Ministero degli Affari Esteri
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2026 | Evaluation Report

Impact Assessment of Projects in Mozambique

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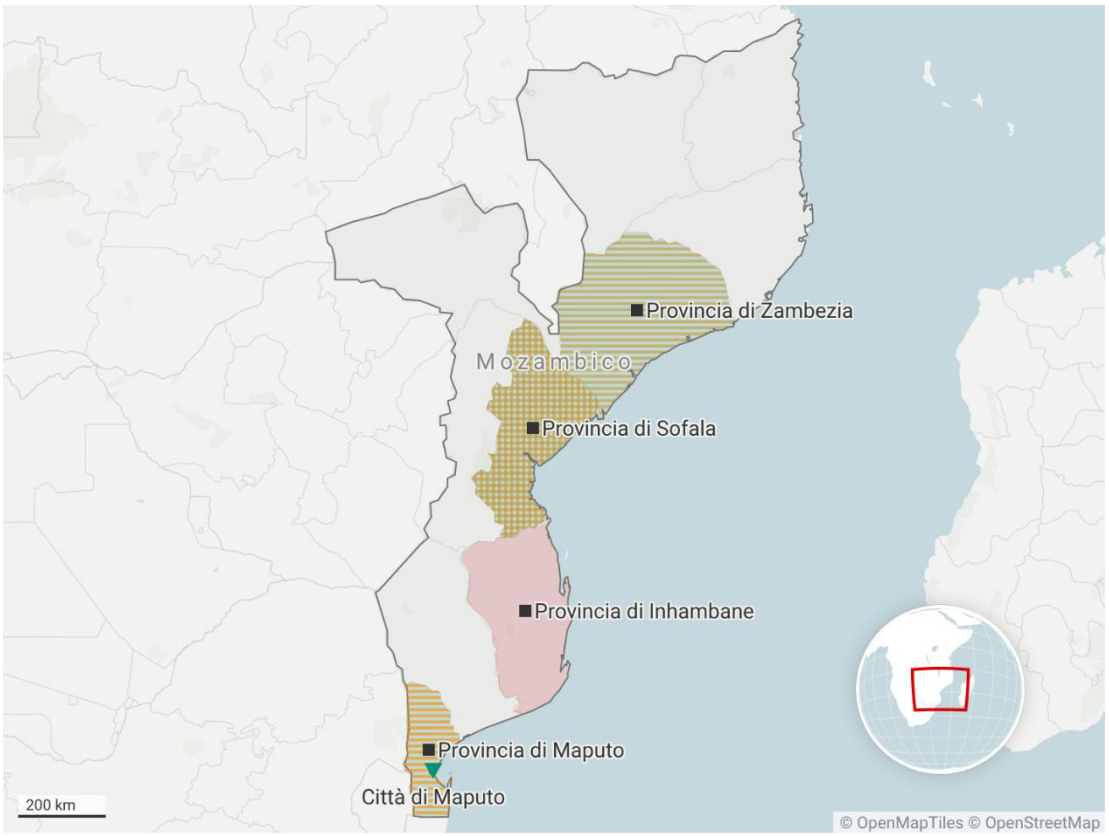
LIST OF ACRONYMS

ACAP	Community of Sant'Egidio – ACAP (name of the association)
ACS	Community Health Workers
ADPP	Ajuda de Desenvolvimento de Povo para Povo (People-to-People Development Aid)
AGYW	Adolescent Girls and Young Women
AICS	Italian Agency for Development Cooperation
AID	Italian Development Aid (project identification code)
AIDS	Acquired Immunodeficiency Syndrome
AIFO	Italian Association of Friends of Raoul Follereau
APE	Elementary Multipurpose Agents (Community Health Workers)
ATS/UATS	Health Counseling and Testing / Health Counseling and Testing Unit
CACUM	Cervical and Breast Cancer
CCM	Country Coordinating Mechanism
CCR	Consulta da Criança em Risco (Consultation for Children at Risk)
CCS	Centro de Colaboração em Saúde (Health Collaboration Center)
CD4	CD4 T-cells (indicator of immune status)
CIOB	Beira Center for Operational Research (Centro de Investigação Operacional da Beira)
COVID-19	Coronavirus Disease 2019
CS	Health Center
CUAMM	Doctors with Africa CUAMM (University College for Aspiring Medical Missionaries)
DGCS	Directorate General for Development Cooperation
DNT	Noncommunicable Diseases
DPS	Provincial Health Directorates
DREAM	Association for the Right to Health Care and the Fight Against AIDS
DUP	Single Project Document
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
EMTCT	Elimination of Mother-to-Child Transmission

FGD	Focus Group Discussion
Global Fund	Global Fund to Fight AIDS, Tuberculosis, and Malaria
HIV	Human Immunodeficiency Virus
HPV	Human Papillomavirus
HRBA	Human Rights-Based Approach
IARC	International Agency for Research on Cancer
STIs	Sexually Transmitted Infections (STIs)
KAP	Knowledge, Attitudes, and Practices
KII	Key Informant Interview
LEEP	Loop Electrosurgical Excision Procedure (LEEP)
M&E	Monitoring and Evaluation
MISAU	Ministério da Saúde (Ministry of Health of Mozambique)
MMI	Medicus Mundi Italy
NCD	Non-Communicable Diseases
OECD-DAC	Organization for Economic Co-operation and Development – Development Assistance Committee
WHO	World Health Organization
NGOs	Non-Governmental Organizations
CSOs	Civil Society Organizations
SSO	Sustainable Development Goals
PEN	National Strategic Plan for the Response to HIV and AIDS
PESS	Health Sector Strategic Plan
PHIA	Population-Based HIV Impact Assessment
PIL	Gross Domestic Product
PIP	Multi-Year Indicative Plan
LDC	Least Developed Countries
PMTCT	Prevention of Mother-to-Child Transmission
PNCT	National Tuberculosis Control Program

