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Improving Family Planning and Maternal and Child Health Among First-time Mothers: Lessons from the Momentum Pilot in Kinshasa

PURPOSE

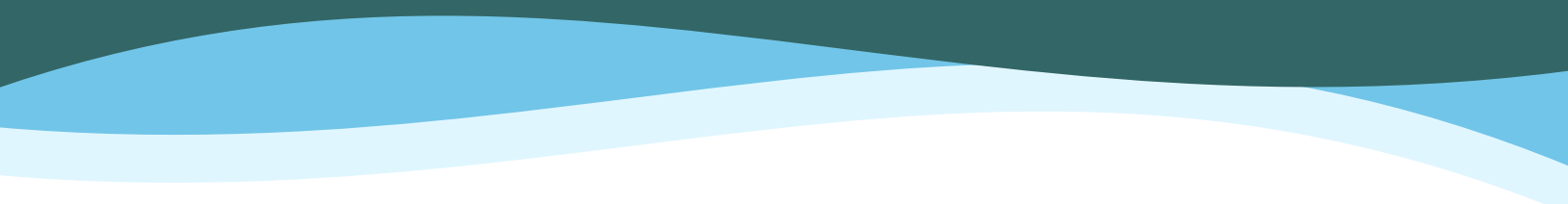
The purpose of this brief is to capture key lessons from the three-year Gates-funded Momentum pilot. We document what went well and what did not, describe solutions and adaptations implemented by the project, and identify actionable recommendations about what should be changed, scaled, or reconsidered.

EXECUTIVE SUMMARY

The Gates-funded Momentum pilot project tested a gender-transformative model of integrated family planning (FP), maternal and newborn health (MNH) and nutrition community-based service delivery, focusing on first-time mothers (FTMs) aged 15–24 and their husbands/male partners in Kinshasa, Democratic Republic of the Congo (DRC). The project's interventions included (a) home visits by nursing student providers; (b) nursing student-led and peer-assisted group education sessions for FTMs and their husbands/male partners; (c) gender-transformative community dialogue and communication; and (d) institutional capacity strengthening aimed at the development of a plan to institutionalize the Momentum model in the nursing curriculum in the DRC.

KEY FINDINGS

- Strong involvement in and commitment of government institutions to all phases of the pilot were critical for Momentum's success.
- Community health workers were instrumental in fostering project visibility and participant recruitment and retention.
- Building strong home-clinic partnerships required coordination between nursing schools, local health facilities used by the target population, and the health zone management team.
- To keep costs low, the Momentum model proposed for scale-up excluded recruiting and following the same group of pregnant women over time, tracking individual participants who have relocated, and using a digital app for counseling and referral.
- Combined home visits and group education sessions yielded better health outcomes than single interventions.



Momentum achieved significant improvements in postpartum family planning (PPFP) use, male partner engagement in maternal health and newborn care, and gender-equitable behaviors. Implementation challenges included the limited capacity of nursing schools to effectively deliver gender-transformative integrated FP/MNH community-based services at the start of the project, uneven sex ratios in nursing schools, the difficulty of recruiting pregnant women from maternity hospitals to enroll in the study, frequent relocation of FTMs, the difficulty in creating an effective referral system, and problems with nursing students' use of a digital application for health information and counseling. Strong government involvement in and commitment to all phases of project design and implementation were critical for Momentum's success in improving health outcomes. Collaboration with community health workers was instrumental in fostering project visibility and participant recruitment and retention. A pivotal lesson revolved around how to build strong home-clinic partnerships, which required coordination between nursing schools, the local health facilities used by the target population, and the health zone management team. Lessons learned from Momentum shaped the DRC government's development of the "Momentum Approach Implementation Plan", with strategic adjustments/adaptations for institutionalizing gender-integrated community-based maternal, newborn and child health (MNCH) and FP service delivery in nursing school training. In 2023, a process evaluation was conducted for the adapted Momentum implementation plan in 11 nursing schools in Kinshasa, but funding constraints precluded additional replication and scale up.

