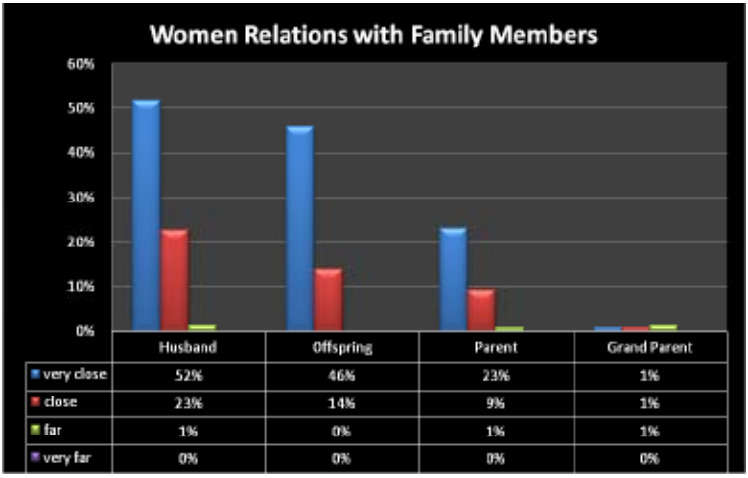
Therefore, the rural people depend on it and receive better wellbeing. Women patients are less likely to go to male doctors. In Labutta, villagers consider it to be men's role to take responsibility for transportation and women's role to take care of patients.

The decision making role for health at the family level

The facilitators used a Venn diagram to identify the role of individuals in decision making at the family level for health issues. In the community meetings the setting was set by people were divided into different peer groups of women aged 18-50 and girls aged 13-17.



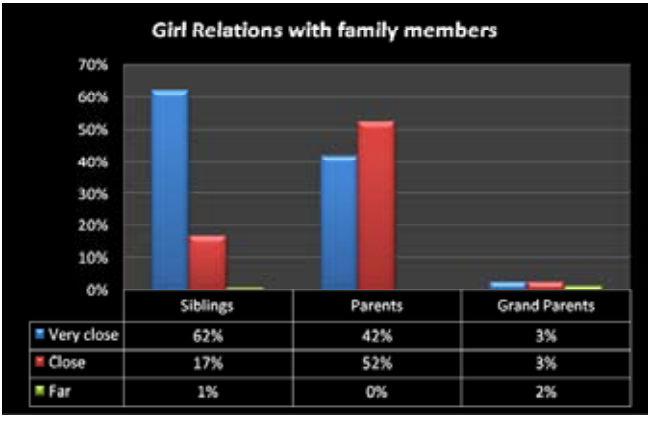
In the discussion, they drew the Venn diagram according to the level of power between men and women. As a result of Venn diagrams from over 200 women, women have less power than men have in 80% of families. It was found that only about 14% of women have higher power than men.



	Husband	Offspring	Parent	Grand Parent
very close	52%	46%	23%	1%
close	23%	14%	9%	1%
far	1%	0%	1%	1%
very far	0%	0%	0%	0%

Significantly, it was found that 6% of women share the same level of power with men. In the girls groups, 100% of the girls described themselves as having lower power in their family than men do. During community meetings, when they reflected on their family relationship in the rural areas, girls said they have a closer relationship with brothers and sisters rather than with parents. They have a distant relationship with their grandparents. In the relationship between women and men, women have a closer relationship with their husbands rather than with their children.

The relationship between grandparents and their grandchildren is also distant. In conclusion, girls tend to have a closer relationship with their brothers and sisters, women have a



	Siblings	Parents	Grand Parents
Very close	62%	42%	3%
Close	17%	52%	3%
Far	1%	0%	2%

closer relationship with
their husbands, and the relationship between grandparents and grandchildren is distant.

When about the women and girls discussed health related decisions, there were three parts to the discussion including prevention, seeking treatment and providing care. The main decision maker for health related issues at home is a man as mentioned above. In relation to treatment, mainly men decide whether a family member will take medicine or, go to the clinic, and will also determine certain conditions for taking medicine, going to the clinic or hospitals and will choose the hospitals or clinic for treatment. Women take a more central role in prevention and long term home-based care. In regard to the Collective Voices findings, women do not have a role in making health related decisions at the family level. Additionally, they have a bigger burden in providing long term home-based care.

The decision making role for health at the community level

According to the community meetings from 30 villages, men have the highest authority for community level health service decision making compared to women..

Daily time spent by rural community

Working in livelihood (Productive Role)

The livelihoods of 30 villages the from selected three townships is mainly through farming, fishing and casual labour. Moreover, some also work in backyard poultry farming.

