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CASE STUDY

From training to practice:

Lessons on mainstreaming gender equality within Tanzania's health system

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Introduction

Gender inequality in Tanzania continues to shape nutrition outcomes by structuring who controls resources, who accesses services and whose priorities are reflected in health decision making.[1] Women and adolescent girls, despite having greater nutritional requirements and bearing primary responsibility for caregiving, often have limited decision making authority, while men frequently control household resources and influence service uptake.[2]

Nutrition International, in partnership with the Ministry of Health (MoH) of Tanzania, has positioned gender equality as a core component of nutrition programming. This approach is grounded in the 2021 sex and gender-based analysis (SGBA), which identified persistent structural and socio-cultural barriers, including spousal consent requirements, early marriage, adolescent pregnancy, gender-unaware service delivery and the underrepresentation of women in nutrition governance. The SGBA further underscored men's central role in household nutrition decision making, highlighting both the limitations of excluding them and the potential gains of intentional, gender-responsive engagement.

To address these challenges, Nutrition International developed a gender action plan centred on skill building and providing materials to support gender-responsive behaviour change. In partnership with the MoH, Nutrition International conducted a training of trainers program for national and regional facilitators, who then trained community health workers (CHWs) in Katavi Region, Nsimbo District Council. Fact sheets and posters promoting shared decision making, male involvement in nutrition and women's agency were developed, approved, translated and distributed through ministry channels for use in services and outreach. As a result, 106 CHWs (55 females and 51 males) from 42 villages in the Nsimbo District Council were trained.

This case study examines the implementation of this approach through CHW training, documenting how gender equality principles are operationalized within health structures, how frontline workers apply gender-responsive tools and how early shifts are emerging at the facility and community levels. It explores the interaction among training, policy alignment and community dissemination, offering insights into how decentralized health systems can achieve more sustained, practice-level change in applying a gender-responsive approach within nutrition programming.

Methodology

This case study employed qualitative methods, including a structured desk review and stakeholder interviews conducted from October to December 2025. The desk review assessed training materials, monitoring data and policy documents to evaluate intervention design and context. Interviews with government officials and service providers explored training relevance, support for gender tools, implementation challenges and early outcomes. Twelve interviewees represented diverse roles, enhancing the credibility and applicability of findings. Data analysis identified common themes and gaps between policy and practice. Informed consent was obtained from MoH representatives and participants during the interviews.

Program overview

The gender equality training cascade was part of Nutrition International's broader initiative to integrate gender equality into nutrition programs through the MoH. Training began at the national level with training of trainers and extended to regional, district and community levels, reaching CHWs in Katavi Region. The approach focused on building the skills of MoH facilitators and frontline workers in gender-responsive methods, integrating gender-responsive communication tools into MoH systems and using these tools in community outreach to promote discussion on gender-related topics. This structure demonstrates how skill building enhances provider engagement and confidence, while communication tools increase community awareness and dialogue about gender roles in nutrition. The program incorporated gender tools directly into existing service delivery platforms.

Table 1: *Program delivery model*

COMPONENT	DESCRIPTION	TARGET ACTORS
Training of trainers (TOT)	National and regional facilitators were trained on gender equality and nutrition, with emphasis on participatory facilitation, male engagement and women's agency.	MoH facilitators, regional and district focal points
Training cascade	Trained facilitators delivered sessions to CHWs in Katavi region, linking gender concepts to routine nutrition and maternal health work.	CHWs, facility-based providers
Tool development and validation	Gender equality fact sheets and posters were developed, reviewed, approved and translated by the MoH.	MoH technical units, Nutrition International
Community application	CHWs used posters and fact sheets as job aids during household visits, facility counselling and community gatherings.	CHWs, households and community members
Government support	Supervision and informal follow-up were conducted through existing MoH reporting and coordination structures.	District and regional health teams

Findings

Gender equality training strengthened frontline provider confidence and legitimacy to act on household-level gender dynamics

The national gender equality training and its cascade to CHWs reshaped how frontline providers understand their roles in households and communities. Previously, many CHWs viewed family matters such as caregiving, corporal punishment or early pregnancy as private issues beyond their mandate. Following the training, providers reported increased confidence to engage when gendered power dynamics posed risks to child health, nutrition or well-being.

