Mma wa Nnete
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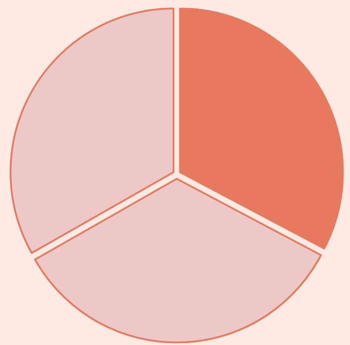
Mma Wa Nnete

An Outcomes-based, Community-Led, Scalable Approach to Maternal Mental Wellbeing

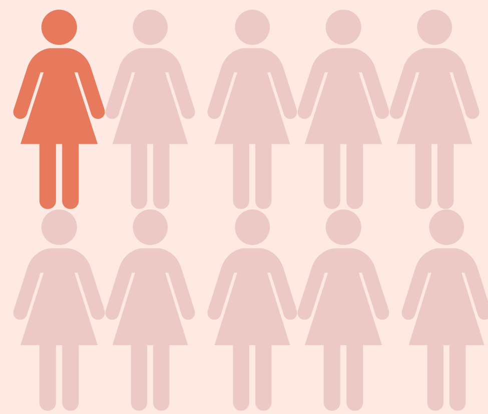
Poor maternal mental health is prevalent in Africa with devastating and intergenerational consequences

Poor maternal mental illness is **highly prevalent** in Africa. In addition, **adolescent pregnancy, sexual and gender-based violence and HIV** make mothers more vulnerable to poor mental health.

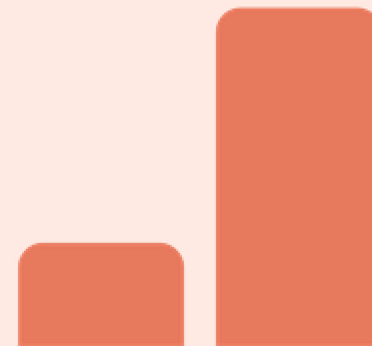
Mothers cannot care for their babies when they are struggling with their emotions. This leads to **babies that struggle** to gain weight, don't reach developmental milestones and are more likely to face mental health challenges later in life.



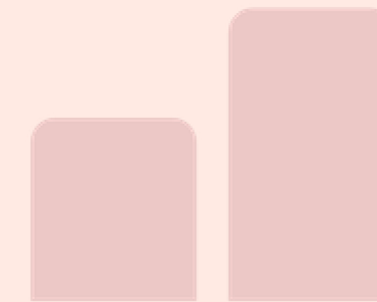
1 out of 3 mothers will experience a common mental health disorder in this period.



Less than **1 in 10** mothers diagnosed with depression receive care.



Mothers with antenatal depression have a **2.26 times** higher risk of a negative birth outcome.



Children born to mothers with perinatal depression are **1.61 times** more likely to experience adverse health outcomes such as malnutrition and febrile illness.

In South Africa, the cost of untreated perinatal depression & anxiety is **$2.8 billion USD** per annual cohort of births.

Mma Wa Nnete (Real Mother) seeks to improve the lives & life chances of mothers & babies.

> ***"I am alone in this."***
>
> **Teenage mother, rural South Africa**

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The solution is community-led, centres on mothers' voices and measures success based on the outcomes that matter most to them.

While national **policies call for the integration of mental health into maternal and chronic care**, **frontline services lack resources**, practical tools, training, and referral pathways.

Mma Wa Nnete is a step towards bridging this gap. Together with a local service provider, HBGI led the design and implementation of a Mma Wa Nnete pilot in **Limpopo, South Africa**.

Mma Wa Nnete was built around the **outcomes** that matter to mothers. It took a **preventative approach** coupled with a wider **health system strengthening objectives**.

Outcomes were co-created with mothers who told us:

- No one actually asks them how they are.
- Their social support has been weakened by their pregnancy.
- They are not aware, or don't know, how to navigate available resources.
- They don't want to go to the clinic for fear of stigma and lack of confidentiality.
- They do not have the emotional awareness or tools to cope with the challenges of pregnancy and motherhood.

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Mma Wa Nnete combined four evidence-backed elements

1 Leveraging assets within a community to support mothers

Mma Wa Nnete **worked with community groups, traditional authorities and local clinics** to increase awareness around maternal mental health, reduce stigma and encourage communities to support all mothers.

