The CCBRT (Baobab) Maternity Hospital: Planning for male involvement and adolescent friendly services

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Disclaimer
The views and ideas expressed herein are those of the author(s) and do not necessarily imply or reflect the opinion of the Agency.
Abbreviations

AIDS   Acquired Immune Deficiency Syndrome
AKH    Allgemeines Krankenhaus der Stadt Linz (Linz General Hospital)
ANC    Antenatal Care/Clinic
AYA    African Youth Alliance
CCBRT  Comprehensive Community Based Rehabilitation in Tanzania
CEDAW  UN Convention on the Elimination of All Forms of Discrimination Against Women
CHMT   Council Health Management Team
CSW    Commission on the Status of Women
DHS    Demographic and Health Survey
ESIC   Employee’s State Insurance Corporation
FCI    Family Care International
FP     Family Planning
GIZ    Deutsche Gesellschaft für Internationale Zusammenarbeit
HIV    Human Immunodeficiency Virus
ICPD   International Conference on Population and Development
IEC    Information, Education and Communication
M&E    Monitoring and Evaluation
MkV1   MEMA kwa Vijana Project
MOHSW  Ministry of Health and Social Welfare
PASHA  Prevention and Awareness in Schools of HIV/AIDS
PATH   Program for Appropriate Technology in Health
PMTCT  Prevention of Mother-to-Child Transmission
PNC    Postnatal Care
SCIH   Swiss Centre for International Health
SDC    Swiss Agency for Development and Cooperation
SRH    Sexual and Reproductive Health
STI    Sexually Transmitted Infection
Swiss TPH Swiss Tropical and Public Health Institute
TBA    Traditional Birth Attendant
UNFPA  United Nations Population Fund
USAID  United States Agency for International Development
WHO    World Health Organization
YFS    Youth-Friendly Services
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Executive Summary

Tanzania is characterised by high maternal mortality, and low uptake of skilled attendance and maternity services. Culturally, childbirth is perceived to rest within the female domain and men are not greatly involved or encouraged to participate in maternity services. Equally, cultural ideals of sex and youth are linked to marginalisation of pregnant adolescents from the services they need in order to offset the increased maternal and infant risks and to prevent further unplanned pregnancies and exposure to sexually transmitted infections.

Particularly in rural areas, women have to contend with barriers to accessing skilled birth attendance and that these are heightened for adolescents who depend upon their families for financial resources. This is understood to contribute to the reliance on traditional birth attendants whose practices were found to have very few benefits and some harmful consequences for mothers and their newborns.

A review of the literature revealed gender dynamics and power inequalities, combined with a lack of male engagement to have a negative impact on both maternal and infant well being and survival. Although there is evidence of the importance of men in decision-making concerning female reproductive health and of various positive impacts of male involvement in sexual and reproductive health, it was also found that men are rarely integrated into planning and programming.

Given then importance of engaging men and encouraging adolescents into formal maternity services, the lessons learned from research and best practice initiatives point to a number of recommendations to inform the fit-out and functioning of the CCBRT (Baobab) Maternity Hospital.

In terms of steering both the establishment and future functioning of a male and adolescent-friendly maternity hospital, it is recommended that a working group -including men, adolescent representatives as well as health and opinion leaders-, is formed and mandated to steer, monitor, evaluate and adapt approaches. Guidelines, adapted from the pioneering Gender Friendly Hospital Project of the Linz General Hospital in Austria provides a useful tool in steering mainstreaming and gender-sensitive approaches, staff training, health promotion, service delivery and structural organisation.

Given the scarcity of research on male involvement in maternity services within the Tanzanian setting, it is recommended that a specialist be engaged to conduct a context analysis to inform the planning by tailoring approaches to meet the realities of the targeted groups. In this way, males and adolescents will be catered for not as homogenous groups, but according to their cultures and educational levels.

The CCBRT already engages in outreach activities within its disability services. Male and adolescent inclusion would benefit from linkages of maternity services with existing outreach and community activities to prepare men and young people for the maternity experience and to strengthen the public image of the maternity hospital as a place that includes these traditionally excluded groups.

Religious, opinion leaders and champions could be engaged as change agents to encourage a cultural shift towards a model of greater engagement and active participation of men in the antenatal visits, birth and early care of their children. Males and adolescents who have engaged in these processes could be initiated as peer-counsellors to further raise demand for the hospital’s maternity services within communities and to act as liaison personnel with clients, management and staff.

In terms of service delivery a context analysis would be useful to inform on any adjustments that may be adviseable to opening times as well as structural issues such as the fit-out of waiting and birthing areas to accommodate males, adolescents and couples in relative privacy. Linkages with health
promotion, men’s health, family planning and wider health issues would not only make positive use of waiting time, but could actively encourage male and adolescents to the hospital.

A context analysis could also inform provision for training staff to strengthen their skills in encouraging and managing male and adolescent engagement in the maternity hospital. This is important given that staff attitudes, although less tangible than infrastructure, can have a profound positive or negative impact on demand for and use of health and maternity services.

The gender and adolescent-sensitive interventions recommended here should be accompanied by wider lobbying at central government as well as strong monitoring and evaluation. These serve the multiple purposes of informing adaptations and future development of approaches, as well as providing an evidence base for the health and social benefits of actively encouraging men and adolescents to engage actively and positively in maternity.
1 Introduction

1.1 Report methodology
This report was mandated by the Swiss Agency for Development and Cooperation (SDC) to inform the planning process of the CCBRT Maternity Hospital, in Dar es Salaam, Tanzania, which has been referred to in the past as the Baobab Maternity Hospital. It also provides a review of the literature relating to male involvement and adolescent-friendly services in improving women’s access to skilled maternity services.

In the literature, the terminology surrounding adolescents is variable. According to WHO definitions, the term “adolescence” refers to the age-group 10 to 19 years, “youth” is defined as persons aged 15 to 24 years and “young people” as persons between the ages of 10 and 24. The period 10-24 years has been adopted in this paper as it comprises both the period of adolescence and youth and is therefore comprehensive in capturing the young people of concern.

As well as the literature review, a pre-report interview was conducted in-country with staff of the Comprehensive Community Based Rehabilitation in Tanzania (CCBRT) by Claudia Kessler and a second interview conducted post-first draft by Kate Molesworth of the Swiss TPH. In the course of researching and writing this report, the author engaged the broader resources of the Swiss Tropical and Public Health Institute by presenting the mandate and early findings from the literature to the Sexual and Reproductive Health and Gender Working Group. This consisted of a PowerPoint presentation to senior staff and researchers from the wider Institute who then discussed and contributed to the evolving report.

This background paper has been researched and written to support CCBRT managers and those involved in planning the new maternity hospital; other hospitals and health facilities concerned with maternity and sexual and reproductive health (SRH) services as well as members of the health network of the Swiss Agency for Development and Cooperation.

1.2 Limitations of the methodology
The literature review was largely undertaken as desk-based research. This highlighted the shortcomings in the electronic availability of some of the literature. As a consequence some documents, available only in hard copy, had to be sent between Dar es Salaam and Basel.

Some of the best practices found during the literature search also appear not to have been fully reported with regards to their progress and conclusions. While a number of case studies appeared promising in their early documentation, over time their progress has not been made publicly available. Staff rotations also appear to have hampered the continuity of some promising case studies and tracing developments in the course of this review.

Although the evidence base on gender- and youth-friendly hospitals is scant, particularly relating to the Tanzanian context, the literature yielded some research papers and case-studies, and best-practices which have a value in informing the approaches to be adopted by the CCBRT Maternity Hospital.