CONTEXT

The Momentum pilot addressed a complex set of health, social, and cultural issues surrounding FTMs aged 15–24 and their babies. At the time the project was designed, many teenage girls between the ages of 15 and 19 in the DRC were becoming pregnant. In fact, in 2017–2018, the number of teen births in the DRC was more than twice the global average. Most of these pregnancies—around 80%—were not planned. Many ended in abortions, a lot of which were unsafe, putting girls' health at serious risk. It was also common for girls to become pregnant again soon after giving birth. One in four girls had another baby in less than two years. This can be dangerous for both the mother and the baby. A major reason this happened was that many girls did not use contraception, even when they did not want to get pregnant. In 2018, nearly half of married girls aged 15–17 needed contraception but did not use it. The need was even higher—up to 66%—among unmarried girls aged 15–17. Unfair gender norms made it hard for girls to make their own choices about their health and future. These norms often stopped them from using FP or getting proper health care during and after pregnancy, which increased the chances of poor outcomes for both mothers and newborns. Even though many pregnant women in the country were obtaining antenatal care (ANC) and giving birth in health facilities, many women still died from preventable causes related to pregnancy and childbirth—about 846 mothers dying for every 100,000 live births— and many children died in the first 28 days of life—about 29 newborns dying for every 1,000 live births (Ministère du Plan et Suivi de la Mise en oeuvre de la Révolution de la Modernité et al., 2014). Gender norms and gender-inequitable attitudes often made it harder for young women to get FP and MNH services and limited their ability to make their own decisions about their health and their babies' health.

PROJECT OVERVIEW

Building on a project that started in Kinshasa in 2015, Momentum worked with trained third-year nursing students to help women aged 15–24 who were about six months pregnant with their first child learn about and get access to postpartum contraception and MNH services. Momentum did not just focus on young mothers—it also worked with their husbands/male partners and even their parents. The goal was to help everyone understand and support healthier ideas about what it means to be a man or a woman and to encourage shared decision-making in families.

Momentum aimed to improve the following health behaviors: contraceptive use after giving birth, use of MNH services when needed, and the adoption of healthy practices at home during pregnancy and after the baby was born. Momentum also worked to promote respect and equity in relationships and positive norms about what it means to be a man and what it means to be a woman. If a young pregnant woman named someone as her partner, Momentum involved him in the program, even if they were not married or if he was not the baby's father. Another objective was to develop a plan to institutionalize the Momentum approach within the nursing curriculum. The three main interventions were home visits and referrals for young FTMs by 150 nursing students, support group sessions for FTMs (based on Program M, *A Manual on Working with Young Women* (Promundo et al., 2006)) and their husbands/male partners (based on Program P, *A Manual for Engaging Men in Fatherhood*, Caregiving, Maternal and Child Health (Promundo et al., 2013), and community talks/discussions with parents and others. Nursing students worked in pairs. Each pair consisted of one male and one female.

Momentum was implemented between 2017 and 2020 in six different health zones of Kinshasa. Three of these health zones got the full set of interventions, while the other three were used for comparison. The pilot was led by Tulane University and included other international and local health and communication organizations, including Action Santé et Développement, Conduite de la Fécondité, Johns Hopkins Center for Communication Programs, and Tulane International, LLC. Before starting the program, Tulane staff and local partners talked with young people and youth-focused groups and conducted a literature review and formative research to make sure the planned activities fit their needs. The implementation team worked closely with the National Adolescent Health Program (PNSA), the National Reproductive Health Program (PNSR), and the Directorate of Health Sciences Education (DESS) of the Ministry of Health (MOH) (which oversees training institutes for nurses nationwide), and the Ministry of Gender to help support the work and make it sustainable. Tulane brought together a group of local experts who worked with young people to provide advice throughout the project. In the next sections, we present key implementation challenges and lessons learned from the Momentum pilot to guide future decision making and help program implementers avoid pitfalls encountered by the project.

IMPLEMENTATION CHALLENGES AND STRATEGIES

Limited capacity of nursing schools to effectively deliver gender-transformative integrated FP/MNH community-based services

- Challenge: In general, community internships help nursing students learn and practice how to keep people healthy, prevent sickness, and detect health problems early. These services are especially helpful for people who have a hard time getting healthcare because of money, gender norms, and cultural barriers, or not knowing what care is available or when to seek care.

When the Momentum project started, none of the nursing schools in Kinshasa had tools or training to address gender, PPFP, and care for mothers and newborns in an integrated way and ensure quality community-based service delivery in their educational programs.

