



Gender integration in the Plantwise programme: an assessment

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Summary

Gender integration focuses on applying a gender lens to look at how social relations of gender and underlying power dynamics affect men's and women's participation in and benefit from development programmes. In Plantwise, gender mainstreaming aimed to (1) understand gender relations and how they affected access to agricultural advisory services and adoption of plant health management practices, and (2) remove gender related barriers to access and

adoption and improve gender equity. This study used desk reviews and key informant interviews to understand how the different measures taken by Plantwise countries helped improve women's participation, as well as, the overall constraints women faced in participating and benefitting from the programme interventions. Findings showed that while efforts were made to mainstream gender in Plantwise, the efforts were not consistent and systematically designed, and there were limits in ensuring that services were delivered equally to women and men farmers. However, innovations and adaptations within the studied countries (Ghana, Uganda, Bolivia, Afghanistan and India) did increase women's participation and benefit from Plantwise, even if more can be done.

Key highlights

- The presence of women plant doctors, and women only clinics, where culturally necessary, does increase women's attendance at plant clinics.
- The communication channels used to promote plant clinic services are critical and efforts must be made to ensure channels are used that reach women, with clear messaging about services being available to all farmers.
- Women face considerable time and mobility constraints in accessing plant clinics, and adapting the time and location of the clinic can increase the chances of women visiting a clinic. Integrating interventions that reduce and redistribute the burden of unpaid care and domestic work on women in agriculture programmes can go a long way in addressing women's time and mobility constraints.
- Lack of control of resources and affordability of agricultural inputs restrict the ability of women to implement the advice they receive. Integrating interventions that focus on shifting gender based social norms influencing access and control over resources and improving women's access to credit are needed to remove these barriers to equality.
- Increasing the gender awareness of plant doctors and equipping them with skills to deliver gender sensitive advisory services is a key way to increase women's access to agricultural extensions services, including participation at plant clinics.
- Carrying out a gender analysis at the start of any project or programme is essential to ensure that the intervention mainstreams gender and provides equal benefits to women and men.

Context

Integrating gender in development programmes is about applying a gender lens to look at how social relations of gender and underlying power dynamics affect men's and women's participation in and benefit from development. Gender integration is required to ensure everyone benefits equally from development interventions, to make sure inequality is not perpetuated and to enhance the impact of development investments. Actions taken to integrate gender can range from removal of gender related barriers or constraints to improving gender equity, change in gender roles, improving gender power relations in access to or control of resources, in decision making etc, depending on the level of ambition of projects. At the minimum, development programmes should not be gender blind and should be designed with a prior analysis of culturally defined set of economic, social, and political roles;

responsibilities; rights; entitlements; obligations; and power relations associated with being female and male, in a given context. They should acknowledge that people may experience development problems differently, based on their gender and other social categories, and aim to reduce the gender gap in access to resources. They should also measure progress in bridging the gender gap. More gender transformative programmes will go beyond this minimum compliance and try to address the systemic causes of gender inequality imbedded in formal and informal institutions and structures.

Plantwise, a global programme led by CABI, implemented in over 30 countries world-wide, aims to contribute towards increased food security and improved rural livelihoods by reducing crop loss. The programme, working with agricultural extension and plant health advisory service providers, government regulatory organs, agriculture research institutions and agro-input suppliers, has supported development of plant health systems and facilitated stakeholder platforms. It has introduced village-based plant health clinics and plant health data collection in at least 35 countries and has trained over 10,000 personnel in pest diagnosis, pest management options and other relevant topics. To varying degrees, the approach has been embedded in the agricultural extension programmes run by partners who, in some cases, have made structural changes to revise staff job descriptions and allocate budget for the programme activities. The Plantwise Knowledge Bank provides pest distribution maps, online diagnostic tools and pest management decision guides and fact sheets, and other information resources that are used as reference materials in Plantwise countries.

Despite the evident successes of the Plantwise programme, there were limitations in systematically mainstreaming gender and ensuring the services delivered by the programme were accessed by male and female farmers, equally. After observing the limited participation of women in the programme initially, some Plantwise implementing countries took different measures to address the problem. This study aimed to understand how such measures helped improve women's participation, as well as, the overall constraints women faced in participating and benefitting from the programme interventions. This understanding can inform future programmes, to enable more gender equitable outcomes.