" My husband works for our family income. So,I have nothing to do if I don't do house chores and cooking." Voice from a woman in War Kone Village

The 10 Collective Voices villages from Myan Aung Township farm for monsoon paddies, summer paddies, groundnuts, green gram and sesame.

The 10 Collective Voices villages from Magway Township cultivate paddy, groundnuts, sesame, corn, cotton, onions and a variety of peas.

The 10 Collective Voices villages from Labutta Township have only one crop that is paddies. They also conduct farming with pigs, chickens, ducks, prawns, crabs and fish.

“ Both women and girls do not have a daily income so we are looking forward to some daily paid jobs to support our family expenses.” Voice from Daily time use session in Loon Chaung Village

In the agriculture sector, men take on the role of plowing and seeding. Women take on the role of transplanting paddies, weeding and pulling out grass. Men and women work together for cultivation. In poultry farming, women take on the role of feeding and taking care of animals. Men take on the role of casting nets, laying nets in water for fishing and catching crabs while women take on the role of picking prawns and selling water products.

“ It is already defined what men have to do and what women have to do. Everyone knows about it and follows it of course.” Voice from a woman in Kyar Chaung Village

Working in Household chores (Domestic Role)

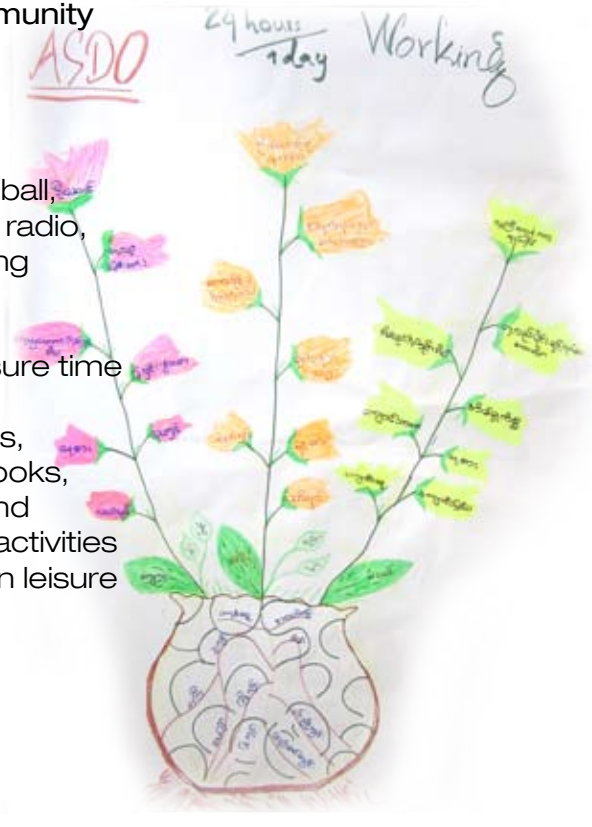
Women take the main role in completing domestic tasks rather than men. The tasks that women do are cooking, cleaning, doing the washing, getting water, cultivating grass for cows' feed, collecting cow's feces, tidying the compound, cutting cow's feed (palm, grass, corn, hay).

The household tasks that the men do are knitting nets for repair, cultivating cows' feed, carrying water by using wheeled- barrels or shoulder-yoke barrels, feeding cows and cleaning the land.

Thus, men and women work together on cultivating cow's feed, feeding cows, getting water and tidying the compound.

Leisure and social time(Community Socialization Role)

Men usually spend their leisure time talking over plain tea, playing volleyball, playing cane ball, playing football, listening to the radio, reading journals and news, using the internet on mobile phones (Magway)and drinking alcohol. Women usually spend their leisure time chatting, watching TV, visiting neighbours, skipping with ropes, reading books, swimming, watching movies and making snacks. The common activities that men and women spend on leisure time on are using mobile phones, watching TV, group chatting and resting.



Involvement in community affairs
(Community Socialization Role)

Men are involved in auxiliary fire fighting units, fire watch, constructing community buildings, making drainage systems, digging mud, cleaning the ground, cutting trees and mobilizing people for charity.

Both men and women in the community are involved in cooking, serving food and cleaning on social occasions of joy or grief, asking for donations and renovating roads.

All women from Payarpyo village in Magway Township are involved in collecting rubbish bi-monthly.