- Practical implications: This challenge meant that, at the start of the Momentum pilot, nursing students were not fully prepared to address gender-related health needs and integrate FP, MNH, and nutrition in community care. There was a clear need to build the capacity of nursing schools—in terms of trainers, curriculum, and resources—to deliver community-based education that included gender, FP, and MNH. Adolescent girls/young women facing gender or cultural barriers would continue to be underserved if nursing students were not trained to engage them, their husbands/partners, and their parents effectively and sensitively.
- Solutions/adaptations: To address this challenge, Momentum worked with the MOH; the Ministry of Gender; and non-governmental organizations (NGOs) in Kinshasa to develop a gender-transformative FP/MNH and nutrition counseling and referral package for FTMs aged 15–24 years and their husbands/male partners. This training package included materials adapted from Program M and Program P. The adapted Program M materials focused on helping young women learn about their bodies, rights, and relationships. The training package also included technical sheets for the various tasks that nursing students would conduct. Momentum trained government staff, teachers in nursing schools (i.e., Institut Technique Medical (ITM)/Institut d'Enseignement Médical (IEM)) participating in the pilot, and 150 nursing students to deliver these services to FTMs and their husbands/male partners.

The students took a test before and after the training. If they did not pass (i.e., earn at least 70% on the post-test exam), they took an extra workshop to help them improve. During this recovery workshop, we found that some students had difficulty understanding French, which had contributed to their poor performance in the initial training. Therefore, we conducted the additional sessions in French combined with Lingala (the local lingua franca) to help the students acquire the knowledge and skills needed to conduct home visits and group education sessions. Before they started home visits, all students also received refresher training.

Momentum also conducted a training-of-trainers (ToT) workshop for the digital app to be used by nursing students for counseling and referrals. All trainers had earlier participated in the ToT workshop on the Momentum gender transformative FP/MNH and nutrition package. All nursing students (150) and their school supervisors (20) were also trained on the use of the Momentum digital app.

Uneven sex ratios in nursing schools

- Challenge: There were more female than male students enrolled in nursing schools located in the intervention health zones.
- Practical implications: The Momentum pilot targeted not only young FTMs, but also their husbands/male partners. The practical implication of this challenge included limited male engagement since husbands/male partners may feel less comfortable discussing sensitive topics like FP or gender roles with female providers, reducing their willingness to participate in the pilot study. All-female nursing student providers may have unintentionally reinforced the idea that reproductive and maternal health is only a “women’s issue,” rather than a shared responsibility. A lack of male nursing student providers could have undermined Momentum’s objective of addressing gender dynamics and promoting more equitable relationships between young FTMs and their husbands/male partners.

In addition, engaging men is key to shifting harmful gender norms and promoting shared decision-making. Without male nursing student providers, the project could struggle to influence male attitudes and behaviors effectively.

- Solutions/adaptations: Momentum recruited male nursing students from schools that were located outside of the intervention health zones and included in the DESS program to integrate FP in the nursing school curriculum. These schools included ITM Kinkole, ITM Gracia, and ITM Elikya. They provided a total of 26 male nursing students. This enabled the Momentum to put together 75 two-person teams, each consisting of one male and one female nursing student.

