Summary of Key Findings

mothers2mothers Internal Programme Evaluation 2012

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mothers2mothers

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About mothers2mothers

mothers2mothers (m2m) trains, employs, and empowers women living with HIV to eliminate the transmission of HIV from mothers to babies, keep HIV-positive mothers alive, and improve the health of women, their partners, and families. Working alongside doctors and nurses in understaffed health centres as members of the healthcare team, Mentor Mothers provide essential health education and psychosocial support to HIV-positive pregnant women and new mothers. Their first-hand knowledge of HIV and the power of shared experience make them highly effective at mentoring and supporting these women. Mentor Mothers are paid and rigorously trained, which benefits their respective families and the community as a whole, as well as reducing stigma associated with HIV.

Since m2m was founded in 2001 with a single site in Cape Town, South Africa, the organisation has grown to reach more than one million mothers in nine countries, and helped establish affiliated Mentor Mother programmes in two additional countries. m2m is a leader in the global effort to eliminate new HIV infections among children and protect the health of mothers.

The Challenge

Paediatric AIDS has been virtually eliminated in the developed world. Yet, UNAIDS estimates that 330,000 children were newly infected with HIV worldwide in 2011 [1]. Most of these children 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 infection is untreated. Moreover, HIV/AIDS is a leading cause of maternal mortality in sub-Saharan Africa, with an estimated 37,000 maternal deaths in 2011 attributable to HIV/AIDS [2].

This situation is both tragic and unnecessary. Effective and inexpensive medical interventions that can prevent the spread of HIV to babies and keep mothers alive are widely available.

However, there is a severe shortage of medical personnel in sub-Saharan Africa, which makes it difficult for women to access the medical care they need. Doctors and nurses frequently do not have the time, language, or shared experience to adequately counsel mothers on preventing transmission of HIV to their babies and address other serious healthcare issues prevalent in the region.

Pregnant women and mothers diagnosed with HIV continue to face crippling stigma and discrimination in many regions of Africa, leaving them too frightened to access services and creating another barrier to care. For example, recent data indicate that of the women tested and found to be HIV positive, only 61% received an antiretroviral (ARV) regimen to prevent mother-to-child transmission of HIV [3].

The Opportunity

In June 2011, UNAIDS released the Global Plan Towards the Elimination of New HIV Infections Among Children by 2015 and Keeping Their Mothers Alive, signifying a renewed international commitment to create an HIV-free generation and acknowledging the critical need to better address maternal health challenges. The Global Plan identified 22 priority countries that contain 90% of the world's HIV-infected children. It set ambitious new goals to halve the number of maternal deaths and achieve the virtual elimination of new HIV infections in children by 2015.

The Global Plan identified m2m's Mentor Mother model as a key strategy in achieving its goals, and stated that women living with HIV should be at the centre of the response.

Nearly two years later, the Global Plan has been successful in galvanising international support for eliminating mother-to-child transmission of HIV (eMTCT) and spurring countries to scale up their HIV/AIDS care and prevention efforts. The UNAIDS Global Plan Progress Report, released in June 2013, shows that significant progress has been made in reducing paediatric AIDS. The numbers of new HIV infections among children between 2009 and 2012 dropped 38% in 21 of the Global Plan priority countries [4]. However, numerous challenges remain in order to protect the health of more mothers and babies, such as ensuring that more HIV-positive pregnant women and breastfeeding mothers and their infants receive ARVs to prevent mother-to-child transmission, and enrolling more HIV-positive children in treatment.

m2m currently operates in seven of the 22 Global Plan priority countries (Kenya, Lesotho, Malawi, South Africa, Swaziland, Tanzania, and Uganda) and is exploring expansion to several additional priority countries. Its work is focused on eliminating paediatric AIDS and improving maternal health in the Global Plan's priority countries by providing mentoring and education services that are the hallmark of its Mentor Mother programme. There is a proven link between peer mentoring and improved health outcomes for diseases such as diabetes [5] and substance abuse [6], as well as HIV [7,8] . For example, research shows that peer mentoring can increase adherence to HIV medication, which is critical to preventing paediatric AIDS [9].

m2m's Footprint in 2012

In 2012, m2m operated Mentor Mother programmes in seven countries at more than 600 sites. Mentor Mothers and Site Coordinators enrolled close to 152,400 pregnant women and new mothers living with HIV into the programme over the course of the year. m2m trained 1,938 site staff to provide Mentor Mother services — that included basic training for 312 new Mentor Mothers and Site Coordinators, and additional training for 1,626 experienced site staff.

