



Webinar summary

Gender inclusion in project implementation

ADDRESSING THE BARRIERS STOPPING MEN, WOMEN, GIRLS AND BOYS FROM PARTICIPATING IN PROJECTS IN NIGERIA, BANGLADESH AND THE PHILIPPINES.

One of the things that CBM strives to achieve is to make sure that no one in need misses out when we implement a project. The reality is however that sometimes women and girls miss out on opportunities within a project, and sometimes men and boys do too.

We recently spoke to our local partners in Nigeria, Bangladesh, and the Philippines about what has stopped some men, women, girls, and boys from being involved in their projects, and what they have done to address this. This is what we learned.

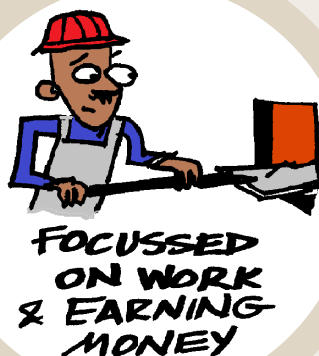
Traditional gender norms and roles continue to play a big role in influencing participation rates, for both males and females.



Women are expected to have and raise children and look after the home. This means they often struggle to find the time to participate in project activities.

In one of our projects in Bangladesh, getting both men and women to agree on a time for group meetings became a challenge. This was because men prefer to have meetings in the evening because they work during the day, while women prefer to have meetings during the day because in the evening, they are busy looking after the children and cooking dinner.

To address low female participation rates in self-help groups, our partner advises male members to give priority to female members when deciding on a time and place for meetings and events.



Men are expected to provide for the family financially. This means they are often too busy working to participate in other activities.

In a project in the Philippines that focuses on home-based rehabilitation for children with disabilities, our partner found that when men do participate, it is in activities that are masculine in nature, which does not typically include looking after their children.

To address low participation rates of fathers in activities involving the rehabilitation and development of their child with a disability, our partner has implemented policies that require both parents to attend meetings discussing both their roles in the rehabilitation of their child.

To further encourage fathers to take on more of the non-traditional gender roles, our partner is providing specific training for fathers about how to look after their child with a disability. They are also helping connect fathers with other fathers of children with disabilities, creating a safe environment for them to talk, share stories and seek support.

Religious and social expectations continues to play a big role in shaping gender roles and norms.

In Bangladesh, our partner explained how, due to religious and social expectations, women in some project locations are discouraged to participate in group activities, including in self-help groups. This, coupled with the lack of available time, meant that women were missing opportunities for self-development. This made some women feel stressed and, in some situations, led to family conflict.

Our partner found the following strategies effective for changing community and family attitudes towards women's participation in the project activities.

- Sharing success stories about women and women role models.
- Organising awareness raising activities for the community, including religious leaders, about women's rights.
- Providing counselling sessions for family and community members about the importance of women's participation.
- Getting self-help group members to meet with family members to explain to them about what it is that they do, and how it aligns with religious and social norms.
- Training peer responders to provide women with basic level psychosocial support, if and when required.

Similarly, our partner in Nigeria also noted how the gender norms and roles of some ethnic groups affected access to water, sanitation, and hygiene (WASH) services and services for the prevention and treatment of neglected tropical diseases (NTDs).

They told us how, in communities in Northern Nigeria where the project is implemented, some women and girls were at risk of missing out on accessing critical medicine due to the religious practice of

purdah or female seclusion which excludes unrelated males (including male health workers or community volunteers) from entering homes without permission from the head of the household, which is usually a man.

They also noted how women and girls were at high risk of contracting a NTD because they are typically the ones responsible for collecting water. Additionally, because water points are often located far away, this responsibility also limits the amount of time they have to spend on other activities, such as participating in project activities or getting an education.

To overcome this challenge, our partner consulted traditional and religious leaders and women's groups for feedback and advice. They then came up with an approach that both respected religious norms and made it easier for women to participate in project activities, including accessing medicines. The approach included:

- Giving priority to women and children during treatment for NTDs (those at higher risk), especially when the medicines are insufficient.
- Ensuring there are women community volunteers and that they are paired with males so they can enter the homes of women and girls and administer medicines.
- Supporting the construction of accessible water points closer to homes thereby easing stress that women and girls undergo in getting water and freeing up time to participate in other activities.

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