2 Embedding peer support to help mothers reduce stress and angst

Mma Wa Nnete was led by **Mother Champions**, recruited from **local communities** and with **lived experience** of maternal mental health challenges. Mother Champions **guided mothers** through their perinatal journey by offering emotional support, practical guidance and health service navigation.

3 Promoting mental wellbeing by equipping mothers, health workers and the community

Clinic staff and **community representatives** were encouraged to talk about their own emotions and equipped to facilitate **wellbeing conversations** with mothers. **Co-created, culturally resonant resources** and tools (e.g. emotion identification chart) were used to support mothers and those interacting with them.

4 Managing against outcomes to inform larger systems change

Real-time evidence was generated from interactions with Mother Champions, the health system and mothers themselves. This was used to **engage with government** and key **system partners** to be **responsive** to the needs of mothers, **inform improvements** and support **scaling decisions.**

> ***"When I started the programme, I was terrified…Meeting a Mother Champion changed everything."***
> **Mother, Limpopo Pilot**

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To keep a continuous feedback loop between programme activities and outcomes, Mma Wa Nnete was paid on a set of outputs, outcomes and impact.

Activities

- Build health workers' capability
- Engage with community structures, faith-based, traditional, education etc.
- Build community-based organisations' capability to support mothers.
- Community awareness activities.
- Integrate tools & resources into points of care with expectant mothers/mothers.
- Share tools & resources with mothers.
- Build mothers capability to utilise tools & resources.
- Provide peer support interactions.
- Invite mothers to support platforms (moderate & facilitate platforms).

Outputs

- Mothers are enrolled on the programme and support platforms.
- Healthcare workers check on a mother's wellbeing and support her.
- Community members check on a mothers' wellbeing and support her.
- Mothers use tools & resources provided by programme.
- Mothers participate on support platforms.
- Postnatal wellbeing check-in completed with mother.
- Referrals are made for mental health escalation.

Outcomes

- Mothers know what they feel & what to do to cope if they are not ok.
- Mothers know what to expect during pregnancy, delivery, when their baby arrives
- Mothers have someone who asks if they are ok & with whom they can rely on for support.
- Mothers feel happy they are a mother, enjoy caring for their baby and want to ensure they are immunized & have regular check-ups.
- Antenatal 1st visit before 20 weeks rate improves

Impact

- Improved maternal mental wellbeing.
- Mothers and babies have better health outcomes including improved vaccination, prevention of mother to child HIV transmission & viral suppression.
- Babies achieve predetermined developmental milestones.

Possible paid results.

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The pilot was successful - it confirmed need & demand, supported 1800 mothers through their perinatal period, & helped mothers to achieve the outcomes that mattered to them.

We discovered that:

- Mental health support improves health seeking behaviour, which reduces risks for mothers and babies - **early antenatal attendance improved from 59% to 75% in 10 months**.
- **Additional support needs** of mothers whose perinatal journey does not end in a live birth - 3% of all mothers on the programme had miscarriages or stillbirths.
- Mothers with improved mental wellbeing started to **adhere to anti-retroviral therapy and brought their child in for regular testing.**
- Mothers started **advocating for themselves e**nquiring about support to seek employment and assistance in supporting their baby's development.

Most mothers were able to achieve the outcomes that mattered to them through support from a Mother Champion and meaningful connection to existing services within the community.

- 86% of mothers could **name their feelings and identify a coping strategy** to deal with negative emotions.
- 80% of mothers **knew what to expect** during pregnancy and childbirth.
- 84% of mothers reported they **felt someone cared** about their wellbeing.
- 97% of mothers reported they **felt connected to their baby**.
- **5% of mothers were referred** to specialized mental health services when the need for extra help was identified.

Mma Wa Nnete was built for scale, leveraging the infrastructure and approach built in the pilot and adapted for local implementation

Locally Created and Community Led

- Proven uptake from mothers, community-led.
- Asset based and preventative.

Outcomes-based

- Allows for flexibility & responsiveness.
- Creates systems change.

Integrated

- Supports referral pathways with the health system.
- Builds health worker capability.
- Works with existing investments in maternal, child, and chronic disease care.

Partnerships

- Supported by the Ministry of Health, South Africa.
- Connected with local and regional partners to support greater reach and deepen impact – Reach Digital Health, African Alliance for Maternal Mental Health etc.