CHWs described using the training to reframe nutrition and child wellbeing as shared household responsibilities, allowing them to address harmful practices without relying solely on formal authority or enforcement, and to assist in preventing harm that could worsen over time. One CHW explained how the training enabled her to intervene in a case of severe corporal punishment by confronting a father directly and repositioning the issue as both a parental and public concern:

"Before, I could not interfere because these are family issues. After the training, I remembered how we were taught, and I talked to the father directly."
– CHW, Nsimbo, Katavi

At the district and regional levels, respondents emphasized that the training's effectiveness lay in how gender was introduced through nutrition, family wellbeing and everyday life. Currently, health providers actively engage to address gender dynamics related to health:

"When gender issues are raised repeatedly on many platforms, people get tired and start seeing them... as women's issues. Using community health workers and approaching gender through nutrition has been different. When you explain gender through nutrition and daily life, people understand how it affects health, family wellbeing and livelihoods."
– MoH, Katavi

The case study suggests that the training shifted providers' self-perception from technical messengers to social actors with a legitimate role in influencing household norms. Providers described increased confidence in using tools, language and positioning strategically to engage families and community leaders:

"The training showed us different ways to help our society understand gender equality. We learned about creating champions, people who can influence others in families and villages. The tools helped us find space to speak and use it well. We now have different ways to reach people and connect with what they already believe."
– Nutrition officer, Nsimbo, Katavi

While it is too early to claim impact, the findings show that gender equality training builds knowledge and expands providers' perceived mandate. The training of trainers helped ensure appropriate gender and nutrition messages were shared, from the health facility outwards. Additionally, the trained health providers are legitimized actors to engage with household relationships and decision making; the training enables frontline providers to integrate gender-responsive practices into daily nutrition service delivery.

Male engagement has increased where gender is operationalized through nutrition advice and service delivery

The CHWs and facility staff reported increased male involvement in antenatal care, child health visits and nutrition-related decision making. Men are more frequently accompanying partners to facilities, remaining present during counselling and engaging with questions about diet, breastfeeding and childcare. These changes were described as meaningful, reflecting a gradual renegotiation of caregiving roles. As one facility-level respondent explained:

"There are some changes...You can see it because when you go to the clinic, men are now coming. Before, you would mostly find mothers, but now men are also present. Sometimes they come as husbands, sometimes as escorts, and through that they receive education. Over time, this changes participation. It has not happened overnight, but you can see men increasingly involved when we organize health and nutrition activities in villages and health centres. When education is provided in a way that fits the community and timing, men do come."
– Municipal health promotion coordinator, Mpanda, Katavi

Respondents were explicit that these shifts do not signal immediate transformation of gender norms. Decision making authority within households often remains gendered and resistance persists. However, many framed gradual changes as both realistic and strategically important. Small, socially acceptable adjustments were seen as creating space for dialogue and learning without provoking backlash.

At the facility level, providers described a clearer understanding of why advice is not always followed and greater confidence in engaging men and other family members in nutrition solutions. This was reinforced by the proximity of trained providers to communities, which respondents viewed as essential for legitimacy and uptake:

"I have seen a change. First, it shows the importance of training. I saw it through the people who are very close to our communities...have seen changes in traditions, as men now come to the clinic. Mothers come with their husbands...Traditions start changing there. You can see that people understand differently now compared to before. We see a change, but it is not something that happened overnight." – Nutrition officer, Nsimbo, Katavi

Small, socially acceptable adjustments were seen as creating space for dialogue and learning without provoking backlash.

At the national level, respondents linked these practice-level changes to emerging shifts in how nutrition and gender are framed within policy and supervision. One ministry actor highlighted changes in household food norms as an early but significant outcome:

"There is a change. People are moving away from the traditional thinking that certain foods belong to the father or that men must eat first. Now they are starting from the perspective of the breastfeeding or pregnant mother, asking what food she needs to be healthy, to produce enough milk and to support the child's growth. Fathers are beginning to see themselves as part of the journey of pregnancy, birth and child growth, asking how they can support their wives and children to get the right nutrition...and we are seeing the changes we hoped for." – MoH, Dodoma

Integrating gender tools into Ministry of Health systems has enhanced credibility and acceptance of gender equality initiatives in nutrition programs

Rolling out gender tools through the MoH systems, gender-responsive nutrition work feels official and legitimate. At the same time, it has exposed where things still break down in day-to-day practice.

