

mothers2mothers: A Simple Solution to a Complex Problem



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What is the prevalence of paediatric AIDS?

Mother-to-child transmission of HIV has been virtually eliminated in resource-rich countries yet everyday more than 600 children worldwide are newly infected with HIV. Almost 90% live in sub-Saharan Africa and nearly all of them acquire HIV from their mothers during pregnancy, childbirth, or breastfeeding. Approximately half of these children will die before the age of two if their HIV goes untreated. Furthermore, AIDS is a leading cause of maternal mortality resulting in many children losing their mothers in their early years.

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If a pregnant woman has HIV, what is the risk that her baby will contract HIV?

Safe, effective, affordable medications and other interventions, such as safer breastfeeding practices, can significantly reduce mother-to-child transmission of HIV and keep HIV-positive mothers healthy to raise their families. If a pregnant woman with HIV receives

anti-retroviral medications (ARVs) for the duration of the pregnancy, delivery and breastfeeding period, the risk of transmission to her baby can be as low as two percent. If a mother living with HIV receives no medical intervention for her HIV during breastfeeding, there is an approximately 60% risk that the baby will become infected with HIV.

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If prevention is possible, why is paediatric AIDS a problem?

The reason paediatric AIDS is still so prevalent in sub-Saharan Africa is that medicine does not equal medical care. Administering tests and prescribing drugs is simply not enough. Fragile health systems and the acute shortage of skilled medical practitioners in resource-poor countries has prevented the optimal distribution of information and medical care, including services to prevent mother-to-child transmission of HIV. [Sub-Saharan Africa carries 25% of the global disease burden and yet has only 3% of the world's healthcare professionals](#), which means that doctors and nurses frequently have only minutes to give a woman her HIV diagnosis and explain the treatment regimen. Often, this brief interaction is further limited by gaps in language and shared experience, leaving the young pregnant mother terrified, confused, and with nowhere to turn.

Furthermore, the stigma associated with HIV in many African communities prevents women from telling their partner and family out of fear they will be abandoned or abused. There is a significant positive correlation between disclosure and adherence to medical treatment.

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How do mothers2mothers prevent transmission of HIV from mother-to-child and keep mothers alive?

Effective, inexpensive medical interventions can prevent the spread of HIV to babies and protect mothers' health. Yet, in under-resourced health clinics in sub-Saharan Africa, medical professionals normally do not have the time to provide women with the information and support they need to seek medical care. mothers2mothers (m2m) fills the gap between medicine and medical care and bolsters health systems. m2m's Mentor Mothers are mothers from the community, living with HIV, who are trained to work alongside doctors and nurses as paid members of the healthcare team. Mentor Mothers provide essential information and support to HIV-positive pregnant women and new mothers about the medical interventions necessary to stay healthy and have a healthy baby. This makes for a very different picture on the ground. Instead of being rushed through a medical appointment, a newly-diagnosed woman is taken into a room filled with other HIV-positive women. A Mentor Mother sits down with the woman and tells her that she is HIV-positive too, is living a healthy and productive life, and that she has children who are HIV negative. The Mentor Mother takes as much time as is needed to educate the woman about all of the necessary tests and drugs, and then continues to give her information and support every step along the way, through pregnancy, labour, and early childhood.

Mentor Mothers' first-hand knowledge of HIV and the power of shared experience makes them particularly effective in encouraging HIV-positive pregnant women and new mothers to come to terms with their HIV status, disclose to families, adhere to lifesaving medical regimens, and deliver babies in health care facilities. These actions can help prevent transmission of HIV from mother-to-child and improve health and wellbeing of mothers. In addition, their m2m employment professionalises them, providing financial independence and positions them as respected role models in their communities, countering HIV-related stigma.

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What's the treatment regimen to prevent transmission from mother-to-child?

The basic treatment regimen to prevent mother-to-child transmission of HIV is straightforward. A pregnant woman may already be on anti-retroviral drugs (ARVs) when she becomes pregnant or will begin ARVs if she is diagnosed as HIV-positive when prenatal care begins. The medical intervention available is guided by a country's national policy as defined by three treatment options:

- Option A: In some countries, mothers will receive one drug for the duration of pregnancy if they have early stage HIV infection and three ARVs for the duration of pregnancy if they have more advanced HIV.
- Option B: In other countries, pregnant women are started on three ARVs irrespective of the stage of their HIV infection. For these women, pregnant mothers undergo treatment for the duration of pregnancy and breastfeeding and then they stop ARVs unless they have advanced disease.
- Option B+: Still other countries have a policy of continuing all mothers on ARVs for life, irrespective of the stage of their HIV infection.

There are pros and cons associated with all three options, although UNICEF and the World Health Organization (WHO) have recently recommended Option B+ whenever possible. All babies born to HIV-positive mothers are treated with ARVs for four to six weeks.

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Can an HIV-positive mother breastfeed her baby?