PNDRHS	National Plan for the Development of Human Resources in Health (Piano Nacional de Desenvolvimento de Recursos Humanos para a Saúde)
PS	Posto de Saúde (Health Center)
PTV	Prevention of Vertical Transmission
QL	Logical Framework
RBA	Results-Based Approach
RBM	Results-Based Management
SAAJ	Serviços Amigos dos Adolescentes e Jovens (Adolescent and Youth-Friendly Services)
SARS-CoV-2	Severe Acute Respiratory Syndrome Coronavirus 2
SDSMAS	District Health, Women's, and Social Action Services (Serviços Distritais de Saúde, Mulher e Ação Social)
SMI	Maternal and Child Health
SPS	Provincial Health Services
SSN	National Health System
TARV	Antiretroviral Treatment
TB	Tuberculosis
ToR	Terms of Reference
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNIPD	University of Padua
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
VIA	Visual Inspection with Acetic Acid

LOCATION OF INTERVENTIONS



Interventi

AID11375 | AID011587/04/1, AID012168/01/9 | AID11817/04/6 | AID012168/02/0

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1 Initial Summary

The independent evaluation analyzed **five initiatives funded by Italian Cooperation in the health sector in Mozambique between 2019 and 2024**, focusing on noncommunicable diseases (NCDs), HIV, tuberculosis (TB), prevention of mother-to-child transmission (PMTCT), and the health of adolescents and young people. Four of the five initiatives are recipients of funding for "synergistic initiatives" with the activities of the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund), proposed and implemented by civil society organizations, public agencies, and universities, to which 5% of Italy's contribution to the Global Fund is allocated. The interventions took place in the provinces of Maputo, Sofala, Zambézia, and Inhambane and were carried out by strengthening health services and capacities, providing community-based services, engaging community stakeholders, and, in some cases, conducting operational research and scientific partnerships. The evaluation adopted a *mixed-methods* approach based on the theory of change, integrating document analysis and monitoring data with semi-structured interviews, focus group discussions, and direct observations. The field mission in Mozambique covered Maputo, Sofala, and Inhambane. For the province of Zambézia, the analysis was based on documentary sources, available data, and consultations with relevant stakeholders.

Overall, the initiatives have produced significant results and changes that are still observable, particularly at the individual, community, and institutional levels. The interventions have helped expand access to and continuity of care, strengthen the capacities of health care personnel and community stakeholders, develop more integrated care models tailored to specific vulnerable groups, and strengthen the link between communities and the health care system. The results are particularly evident when training, equipment availability, practical application, and supervision have been integrated; when services have been brought closer to the population through mobile teams and community actors; and when service delivery has been adapted to the characteristics of the target groups, as in the case of services aimed at adolescents and young people. At the systemic level, signs of change are emerging (including greater attention to NSTs and the gradual consolidation of community-based models), but the evidence does not allow us to identify these as fully established transformations.

The relevance and coherence of the interventions are high, both in relation to health priorities and to the barriers affecting access to services. However, distance, transportation costs, poverty, stigma, family dynamics, and sociocultural norms continue to affect different groups in varying ways. Initiatives targeting women, girls, and young people have incorporated specific responses to some of these vulnerabilities; however, the uneven availability of data disaggregated by sex, age, region, and other factors does not allow for a systematic comparison of outcomes across groups or for determining with sufficient precision which segments of the population have been less effectively reached.

Sustainability varies. The outlook is more robust for skills, practices, and operational methods that are integrated into the functioning of public services and supported by institutional and community ownership. In contrast, components dependent on recurring resources—such as personnel, transportation and fuel, maintenance, supplies, *outreach,* and support for community actors—are more fragile, as they do not appear to be fully integrated into standard funding mechanisms. The experiences evaluated also show that sustainability is enhanced when the essential functions of interventions can be adapted to the capacities and resources actually available within the system.

The contribution of individual initiatives to the observed changes is more clearly documented for services, tools, and practices directly supported by the projects; however, it becomes progressively more cumulative at the institutional and systemic levels. In several regions, interventions have followed one another over time; the same partners have maintained a continuous presence ; and other programs and public policies have contributed to the changes. The

evaluation therefore focuses on contribution rather than causal attribution, distinguishing the degree of robustness of the available evidence.

The main implications for future planning concern the need to make more systematic use of lessons learned from interventions and to strengthen their complementarities, prioritizing the consolidation and adaptation of capacities, services, and practices that have demonstrated value and the potential for integration into the healthcare system. Interventions aimed at institutional, organizational, and community-based changes should be allocated adequate time and resources and incorporate sustainability and exit strategies from the outset, progressively verifying their feasibility with the responsible institutions. Particular attention should be given to consolidating integrated community-based models that link health services and community stakeholders; to capacity building as an ongoing process of training, practical application, supervision, and skills transfer; and to adapting services to address the specific barriers faced by adolescents, young people, and women. Operational research and scientific partnerships should contribute both to the development of national capacities for the production and use of evidence and to the capitalization on lessons learned and the assessment of the adaptability and institutionalization of proven practices. Finally, the design should incorporate mechanisms for adaptive management, operational continuity, and periodic risk analysis, so that external shocks, institutional timelines, and changes in the context do not compromise the essential functions of the interventions or access to services.

