Strategic Plan

2018-2021 Summary

mothers2mothers (m2m) was born in Cape Town in 2001, with the goal of eliminating mother-to-child transmission of HIV. From a single site serving fewer than 100 clients, we have grown into an organisation that employs almost 1,400 HIV-positive women across eight African countries, enrolling more than two million clients into care in 2017. Our success is based on a model that unlocks the power of African women to transform the health of families through peer mentorship, role modelling, and high-impact interventions. These "Mentor Mothers" enable access to healthcare, enhance retention in care, and ensure adherence to treatment.

Today, based on purposeful and careful evolution, this model is applied far beyond the original focus of preventing mother-to-child transmission. This strategy summary outlines how we will continue to evolve and grow from 2018 to 2021—including innovations in client service delivery and our contribution to large-scale health outcomes and health system strengthening.

THE BIG PICTURE

Through this strategy, we aim to:

90-90-90

Play a major role in achieving the United Nations' (UN) 90-90-90 targets[1] to bring the AIDS epidemic under control by 2020

THE GLOBAL GOALS For Sustainable Development

Help to deliver the UN Sustainable Development Goals of ending AIDS and delivering Gender Equality by 2030[2]

Contribute to inclusive socio-economic development across Africa in line with the African Union's Agenda 2063 goals[3]

HARD WORK LIES AHEAD

Despite recent progress, women, children, and adolescents across sub-Saharan Africa face significant challenges to their health and wellbeing:

1 in 11

children born in sub-Saharan Africa dies before age five—almost 15 times the average in high-income countries.[4]

The lifetime risk of maternal mortality in sub-Saharan Africa is

83 times

greater than in Europe. HIV/AIDS is a leading cause of this.[5]

In Eastern and Southern Africa, young women (aged 15–24 years) accounted for

26% of new HIV infections in 2016

despite making up just

10% of the population.[6]

More than 250 children are infected with HIV every day

in Eastern and Southern Africa—either during pregnancy, at birth, or via breastfeeding.[7] Without treatment, almost half will die before their second birthday.[8] However, with appropriate interventions, both transmission and mortality are almost entirely preventable.

According to the World Health Organization, the African continent has a

shortage of 4.2 million

healthcare workers, and by 2030 that figure will

increase to 6.1 million.[9]

The African Union has called for an

extra 2 million

community health workers to be employed by 2020.[10]

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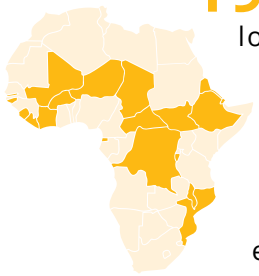


lowest ranked countries in the UN's 2015 Gender Development Index—a composite measure of gender equality—are African.[11]

These statistics point to a future in which Africa cannot realise the Sustainable Development Goals, in particular Goals Three (Healthcare) and Five (Gender Equality). m2m must continue to be a catalyst in accelerating progress, using a multi-pronged approach that comprehensively addresses healthcare, gender inequality, and poverty.

MAKING A DIFFERENCE

Our model is to employ HIV-positive women as paid, professionalised community health workers and peer mentors. “Mentor Mothers” are integrated into the formal healthcare system and work in both health facilities and in local communities. They ensure that women, their families, and their communities are effectively engaged in care and assessed; referred and linked to appropriate clinical services; and supported on their treatment journey.

m2m’s initial focus was to eliminate mother-to-child transmission of HIV. However, following a consultative process with our staff, and in the face of evolving challenges in ending the AIDS pandemic—such as low adherence and retention rates, poor uptake of HIV testing and treatment for children, and stubbornly high rates of HIV infections among adolescents—we embarked on a Strategic Plan (2014-2017) that expanded the scale and scope of our programme to combat the causes and effects of HIV/AIDS in a more comprehensive manner. While eliminating paediatric AIDS has remained at the heart of our efforts, over the course of the 2014-2017 Strategic Plan our approach grew to encompass the full cycle of life from pregnancy, through infancy, to childhood and adolescence.