While replacement feeding (feeding infants with formula) is the only 100 percent effective way to prevent mother-to-child transmission of HIV after birth, in many parts of the world safe formula feeding is not feasible. This is due to a range of factors – the high price of formula, limited access to clean water, the deleterious effects of replacement feeding, the social and health-related benefits of breastfeeding, and the cultural stigma associated with not breastfeeding. Therefore, the [World Health Organization](#) recommends that HIV-positive mothers in low and middle-income countries breastfeed exclusively for the first six months of their child's life while simultaneously taking a regimen of antiretroviral drugs. If the mother is on life-long ARVs and the baby is breastfed, the baby does not need additional drugs. The ARVs the mother takes protect the baby from HIV infection through the consumption of breast milk, reducing the risk of transmission to about two percent. If the mother is not on ARVs after delivery and the baby is breastfed, the baby continues to be treated daily with ARVs for the duration of breastfeeding.

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How much do antiretroviral drugs cost?

When antiretroviral drugs (ARVs) first became available in 1996, a one-year supply for one person cost between [\\$10,000 and \\$15,000](#). Though the drugs were very effective (the death rates for people with AIDS in high-income countries dropped by 84 percent in just four years), only two percent of infected people in low-income countries received the life-saving treatment during the next five years because the cost of the drugs was too high.

In 2000, pharmaceutical companies, influenced by the development of generic ARVs and a resulting price war, as well as pressure from AIDS activists and governments of countries with severe AIDS epidemics, lowered ARV prices. By 2001, three-drug combinations of ARV therapy were available from generic manufacturers for as little as \$295 per person per year.

The cost of ARVs has continued to drop due to a greater number of generic drugs on the market and government-level price negotiations with major pharmaceutical companies. There are many new ARV therapies now, some more expensive than others, but according

to UNAIDS, the average cost of basic medicine is [less than \\$100 per person per year](#) in low-income countries.

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How many people are being treated with antiretroviral drugs in sub-Saharan Africa?

The number of people receiving antiretroviral (ARV) treatment for HIV in sub-Saharan Africa has increased by [100-fold in less than a decade](#). According to UNAIDS, 10.7 million people were accessing antiretroviral treatment in 2014. By the end of 2014, an estimated 41% of people eligible for treatment in sub-Saharan Africa were accessing it, up from fewer than 100,000 people in 2002. This is largely due to the major decrease in the price of ARVs, increased efforts by donors to provide financial resources to countries to purchase ARVs, and the increased capacity of health systems and their partners to deliver ARVs to people who need them.

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Are pregnant women and new mothers with HIV generally willing to take ARV drugs in sub-Saharan Africa?

Pregnant women and new mothers living with HIV are often too fearful or disempowered to pursue medical information, services and treatment because they are uninformed and face gender discrimination, HIV-related stigma and the disadvantages imposed by poverty. However, with adequate education and support, these women are often eager to get the best possible outcomes for their infants and have the opportunity to sustain their own health.

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How many Mentor Mothers does mothers2mothers employ? Where do they work?

As of November 2015, mothers2mothers (m2m) employs over 1,200 Mentor Mothers at approximately 340 sites in six countries (Kenya, Lesotho, Malawi, South Africa, Swaziland, and Uganda). More than 1.3 million HIV-positive women have been reached by our programme since the organisation was founded in 2001.

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What is the impact of the Mentor Mother programme?

In 2012, mothers2mothers (m2m) enrolled almost 152,400 new HIV-positive pregnant women and new mothers into the programme. A recent internal evaluation confirmed that m2m has a tangible, positive impact on the health of mothers and their babies:

- *ARV uptake during pregnancy:* Mothers attending m2m programmes in most of the countries where we work are more likely to use antiretroviral (ARV) medications than the national averages. For example, in Lesotho, 99% m2m clients received ARVs to reduce mother-to-child transmission of HIV, compared to 62% nationally. In Uganda, 96% of clients received ARVs versus the national ARV uptake rate of 50%.
- *Infants receiving ARV prophylaxis:* The infants of HIV-positive mothers in m2m's programme are more likely to receive ARV prophylaxis within the first 24 hours of birth, which is highly recommended to protect them from HIV. UNICEF estimated that 55% of exposed infants received ARV prophylaxis in eastern and southern Africa in 2011, compared to 89% of infants in m2m's programme in 2011 and 95% in 2013.
- *Early infant diagnosis (PCR test):* Participation in m2m's programme also increased the likelihood that an infant will receive a test to determine their HIV status, which is critical in order to put infants who are HIV-infected on the medications they need to stay healthy. The PCR (Polymerase Chain Reaction) test provides the most accurate HIV diagnosis for children younger than 18 months born to HIV-infected mothers. At

m2m, infant PCR testing was 87% in 2013, which is much higher than global testing rates. UNAIDS estimates that globally the early infant diagnosis rate is 35%.

- *Mother-to-child transmission rate:* Women who visited an m2m site during their pregnancy and continued to participate in m2m's programme after their child's birth had a significantly lower mother-to-child transmission rate (1.9%) than mothers who came to m2m only after they had their baby (5.0%). This suggests the possible impact that m2m's education and support services can have during pregnancy in helping mothers keep their babies healthy.

