**Title of the Innovation/Practice**

Mma wa nnete (Real Mothers)

**Lead Organization(s) and Country/Region**

Right to Care, South Africa

**Problem Statement (100–150 words) – What health or service gap does this address?**

In Limpopo, over 30% of pregnant women experience antenatal depression1, worsened by high rates of gender-based violence and teenage pregnancy2,3. Adolescent mothers face especially high risks; twice as likely to suffer from depression4, women account for 67% of new HIV infections5, often discovered during pregnancy and high rates of unemployment. Poor maternal mental health leads to poor nutrition and tripled infant mortality6,7. Family instability, driven by transient mining labour, leaves many women as single mothers. The local healthcare system lacks the capacity to support maternal mental health, referring cases to overstretched regional facilities that handle only severe conditions. Stigma is widespread; in local languages, depression is often equated with "madness," leading to further isolation. One young mother said, “No, I am alone in this.” These overlapping issues reveal a critical gap in maternal mental health care, particularly for adolescent mothers, calling for targeted, accessible, and culturally sensitive services.

**Innovation or Practice Description (200–300 words) – What was done, by whom, and how? Geographical scope.**

The Mma wa nnete programme uses a promotive, community-based methodology to support the mental wellbeing of pregnant and new mothers, many of whom are survivors of rape and abuse. Cognizant that traditional mental health diagnosis and treatment is heavily stigmatized in the community, mothers themselves developed locally resonant and relevant measures of success – such as feeling supported rather than ostracised during pregnancy, identifying and managing emotions and seeking out medical services for their pregnancy and new babies.

The Mma we nnete programme has redesigned mental health access around the specific needs of mothers in Limpopo. Community-based mother champions use visual tools and simple guides to help women identify, name, and manage their emotions while preparing for motherhood. Integrated into eight primary healthcare facilities, the programme ensures accessibility and alignment with existing services. Most women are supported through localized interventions at home, with clear referral pathways to social workers, psychologists, phone-based cognitive behavioural therapy, and psychiatric services where needed.

By embedding emotional support into the routine maternal care journey, and by strengthening early identification through peer-led intervention, the methodology ensures sustainable, scalable impact for women, their families, and the health system.  Unlike traditional development programming, this project is managed and paid against achievement of mental health outcomes set by mothers themselves rather than against the delivery of activities.

**Results and Evidence of Impact (150–250 words) – Include quantitative or qualitative data, outcomes, or evaluation results**

In its first month 600 mothers 8 have been enrolled, confirming that the intervention addresses a real and sizable need. Around 50% of enrolments are mothers in their first trimester, aligning to the evidence that mothers present later for antenatal care8. 40% of the mothers preferred telephonic support, as opposed to in person, sms or WhatsApp support. This could be due to stigma of engaging in-person support and the prohibitive cost of data to use WhatsApp8. In the Discover phase, mothers did not delve into their experiences of miscarriage and stillbirths but when engaged by mother champions, many mothers expressed distressing emotions around these losses8.

There have been in excess of 300 antenatal support sessions and over 60 post-natal support sessions to date8. One month into the programme, 83% of mothers expressed positive emotions when asked what they feel and a neutral in intensity of these emotions8. This is to be expected given the novelty of identifying and communicating their emotions, as well as hesitancy around communicating perceived negative emotions. Referrals have been practical around securing identity documentation and social grants as well as enabling access to safe termination of pregnancies8.

A mother on Mma wa nnete thanked a Mother Champion saying, “Thank you for caring, my birthing partner is even communicating with me and the baby now.”

One Mother Champion shared “Mothers have the solutions to their problems; they just need a safe space to explore them.”

**Scalability & Sustainability (100–150 words) – Is it adaptable for other contexts? What resources or policies support it?**

Our programme aims to reach 2,000 mothers in its first year, with 600 already enrolled in the first month – demonstrating both demand and feasibility. The approach is designed for adaptability, with scalable components such as peer-led support that can be embedded within community-based organisations or integrated into existing Department of Health lay health worker roles. The approach aligns with global and national policies calling for the integration of mental health into maternal and child health services. The programme is also generating contextually relevant tools and visual resources that are adaptable and sharable across multiple platforms to enable replication.