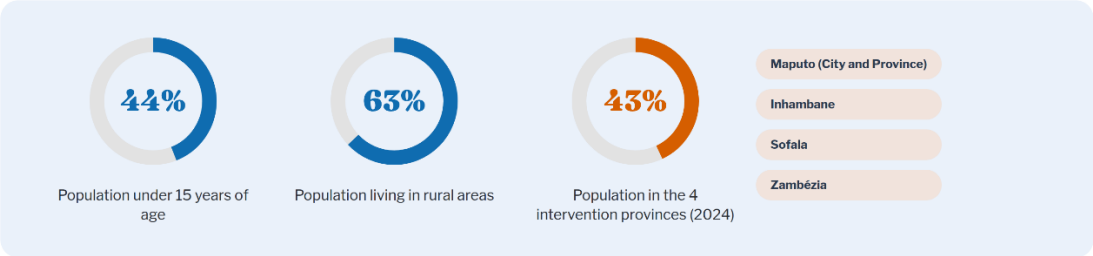
2 Geographic and Socioeconomic Context

This section describes the country situation in Mozambique, the structure of its health care system, the epidemiological situation regarding the diseases of interest for this evaluation, and the most relevant development policies in the country, with reference to Italian cooperation.

2.1 Country Situation

Mozambique is a semi-presidential republic located in the southeastern part of sub-Saharan Africa with a population of over 35 million people.

Figure1: Mozambique – Demographic Context



Source: UNFPA[1] ; World Bank[2] ; Mozambican Ministry of Health (PESS 2014–2019)[3] .

Mozambique was under **Portuguese colonial rule** from the early 16th century until 1975. The first 15 years of independence were marked by a violent civil war that destroyed much of the country's infrastructure. Currently, the country is facing a conflict in the northern region that has been ongoing for eight years and remains unstable, with low-intensity attacks by the Islamic State of Mozambique throughout Cabo Delgado province and in the neighboring provinces of Niassa and Nampula[4] . Mozambique is also grappling with broader social unrest, as evidenced by the controversial 2024 general elections that sparked widespread violence[5] .

The country is classified by the World Bank as a **low-income** country[6] , with a per capita Gross Domestic Product (GDP) of approximately **$627 per year** (2025)[7] and more than 80% of the population living below the poverty line (2022)[8] . Mozambique is also classified by the United Nations as a *Least Developed Country* (*LDC*) because it faces critical structural impediments to sustainable development, a high degree of economic and environmental vulnerability, and a low level of human capital[9] . This situation is also highlighted by the Human Development Index, which stands at 0.493 in Mozambique—one of the lowest values in the world, albeit one that is steadily rising[10] . Average life expectancy at birth in the country in 2024 was 64 years, in line with the average for sub-Saharan Africa (63) and slightly lower than that of the Least Developed Countries (67)[11] , with significant differences between women (67)[12] and men (60)[13] .

[1] https://www.unfpa.org/data/world-population/MZ
[2] https://data.worldbank.org/indicator/SP.RUR.TOTL.ZS?locations=MZ
[3] Republic of Mozambique, Ministry of Health – Directorate of Planning and Cooperation (2024). Strategic Plan for the Health Sector (PESS) 2014–2019 (Extension 2020–2024). https://docs.bvsalud.org/biblioref/2023/12/1519224/final_pess-revisao-extensao_07-marco-2021_3082022.pdf
[4] https://www.worldbank.org/ext/en/country/mozambique#tab-about
[5] Ibid.
[6] https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups
[7] https://data.worldbank.org/indicator/NY.GDP.PCAP.CD?locations=MZ
[8] https://pip.worldbank.org/country-profiles/MOZ
[9] https://policy.desa.un.org/sites/default/files/2025-06/ldc_profile_mozambique.pdf
[10] https://hdr.undp.org/data-center/specific-country-data#/countries/MOZ
[11] https://data.worldbank.org/indicator/SP.DYN.LE00.IN?locations=MZ
[12] https://data.worldbank.org/indicator/SP.DYN.LE00.FE.IN?end=2025&locations=MZ&start=2000&view=chart
[13] https://data.worldbank.org/indicator/SP.DYN.LE00.MA.IN?end=2025&locations=MZ&start=2000&view=chart

The country is endowed with **vast natural resources**, including *offshore* gas reserves, mineral deposits, arable land, hydroelectric potential, and rich biodiversity; however, many of its inhabitants lack access to basic services and meaningful economic opportunities[14] . Agriculture is the main source of income for over 70% of Mozambique's population and provides employment for 80% of the workforce, but agricultural productivity is low due to a lack of adequate technology[15] . National growth remains constrained by a combination of immediate economic pressures and long-standing structural challenges, including growing macro-fiscal imbalances, weak *governance*, inadequate infrastructure, low levels of human capital and skills, a hostile business environment, vulnerability to external shocks, institutional fragility, and deep-rooted conflicts, as well as marked regional disparities[16] .

Mozambique's climate is characterized by frequent extreme weather events such as droughts, floods, and tropical cyclones[17] . Climate change is expected to exacerbate the country's vulnerability to these events, posing a serious obstacle to inclusive and resilient socioeconomic development[18] .

