UNITED REPUBLIC OF TANZANIA

Ministry of Health, Community Development, Gender, Elderly and Children

National Guideline for Gender and Respectful Care Mainstreaming and Integration Across RMNCAH services in Tanzania

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This publication has been produced by the Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC)— Reproductive and Child Health Section (RCHS), with the generous support of the American people through the United States Agency for International Development (USAID), under Jhpiego's USAID Boresha Afya project. The contents are the responsibility of the MoHCDGEC and do not necessarily reflect the views of USAID or the United States Government.

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Foreword

Gender responsiveness and respectful care are two closely interrelated concepts that strive in contributing to improving quality of care of reproductive, maternal, newborn, child and adolescent health (RMNCAH). While most of other interventions for quality improvement are targeted at improving infrastructures, hardware (equipment and supplies) and software (service delivery packages) for service delivery. Gender and respectful care strive to make the process of service delivery be client centered. This is the way that the World Health Organization (WHO) has always urged countries to ensure that health policy, programmes, services and delivery models are responsive to the needs of the health system clients (women, men, girls and boys) in all their diversity (WHO, 2017). It is in-line with the essence that our two ministries (Ministry of Health, Community Development, Gender, Elderly and Children - MoHCDGEC and the President Office, regional Administration and Local Government - PORALG) derived the rationale and need to ensure gender and respectful care are mainstreamed and integrated in RMNCAH service delivery packages.

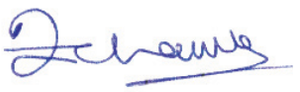
The goal of these guidelines for gender and respectful care mainstreaming and integration into the National RMNCAH interventions is to accelerate access to and utilization of high-quality, comprehensive and integrated health services that are client centered. The core intent is to ensure that, mothers' and children's lives are saved through services that are respectful and gender responsive. The main focus is on improving RMNCAH outcomes, by reducing barriers related to gender inequity and inequalities at all levels of the health system; from household to community, to health facility, and across governing bodies. Furthermore, the main emphasis is to improve availability of quality, respectful, client-centered and gender-sensitive integrated services for children, adolescents and adults of reproductive age regardless of their social-economic status.

These guidelines were developed while cognizant of existence of a number of gender related bottlenecks to achieve the above of which the Government and all RMNCAH stakeholders desire to see happening in our country. This is one reason why the development of these guidelines was very important and timely. Unlike most of standard guidelines, these guidelines include beyond the standards and procedures for realizing gender and respectful care mainstreaming and integration, proposals for interventions and key activities as well as the tracking mechanisms for those interventions and activities. This is because; the two aspects of gender responsiveness and respectful care are somehow new in our ways of delivering health services and may need a closer guidance on their implementation than as the case for many other guidelines.

This document is intended for use by decision makers at all levels (including ministry, departments, regions and district councils), health service providers across all levels of the service delivery, development partners and all stakeholders who supports implementation of RMNCAH related activities. Among the targeted stakeholders include professional associations and bodies, academicians, training institutes, researchers, private sector that supports RMNCAH services as well as community leaders, religious leaders, influential people and the community at large.

The National Guidelines for Mainstreaming and Integration of Gender and Respectful Care in RMNCAH services should be used in conjunction with other available guidelines including the Respectful and Compassionate Care guidelines. It is not intended to replace any of the various existing RMNCAH guidelines but be used together to achieve gender responsive and client centered services when rendering RMNCAH services to clients.

I urge all those involved in managing and providing RMNCAH services to ensure that they adapt the culture of gender responsiveness and client centered respectful care as guided by these guidelines so that we ensure provision of quality RMNCAH services to all Tanzanians and ultimately achieve more client satisfaction, more facility based delivery and accelerated reduction of maternal and neonatal morbidity and mortality.



Dr Zainab A.S. Chaula
Permanent Secretary

Acknowledgement

The Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC) would like to express sincere gratitude to the many individuals who worked with the Ministry to develop these guidelines for mainstreaming and integrating gender and respectful care in RMNCAH services. The gratitude are specifically extended to our colleagues, the President's Office, Regional Administration and Local Government (PO-RALG) for their active engagement and participation through the process of developing these guidelines. In particular, we express our gratitude to the members of the Gender Technical Working Group and the Respectful Maternity Care (RMC) Steering Committee for their technical guidance on the two subjects.

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Special thanks for collaboration and technical input is extended to all partners who in one way or the other contributed technically during workshops or online in reviewing and framing the content of these guidelines. Inclusive under this category are our development and implementation partners namely WHO - Tanzania country office, CDC, UNFPA, UNICEF, URC, MDH, White Ribbon Alliance, EngenderHealth, Ifakara Health Institute, PATH, Marie Stopes Tanzania and Plan International Tanzania. Similarly we acknowledge the professional inputs from the Association of Gynaecologists and Obstetricians of Tanzania (AGOTA), Tanzania Midwives Association (TAMA) and Tanzania Nursing and Midwifery Council (TNMC).

The Ministry recognizes and acknowledges the participation of many individuals from its various departments and from PORALG including representatives from health facilities from Singida, Kagera and Dodoma. These individuals have been fundamental in providing policy guidance and technical inputs to the guidelines and exercise leadership of the whole process. While many were involved either directly or indirectly; the Ministry would like to acknowledge Dr. Leonard Subi - Director of Preventive Services, Dr Ahamad Makuwani –Acting Assistant Director of the RCHS section, Dr Grace Mallya, the former Coordinator of gender program, Mr. Gerald Kihwele and Ms Notgera Ngaponda from the Gender, Adolescent, Sexual and Reproductive Health unit of the RCHS sections well as Ms. Rennie Gondwe, Salome Mwenjuma, Edwin Damas, Dr.M.D Kajoka,Grace Denis from MoHCDGEC as well as Mr Shaban Muhali from PORALG. We acknowledge them collectively for providing technical oversight and leading the coordination of all stakeholders engaged in the process of developing this document.

Prof.Muhammad Bakari Kambi
Chief Medical Officer

Executive Summary

In the health sector and especially in the reproductive and maternal health gender and respectful care are twin concepts. If these issues are not well addressed can lead into undesirable power dynamics, inequality and inequity of access to health services and ultimately poor quality of reproductive and maternal health services. The World Health Organization defines gender as the socially constructed characteristics of women and men – such as norms, roles and relationships of and between groups of women, men, girls and boys in all their diversity - the relationship which if imbalance they tend to lead to unfair interactions during provision and receiving health care services. On the other hand respectful care concerns efforts to prevent morbidity or mortality and elimination of all manifestations of disrespect and abuse to ensure respect for women's basic human rights, including respect for women's autonomy, dignity, feelings, choices, and preferences.

In efforts to improve quality of reproductive maternal, newborn, child and adolescent health (RMNCAH) services in Tanzania, the Government is committed to integrate and mainstream gender and respectful care all through within the policy framework and in service delivery. The MOHCDGEC through the Reproductive and Child Health (RCH) section is responsible for overseeing implementation of these efforts. A situation analysis conducted as part of the process of developing these guidelines showed that there are gaps related to gender and respectful care on leadership and governance, human resource (HR) for provision of RMNCAH services, service delivery, HMIS for RMNCAH and gender responsive and respectful care in the community.

After a decade of generating evidence on gender disparities and inadequate respectful care women receive when accessing maternal health services, the MOHCDGEC is now determined to tackle these issues. With this understanding, the best option to improve health care worker's attitude toward clients (and vice versa) is addressing both gender inequality and social norms together with mistreatment behaviors under broader term of Respectful Care (RC) as related and overlapping concepts.

The goal of gender and respectful care mainstreaming into the National RMNCAH guidelines is therefore to accelerate access to and utilization of high-quality, comprehensive and integrated health services. The core intent is to ensure that service delivery is client centered with a high focus on preserving woman dignity while ensuring that gender equitable institutions are in place in order to save women's lives. The focus is on RMNCAH outcomes, by reducing barriers related to gender inequity and inequalities at all levels of the health system; from household to community, to health facility, and governing bodies. Through these guidelines, health systems should strive towards improving availability of quality, respectful, client-centered and gender-sensitive integrated services for children, adolescents and adults of reproductive age regardless their social-economic status.

These guidelines have been prepared to respond to the needs of the Government strategies as well as of development and implementing partners supporting the Government efforts. It is therefore useful to decision makers at all levels of the health system, health service providers across all levels of care, partners and stakeholders who supports implementation on RMNCAH interventions including professional associations and bodies, academicians, training institutes, researchers, private sector and various categories of community leaders.

In these guidelines, guidance on how best mainstreaming and integration of gender and respectful care have been provided. Key areas of focus include creating enabling environment for gender and respectful care mainstreaming in policy and guidelines, integration of gender and respectful care

in routine service delivery practices across all levels of care, including promoting adherence to the principles of gender responsive client centered care and ensuring and monitor for compliance to updated standards of care. In addition, integration of gender and respectful care in community intervention packages and make it routine at community level has been given a very high importance.

Several specific interventions have been recommended throughout the guidelines, some of which are evidence based with reliable positive outcomes. It is expected that implementation of these guidelines will enable key stakeholders including ministries, regions, districts, health service providers, private sector and partners who support implementation of RMNCAH interventions to address gender responsiveness and respectful care interventions in-line with Health Sector Strategic Plan and RMNCAH intervention packages in a manner that will bring an effect to improved quality of RMNCAH services.

Abbreviations

Abbreviation	Long form description
AIDS	Acquired Immune Deficiency Syndrome
D&A	Disrespect and Abuse
DHIS-2	District Health Information System -2
FGM	Female Genital Mutilation
GBV	Gender Based Violence
GSR	General Service Readiness (Index)
HFs	Healthcare facilities
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HSSP	Health Sector Strategic Plan
MBM – RTz	More and Better Midwives for Rural Tanzania
ME	Male Engagement
MIS	Malaria Indicator Survey
MoHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children
MOHSW	Ministry of Health and Social Welfare
NBS	National Bureau of Statistics
NM	Nursing and Midwifery
PMTCT	Prevention of Mother to Child Transmission (of HIV)
PORALG	President Office, Regional Administration and Local Governments
QoC	Quality of Care
RC	Respectful Care
RCC	Respectful and Compassionate Care
RCH	Reproductive and Child Health
RMC	Respectful Maternity Care
RMNCAH	Reproductive Maternal, Newborn, Child, and Adolescent health
SDG	Sustainable Development Goals
SOPs	Standard Operating Procedures
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health Rights
STIs	Sexual Transmission Infections
TDHS	Tanzania Demographic Health Surveillance
TOR	Terms of Reference
TWG	Technical Working Group
UNDESA	United Nations Department of Economic and Social Affairs
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Emergency fund

USAID	United States Aids and International Development
VAC	Violence Against Children
WHO	World Health Organization
WRA	White Ribbons Alliance
YFS	Youth Friendly Services

Glossary of Terms

S#	Term	Description of meaning as used in this document
1.	Adolescent Sexual and Reproductive Standards	These are standards of care for Comprehensive Adolescent Sexual and Reproductive Health Care that need to be abided with when providing sexual and reproductive health care to adolescents. They provide a measure of quality of care provided to adolescents (MOHSW, 2011; WHO, 2012)
2.	Adolescents	Individuals in a period of life with spanning age between10 to 19 years (MOHSW, 2011; WHO, 2012; UNDESA, 2015)
3.	Birth Companionship	Companion of choice at birth is defined as the continuous presence of a support person during labour and birth. The intervention has been recommended by the World Health Organization (WHO) to improve labour outcomes and women's satisfaction with care. It has also been identified as a key element in the WHO vision of quality of care for pregnant women and newborns. Different names have been given to the intervention including continuous support during childbirth, companion of choice at birth, labour companion and emotional support during birth (Khasholian and Portela, 2017).
4.	Community	In these guidelines, community refers to as a group of people with diverse characteristics who are linked by social ties, share common perspectives, and engage in joint action in geographical locations or settings (MacQueen et al., 2001). While such groups can be of different types the definition in this context is limited to only people in a defined geographical setting who are identified as users and beneficiaries of health and social services as provided by the state and its partners.
5.	Continuum of care in RMNCAH services	The "Continuum of Care" for reproductive, maternal, newborn, child and adolescent health (RMNCAH) includes integrated service delivery for mothers and children from pre-pregnancy to delivery, the immediate postnatal period, childhood and adolescence. Such care is provided to families and communities, through outpatient services, clinics, outreach services and other health facilities (WHO and PMNCH, 2011).
6.	Disrespect and Abuse (D&A) or Mistreatment	Disrespect and abuse in childbirth relates interactions or facility conditions that local consensus agree to be humiliating or undignified, and those interactions or conditions that are experienced as or intended to be humiliating or undignified. Forms of D&A can be physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination based on patient attributes, abandonment of care and detention in facilities (Freedman et al, 2014). WHO builds on D&A typology to Mistreatment (Boren et al, 2015)
7.	Equality	Is a systemic approach and effort that aims to ensure that everyone gets the same services/care in order to enjoy full, healthy lives. It intends to promote fairness and justice among the various sub-populations and individuals in a particular society. (Kawachiet al., 2002; Braveman and Gruskin, 2003; EQUINET, 2006)
8.	Equity in health	Health equity is the absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically or by other means of stratification (WHO, 2017). It entails providing priority to those with greatest needs and those with least ability to pay for health services while avoiding unnecessary avoidable and unfair differences in health services and in access to health care. It flags absence of systematic disparities in health (or in the major social determinants of health) between groups with different levels of underlying social advantage/disadvantage—that is, wealth, power, social class, etc. (Kawachiet al., 2002; Braveman and Gruskin, 2003; EQUINET, 2006)

S#	Term	Description of meaning as used in this document
9.	Gender	Refers to the socially constructed characteristics of women and men – such as norms, roles and relationships of and between groups of women, men, girls and boys in all their diversity. It varies from society to society and can be changed. The concept of gender includes five important elements: relational, hierarchical, historical, contextual and institutional. While most people are born either male or female, they are taught appropriate norms and behaviours – including how they should interact with others of the same or opposite sex within households, communities and work places. Gender requires us to ensure that health policy, programmes, services and delivery models are responsive to the needs of women, men, girls and boys in all their diversity (WHO, 2017).
10.	Gender analysis	Gender analysis refers to the variety of methods used to understand the relationships between men and women, their access to resources, to health and other social services and their activities; and the constraints they face relative to each other. It examines the differences in women's and men's lives, including those which lead to social and economic inequity for women as well as analyzing the underlying causes of these inequities and applies this understanding to policy development and service delivery with the aim of achieving positive change for women and men (WHO, 2015; Plan International, 2017).
11.	Gender Based Violence (GBV)	Is a collective term for any act, omission or conduct that is perpetuated against a person's will and that is based on socially ascribed differences (gender) between males and females. In this context, GBV includes but is not limited to sexual violence, physical violence and harmful traditional practices and economic and social violence. The term refers to violence that targets individuals or groups on the basis of their being female or male. In this report, GBV integration has been considered as part and parcel for every reference to gender integration. GBV is used as an umbrella term that encompasses different types of violence against women, including mistreatment during childbirth, FGM, and child marriage (MoHCDGEC, 2011)
12.	Gender equality	Is the state in which access to rights or opportunities is unaffected by gender. Gender equality is achieved when women and men enjoy the same rights and opportunities across all sectors of society, including economic participation and decision-making, and when the different behaviors, aspirations and needs of women and men are equally valued and favored (WHO, 2015)
13.	Gender equity	Gender Equity is the process of allocating resources, programs, and decision making fairly to both males and females without any discrimination by observing those with more needs than others while addressing any imbalances in the benefits available to males and females (WHO, 2015).
14.	Gender integration	It refers to strategies applied in program assessment, design, implementation, and evaluation to take gender norms into account and to compensate for gender-based inequalities
15.	Gender mainstreaming	Is the process of incorporating a gender perspective into policies, strategies, programs, project activities, and administrative functions, as well as into the institutional culture of an organization.
16.	Gender sensitivity	Is the act of being sensitive to the ways people think about gender. Is the way decision makers, program implementers and service providers treat male or female clients when serving them while they are aware of the differences. It is an indication of gender awareness, although no remedial action is necessarily developed (WHO, 2017).