What we did

The overall objective of this assessment was to examine how gender was mainstreamed in the Plantwise programme, by identifying strengths and limitations and drawing out lessons to inform the development of the next phase of the programme.

Specific questions addressed by the assessment were:

- (1) What gender considerations were made during the design and implementation of the programme?
- (2) What gender related challenges were encountered and what gaps were observed during implementation?
- (3) What recourse measures were introduced and what changes were observed as a result of implementing these measures?
- (4) What are the lessons learnt for more gender equitable outcomes?

The assessment focused on the programme design at the global level and implementation in five countries: Ghana, Uganda, India, Afghanistan and Bolivia, as well as on the plant health systems development component, with the assumption that farmers' main interaction is with plant clinics and plant doctors. Other in-country interventions, such as extension information that is available through the Knowledge Bank, was considered to be accessed mainly by plant doctors and other sector experts, rather than farmers.

The assessment was conducted by carrying out a desk review and key informant interviews with Plantwise CABI Country Coordinators of the five selected countries. The documents reviewed included: Plantwise five-year programme strategy, the logframe, the gender mainstreaming strategy, global and annual reports of the selected countries; external evaluations; impact stories and studies done on gender aspects of the programme. Data for the five countries in the Plantwise Online Management System (POMS) was also reviewed to understand the trends in men and women farmers seeking extension advice from plant clinics.

What we found

Some efforts were made to mainstream gender in the Plantwise programme design and implementation, although the efforts lacked consistency with the intentions outlined in the programme strategy and gender mainstreaming strategy. The 2015-2020 Plantwise programme strategy acknowledged the need for gender analyses to be done at country level. The strategy also recommended specific actions to be undertaken to address gaps in participation of women in the programme, a limitation that had been observed since the programme's implementation in 2012. The same recommendations were reflected in the gender mainstreaming strategy of the programme developed in 2012. The logframe, revised in 2016, included gender-disaggregated indicators at impact, outcome and output levels. Country programmes collected and reported sex-disaggregated data from programme activities and outputs, although they were rarely accompanied by a discussion about the implication of the data and how they might inform the design and implementation of ongoing activities.

Various studies commissioned by CABI and monitoring reports show the attendance of women in Plantwise clinics is generally low, as compared to the proportion of women employed in agriculture or contributing to agriculture labour force, with wide differences across countries. Women make up 43% of the agriculture labour force globally and 50% in Sub-Saharan Africa and 45% in South East Asia (FAO, 2011). Women's participation in plant clinics, on the other hand, ranges from 24% in South Asia, to 35% in Sub-Saharan Africa and 37% in South East Asia (Williams and Taron, 2020).

- Participation of women in plant clinics in Ghana has shown a gradual increase from 22% in 2013 to 34% in 2017.
- In Uganda numbers increased from 23% in 2012 to 38% in 2017. Women overall account for 29% of plant clinic users, and according to the 2016 country annual report, 1/3rd of participants in plant health rallies were women. Overall, women constitute around 45% of the farmers reached by different Plantwise programme activities in Uganda.

- In Bolivia, attendance of women has averaged at about 15% of plant clinic participants throughout the programme implementation, though this varies by region and crop (Quiroga and Kernan, 2016).
- In India, the participation of women in the programme varies between regions. Women are actively involved in Tamil Nadu state, while their participation is lower in Jammu & Kashmir. Attendance of female farmers in plant clinics was initially low, but it gradually improved in locations where the NGO partner M.S. Swaminathan implements the programme. The partner used innovative approaches to reach women farmers and promote plant clinics, such as, video clips of women role model farmers giving testimony about the benefit of using plant clinics, experience sharing among women farmers and training of women lead farmers to work as a cadre of facilitators linking women farmers with plant doctors. Women participating in plant clinics increased from 17% in 2012 to 20% in 2019. Overall, women account for 16% of farmers attending plant clinics, and their participation in plant health rallies and extension campaigns reaches 45%.
- The participation of women farmers in Plantwise activities in Afghanistan is very low, although it has improved slightly over the years. Socio-cultural norms in Afghanistan prevent women and men from attending public events together. There were also very limited number of women working in agriculture at the district level. Only 1% of plant clinic attendants were women in 2012. This figure grew to 5% in 2019.