In addition to directly providing Mentor Mother services, m2m began expanding its role to provide technical assistance and capacity building to Ministries of Health so that governments can integrate Mentor Mother programmes in their national health systems. In 2012, the governments of Kenya and South Africa, with m2m's technical assistance, began establishing national Mentor Mother programmes. This is in line with the Global Plan which encourages national accountability and country-driven initiatives to achieve its goals. Integration will make the Mentor Mother model more sustainable and, over the long term, reach even more pregnant women and new mothers with peer support to eliminate mother-to-child transmission of HIV.

As part of this transition, m2m has begun to scale down its direct service operations in South Africa in 2012. One-hundred (100) sites in South Africa, as well as 30 sites in Kenya, now serve as model sites for teaching, service innovation and demonstrating the Mentor Mother model to government and implementing partners. Once national programmes are fully rolled-out in both countries, Mentor Mothers will be in a position to reach even more women and families with quality care than in the past.

The Goal of the 2012 Evaluation

To provide the highest quality services at all of its sites, m2m conducts an annual internal evaluation to assess how its country programmes supported clients in the uptake of and adherence to PMTCT services and behaviours. More specifically, the evaluation looks at whether m2m country programmes have accomplished m2m's three strategic objectives, as outlined in the organisation's Results Framework:

- Availability of quality PMTCT and maternal, newborn, and child health (MNCH) services for women and their infants
- Increased uptake of PMTCT services and improved health behaviours
- m2m clients who have disclosed their HIV status
- Empowerment of women living with HIV

The evaluation also analyses m2m's progress in meeting annual targets set by the organisation's country directors and management team. Finally, it identifies programme gaps that can be improved to strengthen m2m's peer education and psychosocial support outcomes.

Data Quality Improvements

In response to previous evaluation findings, m2m rolled out two major evaluation and performance tools across the organisation in 2012 — Strengthening Outcomes by Analysing Results (SOAR) and Active Client Follow Up (ACFU). Close to 100% of sites in Kenya, Lesotho, Malawi, Swaziland and Uganda are operating SOAR and ACFU. These initiatives have improved m2m's ability to collect data, track programme results and link Mentor Mother activities to final health outcomes.

- Strengthening Outcomes by Analysing Results (SOAR): In recent years, m2m has placed great emphasis on Monitoring and Evaluation (M&E) to better assess and improve the quality of its services. SOAR is a quality improvement programme designed to build the capacity of Site Coordinators to collect and analyse their own data. Every three months, Site Coordinators in the same district meet, review data collected from their sites, identify key problems and develop action plans to address them. SOAR empowers site staff to both understand and use data to make informed decisions to achieve better results. Data are also used to compare trends between districts and provinces and across countries to understand programming achievements on different levels.

- Active Client Follow Up (ACFU): The other significant performance intervention that m2m implemented in 2012 is ACFU, which provides training, tools, and systems to retain HIV-positive pregnant women and new mothers in PMTCT care and treatment. m2m site staff use phone calls, short message service (SMS) texts and home visits to track and follow up with patients who miss key PMTCT appointments. Overall, in 2012, m2m was able to reach out to almost 70% of the clients who missed an appointment. Of those clients who were reached, close to 80% of cases were successfully resolved — meaning the client returned to the facility for the missed appointment, reported accessing the service at a different facility, or the Mentor Mother was aware of the reason why they did not return to the facility.

Differences between the 2012 and 2011 Evaluations

The 2012 evaluation differed from the assessment conducted in 2011 in several significant ways. Site Coordinators collected the data used in the 2012 evaluation using SOAR, as opposed to the 2011 evaluation in which research assistants were hired to extract data from the logbooks in each facility and enter it into a database. In 2011, m2m abstracted data for pregnant and postnatal clients who had been enrolled in the programme between 15 and 18 months since their first visit to m2m. The 2012 evaluation, on the other hand, looked at clients who were enrolled in m2m's programme between 12 and 15 months to correspond with the period during which ACFU and SOAR were implemented at the majority of m2m sites.

m2m conducted qualitative research for the first time in 2012 through one-on-one interviews and focus group discussions with key external stakeholders and Mentor Mothers. This enabled m2m to collect feedback on the quality of m2m services and the impact the programme is having on women living with HIV.