At the regional level, leaders described what made the tools and training stick was how gender was introduced through issues people already care about such as nutrition, child growth and family well-being. As one MoH respondent explained:

"Linking it to nutrition, growth and family life, economic and social issues made it clearer and more impactful."
– Regional nutrition officer, Katavi

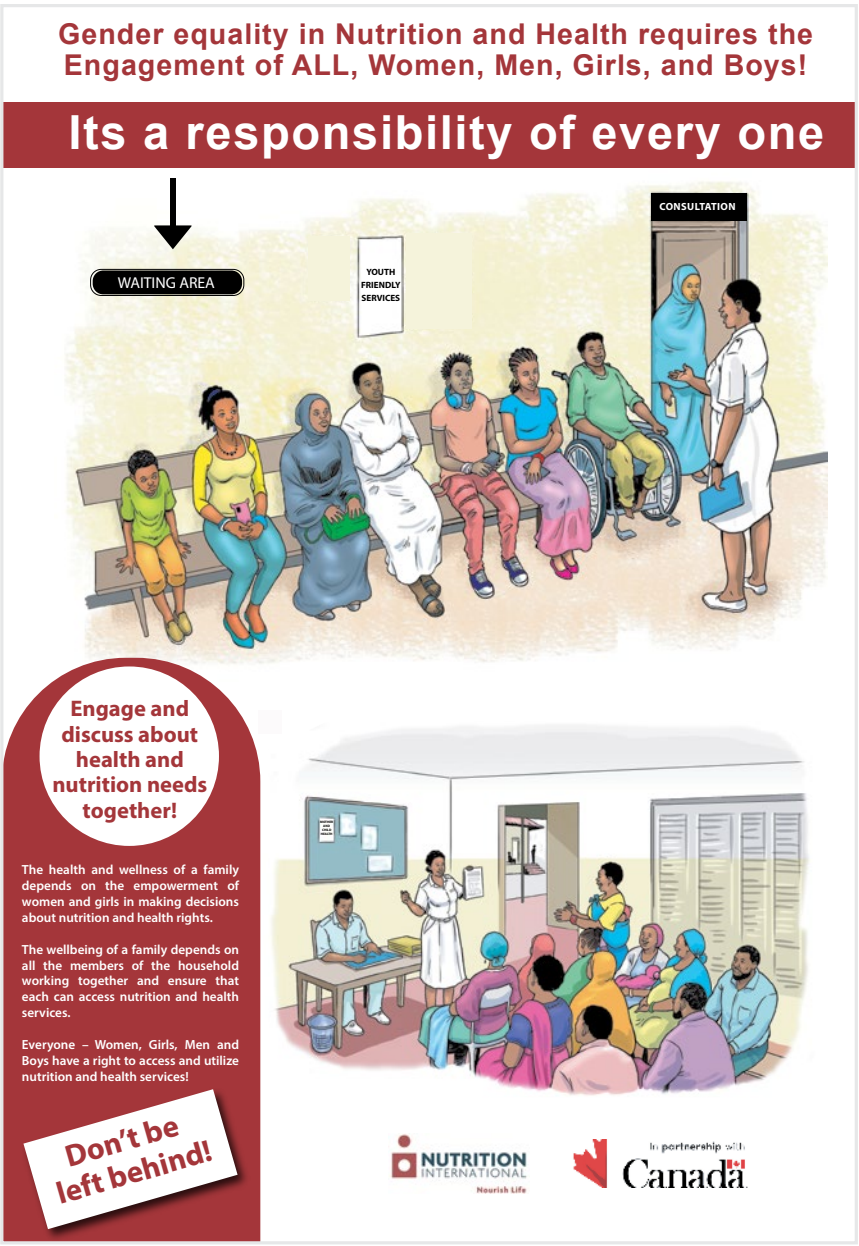
A regional actor described the training as correcting confusion that can undermine community engagement:

"For me, first of all, it was understanding the concept of gender equality issues. We were mixing up 'gender' and 'sex'."
– Regional nutrition officer, Katavi

He added that misconceptions can create early tension, but a clearer explanation shifts how messages are received: "Nowadays, when people hear about gender issues, they immediately think about sexual matters, which is not the case at all. But once you explain, people understand it." Across national and regional respondents, the tools were also described as increasing confidence and strengthening supervision and engagement. As one MOH respondent stated, "Those tools really supported my work...I wasn't worried about using them" (Katavi).