1.3 Swiss engagement in gender in development
For SDC, gender inequality is a theme that is mainstreamed within all the organisation’s development programmes. As a transversal theme, gender is approached holistically and dynamically, rather than simply focussing on “women” alone. SDC acknowledges that there is variation between the cultural
roles assigned to the sexes in different settings; however, it works towards equal opportunities and rights for men and women, boys and girls. SDC addresses gender issues as a fundamental approach to development, poverty reduction, human rights and health for all within the framework of the UN Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW).

Gender is one of Switzerland’s strategic priorities which SDC implements in the following ways:

- Gender mainstreamed as a cross-cutting theme;
- The support of projects empowering women;
- Advocacy towards institutional change.

To enable these processes SDC has produced a gender tool kit as well as specific thematic aids.

1.4 Rationale for this mandate

Although national efforts have resulted in progress towards reducing child mortality, maternal mortality in Tanzania remains persistently high with a ratio of 454 per 100,000 live births.\(^2\) In the Dar es Salaam region there is an urgent and unmet need for additional and quality obstetric and neonatal services as there are only four public hospitals assisting the deliveries of the municipality’s population of three million people. The Tanzanian Ministry of Health and Social Welfare (MoHSW) acknowledges that existing health facilities and service provisions are not adequate or appropriate to reduce current maternal and neonatal mortality rates. It has therefore requested the local NGO Comprehensive Community Based Rehabilitation in Tanzania (CCBRT) to establish a new maternity hospital. CCBRT was established in Dar es Salaam in 1994\(^3\), since when it has offered comprehensive clinical and community services providing surgical and rehabilitation care especially for children. Its services include orthopaedic surgeries, most commonly for clubfoot in children, eye surgery, cleft palate correction and fistula repair.

1.5 The planned CCBRT Maternity Hospital

Following the request by the MoHSW, the CCBRT has entered into a public-private partnership with the Government of Tanzania to establish a new 210 bed maternity hospital in Dar es Salaam. The CCBRT Maternity Hospital is otherwise commonly known as the Baobab Hospital and building is planned to commence this year on land donated by the government on the site of the existing CCBRT Disability Hospital. The hospital is expected to be completed in 2013, when the CCBRT Maternity Hospital will become a Zonal Designated Referral Hospital for emergency obstetric and neonatal services, providing tertiary-level services to the whole Dar es Salaam region with its three municipalities as well as the wider Eastern Zone (Pwani and Morogoro Region).

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3 For more information, visit: [www.ccbrt.or.tz/about-ccbrt/facts-figures/](http://www.ccbrt.or.tz/about-ccbrt/facts-figures/)
It is estimated that some 12,000 deliveries will be attended and 6,000 newborns cared for each year. Through the hospital, outreach and community services, the CCBRT aims to provide high quality health services in order that women and children survive childbirth without impairment. The project aims to support vulnerable mothers and newborns and to assist with improving human resource capacity within the Tanzanian health system. The European Union recently approved funding for infrastructure and developing technical skills amongst health workers in Dar es Salaam.

2 Literature review

2.1 Use of and access to maternity services

Skilled attendance of childbirth has formed a cornerstone of international guidance and national strategy towards improvements in maternal and neonatal health and delivery outcomes, maternal and neonatal mortality. In Tanzania, there has been a marked improvement in antenatal care (ANC) attendance and an estimated 96% of all pregnant women make at least one ANC visit. However, the occurrence of actual deliveries at health facilities with skilled attendance is comparatively low. According to the 2010 Tanzania Demographic and Health Survey, only 50% of Tanzanian women deliver in facilities and only 51% with skilled assistance. These patterns of high initial ANC compliance and comparatively low use of designated facilities reflect a number of barriers in existence.

A constellation of factors constrain women’s access to skilled maternity services in Tanzania. These include issues associated with proximity to health outlets, costs and transport availability, most commonly affecting rural populations; as well as socio-cultural issues such as marital status, age and the need to obtain permission from the male head of household. As well as factors relating to access, traditional beliefs, attitudes and practices also impact on the uptake of existing maternal and health services in Tanzania. The 2010 SDC-funded study on Traditional Knowledge of Traditional Birth Attendants Related to Maternal Health in Dar es Salaam and Mtwara Region revealed that particularly in rural areas women have problems accessing skilled attendance and that these problems are heightened for adolescents who depend upon their families for financial resources. This is understood to contribute to the reliance on traditional birth attendants whose practices where found to have very few benefits and some harmful consequences for mothers and their newborns.

2.2 Why involve men in maternity?

The 1994 International Conference on Population and Development (ICPD) recognized men as having an unmet need for sexual and reproductive health promotion. This was born of the experience of many

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health promoting agencies in the 1980s and 1990s, which indicated that active male participation was crucial to the success of health interventions and the empowerment of women.\(^8\)

Although the involvement of both parents in the maternity process is desirable from the modern western cultural perspective, in terms of investing in maternal and child health, the objectives of male involvement need to be identified in specific contexts to guide interventions. In many national and regional settings, men are the primary household decision-makers and therefore are key potential change-makers. This is particularly important in terms of sexual and reproductive health as masculinities and behaviours impact heavily on multiple aspects of female choice regarding reproduction, contraception and maternity.\(^9\) When this gendered power is coupled with a lack of male awareness, engagement or effective exclusion, both maternal and infant well being and survival are placed at risk.

An extensive review was conducted in 2004\(^10\) of men's roles in women's reproductive health in the medical anthropology and public health research literature. This concluded that there was substantial evidence of the importance of men in decision-making concerning female reproductive health. Furthermore the review found cumulative evidence of positive impacts of male involvement in the fields of family planning, abortion, infertility, sexually transmitted infections and HIV.

Research into HIV-positive women's access to-, uptake of- and adherence to prevention of mother-to-child transmission (PMTCT) provides significant insights into the importance of gender dynamics and male involvement in maternal and child health. PMTCT, properly administered and adhered to, is highly effective in preventing transmission of the virus from HIV-positive mothers to their infants during pregnancy, birth and breastfeeding.\(^11\)\(^12\) However, in some socio-cultural settings gender dynamics can be such that men are regarded to hamper female access and adherence to PMTCT as studies have shown in Uganda\(^13\) and Malawi\(^14\). Indeed, a study carried out last year in neighbouring Uganda\(^15\) indicated male and female roles and gender identities to act as “gate-keepers” of male involvement in the effectiveness of PMTCT. Although male involvement is widely acknowledged to be key to successful PMTCT\(^16\)\(^,17\) men are rarely included in programming and planning.

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According to staff interviewed at the CCBRT Hospital for this background paper, in Tanzania, it is rare for women attending maternity services to be accompanied by men, as reproduction is viewed as a female domain. This cultural context has diverse implications for female access to skilled services and reduces opportunities for males to engage in the safe delivery and early days of their children’s lives.

As pregnancy is biologically a female phenomenon, and in many cultures is viewed to be an exclusively female domain, in many SRH services such as family planning, women have been the focus of maternity services, to the exclusion of men in many countries. Maternity impinges upon and is highly bound by culturally-defined masculinities. Although taboos and even stigma may surround male and female roles in maternity, it is acknowledged that pregnancy, childbirth and rearing are best addressed with both male and female involvement.