Plantwise programme countries identified gender related barriers to women's access to plant health services during implementation. The gender related barriers identified during implementation have similarities across countries, although the emphasis varied depending on the context. Socio-cultural and gender norms are one of the major barriers to women accessing extension advice and adopting new practices and technologies.

Identified challenges

Limited availability of women plant doctors

In all the countries assessed in this study, the proportion of female agriculture extension workers is lower than men. Only 15% of agricultural extension workers are women (GFRAS 2012). This greatly reduced the availability of female extension workers who can be trained as plant doctors. In Bolivia and Uganda 25% of the trained plant doctors are women, in Afghanistan 32 out of 573 (0.06%) plant doctors are women and in Ghana 9 women out of 170 (0.05%) were trained as plant doctors. One of the contributing factors to the limited number of women working as agriculture extension agents is that the working conditions for extension workers are not conducive for women, according to the Ghana Plantwise CABI Country Coordinator. For example, women extension agents with young children struggle to carry out their field activities, as there are limited child care facilities and the extension agents can be posted in rural sites away from their families (Ghana GRASST assessment report, forthcoming).

In India, equal numbers of male and female plant doctors were trained. In Jammu & Kashmir, out of the 11 women trained, only three are now working as plant doctors, while in Tamil Nadu there are 10 active female plant doctors out of a total of 30 plant doctors. The higher drop out of female plant doctors is due to lack of incentives or poor attractiveness of the job of an

agriculture extension agent, according to staff of CABI's implementing partner in India. However, most of the women plant doctors that left are those hired by government partners, while those hired by civil society partners have continued to work. It would be useful to understand if different approaches employed by the partners have contributed to the different results observed.

A consequence of the low number of women plant doctors is lower attendance of women farmers at plant clinics. In Bolivia, a 2015 study showed there is a significant increase in participation of women in plant clinics, when the plant doctors are women. Women plant doctors were seen as role models by women farmers (Gomez Vargas, 2015). In Ghana, the norms of the traditional Muslim communities prohibit women farmers from meeting and receiving advice from men outside their family. In these communities, the lower number of women plant doctors restricts women farmers' access to extension advice.

Attendance at plant clinics

Social and gender norms restrict women's mobility, dictate gender roles in agriculture, determine what sources of information women can access and which meetings they can attend. Social and gender norms also influence the way extension workers perceive male and female farmers and interact with them. For example, in central Uganda, gender roles and social norms dictate that linking with extension agents is men's responsibility, despite the fact that women do most of the farm work.

The channel of communication used to advertise clinic services affects the programme's ability to reach men and women farmers. A gender assessment done by CABI in 2015 in Uganda, found that women accessed informal sources of information, such as other farmers or women's groups, while men accessed more formal sources of information, such as communication by agricultural extension workers and plant doctors (Miuro et al, 2015). In the early period of the programme in Ghana, information about plant clinics was communicated through extension workers and local leaders in agricultural meetings, which were mostly attended by men. These channels did not reach women and, as a result, women used to associate services provided by plant clinics as services meant for men (Surrige and Begum, 2015).

Another major challenge shared by many of the implementing countries is the burden of unpaid care work. Women's unpaid care work responsibility, coupled with lack of redistribution in the household, and limited access to technologies and infrastructures that can reduce the time and labour required to do care work, reduces the time women can have for attending plant clinics, agricultural meetings and trainings.

In Ghana, lack of time was a barrier for women's attendance at plant clinics and plant health meetings, especially for single female heads of households, while in Uganda, women particularly those with young children, faced the same time constraints. This time constraint was exacerbated by the distance of clinics from communities, especially for those living in remote areas, where local transportation is not available. Although it differs from one region to another, women usually preferred plant clinic sites to be closer to them, such as local trading areas, while men preferred clinics to be located in bigger markets, places that they usually access (Miuro et al, 2015). In terms of time, Ghanaian women generally preferred clinics to be held in late afternoons (after 2 pm), after they finish their care work activities and farm work, while men preferred earlier hours (Surrige and Begum, 2015).