Difficulty of recruiting pregnant women from maternity hospitals

- Challenge: Momentum's original plan was to recruit pregnant women who were six-months pregnant from maternity hospitals where Jhpiego had ongoing Gates-funded activities to improve the quality of care for mothers and babies. It was agreed that the Momentum pilot project would take place in health zones where Jhpiego was already working. Momentum would find young women who were six months pregnant with their first baby at these hospitals and enroll them in the project with their consent. The areas chosen for the project were Kingasani, Lemba, and Matete, while Bumbu, Ndjili, and Masina I were selected for comparison. All six areas had clinics supported by Jhpiego. But after two months of intensive recruitment at these sites, only 40 out of 2,426 eligible young women had enrolled in the Momentum pilot, even though trained healthcare workers at 11 ANC clinics were helping with recruitment. The reason for the slow pace of recruitment was that women who were six-months pregnant with their first child did not use high-volume maternity clinics/hospitals for ANC, but for delivery care. Momentum aimed at initiating home visits during pregnancy.
- Practical implications: Key activities like home visits and group sessions could not begin until enough participants were recruited, slowing the entire pilot timeline. Without sufficient sample size, the baseline study would not have provided reliable information for measuring change or evaluating impact. Small or delayed sample sizes could weaken the ability to detect program effects, making it harder to assess whether the intervention was working. If women were recruited too late in pregnancy or after giving birth, opportunities to influence behaviors during pregnancy and the early postpartum period may have been lost. Staff time, training, and coordination efforts may be underutilized or need to be repeated, increasing program costs. The project needed to reassess recruitment approaches to speed up enrollment.
- Solutions/adaptations: Momentum teamed up with a local group called Conduite de la Fécondité to find young FTMs in the community. This took more time and money than expected because special workshops had to be held to train recruiters. These workshops taught local recruiters about ethics, how to choose the right women for the pilot project, how to use recruitment forms and invitation coupons/cards, and enter data into smartphones. The local recruiters worked with community relays called relais communautaires (Recos), who were trusted by people in their neighborhoods. Recos helped to find women who had moved and were lost to follow-up, talked to families who did not want their daughters to participate in Momentum, and explained why the project was good for new mothers and their babies. They also encouraged FTMs and their partners to attend group education sessions, reminded them about home visit dates, and helped spread the word about Momentum's community dialogue activities and when and where they were taking place.

The referral system

- Challenge: During home visits, nursing student providers played an important role in referring FTM and their infants to health facilities for immediate or follow-up care, which could be lifesaving. FTM were referred for immediate care from a doctor or nurse at a health facility if they reported or the nursing student observed clinical signs that something might be wrong. In the prenatal period, for example, warning signs requiring immediate referral include severe abdominal pain or bleeding; persistent headaches, blurred vision, or swelling (possible signs of pre-eclampsia); high fever or signs of infection; reduced or absent fetal movement; signs of labor before 37 weeks (preterm labor); and difficulty breathing or chest pain). Missed or delayed ANC or postpartum care; mental health or psychosocial concerns (e.g., depression or anxiety symptoms, partner violence); chronic conditions needing medical attention (e.g., hypertension, diabetes); and postpartum contraception needs that cannot be addressed at home (e.g., IUD insertion/removal, implant removal, and side effects of contraceptive use) were also requirements for immediate referral.

Nursing students referred infants (and their mothers) to health facilities if they showed danger signs (e.g., fever, lethargy, or poor feeding; jaundice, difficulty breathing or rapid breathing; convulsions; umbilical cord infection (redness, pus, foul smell); low birth weight (<2.5 kg) or prematurity; no stool or urine output in the first 24 hours; and signs of dehydration (sunken eyes, dry mouth, poor skin turgor). Infants were also referred to a health facility if they had not received postnatal care within the first 48 hours and at 6 weeks postpartum or if they had not started immunizations according to schedule. Maternal referrals for infant care also occurred if the FTM reported difficulty breastfeeding, pain, or poor milk supply.

In areas like Lemba and Kingasani, many FTM who were referred by nursing students to get care at Jhpiego-supported health facilities had trouble going. This was because the health facilities were far away, transportation was expensive, and the cost of care was high. Some FTM did not see any extra benefit in going to those health facilities since they did not offer discounts or special treatment. Momentum then made a list of the clinics that these young mothers were using for pregnancy, childbirth, and infant care, and added them to the referral system. However, some clinic staff perceived the free services provided by nursing student providers as undercutting their revenue, especially for commodities like contraceptives. Also, some clinics did not even keep track of the referrals that came from nursing students who were providing community-based services.

- Practical implications: Delays in care seeking by FTM who were referred to Jhpiego-supported health facilities (due to long distances, high transportation costs, and unaffordable service fees) were leading to missed opportunities for follow-up pregnancy and postpartum care and early child health interventions. The lack of collaboration and mistrust between nursing student community-based providers and health facilities was limiting the effectiveness of the system Momentum was trying to build. Failure to recognize or document referrals from nursing student community providers undermined opportunities to build strong home-clinic partnerships, weakening long-term health system resilience and trust.
- Solutions/adaptations: To address the challenge with uptake of referrals, the Momentum team made a list of the health facilities where FTM went to give birth or took their babies for care. Momentum staff visited these health facilities and selected 11 that were used most often. Five of them were already supported by Jhpiego.