Sexual and reproductive health services are generally designed for female clientele and the role of men in sexual and reproductive health is overlooked and underestimated. However, male engagement can positively impact on maternal and neonatal well-being by influencing decision-making about where and when women deliver. It can encourage broader discussions about SRH including family planning and prevention and treatment of STIs, HIV and AIDS, male sexual responsibility and reduce sexual and gender-based violence. Importantly, male engagement can encourage skilled assistance of deliveries and contribute to improved health seeking behaviour and reduce delays that are associated with maternal and neonatal mortality.

Blake’s 2010 study in Uganda identified points at which pregnant women and health care providers identify male involvement to be key. This is shown in the diagram below:

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19 USAID Interagency Gender Working Group (IGWG). No date. Involving men in sexual and reproductive health. Presentation developed by Men and Reproductive Health Subcommittee, IGWG.
Points at which Ugandan pregnant women and health care providers identify male involvement to be key. Source: Blake, C. 2010.

2.3 Delays in obtaining care

In low-income countries such as Tanzania, delays in accessing skilled maternity and emergency obstetric care may be due to shortages of trained staff, equipment and supplies as well as lack of access to appropriate and affordable transport, and the existence of infrastructure. Research on perinatal mortality in Tanzania suggests that the improvement of institutional health care may have a significant impact on the decision to attend health institutions and, thereby, reduce delays in the decision-making process surrounding care seeking. Obstacles to maternity services can be aggravated for pregnant and unmarried adolescents as staff may lack skills or be unwilling to provide services to them. According to WHO, there is an unmet need for staff to be sensitized to provide appropriate services for adolescents in a non-judgmental manner, and that service providers can be trained to do so.


Interviews conducted with staff at the CCBRT Hospital revealed a local situation whereby men are not included in the maternity process and are therefore reluctant to support and finance skilled care-seeking. There is a strong need to do so as men have important roles in women accessing medical care during emergencies as well as regular antenatal visits, by providing their consent, finances for travel, supporting women within the household and being aware of danger signs for women and neonates during pregnancy, labour and the postpartum period. In recognition of the key role of men, the National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania, contains a component to guide male involvement in the process of addressing MCH. Success is pivotal to reducing delays in accessing care and its impacts on maternal, neonatal and child morbidity, disability and mortality, as illustrated by the “Three Delays” model, which multilateral agencies have made concerted efforts in recent years to address.

The three delays model of maternal mortality (UNFPA 2005, after Thaddeus and Maine 1994)

In spite of the pivotal role men occupy in preventing maternal and neonatal mortality, there is a chronic lack of guidelines on implementing male involvement in maternity in hospitals. Indeed the literature research for this document yielded only one set of guidelines from Linz, Austria, which is set out later in this paper. Unfortunately, even the information from the Linz Gender Friendly Hospital Project is scant.

2.4 Adolescent pregnancy

Adolescents are particularly under-served in terms of SRH and yet health risks of adolescents during pregnancy and childbirth accounts for 15% of the Global Burden of Disease for maternal conditions and 13% of all maternal deaths. WHO estimates that between 14 and 15 million adolescent girls aged 15-19 give birth each year representing more than ten per cent of all births worldwide. For many of these young mothers, pregnancy is unplanned and the experience can be associated with social exclusion, fear and pain. Indeed it is estimated that 2.2 - 4 million adolescent girls undergo abortions each year and that these young women account for 14% of all unsafe abortions. Adolescent mothers aged 15-19 are more likely than older mothers to die in childbirth, while very

young mothers aged 14 and under are at highest risk. A review of adolescent pregnancy conducted by WHO identified that the higher maternal mortality among adolescents is aggravated by poor education and social status and lower use of health services.

A study by Family Health International on adolescents’ use of maternal and child health services in developing countries, revealed that pregnant girls below the age of 19 were significantly less likely than women aged 19-23 to receive skilled antenatal or delivery care. Furthermore, the infants born to adolescents below the age of 19 were significantly less likely to be immunized than babies born to older women.

2.5 Policy environment

In response to the SRH needs of adolescents and to integrate the involvement of male partners, the 33rd session of the Committee on the Rights of the Child in 2003 ratified a general agreement on adolescent health and development, stating:

“Adolescent girls should have access to information on the negative impact of early marriage and early pregnancy and those who become pregnant should have access to health services that are sensitive to their particularities and rights. State parties should take measures to reduce maternal morbidity and mortality in adolescent girls, particularly due to early pregnancy and unsafe abortion practices and to support adolescent mothers and fathers in their parenthood.”

A brief review of the policy environment revealed a substantial body of international commitments to engaging men and boys in achieving gender equality and health equity in recent years. These include:

- International Conference on Population and Development (1994);
- Beijing Platform for Action (1995);
- Programme of Action of the World Summit on Social Development (1995 & review in 2000);
- 26th special session of the General Assembly on HIV/AIDS (2001);
- Commission on the Status of Women (CSW) (2004 and 2009);
- Global Symposium on Engaging Men and Boys on Achieving Gender Equality (2009);
- UNAIDS Action Framework on Women, Girls, Gender Equality and HIV (2009);
- UNAIDS Operational Plan for Action Framework (2009);
- WHO Policy approaches to engaging men and boys, in achieving gender equality and health equality (2010).

As in many other countries, adolescent SRH is also of concern in Tanzania, as many boys and girls experience early sexual initiation. Studies have shown that girls are particularly vulnerable as almost half have sex with adults during primary school years, including with teachers and relatives. This is not only associated with early pregnancies, but also with high rates of sexually transmitted infections.

Recent studies indicate a high incidence of adolescent pregnancies in Tanzania. According to the 2004-5 Demographic Health Survey, almost a quarter (23%) of Tanzanian girls become pregnant between the ages of 15 and 19\(^1\). In most of these cases, the pregnancies are unplanned and have negative impacts on girls’ education and health. This high level of adolescent pregnancy is regarded to be a consequence of limited access to information and appropriate services and is associated with complications related to unsafe abortion as well as vulnerability to HIV and other sexually transmitted infections. Due to the persistence of stigma associated with teenage pregnancy, many girls are also forced into early marriage, either by social convention or economic necessity.

A recent cross-sectional survey carried out among in-school and out-of-school unmarried adolescents ages 10 to 19 in Tanzania was designed to identify sexual practices and risk factors\(^2\). A third (32%) of the study population reported being sexually active and 15% of the sexually active adolescents reported having multiple sexual partners. Indeed, the literature indicates a rise in the proportion of sexually active adolescents in Tanzania\(^3,4\), yet in many parts of the country there are few adolescent-friendly reproductive health services\(^5\). Young people encounter difficulties in accessing reproductive health and HIV and AIDS services as according to a 2003 assessment\(^6\), as most facilities are not youth-friendly but tend to be designed and run for adult clients.

Evidence from a number of countries indicates that insufficient antenatal care is closely linked to health complications among adolescents\(^7\). Many of the health problems associated with adolescent pregnancy and childbearing can be prevented and outcomes improved with timely and appropriate care during and after pregnancy\(^8\), particularly when antenatal care emphasises the specific medical, nutritional, and social aspects of adolescents\(^9\). Adolescents, due to their lack experience can be

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psychologically less mature and emotionally less stable than their older counterparts, which is associated with their acceptance of a lower standard of maternal and child care services\textsuperscript{50}.

### 2.6 Barriers to adolescent use of services

According to WHO\textsuperscript{51} adolescents world-wide do not often use health services because they tend to be more socially constrained than adults from seeking timely and appropriate care, irrespective of whether the pregnancy occurs within or outside marriage. In developing countries where access to antenatal care is often limited, the level of utilization of services by adolescents may be even lower\textsuperscript{52}. Evidence also indicates that when adolescents seek antenatal and maternity services, it is often delayed and of inadequate frequency\textsuperscript{53}. Factors relating to this have been identified as financial constraints\textsuperscript{54}, limited mobility\textsuperscript{55}, socio-cultural norms, lack of knowledge about safe motherhood\textsuperscript{56}, lack of service orientation to adolescents\textsuperscript{57} and providers' attitudes and lack of sensitivity\textsuperscript{58}.