We evolved our model to deliver key services in five areas:

Prevention of Mother-to-Child Transmission (Prongs 1-4)

Reproductive, Maternal, Newborn, and Child Health

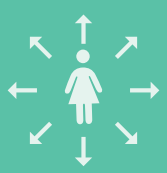
Early Childhood Development

Paediatric Care and Support

Adolescent Health and Positive Youth Development

From 2014 to 2017, we also invested in developing the “community” element of our model, which sees Mentor Mothers working both in health facilities and door-to-door in local communities. This approach is yielding impressive outcomes in terms of enhanced reach, greater client follow up, and retention in care.

To drive scale and deliver impact, we also increasingly provide policy development and other technical assistance services to governments and other implementing partners. For instance, our model was adopted as national policy in both Kenya and South Africa, and we worked with these respective governments to advise, train, and embed the model in national health systems.



This model is proving incredibly flexible and robust. We have consistently demonstrated the ability to improve health outcomes for women, their children, and their families, while simultaneously providing employment and empowerment opportunities to tackle the key drivers of the HIV epidemic and other high priority healthcare challenges across the continent. Moreover, it also addresses issues around stigma, inequality, and discrimination that African women—especially HIV-positive women—face on a daily basis.

OUR SECRET SAUCE

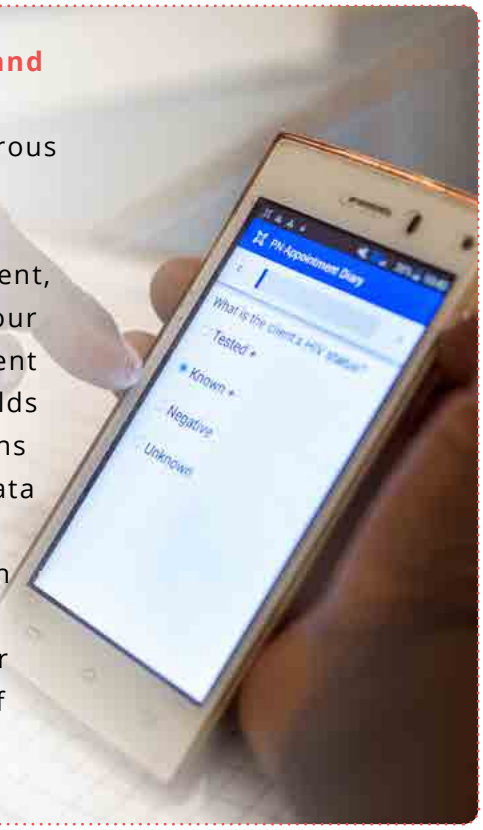
Our past success has been driven by:

Peers helping peers. Advice is one thing, compassion is another. Being able to deliver both underpins the efficacy of our model.

A focus on access, retention, and adherence. We have deliberately built a model that promotes engagement along a critical cascade of care—driving early access to healthcare, retention in care and adherence to treatment. Our retention in care figures are excellent, and the long-term, trusted relationships we build with our clients supports our impact.

Almost two decades of investment in human resources for health. Since 2001, we have been refining our approaches to recruitment, training, and support of African women to act as peer mentors and developing their potential as human resources for health.

Evidence-based and -driven decision making. Our rigorous focus on quality assurance and quality improvement, strengthened by our strategic investment in technology, yields rich data. Decisions based on these data drive outcomes, shorten the length of time to impact, and help us better meet the needs of our clients.



Linking health facilities to the communities they serve, and vice versa. We deploy staff both in health facilities and in surrounding communities. This integrated service platform deepens engagement, breaks down silos in the provision of care, and is proven to improve outcomes across a range of metrics. Perhaps most importantly, it helps women access the services they need, *where* they need them, and *when* they need them.

RAISING THE FUTURE

Our 2018-2021 strategy builds on past successes. We will leverage our experience and build on our proven model to meet emerging public health and socio-economic challenges, with a particular focus on Reproductive, Maternal, Newborn, Child, and Adolescent Health. We will meet these new challenges and deliver even greater impact by:

- **Focusing on three core client groups**
- **Enhancing services**
- **Deepening our footprint in existing countries**
- **Entering new countries**

Clarity

We will create impact for three specific client groups—women, children, and adolescents—and adapt and design programming to meet their health needs. We will re-double our focus on Africa.

Quality

We will increase investment in Monitoring and Evaluation, and Quality Assurance and Quality Improvement systems. Evidence-based decision making means we will improve impact and shorten feedback loops further, ultimately helping our clients achieve better health outcomes and a better quality of life.