> ***"I supported a mother whose HIV viral load was 2994 copies in September. I had a serious talk with her, and she told me her reasons, but we had an agreement, and we set a reminder through her phone . Today I received her results from 2994 copies- 1104 copies . My goal is for her to be on < 20. The most exciting part is that her baby's PCR is negative."***
>
> **Mother Champion, Limpopo Pilot**

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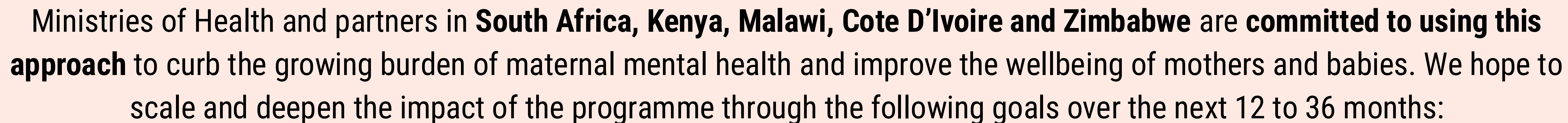
Our Plan and the support we need to reach thousands of mothers and babies across Africa



Ministries of Health and partners in **South Africa, Kenya, Malawi, Cote D'Ivoire and Zimbabwe** are **committed to using this approach** to curb the growing burden of maternal mental health and improve the wellbeing of mothers and babies. We hope to scale and deepen the impact of the programme through the following goals over the next 12 to 36 months:

We are looking for strategic funding partners to help us reach these goals

1

Continue implementation in South Africa to reach 3000-6000 more mother-baby pairs, working with the South African Department of Health and community groups to strengthen their capability to deliver elements of support to mothers across the country.

2

Adapt the programme to be delivered in two other Southern or East African countries to reach a further 2000-4000 mother-baby pairs, while exploring the pathways to sustainably support mothers and babies in these countries.

3

Develop and run a controlled study alongside an implementation programme, to enable the rigorous evaluation of maternal wellbeing outcomes alongside measurable maternal and child outcome indicators, and a review of the cost effectiveness of the programme.

"This intervention is very responsive to the problem of high prevalence of psychological distress and low resources available – we need to think about more universal interventions like this"

Executive Committee Member, African Alliance for Maternal Mental Health

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Annexures

1. Evidence Base
2. Discovery Phase
3. Tools & Resources
4. Outcomes-based Contracting Learnings
5. Operating Costs

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The Evidence Base for Mma Wa Nnete

The programme combines four evidence-backed elements, each supported by empirical research from comparable low and middle-income countries. There is also strong early implementation evidence from the Mma Wa Nnete pilot itself.

Integration into routine maternal care

A review published in Frontiers in Psychiatry examined studies that integrated perinatal mental health interventions into routine maternal healthcare services across multiple LMICs in Africa and Asia.
The finding was that nearly all trials included **reported significantly greater reductions in depression and/or anxiety symptoms among women receiving interventions compared with usual care.** The conclusion was that embedding mental health support within routine maternal
services is feasible and associated with improved maternal
mental health outcomes.

Health-worker training and supportive supervision

A quasi-experimental study evaluated training and supervision for primary healthcare workers in Ibadan, Nigeria. Following structured training to integrate maternal depression education into routine care, 40 clients in intervention facilities sought help for depressive symptoms, compared with none in control facilities. **This suggests that structured training combined with supervision can meaningfully increase detection and help-seeking.**
Complementing this, is a study that explored healthcare providers' perceptions of maternal mental health services for adolescent mothers in Malawi.
Providers identified inadequate staff development, unclear referral systems, and cultural beliefs as major barriers to effective maternal mental health support. This supports the need for structured training and community engagement.

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Peer-delivered psychosocial support

A community-based peer support intervention for adolescent mothers in Zimbabwe evaluated the impact of structured peer engagement and showed that **the intervention group reported significantly lower depressive symptoms and common mental disorders and higher levels of peer and overall social support compared with controls.** Participants also demonstrated **improved coping and communication strategies.** This supports the use of structured peer supporters (Mother Champions).
Further, a trial conducted in Malawi evaluated a Friendship Bench intervention for postpartum women with HIV. The trial reported **improved depression remission, improved retention in HIV care,** and **higher viral suppression at six months postpartum** demonstrating a **plausible pathway between psychosocial support and chronic disease management.**