The National Adolescent Reproductive Health Strategy of Tanzania\textsuperscript{59} acknowledges that many young people lack awareness of available SRH services and fear being stigmatized by adults who may regard their behaviour as irresponsible and their presence in a clinic as a possible indication of sexual promiscuity. Since the introduction of public health facilities in Tanzania in 1974, family planning and reproductive health services have been provided as part of maternal and child health services. This has led to the perception in communities that SRH services are for adult women, thereby discouraging both men and adolescents.

### 2.7 Current policy environment in Tanzania

Taking a fresh, yet contextually grounded approach to addressing the high maternal mortality rate and the high prevalence of pregnancies among adolescents, the Ministry of Health and Social Welfare (MoHSW) is emphasising the importance of male- and adolescent-friendly reproductive health services. This is reflected in the National Health Policy, the Reproductive and Child Health Strategy\textsuperscript{60}, the National Family Planning Programme\textsuperscript{61}, the National Adolescent Reproductive Health Strategy\textsuperscript{62}.

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\textsuperscript{59} United Republic of Tanzania Ministry of Health and Social Welfare. National Adolescent Reproductive Health Strategy 2010-2015. Department of Preventive Health Services Reproductive and Child Health Section
\textsuperscript{60} United Republic of Tanzania Ministry of Health. Reproductive and Child Health Strategy 2005-2010
as well as the National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Death. The government of Tanzania acknowledges that the health system infrastructure does not accommodate male and youth friendly services and that these issues must be addressed if maternal mortality is to be tackled in a holistic and effective way. Tanzania has developed National standards on adolescent-friendly reproductive health services to be provided in line with the “Essential Reproductive Health Package” of the MoHSW, in an effort to sensitively and appropriately meet the needs of young people.

In spite of the supportive policy environment there are many gaps and diverse unmet SRH needs of adolescents in Tanzania. This includes a lack of age-appropriate and accessible SRH information, a lack of community mobilization, and a lack of health worker sensitisation and training.  

Within this context, and given its commitment to gendered and culturally appropriate approaches, SDC is supporting the incorporation of male and adolescent friendly services within the pre-construction planning and development of the CCBRT Maternity Hospital. This is based on the premise that by providing an environment that is both male- and adolescent-friendly the new hospital will enhance women’s access to skilled maternity services and safer delivery services it offers.

3 Best practice examples

In spite of international commitments focusing on gender-equitable and adolescent health, very few studies in the literature report on male involvement in reproductive and obstetric care. However, some case studies are available to inform the planning of the CCBRT Maternity Hospital.

Evidence is emerging which shows that appropriately designed interventions and policies can not only have positive impacts on male and female SRH, but also influence positive social change relating to gender dynamics. A number of studies in countries as diverse as South Africa, Nicaragua and Brazil have shown that interventions with males on the promotion of healthy relationships, SRH and gender issues is associated with safer SRH practices and a reduction in sexual and gender-based violence.

In 2007, WHO conducted a review of projects and programmes carried out with males in various aspects of SRH and maternal and child health. It revealed that while research on male involvement is very limited and short-term, such interventions have resulted in positive shifts in male attitudes and behaviours in relatively short periods of time. The WHO review identified a number of features common to successful interventions. These include:

• Development of approaches informed by evidence from research, monitoring and evaluation;
• Acknowledgement that men are not homogenous and the development of approaches relevant to men’s different experiences and contexts;
• Use an ecological approach that recognizes a range of factors shaping gender roles and relations;
• Incorporation of social change strategies such as community education, community mobilization, media, policy development and advocacy for implementation;
• Integration of positive and affirmative messages;
• Encouragement for men to reflect on the disadvantages of certain aspects of masculinity to both men and women.

3.1 Guidelines on creating Gender Friendly Hospitals

One of the best-documented practice case studies was based in Europe. The Gender Friendly Hospital Project of the Allgemeines Krankenhaus der Stadt Linz (Linz General Hospital) was launched in 2005 and provides a comprehensive example of planning for male involvement. The AKH set up a working group that developed guidelines for use in all general hospitals. These included the following:

• Gender-specific education and training;
• Gender-sensitive approaches;
• Public Relations and improvement of the hospital’s image;
• Respect and consideration of the psychosocial environment;
• Customised gender-specific health care;
• Gender-specific health promotion;
• Individual advice and information;
• Use of gender-specific infrastructures - appointing gender representatives in each department;
• Identifying, defining, and responding to gender-specific needs;
• Improved access and removal of barriers in the hospital setting.

Further details of the guidelines can be accessed online in a PowerPoint presentation: http://www.hphconferences.org/archive/palanga06/htm/proceedings/II-3.4_Dieplinger.pdf. However, details of the promising Gender Friendly Hospital Project are very few and the initiative has not generated further public information.

3.2 Men in Maternity study: Male involvement yields pregnant partner health benefits

Between 2000 and 2003, a study was conducted by FRONTIERS and the Employee’s State Insurance Corporation (ESIC), a government-affiliated insurance agency for low income workers in India, on the effect of men’s involvement on their partners’ pregnancy outcome. The Men in Maternity study assessed the effect of male involvement in antenatal and postnatal care on couples’ subsequent use of family planning and behaviours to reduce sexually transmitted infections. The study took place at six ESIC clinics in New Delhi, with three clinics serving as intervention sites and three as controls. Twelve auxiliary nurse-midwives and 12 doctors were trained to provide couples’ and individual counselling to a total of 2,836 women and 1,897 of their husbands at the intervention clinics. Counselling was provided on pregnancy care and danger signs, family planning, postpartum infant care, breastfeeding, the symptoms and prevention of STIs and the correct condom use. Couples were also offered antenatal testing and treatment for syphilis. At control clinics, the pregnant women received standard care, including weight monitoring, information on nutrition, and tetanus vaccination, but very little counselling on pregnancy danger signs, family planning, or other reproductive health issues.

The study found men to positively respond to encouragement in participating in maternity care and that husbands were significantly more likely to attend the informational consultations at experimental clinics than at control clinics (28% versus 13%, respectively). Surveyed couples at the intervention clinics also reported more frequent communication on family planning than control couples (84% versus 64%, respectively) and higher engagement in joint decision-making relating to contraception (91% versus 71%).

Male involvement in maternity in the Indian 'Men in Maternity study' was found to have a sustained impact on contraception uptake, which remained significantly higher among couples who had attended intervention clinics after six months, than those attending control clinics. Added benefits of the project approach was that significantly more men and women in the male engagement group than the control group were aware that condoms provide dual protection from STIs and pregnancy.

From the service-provider point of view, the study found that health workers were supportive of training to enhance their approaches to encourage male involvement in ANC/STI and maternity services, which is a positive indicator both for effectiveness and sustainability. Clinical staff participating in the intervention found that the support and engagement of their own management together with capacity-building were key factors in the success of the intervention and its outcomes.

In terms of cost-effectiveness, the study calculated that over a two-year period the male involvement intervention cost less than USD 18,000 in the three study clinics combined and that no additional staff were required to change the approach and achieve measurable benefits from engaging male partners in the maternity process. Later research found that scaling-up of the Men in Maternity approach was both possible and sustainable at the dispensary- and hospital-levels. As staff engagement in the approach increased, investment in the development of a broader range of IEC materials was cost-effective. The lesson learnt from this study is that low-investment initiatives towards engaging men can be built around planned or existing infrastructure and staff, with appropriate training and motivation.