Finally, 2012 was the first year in which m2m had a 12-month count of the number of HIV-negative women that Mentor Mothers saw over that time period. m2m Mentor Mothers provide general MNCH messages, care, and referrals to HIV-negative women as part of standard care. As m2m explores broadening its services to include reproductive, maternal, newborn and child health (RMNCH) to both HIV-positive and -negative women, m2m will continue to monitor these indicators to inform programme operations.

Methodology

m2m used a retrospective cohort study design to assess the maternal and child health outcomes of m2m clients who received PMTCT care and m2m support in 2012. In simpler terms, m2m reviewed records of a sample of pregnant women and new mothers enrolled in the programme to see if they adhered to important medical interventions that m2m promotes to prevent mother-to-child transmission of HIV, and the impact these interventions had on their health and the health of their babies.

For the 2012 evaluation, m2m randomly selected client records from programme logbooks at each m2m site that had been open for over a year in the seven countries in which the organisation operated. Using the Lot Quality Assurance Sampling (LQAS) methodology, 25 client records were sampled . These clients were enrolled in m2m services between October and December, 2011, and completed services by January, 2013 (a 12-15 month cohort). The total sample size was 7495 clients.

m2m Achievements in 2012

The 2012 evaluation shows an improvement in m2m programme performance compared to 2011 for all of the key indicators that correlate with the improved health of mothers living with HIV and their children. m2m exceeded the majority of its annual performance targets for 2012 and, for those that it did not meet, demonstrated a marked improvement. Even more significantly, m2m surpassed nearly all national and regional performance measures for several key indicators, where national data are available. However, it is important to note that while national and regional data has been provided where possible as a reference point, these data are not always a precise comparison and vary in methods of data collection, sample size, and time period

m2m believes these improvements are due in large part to the implementation of SOAR and ACFU in 2012. SOAR has improved data quality and enabled Site Coordinators to make immediate programme improvements in response to the data they collect and analyse from their sites. ACFU has increased client accountability by enabling Mentor Mothers to identify and communicate with clients who have missed priority PMTCT events and encourage them to return to the facility for on going care and support.

Key indicators for maternal and child health

Client Profile: The median age of clients in the sample pool at their first (antenatal or postnatal) visit was 27 years. Among m2m clients enrolled during their pregnancy, the median gestational age at their first antenatal visit was 22 weeks. m2m recommends that women present for care as early as possible to achieve the best health outcomes for mother and baby.

Rates of HIV disclosure: 87% of m2m clients in the 2012 evaluation reported to have disclosed their HIV status, an increase over m2m's disclosure rate in the 2011 evaluation which was 70%. Mentor Mothers emphasise the importance of disclosing HIV status as there is a significant correlation between disclosure and treatment uptake. Disclosure of HIV status makes women more likely to take antiretroviral (ARV) medications, and women who take ARV medications are less likely to infect their babies with HIV and are more likely to live longer, healthier lives.

70% 2011

87% 2012

CD4 testing during pregnancy: Overall, the number of m2m clients who had their CD4 count tested increased from 78% in 2011, to 80% in 2012. A CD4 test is a measure of the strength of the immune system, an indication of the how far the viral infection has progressed. A low CD4 count indicates when it is necessary for someone to start treatment with lifelong ARVs.

78% 2011

80% 2012

ARV uptake during pregnancy:

The percentage of m2m clients who reported taking any ARVs to reduce mother-to-child transmission (MTCT) was much greater in 2012 (93%), compared to 2011 (72%). It was also considerably higher than the rate reported regionally. Fifty-nine percent (59%) of HIV-positive women in sub-Saharan Africa received ARVs as prophylaxis to prevent mother-to-child transmission of HIV during pregnancy and delivery [10].

72% 2011

93% 2012

m2m's programme in Lesotho had the highest ARV uptake (either as treatment or prophylaxis) (99%), followed by Swaziland (97%), Tanzania (93%) and South Africa (92%). Malawi was the only country with an uptake rate below 90% (84%).

For the most part, m2m programmes had higher ARV uptake rates than national averages, with the exception of South Africa, for which m2m programmes reported an ARV uptake rate 3% lower than the national average. For example, in Lesotho, 99% of m2m clients received ARVs to reduce mother-to-child transmission, compared to 62% nationally. In Uganda, 96% of m2m clients received ARVs versus the national ARV uptake rate of 50%.