2.2 Healthcare System

The ministry responsible for the health sector is the *Ministério da Saúde* (MISAU). During the project implementation period, the Mozambican healthcare system was organized into **four types of facilities**: the public sector, organized within the National Health Service (SSN)[19] ; the private sector, comprising both for-profit and nonprofit entities; the community-based subsystem; and traditional and alternative medicine. The SSN operated on four levels of increasing specialization: at the primary level (*health centers,* CS, and *postos de saúde*, PS) and at the secondary level (district, general, and rural hospitals, which serve as the first point of referral for multiple districts) were responsible for providing primary care, while the tertiary level (provincial hospitals) and the quaternary level (central and specialized hospitals) provided differentiated specialized care and served as subsequent points of referral for treatment. The *Provincial Health Directorates* (DPS) were responsible for coordinating the implementation of interventions in the field of primary health care, while the *Provincial Health Services* acted as representatives of the health sector in the province and ensured the implementation of non-decentralized activities in the health sector.

The country's health system faces a twofold challenge: on the one hand, it must cope with a **high and persistent disease burden** linked to communicable diseases, particularly HIV and tuberculosis (TB); on the other hand, it is facing a growing **epidemiological transition** toward noncommunicable diseases such as diabetes, hypertension, and cervical cancer[20] . An analysis of the issue highlights the **structural constraints** that directly affect access, quality, and continuity of care, particularly significant geographic distances, barriers to access in rural and peri-urban areas, the shortage of qualified health workers as well as their uneven distribution , the weakness of health information systems, and the sociocultural and gender barriers that hinder the use of services by women, adolescent girls and young women (AGYW), children, and other vulnerable groups. Furthermore, **environmental and external emergencies**, particularly the COVID-19 pandemic, have further compromised essential services, community outreach efforts, the availability of medicines, and the continuity of care.

[14] https://www.worldbank.org/ext/en/country/mozambique#tab-about
[15] https://www.ifad.org/en/w/countries/mozambique
[16] https://www.worldbank.org/ext/en/country/mozambique#tab-about
[17] World Bank (2025). Climate Risk Profile: Mozambique (2025). https://climateknowledgeportal.worldbank.org/sites/default/files/country-profiles/17258-WB_Mozambique%20Country%20Profile-WEB.pdf
[18] World Bank (2023). Mozambique Country Climate and Development Report. https://openknowledge.worldbank.org/server/api/core/bitstreams/2b9fa284-479a-4f38-9cd8-b39a569b4e7b/content
[19] Mozambique's national health care system was reformed effective January 2026.
[20] https://data.who.int/countries/508

In 2023, Mozambique's current **health expenditure** accounted for 8.5% of its GDP, placing it significantly above the regional average (4.9) and the LDC average (3.6)[21] . However, while the portion financed by government resources accounted for 2.3%[22] , approximately 57.7% of national health expenditure in the same year was financed by external resources[23] . Inequalities in resource allocation among provinces remain a persistent problem in the country[24] .

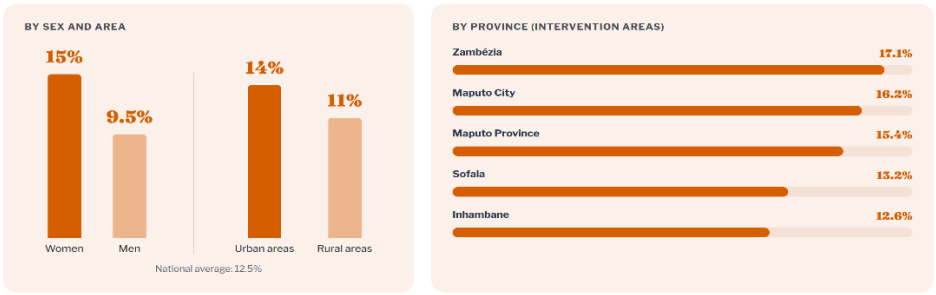
In 2025, the suspension and subsequent closure of USAID programs[25] —which had provided Mozambique with approximately $586 million in 2024[26] —compounded a broader contraction in external health financing[27] . This shock struck a national health system that was already struggling, with a share of the public budget allocated to health care that limits the government's ability to compensate for the loss of external support with its own resources.

2.3 Epidemiological Situation

Mozambique is classified by the World Health Organization (WHO) for the 2021–2025 period as a country with **a high incidence of tuberculosis**, HIV-associated tuberculosis, and drug-resistant tuberculosis[28] . The latter is on the rise: it is estimated that approximately 3.7% of new tuberculosis cases and 20% of retreatment cases are multidrug-resistant[29] .

HIV is the country's primary public health challenge and has a particularly significant impact on the provinces covered by the evaluated interventions.

Figure2: HIV in Mozambique – Epidemiological Overview, PHIA 2021



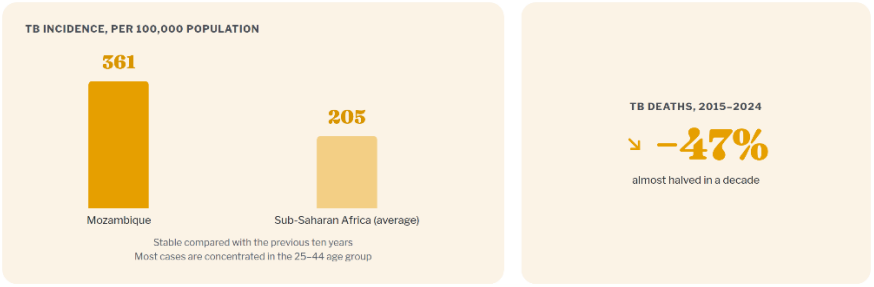
Source: PHIA 2021[30]

People living with HIV are at greater risk of contracting other diseases, including cervical cancer in women, TB, and common chronic noncommunicable diseases, which can in turn complicate clinical care for HIV itself[31] . Overall, HIV/AIDS is the leading cause of death in the country (2021)[32] .