Scalability is further supported through partnerships, including with the African Alliance for Mental Health, which brings a continent-wide network of implementing partners. We aim to utilize these relationships and the evidence we generate to source catalytic outcomes-based funding opportunities to expand the programme to other regions facing similar maternal mental health challenges.

**Lessons Learned or Key Insights**

1. Beneficiaries should be involved in every aspect of a programme. The time the programme invested in a human-centred discovery phase with mothers, health workers, and communities was validated by the rapid uptake of the programme - 600 mothers enrolled in the first month.
2. Positive relationships, preparedness for pregnancy, childbirth, and motherhood along with a retained and regained sense of self, are central to the wellbeing of mothers in rural, peri-mining areas.
3. Programmes should not be developed or managed around deficit-based indicators, but rather around outcomes that matter to the beneficiaries themselves. This enables a flexible, person-centred approach that supports mothers in achieving their own meaningful goals.
4. In developing contexts, medicalising mental health challenges is often unhelpful. A promotive, community-based approach is not only cost-effective but also enables greater reach and acceptance.
5. Mental health should not exist in isolation within the health system – it must be integrated into existing services to reduce stigma and normalise the pursuit of mental wellbeing.

**Partner Quotes or Community Voice (optional but encouraged)**

A mother on Mma wa nnete shared “I was very scared about my pregnancy and motherhood, but I have information and support now to navigate this.”

A clinic manager shared “The awareness event gave knowledge to us and mothers learned a lot. We appreciate Right to Care’s initiative to assist antenatal clients and our mothers through this motherhood journey and rest assured we will give total support to Mma wa nnete to help our clients reach their mental health goals.**”**

References: 1. [South African Journal of Obstetrics and Gyneacology (2022)](https://samajournals.co.za/index.php/sajog/article/view/587), 2. [Gender Links (2013)](https://genderlinks.org.za/programme-web-menu/publications/gbv-indicators-study-limpopo-province-south-africa-2013-11-22/), 3. [Adolescent girls’ experiences of pregnancy in rural Limpopo Province (2023)](applewebdata://4A9DC6FD-A8C6-480C-81BE-503EDC3CDEEB/Adolescent%2520girls%E2%80%99%2520experiences%2520of%2520pregnancy%2520in%2520rural%2520Limpopo%2520Province), 4. [Investigating Postpartum Depression in the Adolescent Mother Using 3 Potential Qualitative Approaches](https://pmc.ncbi.nlm.nih.gov/articles/PMC6823974/#:~:text=Abstract,families%2C%20communities%2C%20and%20society.), 5. [UNAIDS (2023)](https://www.unaids.org/sites/default/files/media_asset/UNAIDS_FactSheet_en.pdf), [USAID, Momentum (2020](https://usaidmomentum.org/app/uploads/2021/09/GECO-357_2021_MCGL-Landscape-Analysis-Brief-for-MMH_sec.508.comp_v2.pdf), 6. [Prenatal maternal depression symptoms and nutrition, and child cognitive function](https://pmc.ncbi.nlm.nih.gov/articles/PMC3844897/#:~:text=During%20gestation%2C%20higher%20depressive%20symptoms,consider%20targeting%20the%20nutritional%20environment.), 7. [Role of maternal mental health disorders on stillbirth and infant mortality risk: a protocol for a systematic review and meta-analysis](https://pmc.ncbi.nlm.nih.gov/articles/PMC7228523/), 8. [Mma wa nnete Comm Care system](https://www.commcarehq.org/a/hbgi-rtc-mma-we-nnete/dashboard/project/).

Photo captions & credits

1. Caption: Mma wa nnete Mother Champion & Mother | Photographer credit: Right to Care
2. Caption: Mma wa nnete stakeholders workshop | Photographer credit: Matchboxology
3. Caption: Mma wa nnete mother workshop| Photographer credit: Matchboxology