Delivery in a health facility: Ensuring that mothers deliver their babies in health facilities is one of m2m's priorities as it increases the likelihood that the baby will receive the correct medication immediately after birth for protection from HIV. There was an increase in the proportion of m2m clients who delivered in a healthcare facility in 2012 (92%) compared to 2011 (79%).

79% 2011

92% 2012

Infants receiving antiretroviral prophylaxis: It is highly recommended that HIV-exposed infants receive ARV prophylaxis within the first 24 hours of birth to protect them from HIV. The percentage of infants in m2m's programme who received ARV prophylaxis increased from 89% in 2011 to 95% in 2012. All m2m country programmes had exceptionally high rates of infant ARV prophylaxis, ranging from 98% in Swaziland to 89% in Uganda.

m2m's performance in this area is substantially higher than rates for the region. UNICEF estimated that 55% of exposed infants received ARV prophylaxis in eastern and southern Africa in 2011, the most recent data that was reported on this indicator [11].

89% 2011

95% 2012

Infant feeding practices: Breast milk is the best food for all babies. 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 and then continue breastfeeding while adding complementary foods through the first year of life. To protect the baby from HIV infection during breastfeeding, either the mother or baby should be taking an ARV regimen simultaneously. While replacement feeding (feeding infants with formula) is the only 100% 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, including the high price of formula, limited access to clean water, and the cultural stigma associated with not breastfeeding.

Among clients reporting infant feeding practices at an m2m postnatal visit within six months of delivery, 82% said they exclusively breastfed, 13% formula fed, only 2% practiced mixed feeding and 3% were unknown. This is an improvement over 2011 when 56% of women reported exclusive breastfeeding, 41% replacement feeding, and 3% mixed feeding.

Mother-to-child HIV transmission rates: Of those infants in m2m's programmes who received a PCR test result, 3.8% tested positive for HIV. Uganda had the highest percentage of infants with a positive PCR test result (5.6%), followed by Tanzania (5.2%), Malawi (4.3%), Kenya (4.2%) and Lesotho (4.1%). In South Africa, clients enrolled in an m2m programme had fewer infants test positive (1.7%) than the national rate which was 2.7% as reported by the Medical Research Council of South Africa (MRC) in 2012.

This data is also interesting to look at from the perspective of when the mother came to m2m. For the mothers who came to m2m only after they had their baby, the mother-to-child transmission rate was 5.0%. But for mothers who came to m2m during their pregnancy and continued to participate in m2m's programme after their child's birth, the transmission rate was only 1.9%, suggesting the possible connection between m2m's education and support services can have during pregnancy in helping mothers keep their babies healthy.

The Performance Indicator Tracking Table

The Performance Indicator Tracking Table (PITT) is a programme management tool that m2m uses to monitor 15 key outcome indicators on a quarterly and annual basis. Where applicable, several of these indicators are the same measurements that the 22 Priority Countries of The Global Plan use to monitor their progress. m2m sets annual targets for its indicators and uses the information it collects to measure the programme's success and inform future planning decisions.

m2m exceeded its 2012 targets for 10 indicators, including the uptake of prophylactic ARVs during and after pregnancy, delivery in a health facility, infant PCR test, paediatric ART coverage, maternal CD4 tests, and disclosure of HIV status. All of these indicators improved notably in 2012, compared to 2011 and 2010. It is encouraging that even for indicators that did not meet the 2012 targets — CD4 tests/results, infants receiving ARVs and PCR test results — there was still marked improvement in 2012 over the previous year's results. m2m also exceeded some of the international targets set by the United Nations Global Plan.

Feedback from stakeholders at the district and national levels of Ministries/Departments of Health:

Overall satisfaction with the m2m programme was reported across jurisdictions. The main areas of satisfaction were seeing women become empowered and the effective delivery of services to women and children in health facilities and the community. m2m programmes were credited for increased PMTCT/HIV services uptake, improved patient retention and outcomes, a reduction in stigma and greater support from partners.

For example, one stakeholder described the m2m programme approach: "m2m chooses to work with people who have the problem (i.e., HIV-positive mothers) to solve the problem (i.e., treatment, care, etc.)... It's an excellent approach... and mothers who previously had stigma are coming to test (for HIV) following testimonies they hear from Mentor Mothers."