[21] https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=MZ
[22] https://data.worldbank.org/indicator/SH.XPD.GHED.GD.ZS?locations=MZ
[23] https://www.who.int/data/gho/data/indicators/indicator-details/GHO/external-health-expenditure-(ext)-as-percentage-of-current-health-expenditure-(che)-(-)
[24] Republic of Mozambique, Ministry of Health – Directorate of Planning and Cooperation (2024). Strategic Plan for the Health Sector (PESS) 2014–2019 (Extension 2020–2024). https://docs.bvsalud.org/biblioref/2023/12/1519224/final_pess-revisao-extensao_07-marco-2021_3082022.pdf
[25] https://www.whitehouse.gov/presidential-actions/2025/01/reevaluating-and-realigning-united-states-foreign-aid/
[26] https://foreignassistance.gov/cd/MOZ/1/2024/obligations
[27] https://sida.se/en/about-sida/how-we-are-governed/swedish-government-decides-to-phase-out-bilateral-strategies-and-close-embassies; https://questions-statements.parliament.uk/written-statements/detail/2026-07-16/hcws287
[28] WHO (2025). Global Tuberculosis Report 2025. https://iris.who.int/server/api/core/bitstreams/e97dd6f4-b567-4396-8680-717bac6869a9/content
[29] Republic of Mozambique, Ministry of Health – Directorate of Planning and Cooperation (2024). Strategic Plan for the Health Sector (PESS) 2014–2019 (Extension 2020–2024). https://docs.bvsalud.org/biblioref/2023/12/1519224/final_pess-revisao-extensao_07-marco-2021_3082022.pdf
[30] https://phia.icap.columbia.edu/wp-content/uploads/2023/10/050324_INSIDA_ENG_RR5.pdf
[31] Ibid.
[32] https://data.who.int/countries/508

Tuberculosis is closely linked to the HIV epidemic and continues to have one of the highest incidence rates in sub-Saharan Africa; although mortality has declined significantly over the past decade, the rise in drug-resistant tuberculosis poses a threat to tuberculosis control efforts. HIV is the risk factor responsible for the highest number of tuberculosis cases in the country[33] .

Figure3– Tuberculosis in Mozambique



Source: WHO[34] , Global TB Report/TB Profile Mozambique, 2024–2026; World Bank[35]

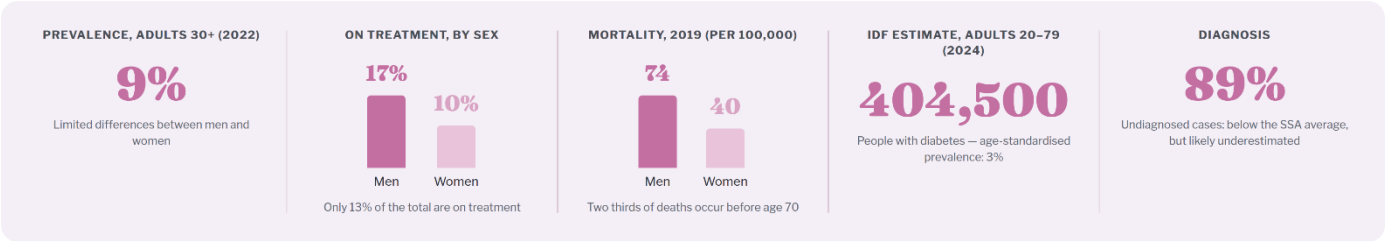
According to data from the National Tuberculosis Control Program for 2019, there is a geographic variation in the distribution of TB cases across the country: the highest number of new tuberculosis cases was recorded in Zambézia Province, while the southern provinces (including the city and province of Maputo) have high rates of tuberculosis and HIV coinfection[36] . The treatment success rate has been estimated at 91%, but treatment coverage stands at only 60%[37] .

As discussed in the previous section, **the persistent burden of communicable diseases is accompanied by an epidemiological transition toward noncommunicable diseases, which already account for a significant proportion of mortality**. It is estimated that 31% of deaths in Mozambique are due to noncommunicable diseases (*Doenças Não Transmissíveis*, DNT) and that the risk of premature death from the four main DNTs (cardiovascular diseases, cancer, diabetes, and chronic respiratory diseases) is 27% (2021)[38] , with a higher probability for men than for women (34%[39] vs. 22%[40]). Among the NCDs addressed by the interventions covered in this evaluation are diabetes, hypertension, and cervical cancer.

Diabetes has a significant but likely underestimated prevalence, given that treatment coverage remains very limited and a large proportion of cases remain undiagnosed.

[33] https://phia.icap.columbia.edu/wp-content/uploads/2023/10/050324_INSIDA_ENG_RR5.pdf
[34] WHO (2026). Tuberculosis Profile: Mozambique. https://worldhealthorg.shinyapps.io/tb_profiles/?_inputs_&tab=%22tables%22&lan=%22EN%22&iso3=%22MOZ%22&entity_type=%22country%22
[35] https://data.worldbank.org/indicator/SH.TBS.INCD?locations=MZ
[36] Republic of Mozambique, Ministry of Health – Directorate of Planning and Cooperation (2024). Strategic Plan for the Health Sector (PESS) 2014–2019 (Extension 2020–2024). https://docs.bvsalud.org/biblioref/2023/12/1519224/final_pess-revisao-extensao_07-marco-2021_3082022.pdf
[37] Ibid.
[38] WHO (2025). *Noncommunicable Diseases Progress Monitoring 2025*. https://iris.who.int/server/api/core/bitstreams/7a228681-a190-4c29-b2a8-9d4255dc49d1/content
[39] https://data.worldbank.org/indicator/SH.DYN.NCOM.MA.ZS?locations=MZ
[40] https://data.worldbank.org/indicator/SH.DYN.NCOM.FE.ZS?locations=MZ