Cultural adaptation and emotional regulation mechanisms

A study in Sierra Leone documented the cultural adaptation of the Friendship Bench intervention using structured adaptation frameworks.
The study demonstrated how **structured cultural adaptation can maintain fidelity while improving contextual fit**, supporting Mma Wa Nnete's localisation approach.
Additionally, a 2024 South African observational study (using regression modelling), found **significant positive associations between depressive symptoms and emotional regulation difficulties,** supporting the plausibility of **interventions that strengthen emotional identification and coping skills.**

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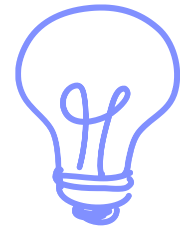
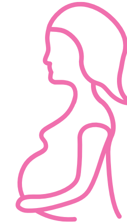
The Discovery Phase: What Mother's said their Mental Wellbeing Needs are

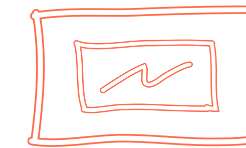
Mma Wa Nnete utilised a human-centered design process to listen to mothers.



We set out to **understand** the mental wellbeing needs of mothers, according to mothers themselves.



We conducted **immersion interviews** & **focus groups** with mothers, healthcare workers and community leaders.



6 key findings emerged which guided our understanding of **peripartum mental health challenges** in our setting.

Key Findings

- Mothers feel isolated.
- Mothers feel unprepared and vulnerable.
- Mothers are not aware of or can not express their emotions.
- Mothers have no one to ask how they are.
- Mothers feel that they have lost themselves and their dreams.
- The quality of relationships influence a mother's mental wellbeing.

"I have been beaten my whole life: by my mother, my father, my brother, and now my husband. Sitting here today is the first time I have ever been told that this is not normal. That it is not ok. That there is a reason I feel this way."
Mother, Limpopo

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The Discovery Phase: Mapping for Additional Vulnerabilities (adolescent motherhood)

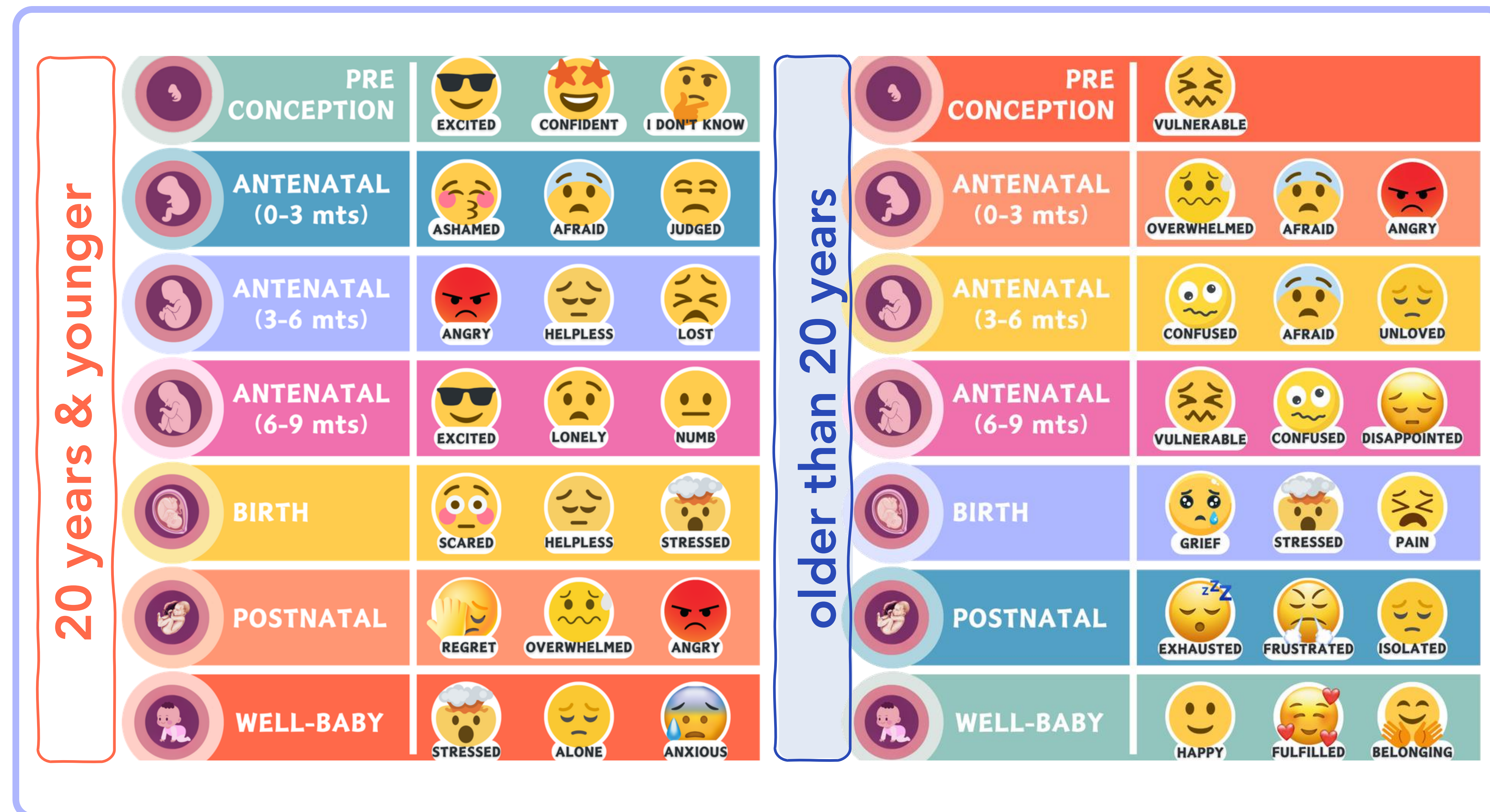
Adolescent mothers have a **30% higher likelihood of developing a common mental health disorder** in the perinatal period than their adult peers. Around **12.9% of mothers in Limpopo are aged 20 or less.**