In India, women's mobility is also restricted and they have limited information and access to agriculture input suppliers, as a result of various factors, such as unpaid care work responsibilities in the house that takes up their time and limits their opportunity to develop networks. Socio-cultural norms also restrict women's mobility. For example, women's limited access to transportation, such as ownership of their own bicycles or motorbikes contributes to limiting their mobility.

Application of advice

Lack of control of productive resources, such as land and cash crops, limits women's ability to access finance to buy inputs and apply recommendations from plant doctors. In India, a complex array of interlinked factors act as barriers for women to apply the advice received from plant clinics. Women have limited access and control of productive resources, including land. They are financially dependent on their spouses and have limited decision-making power in the household. Lack of ownership of productive resources combined with socio-cultural norms limit women's access to credit to buy agricultural inputs. For example, agro-dealers could have credit arrangements with male heads of households and trust men more to provide loans. As a result, women often depend on male relatives to buy agriculture inputs they need.

Affordability is a challenge for both men and women farmers to buy improved variety of seeds or pesticides recommended by plant doctors. For women in Uganda and Ghana, this is especially a constraint because of their limited decision-making power in the household and their agricultural roles are more geared towards production and control of subsistence crops. Households and men usually prioritize cash crops, and subsistence crops are not considered worthy of the investment required (Miuro et al, 2015). Women generally have to rely on their husbands to provide cash to buy inputs.

Agricultural gender division of roles restricts women's ability to apply advice received from plant doctors. The gender division of roles generally means that application of chemical solutions is carried out by men, while women are responsible for implementing cultural solutions. Women therefore, hire labour or depend on male family members. This limits women's opportunity to develop skills in new areas in agriculture production. Some labour intensive recommendations provided by plant doctors are also challenging for time constrained women to implement.

Low literacy levels were another challenge for women farmers, as it was a challenge to read and understand the written prescription provided by plant doctors, and apply the recommendations accordingly. For instance, only 62% of rural women were literate in Uganda, in 2015. Limited literary also prevents women from verifying that the inputs supplied by agro-dealers are in line with recommendations of plant doctors, often sent through SMS messages, in particular in India.

Innovative solutions

Different countries have developed innovative solutions to address the identified gender related barriers. Strategies have mostly tried to meet the practical needs of women and other excluded groups, in order to achieve the programme objectives, without challenging social norms and institutional practices, which are the underlying causes of inequality.

Women only plant clinics

In places where mixing of men and women in public is a problem, such as Afghanistan or parts of Ghana, women only plant clinics were introduced to work around the restrictive social norms. In Afghanistan, the programme established five women only mobile clinics and is supported by a USAID horticulture project that provides agricultural inputs, such as improved seeds and pesticides to women. In Ghana, the programme worked with Women in Agriculture Development Directorate under the Ministry of Food and Agriculture to set up dedicated clinics for women at times that were convenient to them, and women plant doctors were trained to work in these clinics. Flexible arrangements were adopted as some clinics provided advice to men one week and women, the next week. In India, separate plant clinic sessions for women farmers, which focused on the type of crops produced by women, were held. The women only plant clinics in Afghanistan helped to increase participation of women in plant clinics from 1% at the beginning of the programme in 2012 to 5% in 2019. In India women's participation rose from 17% in 2012 to 20% in 2019, although this can also be attributed to a number of other innovative methods adopted by the programme there. In Ghana women's participation stayed at the same level, with 31% recorded in 2012 and 30% recorded in 2019.

Timing and positioning of plant clinics

Women's time constraints due to unpaid care work, was dealt with by introducing flexible arrangements for plant clinics, selecting a time that was most suitable for men and women, setting up mobile clinics and going closer to communities. In Bolivia for instance, timings were arranged to avoid conflict with other agricultural activities, including irrigation schedules. The time preference differed from morning in some places, to afternoons in others, with women farmers generally preferring the afternoons. In India and Uganda the timing and locations of plant clinics was decided in consultation with both women and men farmers and local communities. In some districts of Ghana, the community preferred to have plant clinics in the village on a day when farmers were not working. In Uganda and Ghana, mobile plant clinics were set up to move closer to communities and reduce the distance they had to travel to access the plant clinics. In addition in Uganda, plant clinic sessions were held during women's groups meetings, such as, saving and loan group meetings. The number of plant doctors trained at the district level increased.