3.3 Policy encouragement of fathers’ involvement

In many country settings male involvement in maternity is limited by culture, practice and the legal framework of employment. As such, many men risk losing not only a day’s pay, but their jobs, if they are regarded to have taken leave of absence for an irregular or unacceptable purpose. Furthermore, examples from Scandinavian countries have shown that where government policy actively encourages male engagement, inclusive parenting and employment policies aimed explicitly at encouraging fathers’ involvement, have encouraged men's engagement in and responsibility for parenting. For example, in Norway, the introduction of the paternity leave scheme in 1993 led to a substantial increase in fathers’ up-take of paternity leave, from 4% in 1993, to 45% in 1994, to 85% by 1998, reflecting broader opportunities for men to engage in maternity and early-child-rearing processes.

3.4 Adolescent-sensitive training

A study conducted in Tanzania in four districts of the Mwanza Region (six hospitals, 24 health centres and 154 dispensaries), evaluated the scale-up of a youth-friendly services (YFS) intervention as part of the MEMA kwa Vijana Project (MkV1)70. This study found that intervention-trained health workers displayed higher levels of knowledge and a better understanding of the needs of young people than those with no intervention training. There was evidence that trained health workers were better able to recognise young people's needs for information and advice and reported themselves to be more aware of the importance of confidentiality, privacy and respect for young people.

3.5 Benefits of creating couples’ spaces

The Ukrainian-Swiss Mother and Child Health Programme, jointly financed by the Ukrainian Ministry of Health and the Swiss Agency for Development and Cooperation introduced a component relating to the accompaniment of pregnant women to health facilities. Although the monitoring data was not disaggregated by sex to enable quantitative analysis of the intervention on male involvement, counselling of men and women in pilot rayons increased male support of women throughout pregnancy, birth and child care. In an interview conducted for this background paper, the Swiss TPH manager of the project reported that the creation of couples’ spaces for counselling and training purposes had an added value in encouraging men’s engagement.

3.6 Community and facility-based approaches to male involvement

A pilot project on male involvement in maternity was carried out by EngenderHealth and USAID in central Bangladesh between 2007 and 2008. Known as the Mayer Hashi Project, it had four main components of capacity-building health workers, community education, awareness-raising and infrastructural improvements. In terms of scale, the Mayer Hashi Project trained 162 health service managers, service providers and field workers and held 250 community and group education meetings, reaching 3,000 people with messages regarding male involvement in maternity and family planning. Awareness was further raised through outreach activities and the distribution of IEC materials. Men who were satisfied with their experience of the service were recruited to provide peer-information to other men whose partners were pregnant. The Mayer Hashi Project also made a number of changes to hospital infrastructure including special signs, male designated waiting areas and toilets.

The initiative resulted in a rise in male-accompanied ANC visits and an overall increase in women attending both ANC and PNC. The following graph illustrates the changes in patterns of attendance before and during the project implementation period.

As the tables below illustrate, there was also a significant increase in men requesting vasectomy and treatment for STIs:

![Graph illustrating a rise in men accompanying partners to ANC visits in the course of the Mayer Hashi Project](image)

Throughout the course of the project changes became apparent in both client and provider attitudes and behaviours. Staff training and sensitization led to more positive attitudes of providers towards male involvement and community-level engagement increased knowledge and acceptability of male friendly services at the participating centres.
Lessons learned from the Bangladesh study show that it is possible to incorporate men’s health interests into primarily female-focused health facilities and improve both male involvement in maternity, as well as demand for male SRH and contraceptive services. In this way, male-friendly services can positively impact on the health and well-being of both men and women. The project also showed that minor changes in physical infrastructure, such as designated waiting spaces can make facilities more welcoming to men. Grassroots empowerment and community engagement were effective approaches to engaging men. Small community meetings and peer advocacy were particularly effective in referring men for SRH services and encouraging their involvement in their partners’ pregnancies.
3.7 Youth-friendly services, institutional capacity building; policy and advocacy, behaviour change communication and life and livelihood skills

The African Youth Alliance (AYA) project was a five year (2000 – 2005) initiative implemented in Botswana, Ghana, Tanzania and Uganda, supported by the Bill and Melinda Gates Foundation and executed by a partnership of the United Nations Population Fund (UNFPA), Pathfinder International, and the Program for Appropriate Technology in Health (PATH). The partner agencies provided technical and financial support to strategically identified implementing partners. AYA also collaborated closely with respective governments in operationalising and coordinating its project activities. The principal aim of AYA was to improve overall sexual and reproductive health of young people aged 10-24 years and to reduce the incidence of HIV and AIDS and other sexually transmitted infections. The framework for AYA’s youth-friendly service intervention is shown in the scheme below:

Framework for AYA’s youth-friendly service intervention

The AYA project had six major component areas: Youth-friendly services (YFS) and institutional capacity building; policy and advocacy, coordination and dissemination; behaviour change communication and life and livelihood skills. In Tanzania, the AYA initiative was established in 2001 and implemented in ten districts of Tarime, Karagwe, Kasulu, and Kibondo and the municipalities of Arusha, and Ilala, Temeke and Kinondoni in Dar es Salaam. In addition, the project was implemented in the Zanzibar Urban/West region and Pemba Island. In total, 1.2 million young people between 10 and 24 years of age in both urban and rural areas were targeted.

The objective of the youth-friendly services component was to increase the use of quality adolescent sexual and reproductive health services. The intermediate results from the component were as follows:

- Increased availability of quality youth-friendly services in the project districts;
- Supportive environment for youth-friendly service provision;
- Demand for youth-friendly services increased;

- Monitoring and supervision system established specifically for YFS clinic and outreach activities;
- Improved capacity of facilities to deliver and sustain quality youth-friendly services activities.

A number of lessons emerged from the African Youth Alliance intervention in Tanzania: The rationale and added value of integrating adolescent-friendly services in existing reproductive health services are not sufficiently understood by policy makers and health officials such as the Council Health Management Teams. Therefore, advocacy for adolescent-friendly services provision and resource allocation must accompany new innovative approaches, and health management structures must be actively engaged. The AYA project in Tanzania found that interventions were strengthened by orienting Council Health Management Teams on youth-friendly services and commissioning them to monitor and supervise the integration of approaches.

The project highlighted that health facilities often require some renovation to become youth-friendly and the training of facility staff is crucial to sensitise them to effectively meet the SRH needs of adolescents. Sensitization efforts should be carried out to raise awareness and gain community support. This together with inclusion of key community stakeholders, such as teachers and religious leaders was found to be crucial to project success in AYA districts.

Pilot projects have the potential to support advocacy efforts and public health facilities have the potential to scale-up and sustain youth-friendly SRH services. Successful integration of adolescent-friendly services at the Infectious Disease Centre in Dar es Salaam has encouraged local government authorities to replicate the YFS approach in other public health facilities using their own resources.

4 Conclusions: What is needed to improve male involvement in maternity and encourage adolescents?

Decisions for women to deliver at home or use different health services are made at the household level, and are often influenced or determined by male decision-making. Interviews conducted in the course of developing this background paper indicated that for accompanying males, a number of issues related to waiting can act as a discouragement.