The Health Zone Management Team (which typically oversees planning, coordination, supervision, and evaluation of health services within a health zone) met with the staff at these health facilities to explain how nursing students working in the community and clinic doctors and nurses could work together. They wanted everyone to understand that both groups offered important and helpful services. The project also set up official visits so the nursing students could meet clinic providers at the eleven referral facilities. They held monthly meetings where they talked about any problems with the referral system and how to fix them. In one meeting, for example, they decided that nursing students should remind FTMs to show the referral token when they went to the clinic. Clinic staff would then record how many mothers and babies came in with these tokens.

Frequent relocation of FTMs

- Challenge: The frequent relocation of FTMs, especially those who were never married, from one residence to another was a challenge for home visits and nursing-student follow-up care. In June 2019, for example, it was found that around 400 out of 1,219 FTMs (a third) were not found at their previous address.
- Practical implications: As Momentum was an intervention study, it would have been harder to assess whether changes in behavior or outcomes were plausibly due to the program if a large portion of participants were lost over time. Fewer participants at follow-up would mean a smaller sample size, limiting the study's ability to detect true effects or differences between groups. Additional time and resources would be needed to trace participants, delaying timelines and increasing operational costs.
- Solutions/adaptations: The Momentum team knew that many FTMs might move around a lot, so before starting field activities, they created a system to keep track of them. They collected each FTM's home address, phone number, and the contact information of someone close to them. If a nursing student could not find an FTM at her address or if the address did not exist, they used the extra contact information to try to find her. The project also worked with local partners and Recos to help find FTMs who had moved to a different part of Kinshasa. Once a new address was confirmed, the team updated their records and gave the new location to the nursing students so they could continue home visits. Nursing students were also told to stay in touch with several family members at the new address in case the FTM moved again. They were trained to do this in a respectful and confidential way. If the FTM's phone number changed, the nursing student had to update that as well.

Many FTMs participating in the Momentum pilot relocated within the intervention health zone. Only 10 out of 1,213 FTMs moved to areas outside the intervention health zones, so there was not much of a risk of contamination. Nursing students kept visiting FTMs who moved but were still in Kinshasa, even though this made transportation and supervision more expensive, especially towards the end of the project. When Tulane staff estimated the sample size, they had assumed that 25% of FTMs and an equal percentage of husband/male partners would be lost to follow-up. Therefore, the estimated sample size was increased by 25%. Of the 2,431 FTMs that were successfully interviewed at baseline, 1,927 were re-interviewed at endline. This meant that about 21% of the FTMs were lost to follow up. There was little difference between the comparison and intervention health zones in the percentage of FTMs who could not be found at endline (20% and 21%, respectively). The percentage of husbands/male partners who were lost to follow-up was higher than anticipated: 29% overall and in both the comparison and intervention health zones.

Experience with the digital app

- Challenge: To help nursing students do a better job during home visits, the project created a special smartphone app with funding from an earlier Gates-funded project, ACQUAL II. This app was created after Momentum was launched and was expected to act like a digital assistant to nursing students (help them give better advice, keep track of the young mothers and couples they were helping, refer young mothers to clinics, and make sure that the FTM's were happy with the care they got, especially after giving birth). However, in the beginning, there were some problems. The information recorded in the app did not always match the information written on paper forms. This was partly because some phones (8 out of 150) were lost, some SIM cards (10 out of 150) went missing, some phones could not be charged due to lack of electricity, and many students (74 out of 150) deleted the Momentum app from their phones to install Facebook and WhatsApp. As the app development timeline and the timeline for the nursing students to start the home visits were not aligned, the home visits began without the app, and much of the app data had to be backdated and entered manually from the paper forms. There was also not enough time to adequately test the mechanism for sending cellular data credit to the nursing students' phones. As a result, some students did not receive the credit required for them to upload their data to the cloud server. Another challenge arose because data was being sent to the students' phones at the beginning of each month, while the home visits generally took place in the middle or at the end of the month. A substantial number of students used all their data up before the home visit, despite being told that the phone was only for work purposes and should not be used for anything else.
- Practical implications: The smartphone app was meant to support nursing students in providing quality information and counseling. When phones were lost or the app was deleted, students lost a key tool meant to improve service quality and counseling. Mismatches between app and paper records also made it hard to monitor progress and track referrals. Problems like phone loss, SIM card removal, deletion of the Momentum app, lack of electricity, and use of data for purposes other than home visits and project activities would eventually raise concerns about the long-term use of digital tools for community-based nursing education in the DRC.
- Solutions/adaptations: a. Before nursing students went on home visits, Momentum held check-in meetings to make sure the app on their phones was working properly and that any unsent forms were reviewed. To prevent students from using up their phone data too early, the project worked with Vodacom, the mobile communications company, to send data the day before the home visits instead of at the start of the month. If students lost their phone or SIM card, they had to give the replacement phone back to their supervisor after the visit and could not keep it. The project also worked with key stakeholders to find sustainable ways to keep using the app successfully.