Communication methods

When mainstream agriculture communication systems were not able to target or reach women, reaching women farmers through women's groups (Uganda), mosques and churches (Ghana, Uganda), mass media (e.g. radio in Ghana, Uganda) and peer communication through community plant health promoters and community change agents (Uganda) was introduced. In Bolivia, women lead farmers were identified and trained to work with the programme acting as community promoters, passing plant health information to other women farmers and linking them with plant doctors. Communication about the services of plant clinics and plant health information was disseminated using videos that show women participating in plant health programme activities. In addition, advertisements were made through public radios with messages tailored to reach women farmers. In places where women have limited exposure to public meetings, different participatory techniques are used to engage them. Local language, including local accents, are used for communication.

In India, various farmers' groups, such as producers' organizations, farmers gatherings in national rural employment guarantee schemes work places, women's self-help group meetings were targeted in communication messages about plant clinics. Village knowledge centres set up to work on different programmes were used to communicate information about the programme to farmers. Various digital and print communication messages were developed including: voice SMS, short video screenings of women farmers participating in Plantwise activities or giving testimonies and brochures and leaflets. Plantwise messages were also put up in advertisement spaces, such as, sign boards, notice boards and bus stops. Farmer peer communication was used as a further method, by training women lead farmers to reach out to other women. The lead farmers served as an intermediary cadre at the village level, as plant health monitors who are trained on identification of pests and diseases and to interact with farmers. Experience sharing sessions among women farmers were also organized, creating opportunities for successful women farmers to share their stories. During outbreaks of pest epidemics, campaigns were organized. During the campaigns, women farmers who frequently visit plant clinics were assigned the job of dissemination of information to mobilize the collective action required to address pests. The campaigns were also linked with farmers producers' organizations, self-help groups and federations.

Gender awareness of Plant doctors

The gender sensitivity of plant doctors played a role in strengthening their ability to reach women farmers. Some extension agents in Uganda made a point of discussing issues with both women and men during their farm visits, conveying that women are farm managers, responsible for application of the advice provided by extension agents, despite the limited decision-making role given to them. In plant clinics, some plant doctors included in their recommendation, advice for women farmers as to how to incrementally implement their recommendations, if the task appeared to be daunting or labour and time consuming (Miiró et al, 2015). In India, plant doctors are guided to ask male farmers who come to the plant clinics to bring their wives, as they are involved in the field operation and their participation is crucial. The programme also tried to ensure a gender balance in selection and training of plant doctors.

Affordability

To overcome challenges related to lack of finance to apply advice received from plant doctors, some implementing partners in Uganda organized women in saving and loan groups, enabling them to access loans to buy technologies and inputs and conduct farming as a business. In Ghana, plant doctors tried to link women farmers with other projects that provide loan assistance for the purchase of agricultural inputs.

All these measures taken helped, overall, to increase the attendance of farmers in plant clinics. Women farmers reported improved skill and knowledge in pest management. In Uganda, women active in farmers' cooperatives, who assumed leadership positions and were seen as role models in the community were used to promote and influence other women to participate in Plantwise programme activities. Meanwhile in Bolivia, the programme worked with technical institutes in universities to recruit students to participate in implementation of the campaigns.

Among the recruited youth were young women studying in agriculture programmes of the colleges to become extension workers.

The way forward

The innovative solutions adopted by Plantwise programme countries have aimed to improve women's participation and benefit from the plant clinics. Most of the strategies did not try to challenge structural factors contributing to gender inequality in access to agriculture advisory services. However, a few of the strategies introduced have tendencies to be gender transformative and try to address underlying social norms and institutional practices that perpetuate inequality. There were attempts to shift social norms around gender roles in agriculture, showing messages and testimonies where women farmers use plant health services and share their experience, which tried to shift the norm that 'seeking extension advice is a man's role'. Another strategy that has a potential to be transformative is training agriculture extension agents to become more gender sensitive, although this was not integrated into the training modules of plant doctors. This strategy could contribute to changing organizational practice of public institutions providing extension service and can have a wide reaching impact.