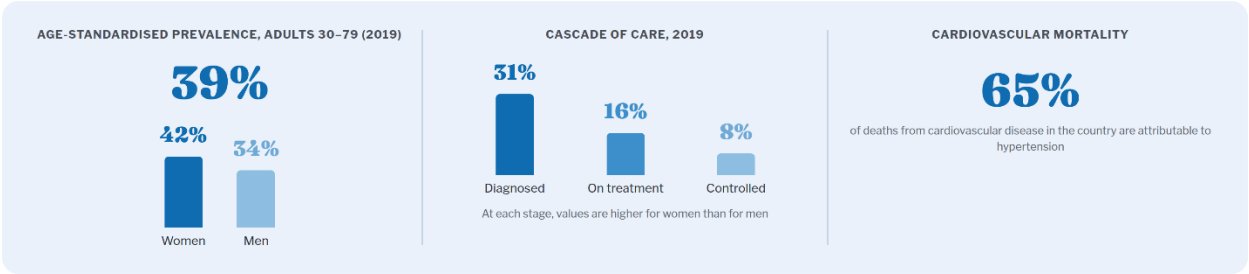
Figure4– Diabetes in Mozambique



Source: WHO, NCD Portal (2019–2022 data)[41] ; International Diabetes Federation, Diabetes Atlas, 11th ed. (2025)[42]

Hypertension is widespread among the adult population, but diagnosis, treatment, and—above all—control of the condition remain largely inadequate, with significant consequences for mortality. According to WHO estimates, in 2019 the age-standardized prevalence of hypertension among adults aged 30 to 79 was 39%.

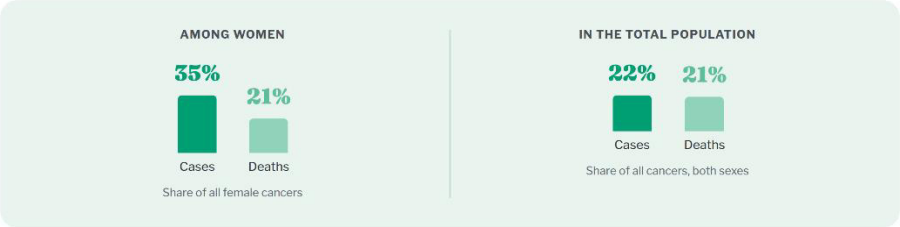
Figure5: Hypertension – Mozambique



Source: WHO, Mozambique Hypertension Profile 2023 (2019 data)[43]

Cervical cancer is the most common and deadly form of cancer among Mozambican women. Cervical cancer accounts for 35% of all cancer cases and deaths among women and, when considering the Mozambican population as a whole, 22% of all cancer cases and 21% of all cancer deaths[44] .

Figure6: Cervical Cancer – Mozambique



Source: IARC, Global Cancer Observatory — Mozambique Factsheet, 2024 estimates (2026)[45]

[41] WHO (2026). Noncommunicable Diseases Data Portal. Mozambique Country Profile. https://ncdportal.org/CountryProfile/GHE110/MOZ
[42] International Diabetes Federation (2025). *Diabetes Atlas, 11th edition*. https://media.idf.org/media/uploads/sites/3/2025/10/IDF_Diabetes_Atlas_11th_Edition_2025_WEB.pdf
[43] WHO (2019). Mozambique Hypertension Profile 2023. https://cdn.who.int/media/docs/default-source/country-profiles/hypertension/hypertension-2023/hypertension_moz_2023.pdf?sfvrsn=34519308_4&download=true
[44] Ervik M, Laversanne M, Lam F, Colombet M, Ferlay J, Filho AM, Bray F (2026). *Global Cancer Observatory: Cancer Today (2024 estimates, version 1.0). Mozambique Factsheet.* International Agency for Research on Cancer. https://gco.iarc.who.int/media/globocan/factsheets/populations/508-mozambique-fact-sheet.pdf
[45] Ervik M, Laversanne M, Lam F, Colombet M, Ferlay J, Filho AM, Bray F (2026). Global Cancer Observatory: Cancer Today (2024 estimates, version 1.0). Mozambique Factsheet. International Agency for Research on Cancer. https://gco.iarc.who.int/media/globocan/factsheets/populations/508-mozambique-fact-sheet.pdf

The high incidence of cervical cancer in Mozambique reflects the high prevalence of HPV and HIV infections[46] ; furthermore, most women in Mozambique are diagnosed with advanced-stage cervical cancer and die from the disease[47] , partly due to delays in diagnosis[48] .

2.4 Development Policies and International Cooperation

To contextualize the interventions covered by this evaluation, we refer to **the general framework of Mozambique's health policies and strategies**, outlined in four policy documents, some of which were adopted after the proposals were formulated. In fact, the proposals primarily draw on the Strategic Plan for the Health Sector then in effect and on the vertical national plans relating to individual areas of intervention (HIV and sexually transmitted infections, tuberculosis, vertical transmission, noncommunicable diseases, and human resources for health), as well as on the relevant international strategies of UNAIDS, WHO, and the Global Fund.