S#	Term	Description of meaning as used in this document
17.	Gender transformative	Is the process that involves acts of transforming gender relations to promote equity as a means to reach health outcomes. In its core intent, gender transformative struggles to change stereotypes, beliefs, norms and values that perpetuate gender inequity and inequality (UNFPA, 2017).
18.	Health System in Tanzania	In these guidelines, health system has been used to refer to the way the health sector has been organized in reaching out to the population with packages of health services. The concept is used to recognize the WHO six building blocks of a standard health system (Stewardship, Service delivery, Health workforce, Medical products, Health information and financing). On the other hand, the concept of health system in this report is also linked to the way service delivery has been structured across levels of care namely specialized care, regional referral hospitals, district hospitals, health centers, dispensary and community.
19.	Inequality	Health inequalities can be defined as differences in health status or in the distribution of health determinants between different population groups. For example, differences in mobility between elderly people and younger populations or differences in mortality rates between people from different social classes (WHO, 2017).It is a situation that prevails when equality is missing. Inequality happens when fairness and justice among the various sub-populations and individuals in a particular society are absent when such sub-populations and individuals strive to access services or care to attain their healthy lives (Kawachiet al., 2002; EQUINET, 2006).
20.	Informed Choice	Informed choice is a voluntary, well-considered decision that an individual makes on the basis of options, information, and understanding. In medical care, informed choice is when a person is given options to choose from several diagnostic tests or treatments, knowing the details, benefits, risks and expected outcome of each. The decision-making process should result in a voluntary and informed decision or consent by the individual about whether he or she wishes to obtain health services and, if so, what method or procedure the individual will choose and consent to receive (Engender Health, 2018) .
21.	Integration	Integration refers to a process of breaking down programming and funding components of a particular program that have developed over the years to a more holistic, client-focused health care delivery model. This model focuses on continuum of care and caters to the multiple and diverse health needs of targeted clients. The push behind integration also recognizes that there are deep and inseparable connections between entities of reference, such as gender, respectful care, friendly care and male involvement as are cases of focus in this report.
22.	Male Engagement (ME)	The word "Reproductive Health" implies both men and women. Male involvement refers to a situation and or practice whereby men are recognized and made to realize that they are partners in reproduction and sexuality. Men's reproductive health and their behaviors impact on women's reproductive health and children's well-being and society as well. Comprehensive male involvement includes: 1) male partnership in reproductive health exist and reflected at policy, facility and community levels, 2) encouraging men to become more involved and supportive of women's needs, choices, and rights in sexual and reproductive health; and 3) addressing men's own sexual and reproductive health needs and behavior (WHO, 2012)

S#	Term	Description of meaning as used in this document
23.	Mutual Respect	Dignity and Respect in health and social care is a concept calling for respect to and from both of the interacting sides namely the providers and clients or service users. One of the times at which people are most in danger of losing their dignity and self-respect is when they need health or social care services. These services are provided when people are at their most vulnerable and so respect for dignity is particularly important. However, while in many cases this respect and dignity is expected to be exercised by service providers, the clients have also their part to respect and recognize dignity to service providers (York Link, 2010).
24.	Respectful Care (RC)	This is a concept adapted from RMC. Due to relevance of RMC in promoting quality of care, there has emerged argument that, the focus may not be directed to during childbirth alone but across the continuum of care for RMNCAH. It is argued that client should be provided with respectful care all through; be it during family planning sessions or during postnatal care (MoHCDGEC, 2017).
25.	Respectful Maternity Care (RMC)	It is an expanded phenomenon of the concept of "safe motherhood". While safe motherhood is usually restricted to physical safety, RMC goes a mile further by recognizing that childbearing is also an important rite of passage, with deep personal and cultural significance for a woman and her family. Because motherhood is specific to women, issues of gender equity and gender violence are also at the core of maternity care. Thus, the notion of RMC not only includes the prevention of morbidity or mortality and elimination of all manifestations of disrespect and abuse but also encompasses respect for women's basic human rights, including respect for women's autonomy, dignity, feelings, choices, and preferences, including companionship during maternity care (WRA, 2012).
26.	Sexual and reproductive health and rights (SRHR)	Is the concept of human rights applied to sexuality and reproduction. They entails human rights of women and men concerning their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence (MOHSW, 2011; WHO, 2012).
27.	Youth	Individuals in a period of life with spanning age between15 to 24 years (MOHSW, 2011; WHO, 2012)
28.	Youth Friendly Sexual and Reproductive Health services	A quality framework for improving the provision and use of health services, including sexual and reproductive health services, by adolescents be ensuring that there is a friendly atmosphere when adolescent seek health services including adolescent sexual and reproductive health service (MOHSW, 2011; WHO, 2012)

Chapter one: The need for these guidelines

1.1 Introduction

The Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC) in collaboration with the President's Office, Regional Administration and Local Government (PORALG) are jointly implementing the Tanzanian Health Policy (2007) that is translated into vision, missions, goals, objectives and targets by the Health Sector Strategic Plan IV (HSSP - IV). The motto for HSSP - IV is to reach out to all households with quality health services.

The maternal mortality ratio is not improving fast enough, if at all, and Tanzania did not meet the MDG targets related to maternal mortality (World Bank 2016b). While there was a modest decline of Maternal Mortality Ratio from 578/100,000 in 2004/05 to 454/100,000 in 2010, it increased to 556/100,000 in 2015/16 (MoHCDGEC, 2016; USAID, 2018).This will undermine prospect of achieving health related Sustainable Development goals (SDGs)

As a result, the Government is revitalizing its concerted efforts to translate the health policy and the HSSP IV into practical terms. Among the key priority area for service delivery is the whole integrated package of Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH). The HSSP - IV provides overall guidelines of how the health sector should be implemented and managed while allowing learning of new skills and innovations that emerge from time to time.

Within the MoHCDGEC, the Reproductive and Child Health (RCH) section is responsible for overseeing implementation of the RMNCAH program and plays four key roles; namely:

- develop, disseminate and review policy guidelines and manuals for maternal, child, adolescent and community health services;
- coordinate, monitor and evaluate maternal, child, adolescent and community based health care including Immunization and Vaccination Development program, community based health care and family planning;
- liaise with other Ministries and relevant organizations dealing with RMNCAH
- Review, disseminate and monitor the list of standards, essential equipment and supplies for provision of quality reproductive health care.

From recent reviews conducted locally by different development partners as well as from meetings and discussions by the RMNCAH technical working group (TWG), the gender and respectful care agenda have been brought up and broadly discussed. In interpreting the mandates and roles that the RCHS have, it was important to review the whole program and establish the extent to which these two issues are mainstreamed and or integrated. This is to respond to the HSSP IV which calls for gender mainstreaming and integration in order to ensure that at both policy and practice levels of the health system in Tanzania gender (and respectful care) is well integrated. It is also to respond to the call made in the one Plan II on ensuring that respectful care now receives a substantial attention as an important component of RMNCAH quality of care.

The newly introduced gender specific department/unit within the RCHS section mandated with gender issues added to the urge of reviewing and updating the RMNCAH interventions with a gender responsive lenses. This calls for a realignment of gender related policy documents to provide guidance at the service delivery level of health system. To some extent, the RMNCAH interventions do have gender mainstreamed in most of the existing policy related documents and guidelines: however they

need to be further emphasized and made operational through practices by service providers and implementers as an important step towards attainment of Sustainable Development Goals (SDG).

While gender equity and respectful care mainstreaming and integration in the whole of the health system is important, the mainstreaming and integration of these to interrelated concepts in RMNCAH component is unique and exceptionally important. This is because, most of the RMNCAH interventions addresses the needs of vulnerable groups of the society especially women and adolescents Over several decades, gender has been associated with women emancipation and RMNCAH is the arena where majority of the women and young people are contacted and gender interactions do exist through unequal treatment. However, it should be noted that as the gender debate grows broad perspectives of gender aspects are increasingly becoming recognized, appreciated and integrated in routine service delivery systems. It is now well understood that gender balance encompasses observing rights of not only for women and men but also for other groups that tend to be overlooked in meeting their strategic needs, such as youth (UNFPA, 2017) and other vulnerable population groups.

Alongside the gender issues is the respectful care concept which is part and parcel of the gender topic as it is related to power dynamics between service providers and clients when interacting within the health system. The cultural aspect of undignified health services particularly those related to mistreatment in form of Disrespect and Abuse (D&A) within maternity care domains is increasingly viewed by the global community as gender-based violence in health facilities. While specific determinants of mistreatment to women when accessing maternal related health services are many (including critical shortages of staff, supplies, insufficient work space, quality of supervision and other health system factors), the influence of gender power imbalance between health workers and the client (in this regards -a woman) is thought to be main underlying factor.

With this understanding, the best option to improve health care worker's attitude toward clients (and vice versa) is addressing both gender inequality and social norms together with mistreatment behaviors under broader term of Respectful Care (RC) as related and overlapping concepts. These two concepts cannot be separated. We should always therefore do our best to make a linkage between disrespectful attitudes in reference to rigid gender inequality norms and practices that disregard women's status and rights when providing health care services, especially during birth processes.

1.2 Background

The World Health Organization (WHO) has continued to urge countries to ensure that health policy, programmes, services and delivery models are responsive to the needs of women, men, girls and boys in all their diversity (WHO, 2017). This emphasis on gender and respectful care mainstreaming and integration comes alongside the emphasis by the United Nations (UN) through Sustainable Development Goals (SDGs). Tanzania is an active member of the UN and the WHO and has always been responsive and adaptive of recommendations that help to accelerate implementation of its health sector strategic plan. The situation analysis on gender mainstreaming and integration at policy and service delivery levels (which was conducted as part of the processes of developing these guidelines) revealed similar need for gender and respectful care mainstreaming and integration as recommended by UN and WHO. It is from such background, the need for mainstreaming and integrating gender and respectful care on RMNCAH services emanates.

The goal of gender and respectful care mainstreaming into the National RMNCAH guidelines is to accelerate access to and utilization of high-quality, comprehensive and integrated health services. The core intent is to ensure that service delivery is client centered with a high focus on preserving woman dignity while ensuring that gender equitable institutions are in place (Figure 1) in order to save women's lives. The focus is on RMNCAH outcomes, by reducing barriers related to gender inequity and inequalities at all levels of the health system; from household to community, to health facility, and governing bodies. Through these guidelines, health systems should strive towards ***improving availability of quality, respectful, client-centered and gender-sensitive integrated services for children, adolescents and adults of reproductive age regardless their social-economic status.*** However, a number of gender related bottlenecks to achieve this desire are reported widely in Tanzania. This is one reason why the development of these guidelines is important and timely.

Generally, like in many other countries in Africa, women and adolescent girls in Tanzania are the most affected population segments by gender related challenges and barriers that cut short their dreams of positive health outcomes. Some of these challenges are embedded in our daily practices and norms and they sometimes translate to behaviours that lead to mistreatment and disrespect when women are seeking care across different levels of the health system. These guidelines are developed with the objective of addressing such challenges and barriers. The challenges exist in all levels (Figure 1) of health system but predominantly in:

- **Policy and policy guidelines**- which involves how laws and policies grantee women access to equal Sexual and Reproductive Health (SRH) services
- **Service delivery points/facility** -that concerns how attitude demonstrated by service providers, client- provider interactions, facility infrastructure, friendly youth services affect different population groups. This includes how **gender responsiveness and respectful care** are valued and how male support in birth planning, education of family planning with partners, sexual relationship power, gender equitable attitudes are exercised.
- **Community** - which refers to how social networks, social and gender norms, collective action (accountability, feedback mechanisms, improved facility-community linkages) influences the gender and RC inter-play and especially in accessing RMNCAH services
- **Individua**l - that refers to packaging, dissemination and effect of health information impacts on empowering individuals on gender aspects hence influencing the pattern of education, assets ownership, earnings, attitudes towards violence, mobility, age of marriage, gender equitable attitudes, decision making [Health, mobility, earnings, purchase and self-efficacy.

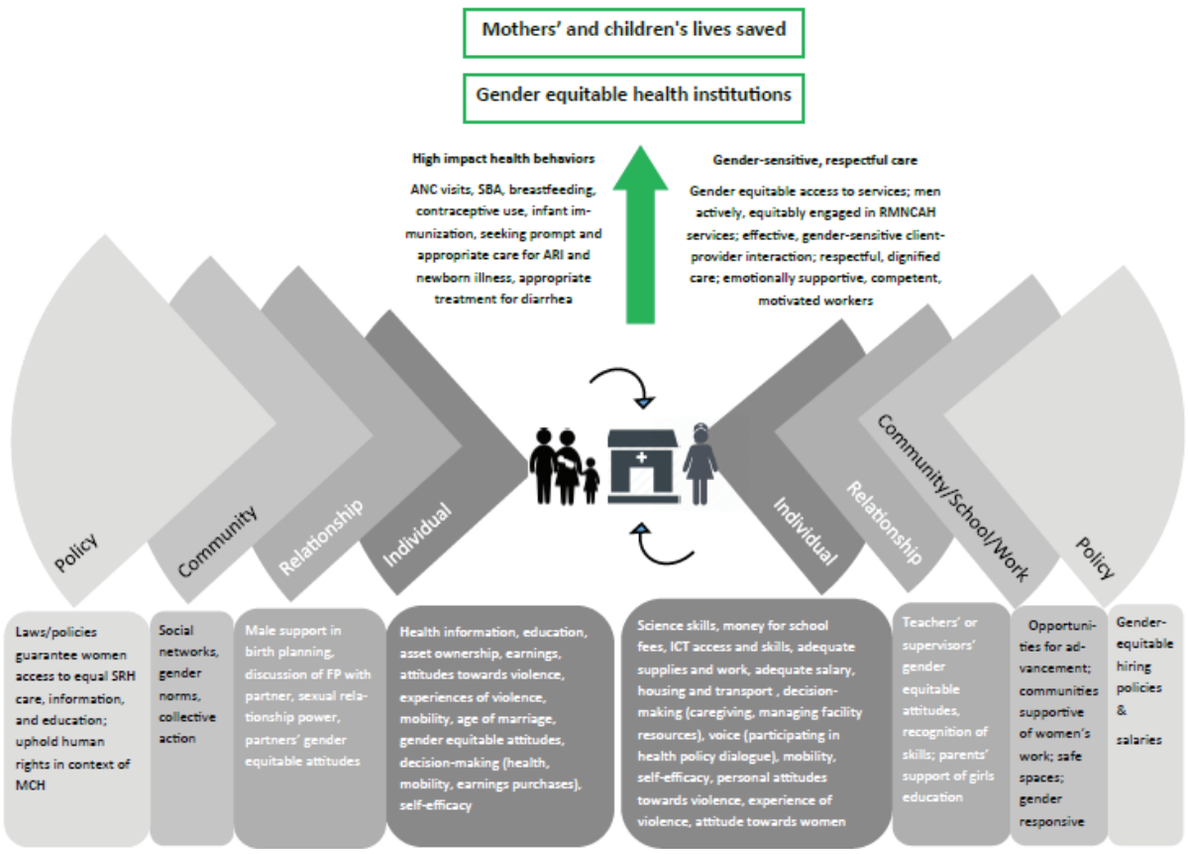

Figure 1: Theory of change for gender, empowerment, and respectful care in reproductive maternal, newborn, child and adolescent health programming: Source: Jhpiego, 2017.