As part of the human-centred design process, HBGI **mapped the emotional journeys** of **adolescent mothers** and mothers aged 20 and older across the pregnancy and postnatal period.

The mapping revealed a striking divergence: while older mothers' emotions often improved following the birth of a healthy baby, **adolescent mothers frequently continued to report negative emotional states** even after a positive birth outcome.

These insights directly informed the design of **targeted support tools** and **age-responsive intervention strategies.**

This tool was used to identify critical emotional inflection points and to understand how different age groups experience pregnancy and early motherhood.



Mma Wa Nnete Tools and Resources

Cuddle box:
helps a mother prepare psychologically for the arrival of her baby & provides guidance to build the mother-baby bond after birth.

Emotional wheel:
to identify & manage emotions.

Mama Mooki Booklet:
to share what pregnant girls & women can expect & locally relevant guidance on how to navigate this.

Cuddle Box

Why? Being pregnant and the idea that you will be responsible for a new baby can be overwhelming. You can help your mind by preparing a box of practical items for the baby. This will help you start connecting with your baby and preparing mentally for their arrival. It will also be useful to help you connect with your baby when they are born.

When your baby is born, you use these items with your baby, and it will help:
- your baby learn what is its body and what is not – where its body ends.
- the baby understand its position in the environment.
- grow your confidence and bond with the baby.
- improve the baby's sense of touch.
- build the baby's language.
- develop the baby's muscles.

Playing with your baby is important for their health.

When? Before bath time or time between housework is a good time to use to prepare your cuddle box.

While using the items:
- Talk to your baby softly and gently – name body parts as you interact with your baby.
- Make eye contact with your baby.
- Hum and sing quietly.

What to collect?
- Ear Buds
- Cotton Wool
- Vaseline
- Baby Cream
- Face Towel
- Mirror

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How to use the cuddle box items when your baby arrives.

Ear Buds
- Gently press earbud at end of each finger
- Gently press earbud at end of each toe
- Gently draw a line along each finger from middle of the hand to the end of each finger

Cotton Wool
- Can be used both wet and dry
- Wipe over skin
- Name body parts as they are touched with cotton wool – e.g. elbow, knee, nose, cheek, chin

Face Towel
- Can be used both wet and dry
- Wipe over skin and name body parts as you wipe
- Use to cover your face and then uncover your face (peekaboo)

Mirror
- Let baby look into the mirror – talk to the baby about what he/she sees
- Let baby touch the mirror to try understand what they see