The overall framework is structured across multiple levels, ranging from national development planning to health sector planning, and includes the following documents:

- The National Development Strategy 2025–2044 (*Estratégia Nacional de Desenvolvimento 2025–2044*)[49] , which places health within a long-term intersectoral development framework;
- The Government's Five-Year Program 2025–2029 (*Programa Quinquenal do Governo 2025–2029*), which defines strategic priorities and objectives for the short and medium term;
- The Health Policy and Strategy for Its Implementation (*Política de Saúde e a Estratégia da sua Implementação*, 2022), which defines the value framework and strategic pillars of the national health policy;
- The Strategic Plan for the Health Sector 2014–2019, later extended to 2024 (*Plano Estratégico do Sector da Saúde 2014–2019, Extensão 2020–2024*)[50] , which outlines strategic objectives and vertical programs organized by disease.

The main health planning instruments focus on several **common priorities**: strengthening the National Health Service (SSN), improving the quality of and access to services, and enhancing primary care, with particular attention to rural and outlying areas and to a structured and participatory community-based component. The **National Development Strategy** sets forth four priority objectives (quality and efficiency of services, expansion of primary care services, safety of care, and community involvement), while the **Five-Year Program** translates these into operational objectives such as the procurement of medicines, the expansion of community health centers and mobile units, strengthening district hospitals and diagnostic and screening services, training specialized personnel, and establishing a public institute for NCDs. The **Health Policy** organizes these guidelines into three pillars (promotion of healthy lifestyles, strengthening of the health system, and implementation of the "Health in All Policies" approach regarding the social determinants of health), while the **Health Sector Strategic Plan** identifies among its priorities the reduction of endemic

[46] Bruni L, Albero G, Serrano B, Mena M, Collado JJ, Gómez D, Muñoz J, Bosch FX, de Sanjosé S. ICO/IARC Information Center on HPV and Cancer (HPV Information Center). *Human Papillomavirus and Related Diseases in Mozambique*. Summary Report, March 10, 2023. https://hpvcentre.net/statistics/reports/MOZ.pdf?t=1787322295816; de Oliveira, C.M., Rangeiro, R., Osman, N. *et al.* Evaluation of HPV risk groups among women enrolled in the Mulher cervical cancer screening study in Mozambique. *Infect Agents Cancer* **20**, 24 (2025). https://doi.org/10.1186/s13027-025-00655-1

[47] Salcedo, M. P. et al. (2023). The Mulher Study: Cervical Cancer Screening with Primary HPV Testing in Mozambique. *International Journal of Gynecological Cancer: Official Journal of the International Gynecological Cancer Society*, *33*(12), 1869–1874. https://doi.org/10.1136/ijgc-2023-004958

[48] Azevedo-Fernandes, F., Chilundo, B. Navigating cervical cancer care in Maputo: a mixed-methods analysis of socioeconomic inequities in patient pathways and health system barriers. *BMC Women's Health* **26**, 353 (2026). https://doi.org/10.1186/s12905-026-04550-8

[49] Republic of Mozambique (2024). National Development Strategy 2025–2044. https://mef.gov.mz/index.php/publicacoes/estrategias/2184-estrategia-nacional-de-desenvolvimento-2025-2024/file

[50] Republic of Mozambique, Ministry of Health – Directorate of Planning and Cooperation (2024). Strategic Plan for the Health Sector (PESS) 2014–2019 (Extension 2020–2024). https://docs.bvsalud.org/biblioref/2023/12/1519224/final_pess-revisao-extensao_07-marco-2021_3082022.pdf

diseases (including HIV, TB, and NCDs), curbing the rise in NCDs, and accelerating progress toward a more robust primary care system.

For decades, Mozambique has been one of **the** main **partner countries of Italian Cooperation in Sub-Saharan Africa**[51] . The collaboration between the two countries has its roots in the post-independence period and has gradually been consolidated through an ongoing commitment to supporting the country's socioeconomic development, combating poverty, promoting human rights, and strengthening public institutions. Italy also played a significant role in the peace process that led to the signing of the 1992 Rome Accords, contributing to the establishment of a long-term partnership with Mozambique[52] .

Through the AICS Regional Office in Maputo, Italian Cooperation supports the development priorities defined by the Mozambican government in line with the **Multi-Year Indicative Plan** (PIP) 2022–2026[53] , which identifies **health**, agriculture, job creation, urban development, and the environment as key sectors of intervention, while mainstreaming the dimensions of good governance, gender equality, and the reduction of inequalities[54] . Within this framework, the health sector represents one of the long-standing and priority areas of Italy's engagement in the country. Italian Cooperation's activities in the health sector are characterized by an approach focused on **strengthening the National Health System**, **consolidating institutional and professional capacities**, **improving access to essential health services**, and **promoting integrated care models** capable of reaching the most vulnerable populations. This approach is developed in close collaboration with MISAU, provincial and district authorities, civil society organizations, academic institutions, and other development partners active in the sector[55] . The national and international policy and strategy documents referenced by each initiative during the formulation phase—and therefore in effect at the time of its approval—are listed in Table 1.