1.2.1 Policy environment in relation to gender and respectful care

A: Policy environment on gender responsiveness

At the policy level, if policies are not responsive of gender issues, the effect of gender imbalances is felt across all levels of the society and may lead to severe health impacts of women and adolescent girls at individual levels. According to the National Bureau of Statistics (2015/16), the total literacy rate is 71.8% - (Males 83.4% and Females 73.3%) of which 6.7% are young, with a gap in educational attainment between males and females. In the general population, 27 percent of females have never attended school; this compares with 18 percent of males. Basic Education Statistics of Tanzania Report 2014 showed Primary school female: male ratio in 2014 was 1:1, however, the female/male ratio observed in primary school enrolment drops off in secondary school to 0.9:1. The Tanzania Commission for Universities Report 2012-13 showed female enrolment in University as 36.02% (TDHS, 2010, TDHS 2015/16). These results are a translation of how gender related policies are implemented in a country.

The Tanzania 2012 Census shows that the Gender ratio is 51.3% in favor of females. Gender Index Score (Human Development Report 2015) ranks Tanzania at 129 amongst 189 countries that have shown efforts to increase positioning women status close to that of men; 36% parliamentarians are women, 10.1% women have secondary education compared to 15.3% for men, 74% female labor force participation compared to 83.3% for men. Again, these findings can be related to gender sensitive policies and their respective implementation.

The policy and legal environment of Tanzania in relation to Sexual and Reproductive Health generally

is supportive to the health and development of adolescents and other segments of the population. The Constitution of the United Republic of Tanzania (1977) provides for the right to life and protection of life; the Sexual Offences Special Provision Act (SOSPA 1998) stipulates that it is an offence for a male person to have sexual intercourse with a girl below 18 years with or without her consent; and the Penal Code (1972) imposes sanction against any person(s) who have cohabitation with girls below 15 years even if married to them (National Adolescent Health and Development Strategy 2011-2015).

However, a number of improvements are still advocated for as they are not a time match and still discriminative. For example, the minimum legal age at marriage for women is 15years and that for men is 18 years.. The Marriage Act of 1971 allows exceptions for girls aged 14 years with parental consent and under "justifiable circumstances". The Customary Declaration Order of 1963 discriminates against a widow from inheriting / benefiting from the estate of her deceased late husband even if such estates were matrimonial assets which were jointly acquired. Men inherit both immoveable and movable properties whereas women only inherit movable property which they have used during their lifetime. Women also cannot sell this movable inheritance unless there are no surviving male members in their family.

The Tanzania Sexual Offences Special Provisions Act, a 1998 amendment to the Penal Code, prohibit Female Genital Mutilation(FGM) from being performed on girls under the age of 18 years, but it does not provide for protection to women ages 18 years or older. Furthermore, national policies and strategies are conducive (in the sense that they exist and supportive) but not widely disseminated and implemented. Service managers and providers continue to ignore the need of providing reproductive health services for adolescents and the process of decision making is hampered by lack of correct data that is disaggregated by age and sex (Abdallah, 2007).

In general national policies have continued to receive great attention to gender sensitivity to address the unequal societal values hence doing away with sluggish improvements in gender mainstreaming and integration. There have been attempts to change the situation for the better from the government and partners, and efforts have been more optimized now than any other time in history. The Government has taken measures to address gender concerns in the Constitution of the United Republic of Tanzania, macro and micro policies, strategies and programmes. The Government amended the 1977 Constitution in 2000 and 2004 among other things, to increase women's participation in the National Parliament and Local Authorities. The Government also formulated the Women and Gender Development Policy (2000[1]) to put more emphasis on the Women in Development Policy (WID) (1992) in line with the Beijing Platform for Action. To ensure effective implementation of the Women and Gender Development Policy, a National Strategy for Gender Development (NSGD) to promote gender equality and equity has been prepared. This strategy covers key areas of gender concerns stipulated in the Women and Gender Development Policy.

In 2011, the Government of Tanzania through the Ministry of Health, Community Development, Gender, elderly and Children developed National Policy Guidelines for Health Sector Prevention and Response to Gender Based Violence (GBV) and Violence against Children (VAC). This was followed by development of GBV and VAC National Management Guidelines for the Health Sector.

B: Policy environment with respectful care

The concept of Respectful maternity care (RMC) which is referred to as respectful care in its broader perspectives in these guidelines, has in the last few decades gained momentum due to its importance

1 This is the only available most recent reference. The policy hasn't been updated since then

generated by a body of evidence (WHO, 2015) It is now widely accepted that RMC is not only a crucial component of quality of care but also a human right need. A body of literature has generated evidence that in the continuum of care for maternal health in general and child birth in particular, women go through a number of unpleasant and unethical experiences that can be categorized in many descriptive categories including physical abuse, sexual abuse, verbal abuse, stigma and discrimination, failure to meet professional standards of care, poor rapport between women and providers and health system conditions and constraints. These negative patient experiences contribute to poor health outcomes and reinforce mistrust of institutional care. Women and families may delay or avoid seeking care in health facilities even at the risk of their own health and that of their newborn. The contrary is also true that elimination of these conditions have a positive effect to both client satisfaction and birth outcomes.

In 2014, WHO released a statement calling for the prevention and elimination of disrespect and abuse during childbirth, stating that "every woman has the right to the highest attainable standard of health, including the right to dignified, respectful care during pregnancy and childbirth. The most recent WHO recommendations on RMC as an essential component of Quality of Care (QoC) has further cemented the need of RMC inclusion in national QoC improvement strategies and in maternity care in particular.

Since 2015 The MoHCDGEC has highlighted the need to "improve access to quality health services" for mothers, newborns, and children. Respectful maternity care (RMC) is considered an essential component of quality maternal and newborn health services ever since. The HSSP IV as well as One Plan-II (2018) have reflected the country's commitment in this endeavor.

In its several meetings of RMNCAH TWG, the scope of RMC was said to be limited only during labor and childbirth. Members of the TWG argued that, respectful care should be on the continuum of care along all RMNCAH interventions and that aligned to WHO quality of care frame work, 2016. As thus, preference to use the term **"Respectful Care"** in broader concept rather than Respectful Maternity Care (RMC) which narrows down towards time of giving birth.

1.2.2 Gender and respectful care mainstreaming and integration at service delivery level

A: Mainstreaming and integration of gender at service delivery level

Gender and age-based discrimination and inequality place a disproportionate burden of productive and reproductive work on women and girls, resulting in little time for health care seeking practices for themselves or their children (MoHCDGEC, 2018; Plan International, 2017). A number of factors are widely reported across the country that perpetuates gender imbalances which compromise the vulnerable groups from accessing health services. These include,

- Gender norms and values which cause service providers to deny adolescents some key SRH services due to misconception aggravated by these norms and values
- Normative gender roles/duties and responsibilities which tend to ascribe some services such as reproductive services being only feminine and exclude male partners
- Limited access to resources and decision making over resources among women and adolescent girls at community level hence denying women opportunity to use available resources for their own health
- Limited access to services as a result of shortcomings in the system including limited number of midwives staff hence denying women quality delivery services.

While appreciating the role of some policies that are in favour of gender and respectful care, we find that, at system level integration of gender in routine service delivery is faced with a number of challenges including

- Insufficient training of service providers on gender issues and especially linking service provision and gender
- Lack of frequent supportive supervision that is gender responsive (i.e. incorporating gender aspects during supervision)
- Unmatched distribution and availability of facility staff according to the requirement in public health facilities with consideration of gender needs (MoHCDGEC, 2018b)
- Limited participation in decision making institutions which denies women and adolescents to be well represented in planning for their own priorities and needs. According to the Tanzanian health system and with regards to health sector reforms, each health facility has a facility governing committee which is representative, with a special consideration of women's participation. Unfortunately, top leadership in these committees are usually held by elder male members of the community; and traditionally opinion from an older committee member tend to receive less criticism even if it does not represent majorities' opinion" (Marie Stopes, 2018).

There is also the issue of violation of human rights associated with provision of healthcare. To this, gender based violence is predominantly reported in Tanzania, both at facility and community levels. Gender based violence may take different forms. In the past decade, gender advocates have also linked Disrespect and Abuse (D&A) to GBV. D&A involves mistreatment and abuse women experience when they are seeking care during labour and delivery. Some forms of the D&A include physical abuse such as being slapped, pinched or even raped. Despite the fact that some of these acts are conducted by female service providers on fellow women, the power dynamics and power imbalance between the women clients and service providers lead to such acts. In Tanzania, studies have shown that up to 20% of women have reported to have been disrespected and abused when they sought assistance during childbirth in public health facilities (Freedman et al, 2018). This rises up to 69% when skilled nurse midwives were used to observe their fellow midwives when assisting women to deliver. Different types of D&A are reported including non-dignified care, non-consented care, scolding, verbal abuse, physical abuse, threatening to withhold care and demand for informal payments (ibid).

B: Mainstreaming and integration of respectful care at service delivery level

The concept of respectful care is very broad. It includes, among other aspects, freedom from harm and ill treatment and the right to achieve the highest attainable level of health care. It entails right to information, informed consent, refusal, respect for choices and preferences including the right to companionship of choice whenever possible. It also urges for confidentiality, privacy, dignity and respect. Respectful care calls for equality, freedom from discrimination, equitable care. It includes highest quality of clinical care including right to timely, competent and correct health care. Finally it promotes liberty, autonomy, self-determination, and freedom from coercion (Vogel et al, 2016; MoHCDGEC, 2017; Dynes et al, 2018).

In Tanzania, like in many other places in the world, an alarmingly high prevalence of women have reported mistreatment which are identified by various typologies (Figure 2) of disrespect and abuse (D&A) with rates between 20% and 70%. It was also established that, D&A are more common in hospitals than in health centres and dispensaries (Bohren et al, 2015 and Freedman et al, 2018). Efforts to understand facilitators of and barriers to respectful care are critical to the design of interventions to promote respectful maternity care (RMC) in particular and respectful care in general in various contexts (WHO, 2012 and Vogel et al, 2016). Some studies have identified several potential patient

related factors associated with inability of RMC environment when seeking care. These include factors such as race or ethnicity and religion, age where unmarried adolescents and older women of high parity being at higher risk. Others include socioeconomic status and medical conditions whereby women with HIV are likely to face multiple forms of discrimination (Dynes et al, 2018).

Most of the above factors have a very close link to gender related issues. Studies from Tanzania and Kenya have identified policy level,(RMC gaps in policies and legislation) health system level,(lack of emphasis and evaluation in pre and in service training, gaps in how to deliver client centered care in local context) health facility level (realistic workload and staffing, lack of support for health care workers, absence of clear and easy to understand standards of care, weak facility quality improvement teams and action plan follow up; as well as inactive client service charter implementation), community level drivers of disrespect and abuse include poor community engagement, lack of a routine feedback mechanism and lack of mutual trust between facility and the community.

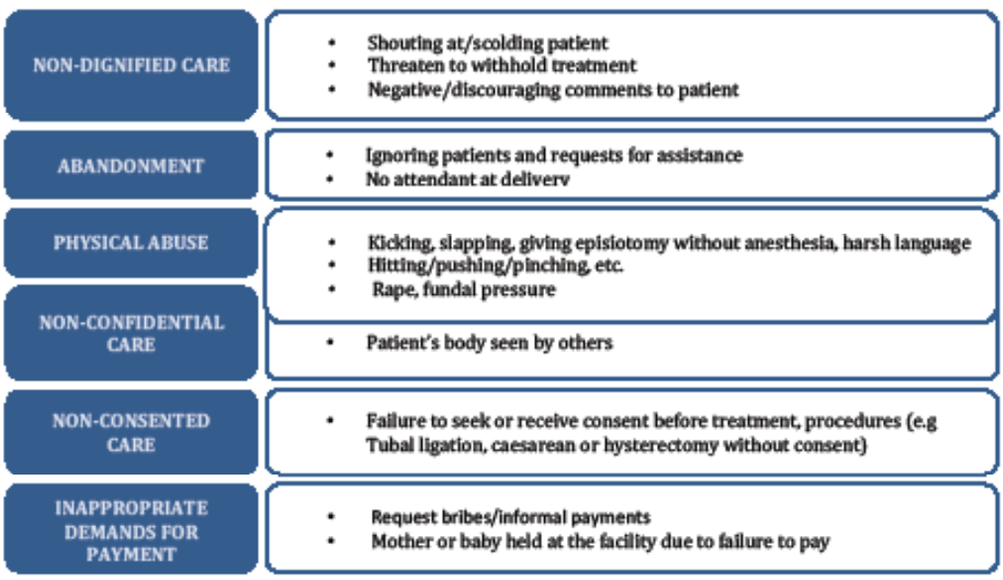

Figure 2: Typologies of D&A.Source: STAHA Project, IHI and AMDD.

On the other hand, other factors that perpetuate lack of respectful care at service delivery level are those from provider perspectives. These include, among others, traditional healthcare provider training which is thought to create "distancing" and separation between providers and patients, potentially generating insensitivity toward women in childbirth. The observation that D&A are more common in hospitals than in lower level facilities may be in support to this distancing factor where societal ties that service providers working in low level facilities (especially in dispensaries) oblige them to act positively as they personally know most of their clients Other factors include system insensitivity and silence which lead to lack of attention to patient-provider dynamics has made the problem grow over time and become normalized or even rationalized (Bohren, 2015). Other provider related factors include poor provider payment, lack of appreciation and encouragement by facility leadership, perceived high workload and burn out, frustration and stress due to weak health systems whereas limited supplies, regular stock outs of medicines, understaffing and facility poor infrastructure (Freedman et al, 2018; Dynes et al, 2018). To this, there is also client provoking service providers as well as poor preparation of clients for childbirth and a discordance between client and provider expectations on cooperation hence contributing to poor provider-client attitude (Freedman et al, 2018).

On the other hand, health system conditions and constraints such as the lack of the resources needed to

provide women with privacy, unfriendly maternity ward infrastructure that hinder mobility of women during labour and delivery (such as areas for exercising), lack of essential equipment, medicines and supplies are also categorized as factors compromising respectful care (Bohren et al., 2015).

Apart from being a global challenge, lack of respectful care at service delivery level as described above is unfortunately predominant in Tanzania across all levels of care. The Government of Tanzania has initiated multiple innovations, interventions and efforts to start addressing this issue. For example, a number of organizations are working with the Government to pilot implementations of birth companionship intervention in a public health setting. In addition to the development of Gender Based Violence (GBV) Management Guidelines in 2011 currently being reviewed), in 2017, the MoHCDGEC -Division of Nursing and Midwifery (N&M)developed the National Respectful and Compassionate Care Guidelines with the overall goal of attaining respectful and compassionate delivery of nursing and midwifery care including HIV and AIDS services. The guidelines were developed to respond to increased public complaints towards nursing and midwifery services, specifically associated with the inadequacy of respect and compassion in providing nursing care. The core objectives of the guidelines were to improve the capacity of nurses and midwives in delivering RCC, to strengthen the relationship nurses/midwives and end users accessing health services and to enhance service utilization and end-user satisfaction. The presence of the RCC guidelines that focus on core values of nurses and midwives will ensure that the promise to deliver high quality care with strong elements of respectful and compassionate care is fulfilled. Along with newly drafted RCC guidelines, advocacy for prioritizing respectful care in the Ministry of Health's strategic planning resulted in action to modification of the most recent "One Plan II" strategy for reducing maternal, newborn and child deaths to highlight the need to respectful care.

A number of partners in Tanzania have as well been contributing to the efforts of addressing gender imbalances and RMC in particular and respectful care as a whole. Through project or program activities, some organizations have demonstrated that, if respectful care or RMC are integrated at service level while being recognized at policy level, changes in practices that lead to less respect bias or discrimination to the vulnerable groups can be promoted. In its efforts in this subject, Jhpiego developed its theory of change for gender strategizing whereas a behavioral model approach was proposed (Figure 2). In this theory of change, Jhpiego proposes behavior change strategy across the different levels of the health system reduce normalized norms and values which tend to impair respectful care and gender sensitivity at an individual level and among the community, service providers, health managers and policy makers.