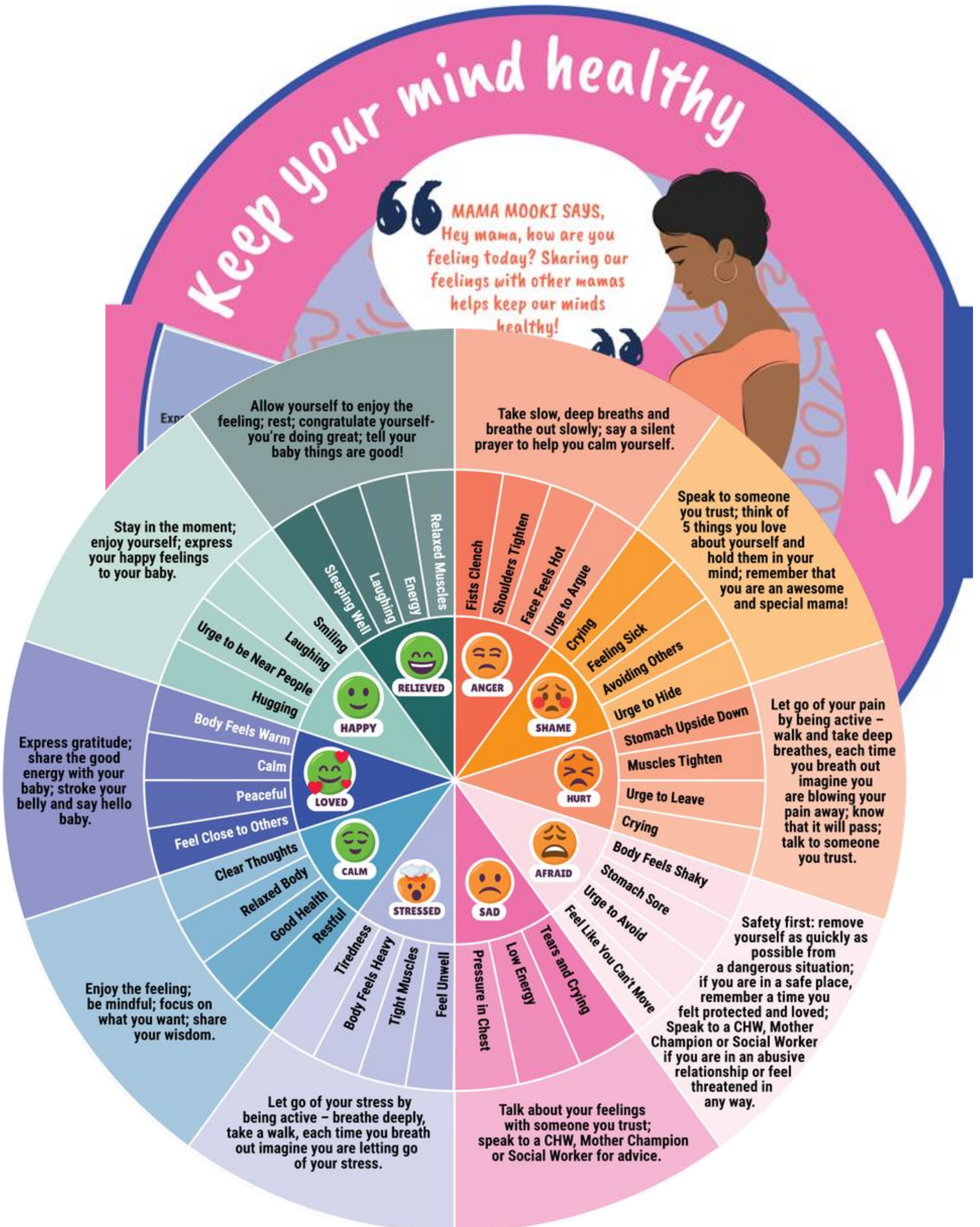
Tummy Time
- Lie your baby on a blanket/towel on their tummy
- Place a small soft object like a rolled-up towel or cloth in front of baby
- Place a rolled-up towel or cloth to the side of baby
- Clap hands at each side of baby

Vaseline
- Rub onto face, hands, feet
- Name body parts as you rub – cheeks, fingers, hands, arm etc.

Baby Cream
Use to rub the baby – arms, legs, body

Additional bonding opportunities
- Breastfeeding
- Skin-to-skin contact
- Wrapping up the baby
- Rocking the baby

Created in collaboration with educational psychologist Janet Brown.



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Hello!
I'M MAMA MOOKI!

Becoming a mum can be one of the best... and one of the scariest things you can do. Having the support of people in your life that you trust is how you'll do this. These are people that encourage you when you feel stressed and remind you that you're doing your best- and that your best is always enough.