The COVID-19 Pandemic

- Challenge: In March 2020, the COVID-19 pandemic was confirmed to have reached the DRC. The Government of the DRC took preventive measures to limit the spread, including the prohibition of any gathering of more than 20 people in a meeting or in public places and the total confinement of the commune of Gombe in the city of Kinshasa. A state of emergency was imposed.
- Practical implications: The Pandemic threatened to shut down data collection for the endline study. Without the endline data, it would have been hard to know if health outcomes changed over time.

- Solutions/adaptations: Momentum amended the research protocol to consider methodologies and approaches that were best suited to the context of the pandemic. To keep everyone safe (researchers, participants, and the public), the project implemented safety precautions for data collection. Before interviews or group discussions began, the data collection team was trained in small groups, following rules like staying apart and washing hands. Trainers and trainees had to check their temperature before entering the training space. If someone had a fever or showed signs of being sick, they were not allowed in and had to follow MOH treatment guidelines. Whenever the stay-at-home order in Kinshasa was lifted, Momentum used the opportunity to collect the endline data in phases, while implementing recommended precautions to keep researchers, participants, and the public safe. These safety measures made the final survey more expensive.

STAKEHOLDER ENGAGEMENT

Throughout the project, Momentum engaged in a participatory process with a diverse group of stakeholders, including experts from various government institutions, non-governmental organizations (NGOs), and other institutions, which are listed below:

Ministère de la Santé Publique :

- Direction de l'Enseignement des Sciences de Santé (DESS)
- Direction de la Santé de la Famille et des Groupes Spécifiques (DSFGS)
- Divisions Provinciales de la Santé (DPS)
- Equipes Cadre des Zones de Santé (ECZS)
- Programme National de Lutte contre les Infections Respiratoires Aiguës (PNIRA)
- Programme National de Lutte contre les Maladies Diarrhéiques (PNLMD)
- Programme National de Nutrition (PRONANUT)
- Programme National de Santé de la Reproduction (PNSR)
- Programme National de Santé des Adolescents (PNSA)
- Programme National de Santé Mentale (PNSM)

Ministère du Genre, Famille et Enfant

Ministère de l'Enseignement Primaire, Secondaire et Technique

National and international NGOs:

- Action Santé et Développement (ASD)
- Conduite de la Fécondité
- Johns Hopkins University /Center for Communication Programs (JHU/CCP)
- Jhpiego
- Pathfinder International
- Save the Children

Local experts, including researchers from the University of Kinshasa

Beneficiaries

Momentum also established a Technical Advisory Group consisting of key staff from the institutions listed above and youth-oriented projects, such as CORDAID, DKT, IRH/Passages, Médecin du Monde, Pathfinder, Promundo, and Tearfund), to monitor progress over the life of the project and provide advice to project leadership. Through a human-centered design process, project beneficiaries (FTMs, husbands/male partners, mothers and mothers-in-law) produced prototypes for community dialogue activities, four of which were selected for pilot testing.