1.3 Interplay of community with gender and respectful care

With the existence of more than 200 ethnic groups, Tanzania is a country with a mix of culture which has resulted to diverse norms and values. These norms and values shape the different ethnic groups but have contributed to some generalized norms and values that cut across the country. As a result social networks and gender norms are as well adaptive of the norms and values originating from the various specific cultures.

Generally a patriarchal society where men are expected to be heads of households and families is predominant in Tanzania with a few exceptions. Women are expected to be submissive to their husbands, fathers or brothers and boys would be expected to exercise leadership over their sisters even of the same age or older. Being a man is associated with being responsible to care and cater for the household members. Women in most of the rural communities (with an exception of some women in cosmopolitan towns and cities) have always accepted their place to be led by men and

less struggle for change is witnessed (UNICEF, 2011). Patriarchal systems, customs and traditions that discriminate against women continue to perpetuate gender inequalities. For example, per Masai custom, a woman cannot lead men. Traditionally, the role of leadership is vested to the old male members of the community under the coordination of the traditional leader termed as "Laigwanani" (WiLDAF 2015; Marie Stopes, 2018).

As far as maternal and neonatal health as well as SRH are concerned, men and women in most of the rural communities have beliefs and taboos that guide their attitude before, during and after pregnancy as well as their sexual life. There are a number of rituals associated with caring for pregnancy, preparations for delivery, delivery and corresponding practices, caring of the newborn as well as care of the mother. These rituals are more tied to women and less to men and they contribute to how women are treated when interacting with health facilities when seeking maternal health services.

The above described gender norms and values and how the communities have organized themselves require strategic targeting to enable to have well informed and empowered communities. Communities need to be made able to realize that reorganization of the societal set up and relationships can be improved to ensure gender equity and equality. It should be remembered that service providers, health managers and policy makers originate from these complex contexts and carry with them elements in their life influenced by their background. As a result responsiveness to gender and overseeing respectful care become limited or lacking.

On the other hand, while often time mistreatment is seen from service providers to women, researchers have documented service providers being mistreated. The norms and values existing in the community shape men and women when interacting with service providers. Some of the norms and values lead to provocative behaviours that make service providers the victims. During the STAHA project in Tanga, a "mutual respect" motto was designed do advocate to recognizing the rights of both sides (Freedman at el. 2014). When service providers suffers from frustrations due to malfunctioning health system and when are provoked by family members and relatives of the women, the chances for mistreatment tend to increase.

1.4 Interplay of individual factors with gender responsive and respectful care

The collective norms and values have different impacts to individual women, girls and people living with disabilities. For example, while child marriage affects both boys and girls, girls and women suffer disproportionately (USAID, 215). It is unfortunate that in many developing countries reliable statistics on child early and forced marriage are missing. Women in Tanzania marry early, 15 for girls and 18 for boys (Marriage Act of 1971) denying them opportunities for education hence having lower education and employment options. About 15% of women have no education compared to 8% of men. The age at first birth for women is 17 (TDHS, 2015-16). Early marriages that contribute to early pregnancies are life threatening to young girls as their bodies are still developing. The likelihood of a young girl losing her baby or experiencing serious delivery complications such as obstetric fistula is high. Early childbearing not only has a negative impact on the health of young girls, but it prevents girls from accessing higher education. Drop-outs due to teenage pregnancy among secondary school girls have increased in recent years, leaving the girls poorly prepared to take on the responsibilities of childrearing and life, while facing diminished income prospects. Literatures indicate that, girls married below 18 years, experience more violence from their partners and in-laws than those married at an older age (UNFPA, 2012). Similarly young people particularly young women are still more vulnerable to contracting HIV/AIDS than young men and the prevalence rate among women aged 15-29 years

is reported to be almost five times higher than their male counterparts (ibid). When accessioning maternity care, the adolescent girls are reported to experience more D&A compare to older women (Khasholian and Portela, 2017).

Gender-based violence (GBV) remains a serious reality in the lives of many women in Tanzania. About 40% of women aged 15-49 have ever experienced emotional, physical and sexual violence and the trend has not improved since the last 2010 Tanzania Demographic Health Survey (Figure 3). Some of these GBV experiences happen when women and adolescent girls seek health services in public facilities hence translated as disrespect and abusive.

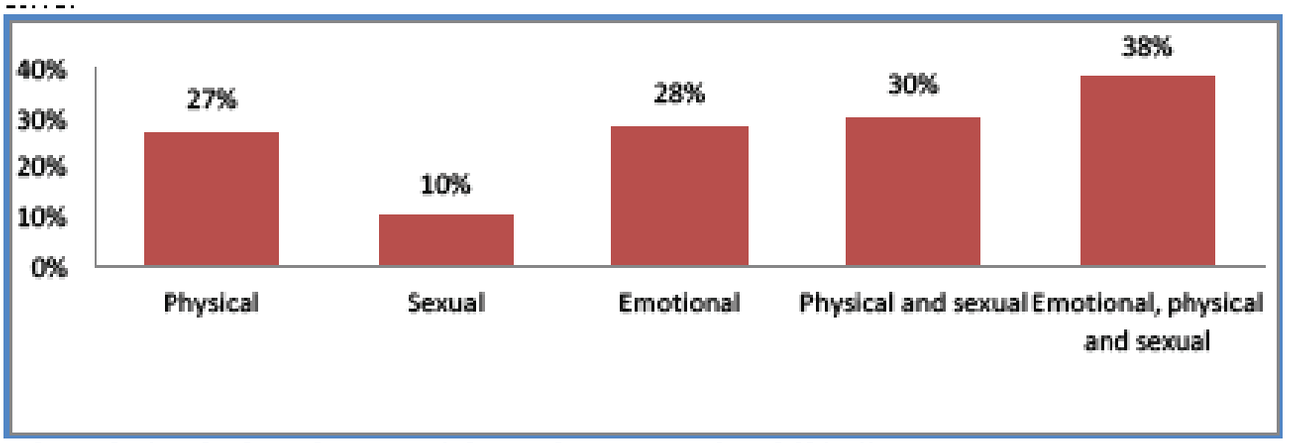

Figure 3: Gender based spouse violence: Source: THDS-MIS (2016).

When health system fails to meet the expectations of its population, women, children, adolescents and people with disabilities are more affected than other segment of the population. Some studies have reported women and adolescents being adversely affected due to stock out of essential commodities and supplies. This group is less protected by the health insurance mechanisms and any stock out implies their inability to afford medicines and other supplies from alternative sources. In a qualitative study conducted by Thomas Wiswa et al., in Tanzania, the authors concluded their key finding by quoting study participants who said that "It's hard to respect women's preferences", "Striving to fulfill women's needs with limited resources", and "Trying to facilitate women's access to services at the face of transport and cost barriers". In the 2012 service availability assessment conducted across the whole of Tanzania, the general service readiness index (GSR) which is a composite measure that combines results from five modules(amenities; equipment; standard precautions for infection prevention; diagnostics; and medicines and commodities), the overall GSR score was 42. Of the five domains, the score was highest for equipment (70) while all other domains score below 50. Readiness for availability of medicines was only at 41% (SARA, 2012). When such conditions prevail women and adolescent girls are the most affected sub-populations (ibid).

1.5 Rationale for development of these guidelines

A situational analysis study was conducted to supplement the already existing body of evidence which further unveiled gaps that exist in policy documents, at service delivery and at community level in promoting gender and respectful care mainstreaming and integration.
These guidelines therefore, intend to fill the following gaps;

1) Unsatisfactory gender and respectful care reflections on leadership and governance.

Gaps include

i. unavailability of sufficient policy guideline that guides gender and respectful care

mainstreaming and integration in health managers routine practices

ii. insufficient evidence on capacity building strategies for health managers at regional, council and facility levels on gender and respectful care

iii. unavailability of reference guidelines for health managers on how best they can integrate gender and RC in their stewardship roles

2) Gaps related to human resource (HR) for provision of RMNCAH services

As far as HR is concerned, key issues that require keen observations and consideration include

i. Insufficient emphasis on mainstreaming of gender, respectful care and youth friendly services in pre-service curriculum

ii. Less attention to gender parity during health personnel allocation and distribution in health facilities where in some cases only male or only female providers are allocated,

iii. Unsatisfactory patient-provider ratio related to workload especially in the RCH and maternity units which in turns influences staff norms, staff activity workloads and roles of the managers and leadership.

iv. Unavailability of practically implementable measures for managing staff emotional well-being in high stress environment and burn out. This includes also insufficient emphasis on provider aspects of health service provision e.g. provider abuse, inadequate compensation, staff motivation, burnout and provider skill shortages

v. Inadequate on the job orientations on gender and respectful care among service providers

vi. Inadequate user friendly easily accessible job aids (similar to guidelines on GBV) for service providers for gender transformative services, as well as routine utilization of job aids as refresher of protocols rather than a poster on the wall.

vii. Unmatched ratio of providers to clients hence heavy workload and burn out for service providers.

3) Gaps related to service delivery

The reviewed literatures identified a number of areas that require improvements. These include

i. Insufficient gender responsive and friendly environment, infrastructure and settings that promote respectful care, youth friendly services and male engagement as a whole

ii. Less mutual trust due to lack of knowledge on roles and responsibilities of healthcare providers and clients

iii. Lack of guidelines, standards and clear expectations for service providers on gender responsive, respectful care and male engagement.

iv. Unavailability of measurement or reporting tool for gender and respectful care. These dimensions are not a component of routine supervisory report

v. Inadequate emphasis on male engagement in some components of RMNCAH (family planning, ANC, immunization, post-natal, L&D) except for Syphilis, HIV testing and PMTCT. This is further intensified by lack of clarity of what male engagement means at a service delivery level

vi. Lack of systematic integration of gender responsive and respectful care interventions in routine service delivery. This includes lack of birth companionship practice across the continuum of care (ANC, L&D and post-natal care)

vii. Insufficient emphasis on ensuring steady availability of essential commodities for

RMNCAH service delivery.

4) Gaps related to gender and respectful care reflections in HMIS for RMNCAH

Gaps included

i. Lack of measurements for respectful care and their integration in the HMIS/DHIS-2

ii. Lack of measurement for male engagement

iii. Lack of measurement of women empowerment on their health

iv. Lack of sufficient community based indicators (beyond quantitative GBV related indicators) that can measure interplay of gender equity and gender equality at community level. Qualitative indicator to monitor behavioral change is almost totally missing in HMIS and DHIS2

v. Insufficient attention of data disaggregation, analysis and use with aspects of gender such as sex and other group specific data.

5) Gaps related to gender responsive and respectful care in the community

i. Unavailability of harmonized and formalized set of interventions for gender responsiveness and respectful care that link community and facilities.

As part of the government's efforts to implement its commitment to reducing gender inequities and inequalities in health, the MoHCDGEC in collaboration with PORALG have embarked onto development of these national guidelines that will ensure both mainstreaming and integration of gender and respectful care issues across the continuum of care of RMNCAH. Specific focus is directed towards making health services gender-responsive, respectful and user friendly to adolescents, people with disability, women and men.

1.6 Vision and Mission

1.6.1 Vision

To have a Tanzanian population[2] that has access to quality, equitable, accessible, affordable, sustainable and gender responsive and respectful RMNCAH services.

1.6.2 Mission

To ensure provision of basic health and social welfare services to the targeted populations through increased attention of gender responsive and respectful care along the RMNCAH continuum of care and that this can be achieved through strengthening a health system that recognizes quality services for all people including those with disability, men, women, adolescents, children and with emphasis on women and adolescent girls.

1.7 Goal and Objectives

1.7.1 Goal

Mainstreaming and integrating gender responsive and respectful care along the RMNCAH continuum of care to promote equitable, accessible, affordable and sustainable quality RMNCAH service delivery.

2 In this context, the population refers to men, women, elders, adolescent girls and boys, and people living with disabilities

1.7.2 Objectives

1. To ensure gender responsive and respectful care are incorporated in relevant RMNCAH policy documents and guidelines.
2. To strengthen national, regional and district capacity to effectively plan, manage, implement, measure/evaluate and coordinate gender responsive and respectful care interventions within RMNCAH services.
3. To provide quality and integrated gender responsive and respectful care in RMNCAH services at health facility and community levels in order to promote dignity and respect for health care service users and health care providers.
4. To promote active community engagement including meaningful engagement of men in addressing gender norms and respectful care at all levels to achieve quality RMNCAH services
5. To ensure availability of essential commodities for RMNCAH interventions addressed as a priority in planning and resource disbursement
6. To strengthen monitoring and evaluations system to include gender responsive and respectful care indicators.

1.8 Intended users of the guidelines

- Decision Makers at all levels (National , , regions, council districts and facility managers)
- Health service providers at HFs level
- Partners / stakeholders who supports implementation on RMNCAH interventions including professional associations
- Academicians, professional bodies, training institutes, researchers
- Private Sector that supports RMNCAH interventions
- Community leaders, influential people and religious leaders

1.9 Conceptual framework for gender and respectful care integration

In order to achieve gender and respectful care mainstreaming and integration, triangulation of interventions for gender and respectful care implementation across the different levels of the health system will need to be employed. Leadership is key to this and those with vested powers of decision making are the champions of this process and should lead the way. Unless leadership at national and all the way to community are sensitized and made to appreciate the importance of gender and respectful care integration in their routine functioning, success to make gender and respectful care bring about the expected outcomes and ultimately impact will be difficult to be realized. Figure 4 below proposes how best gender and respectful care mainstreaming and integration can be implemented.

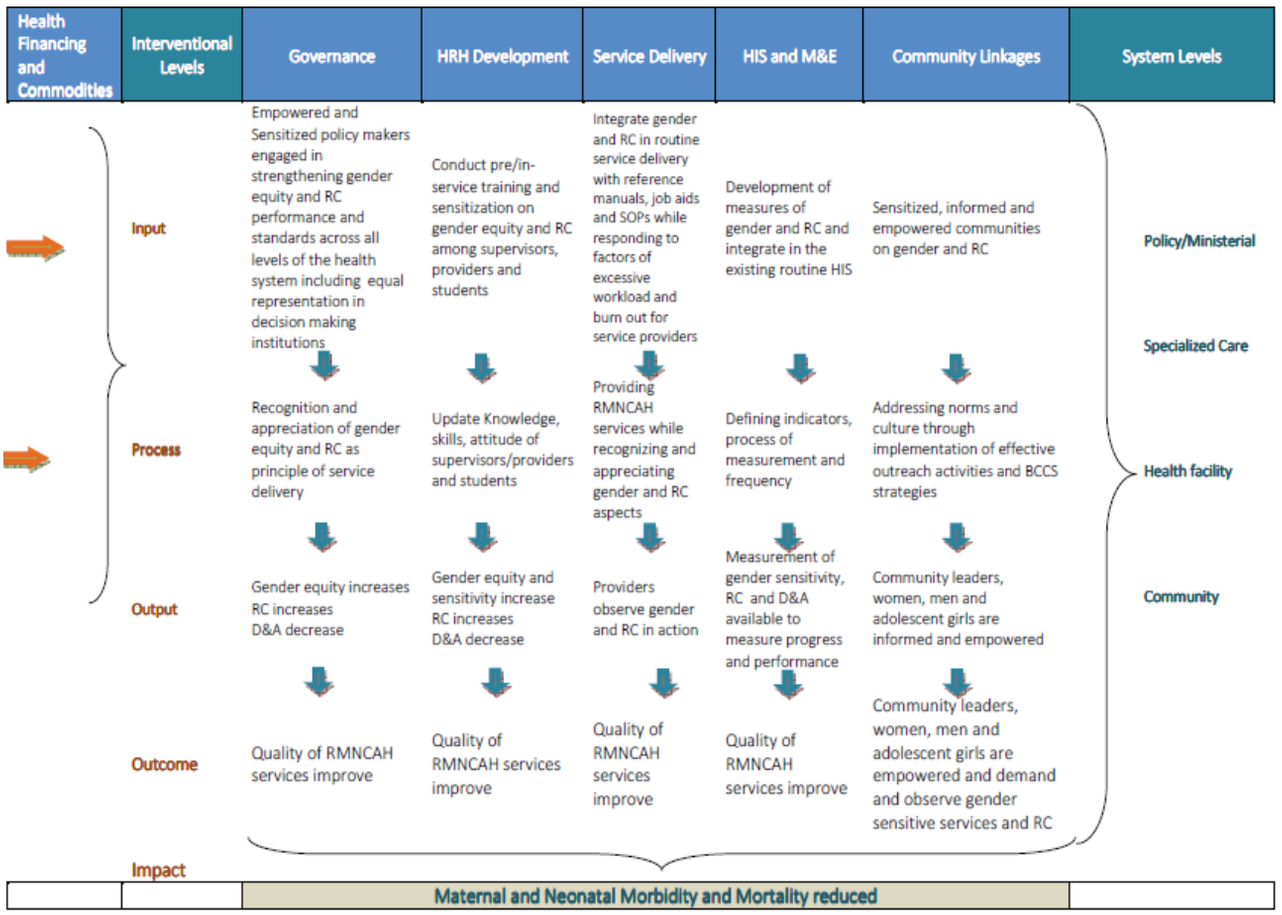

Figure 4: Conceptual framework for gender and RC mainstreaming and integration across levels of the health system.