The duration of the waiting period presents a host of barriers – particularly as many men experience stress related to their absence from their place of work. This may be compounded by a lack of comfortable waiting spaces and amenities such as food, water and wash-room facilities. Any negative associations with waiting may be compounded by the impression that they are in the way of busy hospital staff, or if they feel in any way disrespected. It is therefore important that staff be trained to accommodate and encourage accompanying males and that hospital design accommodates their basic needs. Suggestions are made in the recommendations section for the requisite facilities and staff issues to meet these needs.

Pregnant adolescent girls are often reluctant to use health facilities due to socio-cultural norms and stigma. This reticence can be further entrenched by their lack of experience and transport and financial resources needed to travel to health facilities. To ensure male involvement and utilization of the facilities by adolescent pregnant women, there is a need for the maternity hospital to be welcoming and user-friendly regarding physical infrastructure, services and staff attitudes to men and youth.
Cross-sectoral planning is also needed to ensure transport infrastructure appropriately serves the needs of all hospital users and those accompanying them in order that physical access is affordable, timely, safe and optimal for clinic operating times. Efforts contributing towards positive social change among both communities and health care providers are needed to support the cultural acceptance of male involvement and constructions of masculinities. This relates both to staff attitudes to accompanying males and also to women’s attitudes to male involvement in their pregnancies and deliveries. For the CCBRT Maternity Hospital there is a need to address male and adolescent exclusion from maternity services with inclusive planning and operationalisation of maternity infrastructure and services.

5 Recommendations

This section aims to be comprehensive and the recommendations offered are structured by theme. Priority recommendations are highlighted in boxes.

5.1 Steering

A working group should be established consisting of professional staff, user groups and wider civil society representation to evolve and steer the gender- and adolescent-appropriate aspects of the CCBRT Maternity Hospital development and functioning.

Guidelines should be developed and adapted from those pioneered by the Allgemeines Krankenhaus der Stadt Linz. All guidelines and training materials on male and adolescent inclusion should be translated into Swahili so as to be better understood by all health staff and concerned parties.

An adolescent- and gender-sensitive approach should be developed and linked to staff training and regulations as well as hospital policy. Acknowledging that men and adolescents are not a homogenous groups, approaches should be developed that are relevant to various sub-groups (and sub-cultures), expected within the Hospital’s catchment area. This will include sub-groups relating to age, ethnic affinities, and education.

Approaches to male involvement and adolescent inclusion must be evolved on an evidence-based foundation. Regular monitoring and evaluation, and information obtained from research should be used to hone approaches in an ongoing manner.

Gender-sensitivity and active inclusion of adolescents should be mainstreamed throughout the hospital in order to holistically support positive social change. This should be extended to community education and mobilization activities, hospital policy development, as well as advocacy, public relations and media activities and events.

The hospital should develop a policy to guide its agenda to promote male involvement and adolescent inclusion in maternity services. The policy should be developed together with local communities, gender experts and civil organisations with an interest in these themes and should include representatives of target groups. Policy development should be based upon:
- The promotion of human rights – especially that of adolescents and women;
- Offering clear and tangible advantages to men – particularly the male partners of women requiring maternity services, and also to the parents and wider families of pregnant adolescents;
- Responsiveness to the diverse men and adolescents in the hospital catchment area;
- The promotion of health equity.

Service delivery planning should provide for the special needs of, and to encourage the use by adolescents and male partners of pregnant women. This should include a careful review of opening times to include adolescents and working males. Management should research, consider and trial an approach of “fast-tracking” clients who are adolescents and/or have an accompanying male partner. This would could reduce the discouragement of adult males attendance because of long waiting times and absence from work.

Efforts should be invested in public relations to raise awareness on the focus of the hospital and its staff on adolescents and male partners. Liaison should be maintained with local and national media and linkages should be made with schools, clubs, societies and associated projects such as PASHA\(^{72}\) and SATZ\(^{73}\), where both in- and out-of-school youth can be reached to maximise awareness on contraception as well as youth friendly services offered at the planned CCBRT Hospital. Equally the maternity unit should liaise with a broad spectrum of youth and SRH projects to determine whether materials they have produced could be used within the CCBRT maternity clinic or in its community services.

5.2 Access and infrastructure

To enable and encourage all clients, users and accompanying partners to access the services offered by the new maternity hospital, the planning process should engage and liaise with the public and private transport sectors to ensure that existing and planned transport systems optimally enable physical access. For example, public bus stops should be situated as close as possible to the maternity unit and appropriate waiting shelters should be provided and maintained; and transport institutions and companies should be encouraged to run reliable, safe and affordable services for women and men to access the hospital at the necessary times.

Transport planning should also ensure that emergency transport is in place and in working order for women and their partners to access the hospital rapidly in the event of obstetric emergencies.

Although the architectural plans for the building have been completed, within the physical infrastructure the use of planned spaces must ensure the provision of waiting areas for male partners of women using the maternal services. This should include wash-rooms and toilets and private services such as food-providers and overnight accommodation.

If space and funding allow, the interior fit-out and design of the maternity waiting areas should provide designated spaces that are youth-friendly and male-friendly. In this way, young people will feel less intimidated at the prospect of spending long, empty hours waiting with disapproving adults or being seen by someone who knows them or their families; and men are more likely to feel encouraged to accompany their partners when they are assured that they can wait in a “male-designated space”. Communications systems should be installed and staff trained to appropriately assure people in the waiting rooms that they will not miss information or appointments.

72 Swiss TPH. PASHA project flyer. Prevention and Awareness in Schools of HIV and AIDS. Available at: http://www.swisstph.ch/fileadmin/user_upload/Pdfs/SCIH/scih_pashaflyer07.pdf
73 University of Bergen, Norway. Promoting Sexual and Reproductive Health School-Based HIV and AIDS Prevention in Sub-Saharan. Available at: http://org.uib.no/satz/index.htm
In youth-designated waiting areas, methods of information-dissemination and awareness-raising proven to be effective with young people could be made available, for example, an appropriately-scaled adaptation of GIZ’s Join-in-Circuit on AIDS, Love and Sexuality74 (Mitmach Parcours).

Waiting areas should be situated such that external visitors are separated from technical staff and equipment, both to ensure security and unhindered hospital functioning, and also to ensure that men do not feel that they are “in the way” of busy staff. Services beyond the waiting areas do not need to be separated as clients will have more direct interaction with sensitised staff (and this would not be efficient or cost-effective).

Signs should be carefully designed to guide males and adolescents to their designated spaces and facilities. Signs and room labels should be carefully designed to provide clear information and direction, yet not to be intimidating, embarrassing or potentially stigmatising. For example rooms with potentially delicate technical names, such as “sexually transmitted infections” or “infertility” could be given neutral names – of trees or plants for example, which are also shown in picture form to help guide illiterate clients.

The fit-out of birthing areas should give particular attention to providing couples with privacy. Men are more likely to accompany their partners and adolescents are more likely to use services where they are able to give birth privately rather than in a multiple birthing space. This is also necessary to enable and encourage men to more actively participate in the birthing process.

5.3 Positive use of waiting time
Due to the unpredictable timing of childbirth, accompanying males may have to wait long periods of time. Services should be designed and linked to capitalise on the opportunity to raise male awareness on a variety of health issues and to actively improve their health. Such services should be presented in a positive and in an “added-value” light to men’s health, rather than posing a threat of coercive testing or invasive approaches.