IMPLEMENTATION ENABLERS

While several implementation challenges were encountered, strong government leadership, collaborative partnerships, and community mobilization were key enablers, as described below:

- The strong involvement in and dedication of government institutions to all phases of the project enabled Momentum to achieve consensus on what skills to impart to nursing students for community-based service delivery; develop the gender-transformative FP/MNH and nutrition package for nursing students; agree on how to adapt Program P and Program M for group education sessions; develop and adapt integrated FP/MNH and nutrition management tools and training materials for nursing schools; identify a diverse set of trainers capable of training nursing students on the Momentum approach and providing supportive supervision during field activities; and mobilize inputs necessary for the care of sick children and the community-based delivery of family planning services (e.g., mid-upper arm circumference (MUAC) measuring tapes, child health notebooks, rapid diagnostic tests for malaria, contraceptives, etc.).
- DESS championed the Momentum intervention and brought nursing school personnel on board.
- A strong collaborative link between the Bureau Central de Zone de Santé (BCZS) and the nursing schools facilitated the supervision of home visits and group education sessions. Some BCZS offices served as meeting points for supervisors, some of whom were from government institutions, and nursing students before field teams were dispatched for home visits and group education. The BCZS was also instrumental in strengthening referral links between nursing student providers and the health facilities used by FTMs, which ensured that FTMs received comprehensive services throughout pregnancy, childbirth, and the postpartum period.
- Recos played an important role in recruiting FTMs to participate in the study and locating the addresses of enrolled FTMs. This helped to shorten the duration between the baseline interview and the date of the first home visit. Recos distributed invitations a few days before each monthly home visit, sent out reminders for follow-up appointments and group education sessions, and encouraged FTMs and their husbands/male partners to participate in Momentum activities, which helped to keep enrolled participants in the pilot for the duration of the study.
- Collaboration with other health actors enabled Momentum to mobilize resources to fill existing commodity gaps. For example, UNFPA provided contraceptives that were distributed by nursing student providers. Soins de Santé primaire en milieu Rural (SANRU) provided malaria rapid diagnosis tests, allowing timely treatment of malaria infection. PRONANUT and Association de santé familiale (ASF) provided MUAC measuring tapes to help identify malnutrition in pregnant women and children.
- The participation of all key stakeholders in monthly meetings on the Momentum digital app contributed significantly to strengthening the capacity of nursing students and their supervisors to use the app as it was intended.
- The Momentum endline dissemination workshop brought the evaluation results (discussed below) to a wide audience, also reached through local media (Congolese National Radio and Television, Radio Okapi, and Top Congo). Summaries of the evaluation results were also distributed in hard and soft form to various officials and decision-makers from various government ministries and special programs (e.g., MOH; Ministry of Gender; Ministère de l'Enseignement Primaire, Secondaire et Technique (Ministry of Primary, Secondary, and Technical Education)); United Nations organizations; international, national and local NGOs; and heads of universities and educational institutions.

KEY FINDINGS FROM THE EVALUATION

Momentum conducted a baseline survey in 2018 and an endline survey in 2020 in both the intervention health zones and the comparison health zones. Statistical analyses showed that the project led to significant improvements in FP, male involvement, newborn care, and gender-equitable behaviors. However, the project worked better for older (age 20–24) and married FTMs. FTMs who participated in the project gained more knowledge about contraception and felt more confident in making health decisions. They believed in fewer myths about FP. More women in the intervention compared to the comparison health zones talked to health workers about FP and used modern contraceptives soon after giving birth. The program was less effective for FTMs aged 15–19, especially if they were not married (Gage et al., 2024). The level of program exposure was important. FTMs who participated more fully (both home visits and group education sessions) in Momentum had better results than those with only partial exposure (Gage et al., 2023).

The project also led to significant improvements in knowledge of and involvement in MNH among husbands/male partners. Those residing in the intervention health zones knew more about danger signs during pregnancy and danger signs in the newborn than those in the comparison health zones. As a result of the project, male partners got more involved in ANC, planning for the baby's birth, and caring for the baby. The more home visits or group education sessions men attended, the more involved they became, especially with three or more sessions. However, challenges remained. The program had little effect on helping couples make shared decisions about MNH (Gage et al., 2022a). Male attitudes mattered. When husbands/male partners supported shared decision making and childcare, FTMs were more likely to breastfeed exclusively. Husband/male partners' gender attitudes, relationship quality, and perpetration of partner violence influenced some outcomes (Gage et al., 2022b).