Evolution

We will continue to evolve our model to meet the needs of our clients, the changing nature of the HIV epidemic, evolving public health challenges and policy environments, and shifting socio-economic realities. This means delivering new services, constantly improving the way we deliver existing ones through a model of differentiated care, and harnessing the benefits of mHealth technology even more effectively.

Why clients?

Over the years, many people have asked why we call the individuals we serve "clients" – rather than "beneficiaries" or "patients". For us, "beneficiaries" is too passive. Our peer-based model means individuals do not simply receive our services; rather, they actively work with us to tailor interventions that will best meet their needs. Likewise, "patient" feels too clinical and does not capture the richness of the peer-based relationship or range of services we provide. We believe "client" works best—we design and deliver a broad range of services designed to meet the needs of our clients and we constantly go above and beyond to ensure results.

A differentiated model of care

We plan to change the way we deliver services to our clients. We will use triaging principles to tailor the frequency and intensity of services delivered by Mentor Mothers to maximise impact and value. Clients will be assessed as high-risk or stable. High-risk clients will initially receive higher-intensity interventions to deliver rapid outcomes. Once stable, they will receive fewer visits and follow ups, through the adaptation of treatment protocols for chronic disease management.

Advocacy

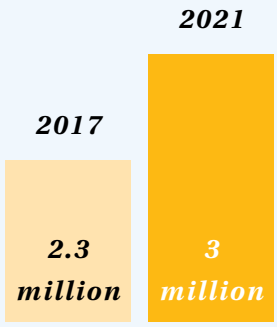
We will support government commitments and catalyse the provision of female community health workers by initiating and strengthening community-led advocacy, as well as contributing to global efforts to prioritise frontline healthcare worker professionalisation, recruitment, and retention.

Ambition

We want to enhance our impact by reaching more target clients. We will do this by deepening our footprint in the countries where we already operate and by entering up to two new countries. We will also continue to scale by expanding our technical assistance services, through which we train and mentor other organisations (such as governments or other non-governmental organisations) to deploy our model.

KEY TARGETS

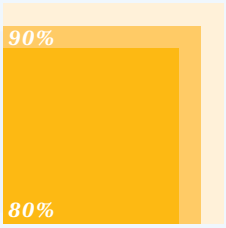
BY 2021, WE WANT TO:



Reach three million clients

– a 33% rise

Operate in two new countries

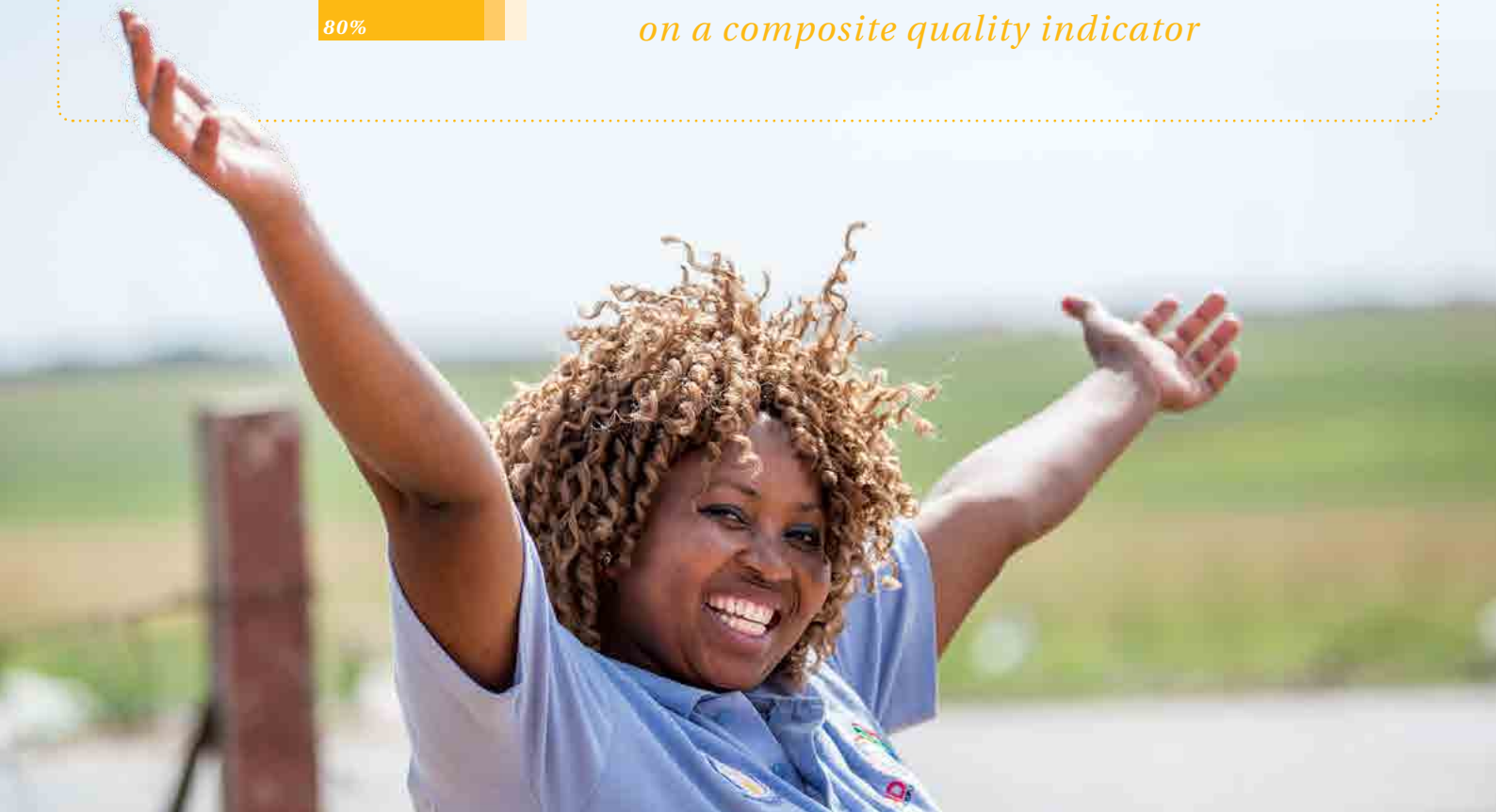


Ensure 90%

of m2m service locations

score 80% or above

on a composite quality indicator



VISION AND MISSION

VISION

We believe in the power of women to eliminate paediatric AIDS and create health and hope for themselves and their babies, families, and communities.

MISSION

Our mission is to impact the health of mothers by putting them at the heart of improving reproductive, maternal, newborn, child, and adolescent health. Our Mentor Mother Model empowers mothers living with HIV, through education and employment, as role models to help other women and their families access essential services and medical care.

We are currently testing an updated vision and mission through a consultative process

For each of our target client groups, we will use our proven Peer Mentor Model to deliver the following:

MEETING CLIENTS' NEEDS

Realities

WOMEN
15 - 49

- Sub-Saharan Africa has the highest maternal mortality ratio in the world. A 15-year old woman living in the region has a 1 in 40 chance of dying in pregnancy or childbirth.[12]
- AIDS-related illnesses remain the leading cause of death among women of reproductive age (15–49 years) globally.[13] Yet, despite global efforts, only 44% of pregnant women in low- and middle-income countries received HIV testing and counselling in 2013, with even fewer receiving testing services with their male partners.[14]
- Women are more likely than men to live in poverty, earn less than men, and are less likely to have secure jobs.

CHILDREN
0 - 9

- One in 11 children born in sub-Saharan Africa dies before age five—15 times the average in high-income countries.[15]
- More than 200 children contract HIV every day in Eastern and Southern Africa during pregnancy, birth, or while breastfeeding—and this is almost entirely preventable.[16]
- The time from conception to age three is now internationally recognised as the most critical phase in a child's development. Deprivation during this phase of life can lead to adults who are less healthy, less able to learn, and less productive.[17]

ADOLESCENTS
10 - 24

- In Eastern and Southern Africa, young women (aged 15–24 years) accounted for 26% of new HIV infections in 2016, despite making up just 10% of the population. [18]
- Teen pregnancy rates hover between 15-38% in m2m's current countries of operation.[19] By contrast, in the UK, this rate is just 2%.[20]
- Only one in three adolescents in sub-Saharan Africa is enrolled in secondary school.[21]

* New services

Our Solution

Expected Impact

Engaging both HIV-positive and -negative pregnant women to engage, assess, and provide services and referrals to ensure healthy pregnancy and childbirth. This includes family planning, nutrition education, and promoting HIV testing for partners and HIV-negative women who are breastfeeding.