Adapted from: McMahon et al, 2018

1.10 Legal framework

The development of these guidelines recognizes existing rules and regulation that govern provision of health care services in Tanzania as well as those which oversee execution of rule of law. Inclusive of the existing rules and regulations include:

- Universal Declaration of Human Rights 1948, Article (2), (12), (25)
- United Republic of Tanzania Constitution 1977, Article 12 (1)&(2)
- The Women and Gender Policy (2000)
- The health Policy (2007)
- The Health Sector Strategic Plan - IV
- Tanzania Nursing and Midwifery Act, 2010
- Code of Professional conduct for Nurses and Midwives in Tanzania, 2007 Revised 2015
- Code of Ethics and Conduct for Public Services, 2005
- National Plan of Action to end Violence Against Women and Children in Tanzania (2018-2022).
- Medical Practitioners and Dentist Act, Cap 152, RE 2002 should be added

2 Chapter two: Gender mainstreaming and integration in RMNCAH services

2.1 Gender mainstreaming at policy level

2.1.1 Concept definition

This entails inclusion of gender statements, guidelines, instructions, plans and budget about gender responsiveness in all RMNCAH policy related strategic documents, guidelines, manuals, standard operating procedures and job aids. It intends to make sure that, at policy level, gender responsiveness becomes a priority when responsible authorities for policy and decision making execute their professional roles towards enforcement of the health sector strategies, guidelines and operations.

2.1.2 Enabling environment for gender mainstreaming in policy and guidelines

1. Review existing policy guidelines to ensure inclusion of comprehensive gender issues to guide gender responsive and mainstreaming as well as integration in health sector leadership.
2. Build capacities of health sector managers and supervisors at national, regional and council levels on gender based strategies.
3. Develop or utilize existing manuals and other reference materials for health managers and administrative leaders on how best they can integrate gender in their stewardship roles
4. Set additional indicators (quantitative and qualitative) to monitor gender visibility at all levels of the health service delivery
5. Adopt and set community based indicators (beyond GBV related indicators) that can measure interplay of gender transformation and equity, including male engagement, at community level
6. Ensure data segregation that considers aspects of gender such as sex, age, ethnic group, disability and other group specific data.
7. Ensure gender parity and gender sensitive work environment (leadership opportunities and equal pay) of HRH in the medical development agencies (MDAs) and private sectors responsible for health and gender activities and train them on gender responsive and transformative approaches to RMNCAH
8. Monitor comprehensive implementation of RMNCAH with focus on gender as defined in these guidelines.
9. Consider budgeting for implementation of these guidelines

2.2 Gender integration at service delivery level

2.2.1 Concept definition

Gender integration at service delivery level refers to gender responsive service as a process of ensuring that when service providers interact with clients, they are aware of the differences in understanding, access and abilities of all clients, resulting from gender constraints , opportunities and that they take into account, without bias or discrimination, the specific needs of men, women, people living with disabilities, adolescent girls and boys with respect to both sex differences and socio-cultural gender differences. It calls to making sure that gender responsive becomes part of routine service delivery.

Gender responsive services aim to create an environment that respond directly to meet the unique needs of that specific gender and challenges of the gender that it serves to increase positive impact on that population. This requires challenging harmful socio-cultural norms and stereotypes related to masculinity and femininity as well as promote both gender equality and health equity and should be grounded in all rights-based approach.

2.2.2 Ensuring gender integration at service delivery level

1. **Promote adherence to the principles of gender responsive client centered care.**

   In order to ensure integration of gender responsiveness in routine service provision across all levels of health facilities, health managers and service providers in health facilities are required to abide to principles provided in these guidelines. The principles for gender-responsive programming (Box 1) are based on a quality-of-care framework, which places the client at the center of programming and service delivery

Box 1: Principles of gender responsive programming

- **Safety**: Avoiding harm to patients from the care that is intended to help them, which includes competent disease appropriate clinical care.
- **Effective**: Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).
- **Patient-centered**: Engaging the patient as a partner in making decisions about her care which involves providing care that is respectful of and responsive to individual patient preferences, needs, and values. It also includes strengthening systems and flows that considers inconvenience experienced by the patient
- **Timely:** Reducing wait times and sometimes harmful delays for both those who receive and those who give care. This also includes taking the right action at the right time, avoidance of withholding care to avoid delays in provision of clinical care especially for those of low socioeconomic groups, adolescents or people with disability.
- **Efficient:** Avoiding waste, including waste of equipment, supplies, ideas, and energy.
- **Equitable:** Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status. Source: PORALG: National Plan of Action (2017/18 - 2021/22)

2. **Ensure and monitor for compliance to updated standards of care.**

- Similarly, for ensuring gender responsive service delivery, the system through health facility managers and service providers must ensure compliance to service delivery standards that the relevant ministries have been providing and updating from time to time. Key national standards for service provisions are listed in Box 2 below. These standards are available in form of booklets or checklists and they must be made available to all health managers, service providers, community and key stakeholders.

Box 2: List of various national standards that are linked to gender responsive and Respectful Care integration
1) Gender and respectful care standards (Table 1 below)
2) National Standards for Quality Health Services for Adolescents (Available in a separate booklet)
3) Adolescent sexual and reproductive friendly service
4) Respectful and compassionate care checklist
5) Gender based violence service provision standards/checklist
6) PMTCT checklist
7) Antenatal care quality improvement tool

2.3 Gender integration at community level

2.3.1 Concept definition

Gender integration at community level entails the collective efforts from different key stakeholders in making sure that community members are informed, aware and understand the concept of gender as defined in these guidelines and begin to reflect on their own attitudes in an effort to transform and advance equality and equity in all aspects of life but specifically when seeking health services related to RMNCAH services. It includes empowering women, men, adolescent girls and boys and people living with disabilities in RMNCAH services utilization and advocating for reduced all forms GBV including practices of female genital mutilation (FGM) and Violence Against Children (VAC).

2.3.2 Ensuring gender integration at community level

1. Promote women empowerment through transformative gender norms and values[3] to increase the percentage of women and adolescent girls who participate in community structures (including Health Facility Governing Committees) for decision-making over their own healthcare. This should be resulting from collective efforts of council, political and administrative structures, health managers, implementing partners and service providers through formal existing mechanisms such as community score card and planning sessions. .
2. Conduct advocacy campaign to religious leaders, influential leaders and policy makers to promote positive norms and values that protect women and children for social transformation.
3. Sensitize communities on GBV (including FGM) issues to reduce the number of women and men who experience Gender-based Violence and children exposed to VAC. Link this activity with what is advocated in the GBV and VAC national guidelines.
4. Awareness creation and sensitization on existence of gender desks (in police posts) and encourage reporting (if and when survivors want to report) of GBV incidences by women, men, adolescent girls and boys and children at any government administrative office.
5. Strengthening linkage with communities through outreach activities that also include components of gender and respectful care, to have informed communities that observe gender and respectful care when interacting with health facilities and service providers.
6. Promote adoption of healthy behaviors, including desirable healthcare-seeking behaviors with a focus on women, men, people living with disabilities and adolescent girls and boys through

3 Refer to the UNFPA "Gender Transformative Programming" toolkit (https://www.unfpa.org/sites/default/files/pub-pdf/tools.pdf) for a comprehensive set of interventions, approaches and methods

innovative behavioral change intervention strategies. Link this activity with support from the Health Promotion Unit of the MoHCDGEC.

7. Prepare messages and use them to conduct community dialogues sessions to discuss gender issues and education on male engagement, women empowerment, harmful gender norms to RMNCAH services and nutrition.
8. Strengthen Health Facility Governing committees to integrate gender responses in their deliverables including women participations in designated positions.
9. Orient and integrate Community Health Volunteers (CHVs) to operate at household level to, sensitize, inform and capacitate men, women, adolescents and people living with disabilities on gender issues. Make use of the CHV platform to also identify, provide initial counseling, and refer community members experiencing GBV incidents to health facilities.
10. Integrate the use of Clients Services Charter and sensitize communities to be informed and become aware of their rights and responsibilities to health services. Through client service charter promote the concept of **"mutual respect"** for communities to also be aware of the rights and responsibilities of service providers.
11. Ensure appropriate and sustainable community accountability mechanism is in place.

3 Chapter three: Mainstreaming and integration of respectful care in RMNCAH Services

The concept of respectful care is defined in the glossary of terms and in contrast with respectful maternity care (RMC). While RMC observes issues related to respect to dignity and observation of ethics and standards during labour and delivery, respectful care cuts across the continuum of care along the RMNCAH interventions. The MoHCDGEC in collaboration with PO- RALG have recently developed national guidelines for RCC. Most of the guidelines for respectful care are thus well defined and presented in the referred document. The guidelines below are therefore either drawing or referring most of their content to the national RCC guidelines.

It is important to note that, while respectful care constitutes the main focus of these guidelines, a special emphasis is provided to RMC. This is due to the sensitivity of the crucial moment of labour and delivery to which most RMC interventions address. At such a moment, respectful maternity care – which refers to care organized for and provided to all women in a manner that maintains their dignity, privacy and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labour and childbirth (WHO, 2018) – is recommended.

3.1 Mainstreaming of respectful care in policy and guidelines

3.1.1 Concept definition

This entails inclusion of respectful care statements, guidelines, instructions, plans and budget about respectful care in all RMNCAH policy related strategic documents, guidelines, manuals, standard operating procedures and job aids. It intends to make sure that, at policy level, responsiveness to respectful care becomes a priority when responsible authorities for policy and decision making execute their professional roles towards enforcement of the health sector strategies, guidelines and operations

3.1.2 Ensuring respectful care mainstreaming at policy level

1. Review and revise existing policy guidelines to ensure inclusion of respectful care interventions (beyond the concept of medical ethics and legal labour laws and regulations) to guide respectful care mainstreaming and integration in execution of their functions. The National Guidelines for Respectful and Compassionate Care and the Revised One Plan II have already paved way to this endeavor.
2. Build capacities of health sector managers, supervisors, service providers across all levels of the health system (national, regional, council levels and in facilities) on respectful care concepts and interventions.
3. Develop manuals and other reference materials for health managers, supervisors, service providers and administrative leaders on how best they can integrate respectful care in their stewardship roles and in routine service delivery practices.
4. Promote advocacy on mainstreaming of respectful care (gender norms, male engagement and Respectful Maternity Care) to create awareness among key policy makers, local and community leaders
5. Set additional indicators to monitor integration and implementation of respectful care across all levels of health service delivery system.
6. Ensure data collection and reporting system that capture client satisfaction from implementing respectful care interventions.
7. Monitor comprehensive implementation of RMNCAH with focus on respectful care as defined

in this guideline.

8. Improve supportive supervision tool/checklist which includes respectful care issues.
9. Integrate a specific budget line in the CCHP for implementation of respectful care mainstreamed interventions.
10. Provide conducive infrastructures of health facilities for provision of quality respectful care services
11. Ensure specific provisions for adolescent /youth friendly services and for people living with disabilities in health facilities across all levels.

3.2 Integrating respectful care at service delivery levels

3.2.1 Concept definition

Integration of respectful care at service delivery level refers to the act of ensuring that when service providers interact with clients, they comply to the principles of service delivery which observe human rights, dignity, respect, friendliness (with two way communication), medical ethics and clinical and nursing care ethics. Similarly, it entails creating "respectful environments" in which providers provide care with ease and which support providers to deliver high quality and respectful care. It calls to making sure that consideration of Respectful Care becomes part of routine service delivery.

3.2.2 **Ensuring integration of respectful care in routine service delivery practices**

Tanzania is a member of the Network for Improving Quality of Care for maternal, Newborn and Child health. Member countries in this network have agreed to adopt quality standards for MNCH services, part of which advocate for respectful care. Table 1 below provides the list of Standards that need to be observed and implemented in order to ensure that respectful care is integrated at service delivery.

Table 1: Standards of Quality Respectful Care

Standard	Respectful Care Quality Statement
Communication with women and their families is effective and responds to their needs and preferences	All women and their families receive information about the care and have effective interactions with staff.
	All women and their families experience coordinated care, with clear, accurate information exchange between relevant health and social care professionals
Women and newborns receive care with respect and can maintain their dignity.	All women and newborns have privacy around the time of labour and childbirth, and their confidentiality is respected.
	No woman or newborn is subjected to mistreatment, such as physical, sexual or verbal abuse, discrimination, neglect, detainment, extortion or denial of services.
	All women can make informed choices about the services they receive, and the reasons for interventions or outcomes are clearly explained.
Every woman and her family are provided with emotional support that is responsive to their needs and strengthens the woman's capability.	Every woman is offered the option to experience labour and childbirth with the companion of her choice
	Every woman receives support to strengthen her capability during childbirth from competent, motivated human resources
For every woman and newborn, competent, motivated staff are consistently available to provide routine care and manage complications.	Every woman and child has access at all times to at least one skilled birth attendant and to support staff for routine care and management of complications.
	The skilled birth attendants and support staff have appropriate competence and skills mix to meet the requirements of labour, childbirth and the early postnatal period.
	Every health facility has managerial and clinical leadership that is collectively responsible for developing and implementing appropriate policies and fosters an environment that supports facility staff in continuous quality improvement

The health facility has an appropriate physical environment, with adequate water, sanitation and energy supplies, medicines, supplies and equipment for routine maternal and newborn care and management of complications.	Bed space, water, energy, sanitation, hand hygiene and waste disposal facilities are functioning, reliable, safe and sufficient to meet the needs of staff, women and their families.
	Areas for labour, childbirth and postnatal care are designed, organized and maintained so that every woman and newborn can be cared for according to their needs in private, to facilitate the continuity of care.
	Adequate stocks of medicines, supplies and equipment are available for routine care and management of complications

Source: WHO (Network for improving MNCH), 2017.

To a large extent, implementation of respectful care during service delivery is well articulated in the National respectful and compassionate care guidelines as well as in the GBV and VAC guidelines. These guidelines should be used together. The Tanzanian RMNCAH TWG has set aside principles for ensuring respectful care integration at service delivery level (Table 2) which are adapted from the gender global performance standards summarized in ***appendix 1***.