" In our village, there are different tasks for what men should do and women should do. However, some people don't care about that and help each other even though the tasks are not related to them."
Voice from Thabyaychaung Village

Conclusion

Water related diseases such as diarrhea, dengue fever and skin infections were found to be common in these townships especially in summer and the rainy season. These diseases are related to sanitation, hygiene and individual behaviours, showing the need for improved personal hygiene habits and better understanding of disease transmission. One conclusion from Stage 1 findings is therefore that the community needs to improve their health knowledge in order to improve their health outcomes. One of the most frequently occurred seasonal diseases is conjunctivitis (eye disease). For eye problems, most of the people go to the private clinic rather than public health facilities although there are eye care services in public hospital. It may be due to the lack of the community awareness of these services.

Regarding health care facilities, the majority of the poor and vulnerable people rely on the government township general hospitals for emergencies and treatment of serious diseases because of its cheap expense despite their weakness such as long waiting times, less reliability, limited consultation time, low feedback acceptability and low levels of responsiveness. This is because they cannot afford to reach other health service sources. For minor health problems, the community usually accesses drugs from small pharmaceutical shops by themselves. In some places, people consult traditional practitioners and even unauthorized health service providers. The background reason is that the community has a very limited budget for their health care. In addition, the community does not have knowledge about the adverse consequences of improper treatment.

The community from hard-to-reach areas cannot easily access basic health care services such as antenatal care and immunization, and there is a lack of coordination and collaboration between the community and Basic Health Staff.

Moreover, one of the most frequently occurring seasonal diseases is conjunctivitis (eye disease). Hence, for eye problems, most of the people go to the private clinic rather than public health facilities although there are eye care services in the public hospital. This may due to the lack of community awareness of these services.

At the family level, the role of men and women in health care was found to be different. Women usually lead in preventive and rehabilitative care such as preparation of healthy food for the family, cleaning the house and long-term patient care. On the other hand, men usually have higher power than women in making decisions about seeking health care both at the family and community level. 100% of the beneficiary girls in this project have no chance to be involved indecision making for health issues in the family, including their own. It shows that there is still room to improve gender equality within the family. Women and men are working together in productive, domestic and community and socialization roles by taking different responsibilities although they do not have gender equality.

To conclude, there are four significant demand-side issues arising from Stage 1 findings as follows:

(1)The community needs to improve its health awareness and health seeking behaviour

(2) The financial saving practices for family health care in the community needs to be developed

(3)Awareness of public health services amongst the community needs to be promoted

(4)Women's empowerment to have a greater role in decision making at both family and community level needs to be strengthened

Recommendations

Recommendations

- Improved health seeking behaviour in the community is an important consideration for Stage 2 project activities to increase the limited knowledge of community members, including on gender equality and specific health issues.

- Since the community is very interested in watching movies and group chatting in their leisure time, it would be more effective to conduct gender and health awareness raising activities by means of theater, show and contests.

- The community should be taught about options to develop financial savings for their health expenditure to minimize suffering from catastrophic expenditure in the event of a health emergency.

- Strengthening the capacity of Village Health Committees (VHCs) is also highly recommended to increase engagement and coordination between health care providers and communities. The VHC can then support Basic Health Staff (BHS) in their routine and special activities all under served and unreached target populations. More over, it can lead to a stronger relationship among between communities, basic health staffs BHS,the township health department and township health committee.

- Social Audit/Social Accountability tools like transparency boards and community notice boards should be used to enhance accountability practices of VHCs and health personnel. Community Score Cards or Citizen Report Card methodologies can also be used to provide health service users feedbacks to decision makers.

- Due to the results that show a power imbalance between men and women in seeking health care, interventions around gender and health should be prioritized at these project sites. Women in these projects are as should be empowered by promoting their decision-making capacity, self-reliance for health care and expenditure options, and management skills to enable them to have an equal opportunity to make health care decisions at both the family and community level.

- It is recommended that Stage 2 project activities align with national and international policies and strategies to empower women and promote gender awareness and equality in the community. This includes:
-The existing Constitution (Articles 367 and 351) that encourages women's empowerment and equality in Myanmar. These articles state that 'every citizen shall, in accord with the health policy laid down by the Union, have the right to health care', and.'mothers, children and expectant women shall enjoy equal rights as prescribed by law respectively'.The Convention on the Elimination of All Forms of Violence Against Women (CEDAW) and developing. The National Strategic Plan for the Advancement of Women (NSPAW)The National Health Policy (2011/122015/16): improving Health for Mothers, Neonates, Children, Adolescents and Elderly.

- Since Women's Health is one of the target areas for the Ministry of Health, we should collaborate with the Department of Health to achieve our common goal.

- Last but not least, there were limitations in methodology, the choice of tools, time and budget during the project implementation. Thus, only commons well-known facts like the lower power of women compared to that of men at family level and at community level could be found out. We need to explore in more detail about health service accessibility related to gender in equality. We will aim to do this through our Stage 2 activities.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