Another stakeholder in a rural setting observed that "... through support group (activities) and (Mentor Mother) visits, discordant couples are now living together... this helps people to be adherent (to treatment) and makes other seek the services freely."

Respondents also said the shifting of non-clinical tasks from healthcare staff to Mentor Mothers enabled healthcare centres to provide better care. A senior nursing officer praised the effective supportive role and dedication of Mentor Mothers at the facility when she said "... because we (nurses) are few in number, and (have) lots of and lots of things to do hence we (cannot) pay special attention (to all patients). (Mentor Mothers) dedicate time to the clients. So most of the times we get to hear the clients' problems from m2m."

Feedback from Mentor Mothers and Site Coordinators: Mentor Mothers stated that their employment at m2m has provided them a sense of empowerment and self-reliance. Specific benefits cited by the Mentor Mothers who were interviewed included: (1) empowerment: financial, health, improved self-esteem, self-worth; (2) education and skills to support other mothers; and (3) improved relationships and friendships with partners and others.

For example, Mentor Mothers in rural areas reported being able to pay for food, school fees, and property; start up small businesses, and participate in saving plans. "Before the m2m programme, my husband, children, and I fell sick often (because of HIV), and life was difficult. We had no friends because they feared HIV.... Now because of the programme, we are able to help ourselves using the money we get and we now have friends," a rural respondent explained.

In addition, Mentor Mothers and Site Coordinators felt empowered in the community and at work, as they perceived themselves to be role models in the healthcare setting and are affectionately referred to as 'nurses'. "I was neglected and known to be sick, useless and just waiting to die. People thought that my child would be HIV positive but (he) is HIV negative. ...I am now seen as a role model in the community and people call me 'Musawo (nurse)", said a respondent.

Feedback on SOAR and ACFU: Mentor Mothers and Site Coordinators reported that these new initiatives are helping them identify problems and make changes to improve PMTCT service outcomes. For example, one respondent said, "SOAR facilitates self-supervision — when we identified gaps at our respective facilities, we did not have to wait for our supervisors to remind us to take action."

Through SOAR and ACFU, Mentor Mothers and Site Coordinators indicated there were noticeable improvements in service delivery and data quality. Several countries (Kenya, South Africa, Swaziland and Uganda) reported that SOAR and ACFU have resulted in increased access to care, client retention, improved follow-up outcomes, increased HIV status disclosure, and reduced stigma and discrimination.

While numerous programme achievements were reported during the qualitative sessions, participants also shared key challenges and issues that hindered programme performance. These challenges can be grouped into three main categories: (1) facility-focused, which were mostly resource-related such as inadequate human, financial, and logistical support; (2) m2m staff-oriented, largely issues faced by Mentor Mothers and Site Coordinators, like stigmatization in the community and among facility staff and pay/work space issues; and (3) client-oriented, which included barriers to care such as stigma and disclosure, incorrect client contact information for ACFU and long distances between clients' homes and health facilities for home visits.

Mentor Mother Programme Challenges and m2m's Response

A number of challenges with the Mentor Mother Programme were identified that impact m2m's ability to help more women and babies stay in care and monitor outcomes.

Measuring Retention: The findings and recommendations from the 2011 evaluation prompted m2m to make retaining women a top priority, resulting in the roll out of programme interventions such as ACFU and SOAR. Measuring client retention is challenging. In some areas, clients routinely attend different facilities for antenatal and postnatal services. In some areas, clients move from facility to facility as they: (1) move from one residence to another to be closer to family; (2) face issues of HIV-related stigma in facilities in which they are recognised by community members; (3) enjoy the benefits of shorter queues or kinder health care staff. m2m is working to strengthen its capacity to both generate increased client retention and effectively measure it. The ***Mother Baby Pair Tracking*** project is one of m2m's efforts to better recognise, understand and measure client movement from facility to facility.

Overall in 2012, of the total number of antenatal clients, 55% had at least one postnatal visit, an increase of 18% from the 2011 evaluation findings.

Even though this increase indicates that ACFU and SOAR had a positive impact on client retention, it is also important to look at the number of times women visited m2m during pregnancy. Though antenatal visits to m2m do not necessarily represent visits to the health facility, they serve as a proxy to measure antenatal care visits. Twenty-six percent (26%) of m2m clients had four antenatal visits to an m2m site as recommended by the World Health Organization. However, obtaining a completely accurate picture of m2m client retention rates is complicated. As described above, nearly one fifth (19%) of m2m clients reported being seen at more than one m2m site.