Furthermore, the knowledge and skills Mentor Mothers acquire working for m2m – the latest in HIV care, public speaking and experience working in a professional context – make Mentor Mothers highly employable after they move on from m2m. A study conducted in 2011 of former m2m Mentor Mothers in Kenya found that 85% were formally employed post-m2m, compared to only 44% before their engagement with m2m.

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What is the Global Plan?

In 2011, world leaders committed to achieving an HIV-free generation by launching the [Global Plan towards the Elimination of New HIV infections among Children by 2015 and Keeping their Mothers Alive](#) at the United Nations. The *Global Plan* aims to reduce paediatric AIDS by 90 percent and cut HIV-related maternal mortality in half by 2015. It calls for “exceptional global and national efforts” in the 22 countries that represent 90 percent of the paediatric HIV infections in the world, with strong focus on the development and implementation of national programmes that hold local governments accountable for their progress.

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How does mothers2mothers fit into the Global Plan?

The mothers2mothers (m2m) model of care – employing Mentor Mothers to educate and support pregnant women and new mothers living with HIV – is identified by the *Global Plan* as a key strategy to realising the 2015 goals. Nationalising the Mentor Mother programme and making it an integral part of a country's health system could accelerate progress towards these goals.

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What is the long-term plan of mothers2mothers?

The Global Plan calls for programmes that improve mother and child health to be incorporated into national health systems as quickly as possible in order to increase national accountability and promote the most effective and efficient use of resources to achieve impact. To that end, mothers2mothers is expanding from its role as a direct service provider – employing mothers with HIV to work in health care facilities as health care professionals – to that of a capacity builder. Much of our work is now dedicated to ensuring that the Mentor Mother model is successfully integrated into national health systems by providing technical assistance to governments and local implementing partners so that they can train and oversee their own team of Mentor Mothers. This integration will ensure the long-term delivery of Mentor Mother services and enable the programme to reach even more women in need.

m2m has extensive experience helping local health agencies develop and run their own Mentor Mother programmes. Most recently, m2m and Kenya's Ministry of Health released guidelines (KMMP) that will serve as the foundation for integrating Mentor Mother services into every health facility in Kenya. m2m is also currently working on integrating the Mentor Mother model into local health systems in priority Provinces and Districts in South Africa. In

2007, m2m identified local implementing partners in Kenya, Zambia and Rwanda and expanded the Mentor Mother model to dozens of new sites in each country. And even earlier, in 2005, m2m provided technical support for local partners in Botswana and Ethiopia to bring the model to those countries. These programmes have continued to operate successfully without additional support from m2m.

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Has progress been made in reducing paediatric AIDS and AIDS-related maternal deaths?

Significant progress has been made in reducing new HIV infections among children, but there is still much work to be accomplished to eliminate paediatric AIDS altogether and AIDS-related maternal deaths. According to [UNAIDS](#), 220,000 children are newly infected with HIV each day, a 58% reduction since 2000. New HIV infections in children declined by 35% in the last three years alone, which is much sharper than the 19% drop seen in the four year period between 2004 and 2008. From 2009 to 2012, ARV medications prevented more than 670,000 children from acquiring HIV infections in low- and middle-income countries. Coverage of antiretroviral programmes for prevention of mother-to-child transmission increased from 36% in 2009 to 73% in 2012. This progress is due to rapid improvement in access to services that prevent mother-to-child transmission of HIV and the introduction in 2010 of more effective preventative regimens.

AIDS-related maternal deaths are also falling. According to [UNAIDS](#), the estimated number of pregnancy-related deaths among women living with HIV fell from 46,000 in 2005 to 37,000 in 2010, a 20% reduction. Among the 22 high-priority countries identified in the Global Plan, pregnancy-related deaths among women living with HIV fell from 41,500 in 2005 to 33,000 in 2010.

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Are the Global Plan goals achievable?

If the current rate of progress continues, it will be possible to meet the 2015 global targets of reducing the number of children newly infected with HIV by 90 percent and reducing the number of AIDS-related maternal deaths by 50 percent. Key to achieving these goals is continued awareness raising and global advocacy to ensure that financial resources are mobilized to support the efforts; enlisting action in the governments and health departments of all 22 priority countries and focusing technical support on countries not achieving annual milestones towards the goals.

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Which Millennium Development Goals (MDGs) is mothers2mothers helping to achieve?

mothers2mothers contributes to achieving the [United Nations Millennium Development Goals](#) that most directly affect maternal and child health:

- #3 – promoting gender equality and empowering women
- #4 – reducing child mortality
- #5 – improving maternal health
- #6 – combating HIV/AIDS

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What awards has mothers2mothers won for its work?

- 2012 – GBC Health – Frontline Heroes Award
- 2012 – Henry R. Kravis Prize in Leadership
- 2010 – Global Health Council – Best Practices Award
- 2010 – Impumelelo Innovations Award Trust – Social Entrepreneurship Award
- 2009 – Schwab Foundation – Africa Regional Social Entrepreneurs Award
- 2008 – Skoll Foundation Award for Social Entrepreneurship
- 2007 – Impumelelo Social Innovations Centre’s Platinum Award
- 2006 – Ambassadors of Caring Award

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