At the same time, respondents identified clear constraints limiting routine use at scale, especially distribution, logistics and inconsistent posting of materials. A regional supervisor noted the challenges related to distributing outreach materials, linking this directly to operational bottlenecks:

"As for CHWs, some who are nearby may have received them. The challenge here is logistics; requesting a vehicle is a difficult process. Going out to distribute leaflets alone becomes a challenge unless it is a joint activity...I cannot speak about the extent of distribution because I have not gone to see for myself."
– Regional nutrition officer, Katavi



Above: *Example of posters that were placed in health facilities with gender equality messages*

These distribution gaps are compounded by facility-level dynamics that undermine shared access and use:

"But at health facilities, there is often a challenge. Sometimes guidelines arrive and are simply shelved... so the issue is not availability but sharing and use."
– Regional nutrition officer, Katavi

To address these bottlenecks, a centralized distribution system could be implemented to pool resources for more efficient delivery. Partnerships with local nongovernmental organizations and/or with women's rights organizations can provide logistical support. Developing a tracking system and conducting regular checking will help ensure materials reach intended facilities and enhance accountability.

Instead of framing gender equality as a standalone or time-bound project concern, some officials noted increasing efforts to link gender considerations to nutrition, service delivery and broader development challenges.

Capacity building within the Ministry of Health influences how gender is considered within nutrition policy and guidance

Capacity building efforts within the MoH are beginning to shape how gender is considered within nutrition policy and guidance. National-level respondents described a growing tendency to reference gender in policy discussions and technical guidance, particularly in relation to how nutrition outcomes are understood and addressed. Instead of framing gender equality as a standalone or time-bound project concern, some officials noted increasing efforts to link gender considerations to nutrition, service delivery and broader development challenges. One national respondent observed that actors are increasingly working to connect gender with nutrition and other development challenges:

"What I observed is that people are increasingly trying to relate gender issues to nutrition and other development challenges. They are making an effort to connect these concepts and see how they work together."
– Regional nutrition officer, MoH, Katavi

Ministry officials emphasized that this emerging shift aligns with the MoH's formal mandate to provide strategic direction and guidance. The cascading nature of this mandate was elaborated further:

"The role of the ministry is to provide guidelines and to oversee that those guidelines reach the end users at the bottom and are acted upon...once it cascades down to the regional level, technical experts need to be in the regions and councils to interpret it so it can carry real meaning for the implementors there."
– Adolescent reproductive health, MoH, Dodoma

In this sense, gender equality is increasingly positioned within formal policy and regulatory frameworks, rather than being advanced through parallel or ad hoc initiatives. Respondents described how gender considerations are gradually being incorporated into technical guidance, training processes and system expectations that shape nutrition service delivery. Embedding gender within these institutional mechanisms signal that gender-responsive nutrition is part of routine policy implementation.

One national respondent pointed to the nutrition sector's existing accountability architecture as a model:

"Nutrition is a good example. It is no longer discussed only by nutrition officers; leaders at different levels are now involved, with reporting and accountability mechanisms in place. Even at [the] village level, executives know they are expected to collect and submit information on nutrition regularly. The opportunity now is to integrate gender into that same system, so it is not treated as an issue for specialists alone... as something owned by political leaders, government officials, frontline workers and communities. If simple guidance is provided at each level so people understand their role, gender can be woven into the existing nutrition system and become everyone's responsibility."
– Regional nutrition officer, MoH

However, the findings also point to uneven management of this integration within a decentralized system. While national approval confers legitimacy, implementation of responsibility rests with councils and facilities, where competing priorities and limited resources constrain consistent follow-through. Regional and district respondents cautioned that gender can easily be deprioritized without active oversight:

"You cannot say today I am going with only one thing. There are many issues to address at the same time."
– Key informant interview, regional nutrition officer, Katavi

Several respondents linked these risks directly to accountability and financing. While gender is increasingly reflected in policies and guidelines, effective implementation depends on whether councils translate these commitments into plans, budgets and supervision practices.