Table 2: Basic principles for ensuring respectful care at service delivery level

Component of respectful care	Description of practice to ensure respectful care during service delivery
1. HEALTH CARE POLICY AND MANAGEMENT THAT ARE CLIENT CENTRED	
Clients and providers can enjoy an environment free of sexual or other abuse	• The facility has a written Client Service Charter, which includes policy against sexual or other abuse of clients and providers • Providers have attained knowledge about what consists of sexual harassment and/or other abuse • Any instances of abuse are acted upon according to facility's policy • Transparent accountability and grievance mechanisms are available and enforced • Facility setting and environment are made such that they ensure safety provide comfort for staff in call, (to enable them be able to sleep or have a rest rooms)
Policy support equal opportunities for women and men for advancement and compensation for comparable work	• Male and female providers receive equal pay and benefits for equal work • There is a non-discrimination policy visibly posted in the facility • At least 30% of the facility's leadership team is female • Both male and female providers have an opportunity to be involved in the facility's planning and policy formulation • Male and female providers of equal seniority and training have equal decision-making and influence • Male and female providers have equal opportunity to work the same number of hours and shifts, regardless of whether or not they have children except when women are on maternity leave • Male and female health providers have the same opportunities for training, professional development and promotion • Women as caregivers/mothers – receiving flexible working arrangements
Providers are trained on gender equality and human rights	• All providers have received training on gender equality and human rights within the past two years
2. AVAILABLITY OF HEALTH SERVICES THAT ARE CLIENT CENTRED ACROSS ALL LEVELS OF CARE	
Services are equally accessible to women, men, adolescent girls and adolescent boys people living with disability, and others regardless their social economic status	•Facility offers services including emergency services (obstetric complications, physical trauma, and essential post-GBV and VAC care, emergency contraceptives, HIV post-exposure prophylaxis and counselling) (24 hours, 7 days a week) •All clients receive the full range of information, services and referrals, regardless of age, sex, marital status regardless of their social economic status or disability •All clients regardless of age, sex, marital status regardless their social economic status are treated by the same type/level sex of health workers for comparable conditions •There are a referral system, referral tools, and an up-to-date referral directory in place and all client receive the full range of information regardless of age, sex, marital status and social economic status.

Facilities' infrastructure and services accommodate needs of all clients including people living with disability regardless of sex/gender, and their social economic status.	• Location of health services is accessible to women, men, adolescent girls & boys • There are clean restrooms available for clients and service providers of any sex/gender with a functioning toilet, water, soap and towels, privacy and the ability to lock from the inside. • Each inpatient client has her/his own bed and is not required to share a bed with another person or use the floor
Clients' agency, autonomy and well-being are respected regardless of her gender & social economic status	• Except for clients who are dependents or minors (e.g. under age 18) according to Tanzania national law there are no services that require a spouse, partner or family member to give consent including information • Women receive information directly (e.g. provider does not give information to male spouse, partner or guardian instead of the woman herself) • Care is provided to client according to the facility's triage system or on a first-come, first-serve basis. • Patients are prioritized for care based on urgency of the medical condition, regardless of sex (e.g. women with obstetric complications are treated as quickly as a man with injuries from a car or occupational accident)
Provider offers couples partner counseling on partner couples communication and joint-decision making on issues of FP, ANC, birth planning, PMCTC, VMMC and HCT	• Provider asks client privately if s/he would like to have a companion present and only invites a companion to be present if the client gives permission • Sexual and reproductive health consultations, communication and negotiation are provided to couples for shared decision making.(FP,ANC,PMCTC,PNC,VMMC & HTC • No client is ever sterilized or given medical procedures without her or his informed consent • Contraceptive counseling includes skills building on couples' partner communication and negotiation • Provider emphasizes the importance of *shared* decision-making and promotes shared care giving and emphasizes s/he is not asking men to take control
Clients have access to and receive information about all available contraceptive methods regardless of their circumstance, gender or age (except for pre-pubescent minors or dependents)	• When indicated, any youth or adolescent can access emergency contraception regardless of age, marital status and without another person's consent • Facility offers a full range of contraceptive options to all medically eligible clients regardless of age, number of children or marital status • Provider explains the different methods and checks that the client has understood • Client's choice of method is respected and provided (if available. If NOT available, an alternative method is offered or client is referred to another site where available.) No client is denied care for refusing a particular method. • Provider identifies whether the youth an adolescent has been exposed to unprotected sexual intercourse within the last 5 days (120 hours) in a non-judgmental manner • Provider asks questions and records responses related to sexual behavior in a professional and non-judgmental manner
The facility maintains condition that ensure and safeguard clients' privacy and confidentiality	• Separate, private rooms are available for confidential client counseling with auditory and visual privacy (cannot be heard or seen from outside) • Client record including the registration book are kept confidential is not accessible to anyone other than the providers/ facility manager • Male and female clients are treated equally with regard to confidentiality (nondisclosure) of health information
Clients can choose the sex of their provider	• Female and male providers are available at the health facility for clients who prefer a particular sex • Client's preference on the sex of their provider is honored, if possible
There are information, education & communication (IEC) materials accessible to clients of all genders	• Materials (e.g. posters) are available in high-traffic locations in the facility such as waiting rooms, in the local language(s), and accessible to a low-literacy audience so that clients of any status can see and understand them • Illustrations and language in IEC materials refer to both men and women in culturally acceptable ways

Clients have access to a continuity of services, supplies, referrals and follow-up necessary to maintain health	• Essential supplies, including contraceptive commodities, supplies and equipment covering a range of methods, for men's and women's health, are integrated within the essential medicine supply chain to increase continuous availability
No client is denied health care because s/he cannot pay fees	• No client (adult or newborn/child) is detained at the facility due to inability to pay fees • No client is asked by providers for fees outside of the approved policy, gifts, favours, bribes or sexual acts in exchange for care
A feedback mechanism exists for clients to report their level of satisfaction or to file complaints	• There is a, suggestion box, email address, exit questionnaire or ombudsperson (impartial representative) that clients can use to give anonymous and confidential feedback on their experience at the facility as well as mechanism for follow up on action plans to mitigate gaps • Provider informs client of the existence of the feedback mechanism(s)
Health information systems data are regularly used for gender analyses and evaluation	• All data are disaggregated and analysed by sex and age, maybe socioeconomic status • Findings from gender/data analyses are used to improve and tailor services offered, approaches used, and commodities stocked for each social group (
3. IMPROVED PROVIDER-CLIENT INTERACTIONS	
Respect for autonomy	• Establish therapeutic relationship with clients and relatives • Listen to clients concerns and respond accordingly • Consider feelings, needs and expectations of minors (such as children) • Involve the client in planning and implementation of care • Allow clients to make choices of care • Respect client decision to refuse treatment and inform the consequences of refusal and document it. If critical and lifesaving will need to consult family to save lives
Consented care	• Provide complete and correct information about client condition, treatment options, and possible results and side effects of treatment. This may be even more important for HIV and AIDS clients adolescents and People with disability • Ensure the clients understand information given for making informed decision • Explain any procedure to the client in full detail and ensure she/he understand it • Obtain verbal or written consent from the client before any procedure such as HIV testing services • Seek permission from a relative or legally authorized person to make decision about care for minors and those who are mentally affected
Confidential care	• Protect client's information from improper disclosure all the time such as information on HIV and AIDS status • Seek client's wishes regarding sharing information with family members or others • Maintain and preserve client's records in a proper manner • Avoid using client information in social settings e.g. home, public transport, social media.
Dignified care	• Provide the client with empathetic care and treat them as unique beings • Strive to provide care to the client/client in a private environment as much as possible • Avoid use of indecent, offensive and abusive language, over unnecessary exposure, over medicalization • Provide individualized care • Do not undermine person's self-respect regardless of any difference. Clients like those having HIV or AIDS are often victims of this
Non–discriminative care	• Respond to clients/clients' needs regardless of their gender, age, race, marital status, wealth, social class in the community, political affiliation, cultural and belief system. • Provide quality healthcare without discrimination. This may be more important in HIV and AIDS care and treatment • Avoid discriminating clients for complaining about services. Receive and respond to feedback given by client in a professional manner without compromising access to quality care

Respect for cultures and beliefs	• Assess and identify client cultural background and belief system • Treat each client individually by respecting their cultures and beliefs • Encourage useful cultural beliefs and discourage harmful ones • When dealing with adolescents, providers should be conscious that they are not parents to adolescents seeking health services and should treat them as clients who have come in for health care and serve them accordingly. Allow client to express spiritual needs and facilitate meeting them e.g. to be visited by a spiritual lea
Non-judgmental care	• Avoid criticizing client opinions rather understand to avoid defensiveness. • Enable clients to express freely and comfortably about problems without feelings that they are being judged, especially related to adolescent pregnancy, or family planning needs • Avoid stereotypes related to societal attitudes towards clients since it may hinder the healing process. • Respect client feelings, experiences and values. And especially so when dealing with adolescents, pregnant women with disability.
Provide timely care	• Set priority in care provision • Organize the working environment for timely service provision • Respond to client's/client's needs timely • Seek for appropriate help if unable to provide timely care • Document time of care and treatment given to enable timely continuity of care • Orient yourself regularly on client's/client's records for continuity of care • Avoid doing personal activities during working hours e.g. use of mobile phones while attending the clients/clients • Provide assistance in case client/client needs consultation from care provider and communicate effectively with honest and openness
Respect for privacy	• Use linen, curtains, screen partitions and private room depending with environment in ensuring privacy • Use reasonable voice to communicate with client • Avoid unnecessary exposure of the client's body parts • Avoid unnecessarily movements in the client's room • Ask permission before entering client's room-when no emergency.
Adherence to treatment	• Provide adequate information on treatment regimen • Give clear and precise directives on how and when medication will be taken • Inform the client about the possible side effect of drugs • Ensure proper and accurate recording of clients' treatment information • Make follow up of the clients to ensure compliance, allow the client to ask questions for clarification.
Maintaining safe care	• Introduce self and the agency to the client, wear badge/name tag/identity card • Protect client from any injuries/harm • Create positive environment that allows clients to provide feedback • Avoid negligence in provision of care • Avoid harassing clients • Adhere to IPC standards in provision of care • Record and report any medical error or incidence

4. SERVICES THAT PROMOTE MALE ENGAGEMENT	
The facility provides a welcoming, male-friendly environment	• Providers to encourage and allow men to accompany their children and partners to routine examinations, malaria treatment, FP, ANC, L&D and post-natal care visits • IEC materials geared toward men are available (VMMC, vasectomy, VCT, condoms, prevention of GBV, participation in joint FP decision-making with their partner, etc.) • The facility has conducted demand creation to increase male utilization of services (e.g., advertising availability of services and conducting outreach in traditionally male-dominated physical spaces such as motorcycle and taxi stands, bars, sports facilities, etc.) • The facility offers services to men, including vasectomy and male condoms • Providers have been specially trained to counsel partners on ANC, Family Planning, PMTCT and VCT, partner communication, and joint decision-making on FP and birth planning • Providers make an effort to educate and engage male partners on the importance of supporting female partners to seek care
5. PROMOTING COMPANIONSHIP	
Women have access and allowed to have companion of choices	• Review .scale up and adapt to local context the proven birth companionship (BC) programs that have been piloted in Tanzania • Provide requirements for facility readiness to accommodate birth companionship • Advocate, sensitize and conduct in-service training for health managers and service providers on BC intervention • Provide women with choices that offer the option to experience labour and childbirth with the companion of her choice • Treat women arriving without birth companion same quality of care like that provided to women with birth companion. • Develop manuals and job aids that will provide guidance on operationalization of birth companionship (BC) implementation in a Tanzania setting. Adapt code of good practice[1] from proven implementation programs and projects on how birth companionship will be operationalized in the public health system

Adapted from MoHCDGEC - RCC Guidelines, 2017 and RMNCAH TWG report, 2019

3.3 Integration of respectful care at community level

3.3.1 Concept definition

Respectful care integration at community level entails the collective efforts from different key stakeholders in making sure that community members are informed, aware and understand the concept of respectful care as defined in these guidelines and are made appreciative to observe and play their part to ensure RC is exercised when seeking health services related to RMNCAH services. Importantly here is a specific attention to adolescents. It is very important to ensure that adolescents have a right to health care especially their sexuality sexual and reproductive health so that we can have a conducive environment that is supportive to adolescents' health care services seeking. Attention for respectful care should address all community members including women, men, boys, girls and people living with disabilities. The efforts to ensure respectful care integration at community level will depend on joint implementation of the recommended strategies by keys stakeholders including local governments, health managers, supervisors, implementing partners, religious leaders and community leaders.

3.3.2 Ensuring integration of respectful care at community level

1. Promote the use of client service charter to encourage mutual respect when community members interact with service providers. It is important to promote the concept of mutual respect to avoid disrespect and abuse towards service providers which in most cases is obscured by D&A towards clients.

2. Promote adolescent health-friendly services at community level by engaging parents, guardians community leaders, religious leaders and adolescent themselves to encourage adolescent to seek for health services without feeling stigmatized by community members.
3. Sensitize communities on GBV and VAC issues to create awareness on what could be violation of their rights (especially for women children and people with disability) when seeking health care. Link this activity with what is advocated in the GBV and VAC national guidelines.
4. Strengthen linkages with communities through outreach activities that also include components of respectful care to have informed communities that observe and appreciate respectful care when interacting with health facilities and service providers.
5. Strengthen accountability structures such as Health Facility Governing Committees (HFGC) and Council Health Service Boards (CHSB) to which community members can report incidents of non-respectful care.
6. Encourage increased participation of women and children in decision making structures and accountability entities such as CHSB and HFGC to echo women and adolescent girls concerns, priorities and preferences in health planning process across different levels.
7. Promote male and boys engagement in advocacy for access for maternal health services in the community
8. Promote and sensitize communities on timely selection and utilization of companionship along the RMNCAH continuum of care.
9. Promote household and community commitment, responsibility and accountability for cost sharing through Community Health Funds (CHF) to increase women affordability to accessing health care hence reducing the retention type of D&A.

4 Chapter four: Disseminating and implementing the guidelines

This document is intended to provide policy guidance aimed at mainstreaming and integration during planning, coordination, implementation, monitoring and evaluation of gender responsiveness and respectful care in RMNCAH interventions. The objectives and recommended interventions in these guidelines will not be meaningful if this document with its content will not reach to the targeted audiences. Section 8.8 lists down key expected users of these guidelines.

A strategic dissemination prior to putting these guidelines is highly recommended. In this context dissemination is both the launching event to create awareness and popularity of the guidelines as well as continuous efforts to make the contents of these guidelines easily accessible and at the right time and all the time to the intended users. Initial efforts of creating dissemination platforms have been made available and will continue to be improved. These include efforts by the Africa Academy for Public Health, who together with other partners and in collaboration with the MOHCDGC are developing a user friendly platform that will enable dissemination of these guidelines and other related resources through web-based platform and as digital information through mobile phones and other electronic gadgets - both on and offline.

It is expected that, implementation of this policy guideline will contribute in revealing and preventing barriers towards access and linkage to provision of health services among targeted populations' including people with disability, men, women, adolescent girls and, children.

Implementation of these guidelines will enable key stakeholders including ministries, regions, districts, health service providers Private Sectors and Partners who supports implementation on RMNCAH interventions to address gender responsiveness and respectful care interventions in-line with Health Sector Strategic Plans and RMNCAH intervention based on Health system building blocks. Furthermore, community leaders and influential people will be also considered as champions in addressing gender norms, male engagement and efforts to promote respectful cares as described in this document. The matrices below provide areas of focus and key interventions and activities that will lead to achievement of mainstreaming and integration of gender responsive and respectful care in the RMNCAH interventions.