Reduced maternal mortality rate among our enrolled clients.

Dramatically reducing or eliminating new HIV infections, while encouraging uptake of services and retention in care for those who are HIV-positive. This includes **adding clinical services such as testing or drug dispensing.***

All directly enrolled clients to meet the UN's 90-90-90 targets—90% of those living with HIV know their status, 90% of those who are positive are on treatment, and 90% of those on treatment are virally suppressed.

Developing and delivering our own household economic strengthening programmes, or referring and linking clients with existing services.*

Increased percentage of households that have access to money to pay for unexpected household expenses, school fees, and other important items.

Using our strong relationships with families to improve children's health and become trusted advisers on and providers of integrated management of childhood illness services. This includes nutrition education and programmes designed to enhance access to immunisations.*

Reduced infant and child mortality rates among our enrolled clients.

Continuing to reduce risk of mother-to-child transmission of HIV.

Virtual elimination of mother-to-child transmission of HIV among our directly enrolled clients.

Creating a safe environment for children to thrive by providing tailored advice to their parents on childhood stimulation, access to education, and the associated need for household economic strengthening. This includes dedicated services to orphans and other vulnerable children.

Children under five years of age receiving m2m ECD services are developmentally on track in health, learning, and psychosocial well-being.

Tailoring peer-led, age-appropriate interventions designed to stop new HIV infections through peer mentoring and role modeling.

m2m's adolescent clients meet 90/90/90 targets; we see virtual elimination of mother-to-child transmission of HIV.

Supporting HIV-positive pregnant teens to ensure healthy pregnancies, prevention of mother-to-child transmission of HIV, and healthy development of children born to young mothers. Simultaneously providing peer-led education and support to dramatically reduce teen pregnancy rates.

Reduced teenage pregnancy rates across our enrolled clients.

Driving access to education and enhancing educational completion rates.*

Improved progression through school among m2m adolescent clients of school-going age

WHAT ARE THE RISKS?

There are certain key risks which we will seek to mitigate or carefully manage throughout the next three years:

Service Quality: The quality of our outcomes is dependent on the service quality provided by our frontline healthcare workers. Expanding our service lines and changing our delivery model means changes and challenges in peer mentor recruitment, wellbeing, and accountability. Further research will be needed to better understand and set core service elements, improve appropriate client management and deliver differentiated care, and fine tune how to prioritise new programme opportunities.

Cost: In our quest for quality, we must manage and reduce costs, while continuing to demonstrate value.

Identity: We continue to expand our model beyond our roots in PMTCT as we strive to create an HIV-free generation. As our programmes evolve, we must be diligent in messaging and managing growth to ensure we maintain a golden thread to who we are, where we have come from, and where we want to go. Ultimately, this is about meeting the needs of women and their families through a lifecycle approach.

STRATEGIC INVESTMENTS AND EVOLUTIONS

To deliver this strategy, we will need to make the following investments, which we estimate to total $3.5M (above revenue necessary for programme implementation) over each of the next three years:

Monitoring and Evaluation: Changes in systems and designs are essential both to refine our ability to measure our impact and act on this data.

Model: Time and resources to design, test, and refine our differentiated care model, as well as other adaptations as needed.

Leadership: Investment in employee leadership capacity-building alongside technical training for our team to ensure we are truly strengthening healthcare systems while "raising the future."

Client Analytics and Measurement: A smartphone or tablet for each of our community health workers, and continued upgrading of our applications.

Advocacy: Resources for senior leadership and key line staff to ensure m2m builds a "bottom-up" advocacy strategy to make effective interventions on critical policy issues.

Training: Next generation training and supportive supervision for our team to deliver clinical services, and contribute towards the African Union's goal of employing two million more community health workers by 2020.

CONCLUSION

For m2m, this is about evolving further to
meet the needs of women, children, and adolescents.
Our ability to deliver services where and when our clients need them by healthcare workers they trust– their peers – will translate into our ability to grow sustainably.

Through the **successful execution** of this strategy, we know we can make a **significant contribution** to the lives of women, children, and adolescents **across Africa** – not just in the public health sphere, but also by unlocking more opportunities for empowerment.

By **helping families to thrive, not just survive**, we will be creating **opportunities for women and their families**, reducing costs for governments, and **contributing to inclusive development** across the continent we were born and raised in, and continue to call home.

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