Sustaining gender-responsive practices depends on strong local governance and dedicated funding

Gender equality training has improved confidence and practice among frontline providers and district actors. However, findings show that training alone is insufficient to sustain gender-responsive nutrition practices without institutional reinforcement through supervision, resources and formal system integration. Across regions and districts, respondents described strong initial momentum after the training, which gradually diluted in the absence of structured follow-up. As one regional respondent explained, "the training opened our eyes, but if there is no follow-up, people return to other priorities" (Regional nutrition officer, Katavi). This concern was echoed by social welfare leadership, who emphasized that capacity gains must be carried by systems rather than individuals: "Capacity was built, but the system still needs to carry it forward" (Regional social welfare officer, Katavi)

A central constraint identified across interviews was the absence of dedicated financing and accountability mechanisms for gender-responsive nutrition work. Gender activities are currently absorbed into broader nutrition or health mandates, without ring-fenced budgets or performance indicators. As one regional official stated plainly, "there is no specific budget for gender and nutrition. We integrate it into other activities, depending on what resources are available" (Regional nutrition officer, Katavi).

Supervision emerged as a critical weak point. While national guidelines and tools are valued, routine supervision systems do not consistently assess whether gender-responsive practices are being applied. One ministry official noted that "we check nutrition indicators, but we do not always check how gender is being addressed" (Community development officer, MoH, Dodoma). This gap reduces accountability and weakens the feedback loop between training, practice and learning, increasing the risk that gender integration remains rhetorical.

Despite these challenges, respondents were clear about the pathway to sustainability. Embedding gender equality within existing ministry systems — particularly district planning, supervision routines and reporting structures — was repeatedly identified as the most viable strategy. One senior government health actor articulated the tension clearly:

"Gender equality and nutrition training is a very big change. It can bring real change, but we do not yet have the close support needed to focus on it as a specific area. In public health education, you cannot put it on its own; it has to sit within many other responsibilities we are managing at the same time. The challenge is that gender equality and nutrition still lack their own budget."
– Government health actor, Katavi

Another ministry official reinforced the importance of systems thinking, drawing lessons from how nutrition has been institutionalized more broadly:

"I believe in building systems, community systems and institutional systems, and continuing to invest in what already exists. In nutrition, responsibility no longer sits only with nutritionists. Leaders at different levels are accountable, there are reporting requirements, and officers know they must regularly collect and report data. That is the kind of system we need, where responsibility is shared, monitored, and sustained."
– Regional nutrition officer, MoH, Katavi

Overall, the case study suggests that the training has established a strong foundation for gender-responsive nutrition programming. However, long-term impact depends on embedding these practices within routine governance structures, including budgets, supervision, reporting and ongoing capacity development, to ensure gender equality is sustained as a system of function.

Conclusion

This case study demonstrates that integrating gender equality into nutrition programs through the MoH systems is practical and effective when implemented as a system-wide policy. In Tanzania, national training, ministry-approved tools and coordination across levels have led to improvements in frontline practice and shifts in gender roles related to nutrition and caregiving. The findings show that gender-responsive change is neither linear nor uniform, but that it depends on policy incentives, resources and social norms. Early progress includes increased male involvement, greater provider confidence and more relationship-focused counselling. Lasting impact requires ongoing policy support and strong systems.

Rather than a one-size-fits-all approach, this case study provides practical guidance for integrating gender equality into existing health and nutrition systems, emphasizing policy alignment, skill development and community involvement as key factors for sustainable, gender-responsive programs.

RECOMMENDATIONS

The following recommendations are directed at Nutrition International, the MoH and partners seeking to strengthen gender-responsive nutrition programming in Tanzania:

1. **Institutionalize gender-responsive practice within routine systems** by embedding gender considerations into supervision tools, reporting requirements and performance frameworks, reducing reliance on individual motivation or discretion.

2. **Sustain capacity** beyond initial training through periodic refresher training, peer learning and mentorship for CHWs and facility staff, with attention to facilitating sensitive discussions on household decision making and power dynamics.

3. **Ensure operational resourcing** at decentralized levels, with a specific focus on prioritizing investments in transport and supervision. These are critical for the immediate impact on the consistent use of gender tools and sustained community outreach. Dedicated budgets for these areas will provide a foundation for further investments in monitoring and other resources as funds permit.

4. **Strengthen learning and accountability mechanisms** by integrating qualitative indicators on household practices, decision making and norm change into existing monitoring and information systems.

5. **Deepen community-level reinforcement** by engaging religious leaders, traditional authorities and other local influencers to legitimize change and mitigate backlash against shifts in gender roles.

6. **Frame gender equality as core to service quality and family wellbeing**, rather than as an add-on, in order to consolidate institutional ownership and support long-term sustainability within nutrition programming.

:: References

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