4.1 Results area 1: Policy and Governance

SN	Activities	Outputs	Outcomes	Indicators	Means of verifications	Assumptions	Possible key stakeholders
1.1	**RMNCAH policy documents that have mainstreamed gender and respectful care**						
1	Review the existing RMNCAH documents to ensure gender and respectful care (RC) inclusion	Reviewed RMNCAH documents	Inclusion of comprehensive gender and RC issues in RMNCAH documents	Number of documents reviewed	Activity report	Availability of funds	RMNCAH partners, MDAs, and related sectors
2	Disseminate reviewed RMNCAH documents that have reflected gender and RC guidelines and standards	Dissemination report	Improved awareness, knowledge and utilization of knowledge of gender responsive and RC among health system players across all levels	Number of regions and districts with reviewed guidelines disseminated	Dissemination report	Presence of political will and commitment Availability of fund	MoHCDGEC, PORALG, RMNCAH partners, MDAs, and related sectors, health managers across all levels of the health system
1.2	**Health sector managers' and supervisors' capacities at national, regional and council levels on gender responsive and respectful care strategies enhanced**						
1	Develop orientation package on gender and RC mainstreaming and integration	Orientation package	Health Managers at all levels oriented and adhere to mainstreamed gender and RC guidelines		Activity report	Availability of fund	MoHCDGEC, PORALG, RMNCAH partners, MDAs, and related sectors
3	Orient managers, supervisors on Gender based strategies ie. Gender mainstreaming and RC	Orientation report		Proportion of health managers oriented on mainstreamed gender and RC guidelines	Orientation reports	Availability of fund	MoHCDGEC, PORALG, RMNCAH partners, MDAs, and related sectors
1.3	**Gender responsive and respectful care integrated manuals and reference material for health managers and administrative leaders are in place**						
1	Develop gender and RC integrated manuals and reference materials	Manuals and reference material in place	Health managers and administrative leaders applying integrated gender and RC concepts in management and leadership roles	Proportion of health managers /leaders applying integrated Gender and RC skills in routine roles	Activity report	Availability of fund	MoHCDGEC, PORALG, RMNCAH partners, MDAs, and related sectors
2	Disseminate/distribute using various platforms the orientation manuals and other materials on gender and RC to health managers and administrative leaders across levels of the health system	Dissemination report			Dissemination report	Availability of fund	MoHCDGEC, PORALG, RMNCAH partners, MDAs, and related sectors
1.4	**Gender &RC visibility indicators at all levels of the health service delivery developed**						
1	Formulate indicators that will be used to track mainstreaming, integration and implementation of gender responsiveness and respectful care	Report of the proposed/ reviewed indicators	Awareness and utilization of tracking indicators	Number of gender and RC related indicators	Activity report		MoHCDGEC, PORALG, RMNCAH partners, MDAs, and related sectors
2	Incorporate Gender and RC indicators in HMIS/ DHIS2	Report of incorporated indicators in HMIS/DHIS systems	Awareness and utilization of tracking indicators	Number of indicators incorporated	Activity report	Availability of resources to facilitate this activity	

SN	Activities	Outputs	Outcomes	Indicators	Means of verifications	Assumptions	Possible key stakeholders
1.5	**Interplay of gender transformation and equity, including male engagement indicators at community level**						
1.	Conduct working session/ workshop to adopt/ set indicators	Activity report	Awareness and adoption of indicators	Number of orientation sessions conducted	Session/ workshop report		Facility managers and partners
2	Share , engage partners and agree on adopted indicators	Consensus Stakeholders meeting report		Number and types of indicators adopted	Activity rport		District and facility health managers,partners, Community representatives
3	Incorporate community based gender and RC indicators to HMIS for monitoring of gender and RC integration at community level	List of indicators for incorporation into HMIS	Incorporated indicators are in HMIS	Number and types of indicators incorporated in the HMIS	Activity report	Availability of resources to facilitate this activity	MoHCDGEC (HMIS), partners, regional, district and facility health managers

4.2 Result area 2: Development of Human Resources for RMNCAH services

SN	Activities	Outputs	Outcomes	Indicators	Means of verifications	Assumptions	Possible Key Stakeholders
Strategic interventions							
2.1	Develop training manual package for Gender and RC mainstreaming and integration for TOT and service providers	Training manuals	Training manual on Gender and RC mainstreaming and male engagement developed	Number and type of Training manual developed	Activity report	Availability of funds and support from stakeholders	MoHCDGEC, PORALG, RMNCAH partners, MDAs, and related sectors
2.2	Conduct TOT Training on gender and RC mainstreaming and integration	TOTs oriented on Gender and RC mainstreaming and integration	Promote and support implementation	Number of TOT trained	Training Report	Availability of fund	MoHCDGEC, PORALG, RMNCAH partners, MDAs, and related sectors
2.3	Conduct training to service provider on Gender and RC integration and male engagement	Service provider trained on Gender and RC integration and male engagement	Services provide adhering on gender responsive , male engagement and respectful care	Number of Service provider trained on Gender and RC integration and male engagement	Training report	Availability of Fund	MoHCDGEC, PORALG, RMNCAH partners, MDAs, and related sectors
2.4	Develop gender and RC supportive supervision tools	Supportive supervision tool	Supportive supervision that integrate gender and RC aspects	Types of supportive supervision tools developed.	Activity report	Availability of fund	MoHCDGEC, PORALG, RMNCAH, RHMT, CHMT, partners, MDAs, and related sectors
2.5	Conduct supportive supervision to service providers using standards for gender responsive and RC?	Supportive supervision conducted		Number of supportive supervisions conducted	Supportive supervision report		MoHCDGEC, PORALG, RMNCAH, RHMT, CHMT, partners, MDAs, and related sectors
2.6	Conduct mentorship on gender and RC integration and male engagement	Service providers mentored	Service provider Competence on gender and RC integration and male engagement improved	Number of Service provider mentored	Mentorship report	Availability of Mentors	
2.7	Integration of gender, RC and male engagement into pre-school curriculum	Curriculum of related programs integrated with gender, RC and male engagement	Pre service providers have awareness, knowledge and competence on gender responsive and respectful care	Number of curriculum integrated with above	Activity reports	Collaboration from pre-schools and NACTE	MoHCDGEC, PORALG, RMNCAH, NACTE partners, MDAs

SN	Activities	Outputs	Outcomes	Indicators	Means of verifications	Assumptions	Possible Key Stakeholders
2.8	Maintain provider -patient/client ratio that reduce provider workload and burn out	Sufficient staff for RMNCAH services	• Provider-client ratio improved, • staff burn out reduced, • client satisfaction improved	• Provider-client ratio • %of staff reporting less burn out • % of clients satisfied with services	• Management reports • Surveys	Fund available	MoHCDGEC, PORALG, RMNCAH, RHMT, CHMT, partners, MDAs, and related sectors

4.3 Results area 3: Service delivery

SN	Activities	Outputs	Outcomes	Indicators	Means of verification	Assumptions	Possible key stakeholders
3.1 Capacity building of health care providers							
3.1.1	Conduct training to clinical mentors on gender responsive, respectful care, male engagement and adolescent friendly service (district)	Trained district clinical mentors on GR, RC, ME and ASRFHS	Service delivery that is gender responsive and which observe and recognizes respectful care	Number of national mentors on gender responsive, respectful care, male engagement and adolescent friendly	Reports with list of Mentors		RHMT, CHMT, Health/F management teams, Partners
3.1.2	Adopt/develop/review and disseminate gender and respectful care job aids to service delivery points	Job aids on respectful care adopted, reviewed and disseminated to service delivery points	Implementation of gender responsive and RC at facility level	Number of facilities at all levels of care with respectful care job aids at service delivery points	Supervision reports		RHMT, CHMT, Health/F management teams, Partners
3.1.3	Conduct on the job trainings at facility level on gender responsive, respectful care, male engagement and adolescent friendly service (clinical mentors)	Trained health care providers on gender responsive, RC, male engagement and ASRFHS services		• Number of Facilities at every level(district, regional, zone, national) with providers trained on providing gender responsive, respectful care, male engagement and adolescent friendly service • Number of providers trained on gender responsive and RC	Training reports	Availability of funds for clinical mentors to conduct on job training	RHMT, CHMT, Health/Facility management teams, Partners
3.1.4	Develop and integrate action plans into CCHP and facility plans for implementing gender responsive, respectful care, male engagement and adolescent friendly services	CCHP and facility action plans that integrate gender responsive, RC, ME and ASRFHS		Proportion of councils and facilities at all levels that have integrated in their action plans gender responsive, RC, ME and ASRFHS aspects	Supervision reports indicating Action plans on GR, RC, ME and ASRFHS		RHMT, CHMT, Health/Facility management teams, Partners

3.2: Provision of gender-responsive services							
3.2.1	Conduct outreach activities that include and facilitate health education sessions at community level to empower women and girls on decision making on reproductive health matters	Empowered women and girls in RMNCAH decision making capacity	Increased women and girls informed decision making capacity on RMNCAH	• Proportion of women and girls participating in decision making organs	Outreach activity reports		CHMT, facility managers, service providers and partners
3.2.2.	Promote response to gender based violence (GBV) and link community with facilities as defined in the National GBV guidelines	Increased availability of commodities in RMNCAH Improved services to GBV victims girls	Availability of gender responsive services that address violence against women and girls	Number of facilities providing GBV services % of Client satisfied with GBV services	Supervision reports and surveys	GBV guidelines and services are put in operation	CHMT, facility managers, service providers and partners
7.	Improve and sustain availability of commodities for RMNCAH Services			Number of facilities reporting no stock out of RMNCAH related commodities	Supervision reports		CHMT, facility managers, service providers and partners
3.3. Create enabling environment for respectful care							
3.3.1	Improve infrastructure at facility level for provision of respectful care	Improved infrastructure at facility level for provision of respectful care		Number of facilities with improved infrastructure for audio and visual privacy for respectful care	Supervision reports	Funds for renovation available	PORALG, CHMT &Partners
3.3.2	Manage provision of respectful care at facility levels as agreed standards (integrate with QI improvement interventions at facility level)	Integrated QI and RC at facility		Number of facilities with integrated QI and RC	Supervision reports	Functional Facility QI teams	CHMT, Health/F management teams, Partners
3.3.3	Conduct multimedia communication campaign to sensitize all players(policy makers, managers, healthcare providers and communities) on respectful care	Multimedia communication campaign conducted		Number of campaigns conducted	Campaigns reports	-Key players are present -Campaign continues	R/CHMT PORALG
3.3.4	Monitor and evaluate implementation of respectful care at all levels of service delivery	Evaluation results for RC			Evaluation findings	Available Funding	PORALG, Partners
3.4. Provision of Adolescent Friendly Reproductive Health Services[2]							
3.4.1	Provide adolescent friendly Reproductive health y services at facility level	Integrated health services that offer adolescent friendly services	Improved access to adolescents health friendly services among adolescents and youth in Tanzania	Number of facilities with integrated adolescent health friendly services	Surveys Supervision report	Skilled health providers present	CHMT, Facility Management teams, partners
3.4.2	Manage provision of health services as per the National Standards for Adolescent Friendly Health Services	Availability of quality adolescent friendly services		Number of health facilities providing adolescent friendly reproductive health services	Surveys Supervision reports		CHMT, Facility Management teams, partners
3.4.3	Construct, renovate and improve infrastructure for adolescent friendly services	Improved health facility with adolescent friendly infrastructure		Number of facilities with integrated adolescent health friendly services	Surveys Supervision report		CHMT, Facility Management teams

3.5. Improve male engagement in RMNCAH services							
3.5.1	Develop guideline and job aid on male engagement RMNCAH Services	Harmonized service provision that engage males	Strengthened male engagement in RMNCAH services	Number of job aids on male engagement RMNCAH Services developed	Surveys Supervision report	Available funds for the activity	MoHCDGEC, PORALG
3.5.2	Improve facility infrastructure to make it "male-friendly" through signboards and IEC materials that target men; spaces for men and privacy	Increased awareness on the role of males in RMNCAH services and their participation		Number of HFs with male friendly services	Surveys Supervision report	Available funds for the activity	MoHCDGEC, PORALG, CHMT
3.5.3	Engage male across RMNCAH continuum of care (pre-pregnancy, ANC, Delivery, PNC, family planning)	Increased couple joint decision making across the continuum of care		Number of couples received health services jointly	Surveys, DHIS2 Facility reports		MoHCDGEC, PORALG, CHMT
3.6.: Monitoring, Evaluation and Learning (MEL) platform for RMNCAH interventions							
3.6.1	Conduct operational research for gender and RC analysis and assessment in RMNCAH interventions	Informed decisions that integrate gender and RC issues	Integrated gender responsive and RC MEL system	Number of studies conducted	Study reports		RHMT, CHMT, facility managers and partners
3.6.2	Develop facility plan and budget that address requirements for gender responsive services, respectful care, adolescent friendly and male engagement.	Gender responsive plan and budget addressed in facility plans		Number of facilities with plans and budget for gender responsive, adolescent friendly and male engagement	Surveys, Supervision reports	Available Mentors & skilled personnel	MoHCDGEC, PORALG, CHMT, Partners
3.6.3	Improve data collection tools that are age and sex disaggregated	Increased data that is age, sex and gender sensitive Availability of data collection tools that are age and sex disaggregated		Number of facilities reporting disaggregated data	Surveys, Supervision reports	MTUHA reviewed to accommodate the need	MOCDGEC
3.6.4	To analyze RMNCAH data with gender and RC lenses	Gender responsive and RC focused analysed		Increased of RMNCAH results that address gender issues	Reports		MoHCDGEC, PORALG, CHMT, Partners

4.4 Result area 4: Health Information System

SN	Activities	Outputs	Outcomes	Indicators	Means of verifications	Assumptions	Possible Key Stakeholders
4.1. Indicators for gender responsive services and respectful care							
4.1.1	Review existing current indicators to include gender responsive and RC	HMIS reviewed indicators in place		Number of reviewed indicators	Activity report		MoHCDGEC, PORALG, CHMT, Partners
4.1.2	Develop additional indicators to monitor gender and RC visibility at all levels of the health service delivery	Additional indicators proposed	Increased gender and RC data coverage and utilization at different levels	Number of indicators developed	Activity report		MoHCDGEC, PORALG, CHMT, Partners
4.1.3	Capture data for reporting on client satisfaction with indicators from implementing gender and RC interventions	Availability of client satisfaction data	Increased data utilization to improve quality of service		Routine data		MoHCDGEC, PORALG, RHMT, CHMT, Partners
4.1.4	Promote utilization of gender and RC related data across different levels of the health system.	Increased gender responsive and RC data use and monitoring	Improved data utilization at all level with a special emphasis on gender and RC		Supervision reports		MoHCDGEC, PORALG, RHMT,CHMT, facility managers, Partners