Reviewing the programme's performance in mainstreaming gender, especially in the five selected countries, the following key lessons emerge, which can be taken forward in future work.

- It is useful to do a **gender analysis** in programme implementation sites to inform the design of programme activities through an understanding of the gender relationships on the ground. For example, such an analysis, could have helped the programme to design equal number of separate plant clinics for women and men farmers in countries and regions, such as Afghanistan, where religion and social norms don't allow men and women to mix to access public services. This is important, especially if women are significantly involved in crop production activities, such as in Afghanistan where they make up over 50% of the agriculture labour force. A social inclusion analysis can also be added to look at a range of farmers who can be excluded from plant health services due to different social exclusion factors and design ways to reach them.
- The practice of training a cadre of men and **women community plant health promoters**, who live within the community and support plant doctors is a good practice to support agriculture extension workers, and is a tried and tested approach in extension systems in other sectors. This is especially useful in contexts where there aren't enough women extension workers or plant doctors working in the community due to various reasons, and in contexts where women farmers are not keen or active in seeking extension advice. Women plant health promoters can easily reach out to other women farmers and serve as a bridge between them and the plant doctors. This is implemented in India and can be replicated in other programme countries.
- **Involving men and women students in colleges** in plant health campaigns, as seen in Bolivia, can encourage young men and women to become agriculture extension agents. It can be particularly effective in getting women involved, through opportunities as interns, in a sector where there aren't enough women represented.
- It is useful to **assess which communication channels** are most accessed by men and women farmers, before starting communication campaigns and all communication

efforts that aim to publicize plant clinic services. Programme countries have tried to apply different strategies, after initial failures in some places. It is also important to use the communication messages to counter social norms that act as a barrier for women's access and use of plant health services. For example, communication messages can show that traditional gender division of roles in agriculture can change and women farmers can and should access extension advice.

- **Consultation of men and women community members about plant clinics sites and time** should be a standard practice. Leaving it to plant doctors to decide on siting of plant clinics with the assumption that they know the community, might lead to oversight of women's needs, as most agricultural extension workers have an image of a man as the primary farmer in need of extension advice.
- Agriculture extension agents' gender awareness can go a long way in facilitating access to extension services for women farmers, as seen in some of the programme countries. **Basic gender awareness training** would help agricultural advisors to become more sensitive to the needs of men and women farmers and the barriers they encounter, in order to provide a better service.
- Beyond access to extension advice, several factors affect women's ability to access and use different agricultural inputs and technologies. It would be useful if **plant health stakeholder meetings include discussions on gender and social inclusion**. For example, the discussion can include challenges faced by women farmers and other excluded groups of farmers to access agriculture supplies and come up with recommendations to address the major hurdles.
- **Social and gender norms** are a huge challenge in enabling women to access extension services. A lot could be learned from a study on specific social norms that affect women's access and use of extension advice, assessing how social norms are maintained and identifying gate keepers of the social norms. Based on the study, a behavioural change communication strategy could be developed and implemented along with plant health information communication.

The set of recommendations below, are more inward looking, focusing on how CABI can improve its capacity to deliver more gender sensitive and transformative projects through developing staff skills, facilitating internal learning and working in partnership.

- **Raising gender consciousness and building skills of CABI and partner's staff** on gender dynamics, gender analysis, gender mainstreaming, developing gender sensitive indicators through trainings can help to improve gender mainstreaming in this and any other programme/project.
- **Collaborating with agencies that have expertise and experience in gender mainstreaming** including government and partners will be helpful for the programme in mainstreaming gender. This has been tried to some extent in few of the countries.
- Standard **reporting templates** that require countries to report against specific gender indicators, or that have guiding questions on gender will help to improve monitoring and reporting on gender. The guiding questions can help to capture more qualitative information on gender related gaps, solutions implemented and changes observed in the programme.
- There are a number of good practices in mainstreaming gender tried in the different countries. It would be useful if some of those **best practices are documented and**

shared and partners are invited to present their best practices in national stakeholder meetings and cross-country learning events organized by CABI.

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Other documents reviewed

Plantwise programme strategy 2015-2020

Plantwise logframe 2017 revision

Plantwise programme gender mainstreaming strategy

Plantwise annual country reports for the five countries

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