While understanding the number of clients with multiple visits to m2m is important, even more critical is understanding why women do not have more visits. ACFU is a key intervention to increase retention and was rolled out in all m2m sites in 2012. Based on 2012 data, it appears that ACFU enrolment corresponds to increased visits. For example, both Kenya and Uganda m2m programmes have among the highest number of antenatal clients with four or more visits (43% and 41%, respectively) and the lowest number of pregnant clients with one visit (19% and 17%, respectively). These countries also have the highest proportion of follow up to new clients who miss key appointments through ACFU (34% and 89%, respectively). The same trend is notable for postnatal clients. By contrast, Malawi's ACFU enrolment is quite low at 9% and has the highest proportion of antenatal clients with one visit (43%) and the lowest number with four or more (15%).

We recommend a detailed review of the ACFU client registries through one or more SOAR sessions to better understand why women are missing appointments and what type of appointments they are missing in order to inform decisions regarding increasing client retention.

Early Presentation for Care: The number of women at m2m facilities who presented early for antenatal care across all country programmes remained low in 2012 — 13%, not much different than 12% in 2011. Further analysis of the data show that clients who presented in the first trimester were more than three times as likely to receive the WHO-recommended four or more antenatal visits. Late presentation for antenatal care, a common trend in sub-Saharan Africa, remains a major cause for concern, particularly considering evidence that late initiation of ARV in pregnancy results in an increased risk of the transmission of HIV from mother to child [12]. The promotion of early antenatal visits during pregnancy is another key priority area for m2m. In response, m2m will implement community outreach and education activities in Uganda and Malawi, with support from SIDA/UNICEF in 2013, to address the problem of women presenting late for antenatal care and weak or no linkages between health facilities and community structures.

Male partner interactions: Increasing the involvement of fathers in PMTCT treatment has long been a challenge for service providers. Male involvement is important in reducing paediatric AIDS infections because their support can influence the reaction of extended family and the community, making it easier for mothers to follow medical interventions critical to keeping herself and her baby healthy. The proportion of male partner visits within all of m2m's client interactions remained relatively unchanged from 2011 to 2012. Male partner participation tends to be higher in countries where males are encouraged, or mandated by policy, to come with their partners for antenatal care (e.g., in Tanzania and Uganda). m2m is currently exploring strategies to increase male involvement.

Infant Feeding Choices: As reported above, m2m observed a significant improvement in exclusive breastfeeding practices between 2011 and 2012 (56% and 82%, respectively). However, the monitoring and measuring of a client's infant feeding behaviour is challenging; as it is often a dynamic indicator. What a mother practices as a feeding method and reports on one day may change before her next visit. There is no means to verify what a mother reports and there is often bias when reporting as most women are cognizant that exclusive breastfeeding is the recommended feeding method even if they may not practice it. However, infant feeding choices are important to understanding mother-to-child transmission. It is the last critical postnatal intervention to minimise mother-to-child transmission and potentially the most important if a woman chooses to breastfeed for an extended period of time. m2m is introducing new M&E tools in 2013 to better capture information on this important indicator.

Conclusion

Overall, m2m's 2012 evaluation revealed improved client health and behavioural outcomes from 2011. m2m believes these improvements are due in large part to the implementation of SOAR and ACFU in 2012, which improved data quality, enabled site staff to make "real time" programmatic improvements based on the data which increased client accountability, and improved the ability of Mentor Mothers to follow up clients missing appointments.

However, there were a few exceptions that are country- and context-specific. For indicators that did not achieve 2012 targets, or that show little improvement from 2011, there is a need to conduct deeper analysis at country level to identify which country's findings may require additional follow up and investigation.

The current evaluation largely focused on programmatic outcomes; there is a need for future evaluations to focus on programmatic processes to provide more context for outcomes. Taking a deeper look at how m2m's programmes have been implemented in each country would provide more meaning and context for differences demonstrated in country performance. These findings would enable m2m to more strategically optimise programme delivery and ensure sustainability.

Furthermore, to isolate the impact of m2m's activities as a stand-alone programme, a different evaluation design is required, as the results reported herein may not be attributed solely to m2m efforts.

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