4.6 Results Area 5: Community Linkages

SN	Activities	Outputs	Outcomes	Indicators	Means of verifications	Assumptions	Possible Key Stakeholders
5.1 Social Behavioral Change Communication on gender and respectful care							
5.1.1	Conduct Community dialogue sessions to discuss gender issues and promote positive gender norms that facilitate, RMNCAH and nutrition	Women, men, adolescent boys and girls sensitized with gender issues and harmful gender norms and educated on RMNCAH and nutrition	Increased and awareness knowledge on respectful care and gender issues, harmful gender norms, RMNCAH and nutrition among community members	Number of community dialogue sessions to discuss respectful care gender issues and promote positive gender norms that facilitate, RMNCAH and nutrition	Community dialogues meeting activity reports	Availability of funds to support community dialogue sessions	CHMT, Health facility managers, service providers, WEO,VEO MEO and partners
5.1.2	Conduct community dialogue sessions to promote male and boys engagement in advocacy for access for maternal health services in the community	Males and boys sensitized on their roles in healthcare seeking and utilization		Number of community dialogue sessions conducted	RCH records, HMIS,	Availability of funds to support community dialogue sessions	CHMT, Health facility managers, service providers, WEO,VEO MEO and partners
5.1.3	Conduct community sensitization meetings on timely selection and utilization of companionship along the RMNCAH continuum of care.	Community members select and support companions along the continuum of care		Number of community sensitization meetings conducted Proportion of women accessing FP, CPAC, ANC, Labour and delivery and postnatal services with companions	Facility-based exit interviews Community-level surveys	Availability of funds to support community dialogue sessions	CHMT, Health facility managers, service providers, WEO,VEO MEO and partners
5.1.4	Conduct awareness to the community during outreach on the male's role in RMNCAH as beneficiaries, partners and fathers	Community outreaches conducted to raise awareness to the community		Number of community awareness outreaches conducted	Outreach activity reports	Availability of funds to support community dialogue sessions	CHMT, Health facility managers, service providers, WEO,VEO MEO and partners
5.2. Information, Education and Communication (IEC) programming							
5.2.1	Review, print and disseminate IEC materials to incorporate gender responsive and Respectful Care.	IEC materials on gender responsive and respectful care reviewed, printed and disseminated	Utilization of IEC materials on gender responsive and respectful care	Number of IEC materials printed and disseminated	IEC materials available and accessible	IEC accessible and utilized	CHMT, Health facility managers, service providers, WEO,VEO MEO and partners
5.3. Peer Education							
5.3.1	Promote adolescent health-friendly services at community and facility level	Health Facilities providing adolescent youth friendly services	Community understand on youth health needs in utilizing health services Adolescents benefiting from YFS	Number of adolescent utilizing friendly health services	Health facility records & HMIS, Youth meeting reports	Adolescent accessible and utilized health friendly services	CHMT, Health facility managers, service providers, WEO,VEO MEO and partners

SN	Activities	Outputs	Outcomes	Indicators	Means of verifications	Assumptions	Possible Key Stakeholders
5.3.2	To advocate for adolescent to seek for health services without feeling stigmatized by community members	Adolescents who are aware of their rights and obligations	Adolescents exercising their rights and obligations	Number of adolescents seeks health service	Health facility records &HIMS,	Adolescent utilize health services Free from stigma Providers become more friendly, improve environment	CHMT, Health facility managers, service providers, WEO,VEO MEO and partners
5.3.3	To conduct peer to peer education sessions	Peer to peer education sessions conducted among adolescents, women and men	Norms and values that supports nonviolence are practiced	Number of peer to peers education sessions conducted	Peer to peer meeting reports	Peers are aware of norms and values	CHMT, Health facility managers, service providers, WEO,VEO MEO and partners
5.4. Women and adolescent representation and empowerment							
5.4.1	Promote and support formation of women economic groups, self-help groups" and participatory action groups such as SACCOSS and VICOBA which will link them with financial services, entrepreneurship skills, Health insurance and GBV messages	Women economic groups formed/ strengthened and financial resources, entrepreneurship skills health Insurance and GBV messages accessed	Women and adolescent empowerment	Improved access to and control over economic resources translating to improved access to health services	Property ownership records, data surveys, no. of credit schemes available to women	Women's participation in credit schemes	Microfinance credits companies, CHMT, VEO,WEO,MEO
5.4.2	Strengthen accountability structures such as Health facility Governing committees and Council Health Service Boards to which community members can report incidents of gender based violence, VAC and non-respectful care	Health facility Governing committees and Council Health Service Boards Strengthened	Committees which are accountable and responds to RMNCAH services	Strengthened accountability structures	Meeting reports, meeting schedule, meeting agenda	Meeting conducted	CHMT, Council Health Service Boards (CHSB) VEO-,WEO,MEO,HFGC members,
5.5: Promotion of Client Service Charter							
5.5.1	Print and disseminate Client service charter to health facilities, community centers(churches, mosques, community offices)	Client Service Charter printed and disseminated	Improved mutual respect between service providers and service users	Number of printed client health service charters	Available and accessible client service charters materials	Printed materials	CHMT, CHSB, Facility health management, VEO,WEO,MEO and partners
5.5.2	Promote the use of client service charter to encourage mutual respect when community members interact with service providers	Service providers adhere and abide to client service charter	Clients satisfaction with quality of services provided	Improved service provision	Guidelines, SOP and posted client service charters	Client and providers satisfaction	CHMT, CHSB, Facility health management, VEO,WEO,MEO and partners
5.5.3	Community sensitization and mobilization on Clients services charter to know their rights and responsibilities to health services	Client who are aware of their rights and obligations	Client who are aware of their rights and obligations	Increased client knowledge	Meeting reports, training session, community sensitization records	Client gain knowledge	CHMT, CHSB, Facility health management, VEO,WEO,MEO and partners

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6 Appendices

6.1 Appendix 1: Gender performance standards

1. Services are equally accessible to women, men, adolescent girls and adolescent boys, children and other regardless their social economic status
2. Facilities' infrastructure and services accommodate needs of all clients regardless of sex/gender, and their social economic status.
3. Clients' agency, autonomy and well-being are respected regardless of her gender & social economic status
4. Provider offers couples partner counseling on partner couples communication and joint-decision making on issues of FP, ANC, birth planning, PNC ,PMCTC, VMMC and HCT
5. Clients have access to and receive information about all available contraceptive methods regardless of their circumstance, gender or age (except for pre-pubescent minors or dependents)
6. The facility maintains condition (ANC that ensure and safeguard clients' privacy and confidentiality)
7. Clients can choose the sex of their provider
8. There are information, education & communication (IEC) materials accessible to clients of all gender
9. Clients have access to a continuity of services, supplies, referrals and follow-up necessary to maintain health
10. No client is denied health care because s/he cannot pay fees
11. A feedback mechanism exists for clients to report their level of satisfaction or to file complaints, suggestion box, filling of questionnaire
12. Health information systems data are regularly used for gender analyses and evaluation
13. The provider establishes a cordial and respectful relationship with the client and their companion (if present)
14. Provider gives appropriate emotional support for post-abortion care, and post-abortion family planning.
15. Clients can make a voluntary, informed decision about their healthcare that is based on options, information and understanding
16. Providers take into account gender barriers that impact health-seeking and utilization of services
17. Providers address myths or beliefs that impact health-seeking and utilization of services
18. Key aspects of a cordial and respectful relationship
19. Clients and providers can enjoy an environment free of sexual or other abuse
20. Policies support equal opportunities for women and men for advancement and compensation for comparable work
21. Providers are trained on gender equality and human rights
22. The facility provides a welcoming, male-friendly environment

6.2 Appendix 2: Code of good practice for implementing a birth companionship program

(Source: Thmini Uhai Project)

1.0 Birth Companions: Definitions and Selection

1.1: Definition of birth Companion

In the context of these guidelines, a birth companion is a female, non-medical person who assists a pregnant woman, her spouse/partner, and her family before, during, or after childbirth by providing emotional support and physical assistance. This may be someone chosen by the pregnant woman from her family or social network, such as her mother, sister, mother-in-law, or a close friend. There may be times when a woman does not bring a birth companion of her choice but would like to have one with her during her delivery, or a woman may prefer a trained companion who does not come from her community. In these cases, the health facility will provide a trained birth companion to assist her during delivery.

The pregnant woman can choose between two types of birth companions:

1. A desired female birth companion (from home) or
2. An on-call female birth companion (based at the facility).

1.2 Desired Birth Companion

A desired birth companion is a non-medical woman selected by the pregnant woman to provide emotional, practical and physical support to her before, during and after childbirth. This may be someone from the woman's family or social network, such as her mother, sister, mother-in-law or a close friend.

1.3 On-Call Birth Companion

An on-call birth companion is a non-medical woman recruited by the community, trained and provided stipends by the project and stationed at the facility. The on-call birth companion is available to provide emotional, practical, and physical support during childbirth for pregnant women who arrive at the facility without a birth companion or for those pregnant women who prefer not to have someone from home.

1.4 Desirable Personal Characteristics of Birth Companions			
1	Loves the woman	7	Reliable and is able to exercise confidentiality
2	Can "soothe" the woman	8	Be patient
3	Can quickly solve problems	9	Keep confidential information private.
4	Is "active" and "faithful"	10	Be compassionate
5	Has given birth before	11	Be trustworthy
6	Is respectful and mature	12	Be diligent.
7	Is able to provide the necessary help		
1.5 Selection Criteria for On-Call Birth Companions			
1	Be a woman	5	Reside within the catchment area of the facility
2	Be a Tanzanian citizen	6	Be someone respected and chosen by the community
3	Be above 25 years of age and have given birth at least once	7	Be willing to work as a volunteer.
4	Be able to read and write in Swahili		

1.6 Selection Process for On-Call Birth Companions

On average, three on-call birth companions will be recruited per facility.

- The District Executive Director will send the necessary information about birth companions' recruitment through the existing administrative setup up to the village council.
- The village council will make a public announcement about recruitment. Interested applicants will be send their applications to the village council.
- The village council will hold a public meeting and citizens will be asked to suggest five women.
- The selected five names will be sent to the health facility.
- Health facility management teams will interview the candidates and select three on-call birth companions for the respective facility.

2.0 Roles, Responsibilities and Work Boundaries of Birth Companions

- The birth companion's primary role is to provide continuous emotional support to a woman throughout labor and delivery.
- Birth companions also provide practical, physical, and informational support as well as serve as an advocate for the woman throughout pregnancy, labor, delivery and the postpartum period.
- Specific responsibilities during pregnancy and childbirth are as follow.

Dos			Don'ts
2.1. Antenatal Period: During this period, the desired birth companions will			During this period, the desired birth companions will not
1	Encourage the pregnant woman to attend the recommended four antenatal care visits and escort the woman to at least two antenatal care visits, at times convenient to both the pregnant woman and the companion.	1	Give the pregnant woman any medicine that is not prescribed by a health professional.
2	At all antenatal visits, encourage the woman to ask questions about pregnancy, labor, and delivery so she is knowledgeable and confident about the process.	2	Perform any medical examination on the pregnant woman.
3	Be aware of the health of the pregnant woman and watch out for danger signs in pregnancy (should know about pregnancy danger signs).	3	Divulge any personal and/or medical information about the pregnant woman to anyone.
4	Help the pregnant woman follow up on necessary, prescribed health services, such as treatment of malaria, sleeping under a mosquito net, and eating nutritious foods.	4	Shout at or speak harshly to the woman.
5	Help the pregnant woman make her birth plan, including facility which she will, how will she get there (transport arrangements), emergency funds, who will help while she is away to care for her home and other children and will she need to bring to the facility.	5	Ask the woman for any compensation for services rendered.
6	Know and notice signs of labor.	6	Take away (steal) the facility's or the woman's belongings and/or property.
7	Comfort, encourage, and soothe the woman.		
2.2 Intrapartum Period During this period, the desired birth companions will			**During this period, the desired birth companions will not**
1	Assist the woman to take all materials needed for the delivery to the facility.		Disclose any information about the expectant mother or the health facility.
2	Make sure the woman is not alone the majority of time during labor and delivery.		Perform the birthing procedure to the woman or any other client outside the facility because she feels she's "experienced" enough.
3	Encourage the woman to ask questions about labor and delivery so she can understand what is happening. Make sure the health providers are explaining all procedures, seeking the woman's permission, and discussing all medical findings with her. Make sure the woman is informed about the progress of her labor.		Perform clinical or medical tasks or prescribe treatment.
4	Encourage the woman to listen to the instructions given by the health provider during labor. If the woman does not understand, help her request all needed information from health providers until she fully comprehends what is happening.		Touch any medication or medical instruments/equipment without instructions or permission from the health providers.

Dos			Don'ts
5	Comfort the woman and soothe her during labor. This could include massaging her shoulders and back, helping her breathe and relax, assisting her to change positions, and helping her walk around.		Give medication to the woman.
6	Praise the woman, encourage her, and reassure her that things are going well.		Clean any medical equipment or instruments.
7	Ensure that the woman's privacy is respected during examinations and discussions.		Take samples to the laboratory.
8	Instruct the woman on aspects of the labor process e.g., having the need to defecate.		Perform any medical procedure.
9	Help the woman change positions and walk around.		Serve any client other than the one she's currently assisting until the end of the birth.
10	Give the woman anything she needs during labor, e.g., tea/food.		Ask for compensation for any services rendered.
11	Give the woman information on what is happening or any other information requested by the woman to help her cope with her current situation.		Wash the client's dirty clothes after the delivery (e.g., bloody clothes).
12	Help with soothing techniques such as massaging the woman, giving her liquids and wiping off sweat.		Give local medication (herbs) to hasten labor.
13	Advise and encourage the woman to breastfeed the baby immediately after delivery.		Insert any substances into the vagina during labor or after delivery.
14	Also, wake the woman at routine intervals so that she can breastfeed the newborn frequently.		Push on the abdomen during labor or delivery.
15	Advise and encourage the woman to practice skin-to-skin contact with her newborn.		Pull on the cord to deliver the placenta.
16	Monitor the health of the woman and the newborn and alert a health provider immediately if there are any concerns.		Put any substance on the umbilical cord/stump other than what a health provider prescribes.
17	Follow up to ensure that the health provider comes to frequently examine the woman and newborn.		
18	Help the woman use a mosquito net to prevent her from being infected with malaria.		
19	[On-call birth companions] Promote family planning.		
	2.3 During Complications During this period, the desired birth companions will		**During this period, the desired birth companions will**
1	Immediately alert the health provider.		Disclose information on death and/or complications of either the baby or the woman to relatives or friends without permission from the health care providers attending the client.
2	Comfort the woman.		Offer any technical services to the client.
3	Pass non-medical instruments/equipment to the health provider, if instructed.		Instruct the health care provider on the clinical management of the woman or her baby.
4	Inform the health provider about anything unusual happening to the woman.		Handle sterile instruments and/or medicines.
5	Comfort the woman and soothe her if the baby dies.		Be allowed to enter the operating room with the woman, if obstetric surgery is required (e.g., cesarean section).
6	Help with any other non-technical issue as instructed by the health provider.		
7	Help a woman experiencing a complication be informed about what is happening and what procedures are being performed. If the woman does not understand the situation, the birth companion should help her get all required information to fully understand the situation and the choices available to her.		
8	Be allowed to offer support during pre-operative preparations and stay with her in the waiting room before entering the operating theater if obstetric surgery is required (e.g., cesarean section). Once the woman is out of the operating room, the companion will be allowed to rejoin the woman and baby.		
	2.4 After Labour (Pre-Discharge): During this period, the desired birth companions will		**During this period, the desired birth companions will**
1	Assist the woman and the baby to remain clean and comfortable.		Offer any technical or medical services to the woman and/or the baby.

Dos			Don'ts
2	Encourage the woman to make sure the baby is comfortable and warm by dressing the baby in warm clothes.		Discharge the woman and/or the baby without the health provider's permission.
3	Assist the woman to properly store all clean and dirty clothes.		Wash any clothes or touch wet things without putting gloves on.
4	Encourage the woman to eat food and drink a lot of clean, potable water.		Bathe the baby before he or she is 24 hours old.
5	Advise the woman to exclusively breastfeed for six months.		Instruct the health provider when the provider is performing technical services.
6	Remind and encourage the woman to follow up on the baby's vaccination schedule without neglect.		
7	Remind the woman to go back to the clinic to follow up on her health and the baby's health on the third, seventh, 28th, and 42nd day after the birth.		
8	Monitor the health of the woman and baby and urge the woman to go to a health facility immediately if she shows any danger signs, including high fever, severe headache, swollen feet, dizziness, severe vaginal bleeding, or smelly vaginal discharge. The mother must also be urged to take her baby to the health facility immediately if she has any trouble breastfeeding her baby.		
9	Advise and remind the desired birth companion of all the necessary services the mother will need when she is at home.