Health promotion, family planning, sexual health screening, men’s health and adolescent health and other services offered by the wider hospital should be linked to the waiting areas of the ANC and maternity units. In this way, accompanying males and adolescents waiting for services may benefit from broader health services, making good use of their time and improving hospital “outreach” within its own walls. Health promotion, public information and other materials and signs in the hospital should integrate positive and affirmative messages regarding hospital and staff attitudes to male engagement in maternity and the sensitivity towards the provision of maternity services to adolescent parents. Where possible, such materials should encourage men to reflect on the disadvantages of certain accepted aspects of masculinity to both men and women.

Awareness-raising on socio-cultural issues relating to maternal and child health such as female genital cutting, positive parenting and the financial responsibilities of fatherhood might be conducted through well-developed IEC materials available in male and adolescent waiting areas.

In the National Road Map, the Ministry of Health and Social Welfare considers that the unmet need for contraception is due in part to both inadequate male involvement and lack of adolescent-friendly health services. Therefore the waiting time of adolescents and male partners could be valuably used by linking with FP services, tailored particularly to the needs of these two groups.

5.4 Community involvement and outreach services

The hospital should also plan to link its service approaches with its outreach and community activities.

Apart from the opportunities for male and adolescent awareness-raising in the planned maternity hospital, efforts should be supported by awareness-raising and inclusion at the community level, and involve opinion-leaders and decision makers. In order to add social power and raise the profile of male engagement and adolescent inclusion in maternity services, a male champion should be selected from an appropriate, influential opinion leader, such as a sports personality. This action could be linked to the Ministry of Health and Social Welfare’s call for advocates and champions as part of the National Family Planning Programme.

Religious leaders should be invited to advise and support the processes of encouraging male involvement in maternity. Community-level meetings should also take place amongst spiritual leaders and hospital staff in order to identify common grounds for addressing the realities of adolescent pregnancy.

Additionally, male partners who have been particularly impressed with the approach should be encouraged to volunteer as peer-counsellors, in an effort to raise male involvement through person-to-person recommendation and dialogue.

Outreach services already offered by the CCBRT hospital should incorporate the distribution of IEC and health promotion materials relating to the male and adolescent services offered. Consideration should be given to strong linkages between the maternity unit and adolescent- and male-focussed health services including contraception, STI, fertility etc. In this way these groups may be encouraged to access these health services at the same time as visiting the hospital for maternity services or accompanying partners. As male presence at delivery is not the norm in Tanzania, outreach services should be used to inform males of what to expect during the delivery process and how they can actively support their partners both, before, during and after the birth. Approaches to enabling male attendance may need to be piloted and developed to the local context including appropriate IEC materials.

5.5 Staff and training

As many frontline staff in SRH clinics and maternity hospitals have concerns about working with male partners and adolescent clients, these concerns should be identified and addressed at an early stage in the process of recruitment of new staff and capacity-building.

Hospital management should consider the gender distribution of its staff and recruit and train to ensure that adequate males are represented among staff with high-client contact – for example receptionists.

76 EngenderHealth has experience of using a champion approach and engaging men in its Champion Project aimed at HIV prevention and addressing the underlying gender issues that drive HIV transmission. More information available at: http://www.engenderhealth.org/our-work/major-projects/champion.php
Training (both initial and refresher) must be instituted to ensure optimal staff interaction with male partners and adolescent clients. Emphasis should be placed on capacity-building staff in identifying, and responding to gender- and adolescent-specific needs.

As well as training clinical, support and administrative staff (particularly those receiving and interacting with male and adolescent clients), a mainstreaming approach should be taken in order that the entire hospital is aware of and applies male and adolescent-friendly approaches. Management should receive training and guidance on supervising, supporting, problem-solving and maintaining motivation of staff in promoting male engagement and adolescent inclusion in services offered by the new hospital.

Where training and IEC materials are inadequate, focussed materials should be purposely developed. These should be translated into Swahili.

Key managers should be identified to take responsibility both for implementation as well as monitoring, evaluation and dissemination of the CCBRT Hospital's experiences, results and lessons learned regarding male involvement and adolescent inclusion in maternity.

Staff focal persons for male involvement and adolescent inclusion in maternity should be appointed and maintained to ensure the continuity of knowledge, training-capacity and momentum, regardless of staff turnover.

### 5.6 Context analysis and tailoring approaches to local needs

Given the scarcity of research on male involvement in maternity within the Tanzanian setting, it is recommended that an appropriate specialist be engaged to conduct a context analysis to inform the planning of the maternity hospital. This should survey the following:
- Socio-cultural issues and gender dynamics surrounding maternity, reproduction and sexual health;
- What men and women want in terms of male involvement in maternity;
- What young people need in terms of adolescent-appropriate services;
- Male attitudes and the context of masculinities relating to maternity and SRH;
- Staff attitudes and training needs to deliver male- and adolescent-inclusive services.

The specialist should also prepare follow-up surveys to punctually assess the efficacy and acceptability of interventions to inform and evolve male- and adolescent-friendly approaches.

The planning process should be fully inclusive of medical and support staff, transport providers, architects, engineers and community members/potential user groups particularly represented by adolescents and males. Focus group discussions should be conducted among the latter to ensure that their needs are identified and appropriately addressed at the early planning stage. The planned maternity hospital should consider having user group-representation on its board, including males and adolescents, to ensure the long-term consideration of their needs. In this way, the nature and extent of male involvement in maternity will be adapted to the local setting, rather than European concepts and experience. Professionals involved in the structural design should be engaged from the outset in discussions of the hospital's male involvement and adolescent friendly approaches.
5.7 Further considerations

5.7.1 M&E and Advocacy
To strengthen ownership and application of approaches, Council Health Management Teams (CHMTs) should be oriented on male involvement and adolescent-sensitive services. As well as internal monitoring of progress of male- and adolescent-inclusion in the hospital’s maternity services, the CHMTs could be commissioned to supervise and monitor integration of approaches and services at the community level.

Monitoring and evaluation of progress and outcomes should be conducted with data analyses disaggregated by sex and age.

5.7.2 Wider political lobbying
Lobbying should be conducted for the necessary legal and policy supports for men to accompany their pregnant partners and engage in the maternity process.

5.7.3 Accompanying females
In the process of enhancing male engagement in the maternity process, it is important to keep in mind the crucial roles of accompanying women, who provide strong psychosocial support to pregnant women and are traditionally key to accompanying them. Therefore facilities and infrastructure, while focusing on men and adolescents should also ensure the space and comfort of female friends and relatives supporting pregnant women.

5.7.4 Traditional healers and birth attendants
Given the important role and reliance on traditional assistance in the maternity process in Tanzania, consideration should be made in staff training to encourage and accommodate accompanying healers. This would only provide reassurance to mothers, but also assist in bridging the gap between formal and informal maternity services to the benefit of pregnant women and their newborns.

5.7.5 Future scale-up
Although studies on the themes of male involvement and adolescent inclusion in appropriate maternity services are scant, emerging results of focussed approaches are promising. It is therefore crucial that the CCBRT Maternity Hospital initiative be rigorously documented, monitored, evaluated and disseminated. This will enable successful approaches to be scaled up elsewhere in Tanzania and in other geographical contexts. Although a mainstreamed and holistic approach is recommended, guidance should be concise and processes kept simple to enable existing staff to integrate new approaches and to encourage their adoption by other health institutions from the regional hospital level down to the grass-roots, dispensary level.

6 Potential resource persons and resources

Key professionals who have contributed to the dialogue, literature, research and policy on adolescent- and male-friendly services are listed below. They might be considered as specialist resource persons for the CCBRT in its planning, implementation and monitoring of approaches.