I am one of them and I'm here for you! You are not alone.
This is my advice on what to expect when you're pregnant.
We will walk this journey together!

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Outcome-based contracting learnings

Focusing on the outcomes that matter to beneficiary partners	• Beneficiaries should lead in the design and implementation of programmes. • An asset and not deficit approach must be taken when working with communities. **Lesson:** People have the solutions for their own lives they just need a safe space to explore this.
Navigating Risk in a Pilot Phase	• A collaborative, transparent contracting process with risk-sharing mechanisms built trust and reduced anxiety. • **Lesson:** Open, frequent engagement with partners helped demystify outcomes-based models and build internal buy-in.
Investing in Performance Management Pays Off	• Developing the performance management system and processes took considerable upfront time and effort: we built a tailored app using CommCare for real-time documentation by mother champions - integrating outcome verification with Department of Health data systems and created a live dashboard to track progress. • **Lesson:** Performance management isn't just about funder accountability — it's a programmatic asset.
Balancing Capital and Outcomes	• Structured staggered payments, combining start-up capital with incentive-based releases, to ensure liquidity while promoting accountability. • **Lesson:** Co-designing the financial structure fosters fairness and shared commitment across all parties.
Building Internal Capacity for Future Models	• Engaging in the outcomes-based process requires a mindset shift — from compliance to results-driven thinking. Our provider now has increased confidence and skill to pursue and manage future outcomes-based contracts. • **Lesson:** Piloting innovative financing models is a capacity-building opportunity, not just a funding mechanism.
Collaboration is the Cornerstone	• Each partner (Right to Care, HBGI, Anglo American, Matchboxology) brought different strengths to the table — from clinical credibility to behavioral insights and funding strategy. • **Lesson:** Success relied on mutual respect, flexibility, and a shared vision rather than rigid roles.

The Operating Cost of Mma Wa Nnete for 18 months

Cost per mother for continuation in Limpopo is $134 USD per mother per year.
Expansion to a new location will require a discovery and adaptation phase before implementation

Description	Cost
Mother Champions & Supervision	$275,000
Outcomes Technical Assistance & Performance Management	$150,000
Monitoring & Evaluation	$110,000
Direct costs, travel, resources for mothers, equipment	$195,000
Overheads	$73,000
TOTAL	**$803,000**

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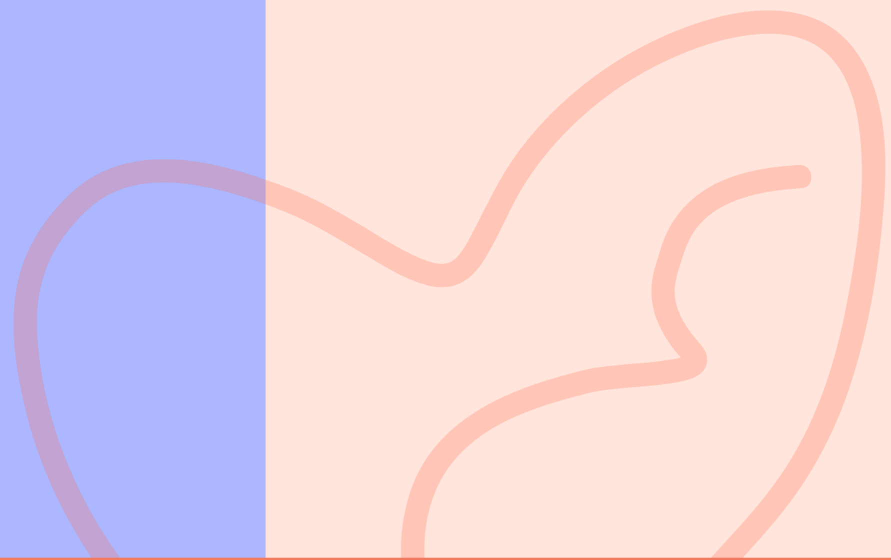
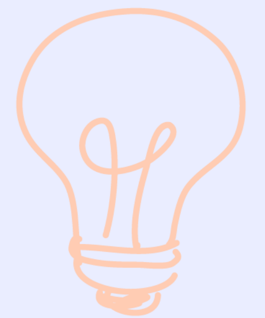
THANK YOU





"People have the solutions for their own lives, they just need a safe space to explore this."

- Mother Champion