Our First Baby

Engaging First-Time Mothers and Their Partners in Mozambique

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Background

In Mozambique, marriage and childbearing start early for young women. According to the 2011 Demographic and Health Survey, among women ages 15–19, 40% are married or in a union, and 40% of women ages 20–24 give birth by age 18.[1] Modern contraceptive prevalence rates among women ages 15–24 are very low, at 9.3%, and 23% of married/in-union women ages 15–24 have an unmet need for family planning (FP). Just over half of women currently married/in union ages 15–24 say they make decisions about their own health. Globally, given the increased risks of adverse maternal and perinatal outcomes for pregnant adolescents and high rates of rapid repeat pregnancies (defined as less than 24 months after the last birth), a growing number of programs seek to address the FP needs of first-time mothers, defined as adolescent or young women ages 15–24 who are pregnant or have one child under age 2. Few programs have taken an approach promoting gender equality, designing interventions to engage male partners to address the holistic needs of the young couple. Our First Baby (OFB) is a unique, couple-based approach to increase the use of reproductive, maternal, and newborn health (RMNH) care, including FP, among first-time parents (FTPs).

Young mothers and their childrenin Mozambique. Photo by Katie Holt/MCSP.

Intervention Design

In Mozambique, the US Agency for International Development (USAID)-funded Maternal and Child Survival Program (MCSP) worked to build on the global evidence and experience by adapting My First Baby, a workbook developed by Save the Children for young mothers in Nepal. Recognizing the importance of male partners in health-seeking behaviors and household well-being of first-time mothers in Mozambique, MCSP brought a strong gender lens to the design and introduced content on gender equality, male involvement, communication, fatherhood, and gender-based violence.

OFB is a small-group approach consisting of nine participatory sessions for the first-time mother and her male partner. Sessions covered fertility, antenatal care, care of the mother during pregnancy, first-time fatherhood, birth planning/delivery, newborn and postpartum care, exclusive breastfeeding, healthy timing

[1] Ministry of Health (MISAU), National Statistics Institute (INE), ICF International. 2013. *Mozambique Demographic and Health Survey 2011*. Calverton, Maryland, USA: MISAU, INE, and ICF International.

and spacing of pregnancy, FP, sexually transmitted infections, HIV, and gender-based violence. Using a facilitator's guide and flipbook, sessions are led by community health workers, *activistas* (ACSs), who also provide referrals to participants for RMNH services. OFB is embedded in the larger MCSP efforts to bridge the continuum of care from the community to the facility in Nampula and Sofala provinces.

MCSP developed and implemented OFB in four phases: community consultations, pre-testing, pilot, and expansion. Initial **community consultations** with adolescents and young women/men and community stakeholders helped identify the knowledge and service gaps for FTPs and gather contextual feedback for the adaptation to Mozambique. MCSP **pre-tested** the adapted materials in the same communities to confirm that products reflected FTPs' inputs and met their needs. The OFB **pilot** was conducted in three districts in both provinces. ACSs participated in a 5-day training alongside their supervisors (maternal, newborn, and child health [MNCH] nurses and community development agents) before implementing the pilot. After learning from the pilot, MCSP **expanded** OFB to additional districts. In total, MCSP implemented OFB in 14 districts with 410 FTPs (271 female, 139 male).

Learning and Implications from OFB

MCSP conducted an end-of-project program documentation activity in 2019 to identify implementation challenges and promising practices for integrating FTP group sessions into the broader RMNH health service platform that could inform implementation and scale-up in other settings. MCSP conducted 23 qualitative interviews with ACSs, their supervisors, district and provincial health officials, and MCSP staff. Responses were analyzed together with qualitative responses from pilot phase monitoring forms. The OFB experience demonstrates the importance of engaging FTPs on these topics and the benefits it can bring to FTPs:

- **Benefits to participants and facilitators:** Interviewees recognized that topics were important and relevant to FTPs' lives. Several felt the groups helped reduce stigma, break down walls to communicating with FTPs about pregnancy and parenthood, and linked them to appropriate health care, including FP services. Many ACSs stated the program strengthened their skills in community organizing, facilitation, and communication, and increased their own RMNH knowledge.

- **Male Involvement:** ACS facilitators, MNCH nurses, and district health officers spoke highly of involving men and felt it was an important program component. Mobilizing men was particularly difficult during the pilot due to cultural norms inhibiting men from participating in maternal health-oriented sessions. Learning from challenges in the pilot, ACSs refined their mobilization and communication approaches, becoming flexible on the time/location for group meetings to accommodate men's work schedules. For men who attended, engagement was high: 85% attended all nine sessions. Future efforts could seek to understand and align with men's aspirations, including how men can be good fathers.

- **Government Partnership and Sustainability:** There is a strong need to engage local- and national-level stakeholders early to advocate for FTP-focused programming. Initial reluctance to embrace OFB stemmed from: 1) the perceived disconnect with national policies that focus on preventing adolescent pregnancy and ending child marriage, and 2) fears that FTP programs incentivize early pregnancy. The inclusion of the local authorities and leaders in activity planning and decision-making led to higher acceptance within the communities. In addition, selecting ACSs, who were already trusted in the communities, as facilitators proved very effective at gaining the confidence of parents and caregivers who were then more willing to allow FTPs to participate. OFB training and implementation benefits extended beyond FTPs to community health cadres, health facility staff, and district health officials by building their capacities to address FTPs' unique needs.

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