- Dr. Elizabeth Mapella, Coordinator of Adolescent Reproductive Health Services, MOHSW.
  emapella@yahoo.co.uk

- Dr. Venkatraman Chandra-Mouli, Coordinator, Adolescent Health and Development, Department of Maternal, Newborn, Child and Adolescent Health, WHO.
  chandramouliv@who.int

- Dr. Claudia Garcia-Moreno, Coordinator, Gender, Rights, Sexual Health and Adolescence, Department of Reproductive Health and Research, WHO.
  garciamorenoc@who.int

- Dr. Anna M. Dieplinger, Author of the Guidelines of the Allgemeines Krankenhaus der Stadt.

- Naomy Achimpota, AYA/Pathfinder Tanzania team.
  naomi.achimpota@undp.org

- Rose Mlay, National Coordinator of White Ribbon Alliance, Tanzania.
  wra_tz@yahoo.com

- Dr John Theopista, WHO National Programme Officer, Dar-es-Salaam, Tanzania.
  theopista@tz.afro.who.int

Further resources

- **Restless Development (Tanzania)** supports the Ministry of Education to roll out peer education across the Southern Highlands. It reinforces the National Multi-Sectoral HIV Prevention Strategy through its youth-centred approach, runs a rural peer education programme (Kijana ni Afya – Youth is Healthy) in the Southern Highlands region, and urban livelihoods and HIV and AIDS programmes in Dar Es Salaam, Mbeya and Iringa.
  http://www.restlessdevelopment.org/tanzania

- **Chama Cha Uzazi na Malezi Bora Tanzania (UMATI)** is an NGO providing Sexual and Reproductive Health (SRH) education, information and services in Tanzania. It provides youth sexual and reproductive health, with clinic and community-based reproductive health information and services.
  http://www.umati.or.tz/
  infor@umati.or.tz
  umati-reo@africaonline.co.tz
  +255 22 2117774,

- **GIZ** has produced a series of health promotion and IEC materials aimed at young people. These include resources on pregnancy, HIV and sexual relationships. They are available in English and can be downloaded from:
  http://www.gtz.de/de/themen/soziale-entwicklung/gesundheitbevoelkerung/10631.htm
7 Annex

Terms of Reference: Background paper for the Baobab Maternity Hospital
To be developed in the frame of the SDC/Swiss TPH Backstopping Mandate 2011.

Client SDC side:
Coof Tanzania (Jacqueline Matoro, Elizeus Kahigwa)

Target audience of the product:
CCBRT managers
Other hospitals or health facilities
Members of the health network of SDC

Service providers Swiss TPH:
Lead: Kate Molesworth
With inputs from Claudia Kessler following a visit at CCBRT

Relevance of service:
Acknowledging the fact that existing public health facilities are not sufficient to tackle the high and stagnant maternal and neonatal mortality rate in Dar es Salaam and other parts of Tanzania, the Ministry of Health and Social Welfare (MoHSW) has requested CCBRT to establish a new maternity hospital in Dar es Salaam – the Baobab Maternity Hospital. Since 2001, CCBRT, a local NGO, is successfully running a hospital that offers comprehensive services for long-term physical rehabilitation especially for children in Dar es Salaam.
The Baobab Maternity Hospital will serve as a Designated Regional Referral Hospital specialized in basic and emergency obstetric services as well as neonatal care. The estimated catchment area of the hospital is the whole of Dar es Salaam region with its three municipalities as well as the wider Eastern Zone (Pwani and Morogoro Region). A total of 12'000 deliveries and 6'000 newborns are planned to be attended at the Baobab Maternity Hospital annually. The Baobab hospital will be a tertiary level facility, offering high quality specialized services, a centre of excellence for service delivery, training, research and management of neo-natal and maternal services. In order to improve the whole referral chain, CCBRT will also upgrade maternal and newborn health service delivery in 9 municipal hospitals and health centres in Dar es Salaam (with funding from the European Commission). As part of its strategy, CCBRT will train health workers of other public and private facilities to deliver quality obstetric and newborn care, including emergency care.

Construction work is planned to start in 2011 and to be concluded in 2013. CCBRT will commit itself to the construction, management and service delivery of the new hospital.

In order to tackle the high maternal mortality rate and the high prevalence of pregnancies among adolescents, the MoHSW is emphasizing the importance of male- and adolescent-friendly reproductive health services. This has also been taken up in the National Health Policy and the Reproductive and Child Health Policy. In the National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Death the weakness has been highlighted that buildings of the national health system do not accommodate male and youth friendly services and that this problem should be addressed.

In this context, SDC is convinced that introducing the topic of male and adolescent friendly services at an early stage of planning of the maternity hospital is critical for the consideration of these issues in the planning and construction of the Baobab Maternity Hospital. Providing a male and adolescent friendly environment in the new hospital will be a very important aspect to enhance the women’s use of the maternity hospital. In particular adolescent pregnant women are often reluctant to use health facilities due to stigma. Decisions for
women to deliver at home or use different health services are made at the household level, and are often influenced by male decision-making. To ensure male involvement and utilization of the facilities by adolescent pregnant women, there is a need for the maternity hospital to be welcoming and user-friendly regarding physical infrastructure, services and staff attitudes to men and youth.

**Objectives of the services:**

1. **Overview on the topic:**
   - Review of studies and research papers on
     - the role of males in health seeking behavior of pregnant women and their possible involvement/place in obstetric and non-obstetric maternal health services during the prenatal period, childbirth and postnatal services
     - health seeking behavior of pregnant adolescents, and their specific needs concerning obstetric and non-obstetric maternal health services during the prenatal period, childbirth and postnatal services
     - experiences made with the implementation of male and youth friendly health services
     - good and bad practices regarding male involvement and adolescent friendly services in maternal care;
     - challenges that limit male involvement and pregnant adolescents’ access to maternal health services and successful strategies how they were overcome
     - success stories and necessary framework factors that determine success
   - Identification of resource persons / existing programmes which could provide further in-depth information / lessons learnt for technical exchange with CCBRT

**Note:**

- The literature review should ideally predominantly focus on Tanzania and practical experiences and lessons learnt in the Tanzanian context, programme set up, programme activities which proved successful over the past years, lessons learnt. In case there is not enough information available on Tanzania, the literature review should focus on East Africa
- The review should look mainly at facility based strategies and intervention, but should also report community based strategies if they are considered critical for the issue

2. **Visit at CCBRT**
   - Discussion with CCBRT about how to guarantee male involvement and adolescent friendly services through constructional measures and setup of the Baobab.

3. **Recommendations based on the literature review and the insights and discussions during the visit at CCBRT on**
   - What measures (regarding construction, infrastructure and capacities) need to be considered in order to enhance male involvement and friendly services for pregnant adolescents at the Baobab Maternity Hospital during the prenatal period, childbirth, and the postnatal period
     - What architectural design of the hospital allows best to accommodate men and to attract adolescent pregnant women with youth friendly services?
     - How spatial and infrastructural arrangements at the inpatient and outpatient department enhance the inclusion and accommodation of men and adolescent pregnant women in ante- and postnatal care and obstetric and non-obstetric delivery services at Baobab Maternity Hospital
     - Which spatial and infrastructural arrangements are appropriate (in- and outpatients department only or also for obstetric services) considering local culture, female preferences and hygienic and work conditions?
     - Are there any other activities that should be implemented at a later stage (community-based initiatives, training of hospital and referral, transport system, etc.)

**Deliverable:**
Overview paper with concrete recommendations, 15-20 pages in English

**Deadline:**
31st of March 2011

**Scope of work:**
The effective number of days worked will be billed, estimate: ten working days.