Regarding infant health and nutrition, the project led to better care for infants and increased emergency planning. More FTMs learned about caring for low birthweight babies and using kangaroo mother care. More mothers used oral rehydration solution (ORS) and zinc to treat childhood diarrhea. The project led to small increases in exclusive breastfeeding for six months. More women in the intervention health zones made plans for emergency transport during childbirth compared to those living in comparison health zones. However, only half of husbands/male partners were reached at home during the prenatal period and only a third participated in group education sessions. Momentum did not reach 16% of FTMs in the intervention health zones. Half of FTMs had full exposure to Momentum, meaning that they were visited at home and they participated in group education sessions. Forty-six percent of FTMs did not participate in any group education sessions, although some did receive home visits. On average, FTMs in the intervention health zones were exposed to Momentum activities 5.4 times.

PROGRAM AND POLICY IMPLICATIONS

Lessons learned from Momentum shaped the development of the "Momentum Approach Implementation Plan," which was validated by the Technical Coordination Committee of the MOH in April 2022. The plan entails introducing gender-integrated community-based maternal, newborn and child health (MNCH) and FP service delivery in nursing school training: both classroom instruction plus a two-year field practicum in which students offer MNCH/PPFP services through home visits and clinic-based group education sessions.

increase the sustainability of the Momentum approach. Formal discussions among key stakeholders resulted in the following adjustments/adaptations that were included in the Momentum Approach Implementation Plan:

- Considering all pregnant women as eligible for home visits, regardless of age and duration of pregnancy. This decision was not based on reducing costs. It was made because too many women are dying during pregnancy, childbirth and after delivery, because pregnant women over the age of 25 years kept asking the nursing students for care at home, and because many pregnant women were starting their pregnancy checkups too late.
- Creating nursing student pairs for the field-based internship without considering sex (due to the relative lack of male students).
- Visiting mothers and children at home for 24 months after delivery.
- Implementing the community-based internship in the catchment area of the nursing student's school to minimize costs.
- Adopting a non-cohort-based approach (i.e., not following the same group of pregnant women and children over time; not conducting home visits for women who have moved out of nursing school catchment area (due to increased costs in terms of time, effort, and transportation).
- Designating all government health facilities (FOSA) that have integrated the minimum package of activities and established formal collaborations with nursing schools as the collaborating health facilities for the nursing community-based internship program.
- Naming DESS and DSFGS as the lead government directorates for the institutionalization and scale-up of the Momentum approach in nursing education.
- Excluding the digital app from the Momentum Approach Implementation Plan.

The nursing curriculum in the DRC was revised according to the Momentum Implementation Plan and piloted in 11 nursing schools in Kinshasa, selected in partnership with DESS and DSFGS. To capture services delivered by nursing student community providers in the national health information system, a workshop was organized in 2024 to strengthen the capacity of the nursing schools and students to (a) complete and use the DHIS-2 registers and summary sheets that were created for the Momentum-integrated/revised nursing curriculum; and (b) enter the data into the DHIS-2 page that was created for community-based FP, sexual and reproductive health, MNCH, nutrition- and gender-related services delivered by nursing students. It would be beneficial to assess whether the institutionalized Momentum approach and two-year community-based practicum in the revised nursing curriculum contribute to improved FP and MCH outcomes. However, due to deep cuts in donor funding and limited resources, there are significant financial constraints to bringing the revised curriculum to more nursing schools in Kinshasa and to other provinces of the DRC.

RECOMMENDATIONS

- Invest in the ongoing institutionalization, adaptations, and future scale-up of the Momentum approach in nursing education in the DRC.
- Introduce innovative strategies that are not only evidence-based but also culturally relevant and context-specific to promote gender-equitable attitudes and behaviors among husbands/male partners and foster their meaningful engagement in MNCH

(e.g., leverage digital technology, reach husbands/male partners in venues that they frequent, accommodate men's work schedules and availability in decisions about the timing of home visits; recruit male role models as agents of change; and offer community-based health screenings for men alongside home visits for expectant and new mothers).

- Tailor future adaptations of the Momentum model to different age and marital status groups and social contexts to ensure that the benefits of home visits and group education sessions accrue equitably.
- Continue identifying and addressing barriers to postpartum contraceptive use among never married teenage FTM.
- Structure the development and use of the app differently. Allow one year for developing and testing the app before official deployment; use App Lock or other security features from the start to prevent accidental deletion or unauthorized access; use SIM cards that are locked to the device; distribute solar chargers or power banks to address electricity shortages; and create a group of digital champions to troubleshoot issues and encourage adherence.

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