[51] Mozambique PIP 2022–2026, https://maputo.aics.gov.it/wp-content/uploads/2023/02/AICS-Maputo-PIP-2022-2026.pdf
[52] AICS Maputo, Official Website, https://maputo.aics.gov.it/home-ita/sede/profilo/
[53] However, the interventions covered by this evaluation were funded through calls for proposals from 2017 to 2020, prior to the adoption of the PIP, which also drew on experience gained from interventions targeting communicable diseases. The programmatic framework at the time was the 2015–2018 Italy–Mozambique Country Program, which identified health as one of three priority sectors, with a particular focus on human resources, along with the 2015–2017 Three-Year Programming Document for Italian Cooperation (https://www.aics.gov.it/wp-content/uploads/2023/10/LLGG_UN_MONDO_IN_COMUNE_2015-2017.pdf) and the 2019–2021 Triennial Programming and Guidance Document for International Development Cooperation (https://trasparenza.aics.gov.it/moduli/downloadFile.php?file=oggetto_allegati/211731234510O__Odocumento+triennale+di+programmazione+ed+indirizzo+2019-2021.pdf).
[54] Mozambique PIP 2022–2026, https://maputo.aics.gov.it/wp-content/uploads/2023/02/AICS-Maputo-PIP-2022-2026.pdf
[55] Ibid.

Table1 . Policy documents referenced by the projects under evaluation

Project	Documents
Prevention and Control of Noncommunicable Diseases (AID 11375)	• Strategic Plan for the Health Sector (PESS) 2014–2019 • Multisectoral Strategic Plan for the Prevention and Control of Noncommunicable Diseases 2017–2025. The proposal specifies that it had not yet been officially published at the time. • National Plan for the Development of Human Resources in Health (PNDRHS) 2016–2025 • National Program to Combat Cervical Cancer • Plan for the Expansion of Pathology Services
TILL THE END. Community Strategies to Combat Tuberculosis and HIV in Inhambane Province (AID 11587/04/1)	• Health Sector Strategic Plan (PESS) 2014–2019 • PNCT National TB Protocol: Assessment and Management of Patients with TB, MISAU/DNSP 2018
Espaço Aberto. Strengthening Health Services for Adolescents and Young Women Living with HIV in Mozambique (AID 11817/04/06)	• PEN IV, referred to as the “IV National Strategic Plan” • Global Fund Strategy 2017–2022 “Investing to End Epidemics” • UNAIDS 90-90-90 Strategy
PRoTeggiMI: Prevention of Mother-to-Child Transmission and Treatment of HIV and TB for Remote Communities (AID 012168/01/9)	• Plan for the Elimination of Vertical Transmission of HIV, Syphilis, and Hepatitis B 2020–2024 • Health Sector Strategic Plan (PESS) 2014–2019 • National Strategic Plan for the HIV Response 2015–2019 (PEN IV) • Strategic Plan for Accelerating HIV Treatment and Prevention 2013–2017 • Strategic Action Plan for the Prevention and Control of STIs 2018–2021 • UNAIDS “Start Free, Stay Free, AIDS Free” • UNAIDS Strategy 2016–2021 • WHO Country Cooperation Strategic Agenda 2018–2022 • WHO Global Health Sector Strategies 2016–2021 • WHO Global Guidance on EMTCT 2017
Knowledge for Care: Mitigating the Impact of COVID-19 on HIV-Positive Adolescents and Young People Through Research and Improved Health Services (AID 12168/02/0)	• Health Sector Strategic Plan (PESS) 2014–2019 • Strategic Action Plan for the Prevention and Control of STIs 2018–2021 • PEN IV • PNDRHS 2016–2025 • National Strategy for School Health and the Health of Adolescents and Young People • National Plan for Preparedness and Response to the COVID-19 Pandemic (March 2020)

3 Scope and Objective

This section describes the **initiatives under evaluation**, presenting their underlying rationale and strategy, general and specific objectives, expected outcomes, and the status of implementation for each project, as well as the general and specific objectives of the evaluation. The initiatives evaluated are as follows.

- *Prevention and Control of Noncommunicable Diseases*, implemented by Medici con l'Africa CUAMM in collaboration with the Italian Association of Friends of Raoul Follereau and the Community of Sant'Egidio ACAP ONLUS (awarded to a civil society organization, €7,073,000);
- *TILL THE END. Community Strategies to Combat Tuberculosis and HIV in the Province of Inhambane*, implemented by Medicus Mundi Italia in collaboration with the Inhambane Provincial Health Directorate and the University of Brescia—Department of Clinical and Experimental Sciences, Clinic of Infectious and Tropical Diseases (Global Fund 5%, €405,000);
- *Espaço Aberto. Strengthening health services for adolescents and young women living with HIV in Mozambique*, implemented by the Community of Sant'Egidio ACAP ONLUS in partnership with DREAM—Associação para o Direito aos Tratamentos Sanitários e de Luta Contra a Sida—and the DREAM Foundation—Community of Sant'Egidio Onlus (Global Fund 5%, €450,000);
- *PRoTeggiMI: Prevention of Mother-to-Child Transmission and Treatment of HIV and TB for Remote Communities*, implemented by Medicus Mundi Italia in partnership with the Inhambane Provincial Health Directorate and the University of Brescia, Department of Clinical and Experimental Sciences, Clinic of Infectious and Tropical Diseases (Global Fund 5%, €455,000);
- Knowledge for Care: Mitigating the Impact of COVID-19 on HIV-Positive Adolescents and Young People through Research and the Improvement of Health Services, implemented by the University of Padua in collaboration with Medici con l'Africa CUAMM, the Centro de Investigação Operacional in Beira, and the Sofala Provincial Health Directorate (Global Fund 5%, €260,000).

3.1 Description of the evaluated initiatives

It is within the context described in the background section that Italian Cooperation has funded—either directly or as initiatives that complement the activities of the Global Fund—the five initiatives covered by this evaluation, which share a **strategic approach** aimed at strengthening the National Health Service (SSN) and aligning it with the policies and priorities defined by MISAU. These projects are based on common principles such as equity, the right to health, the quality and efficiency of services, the decentralization of care to the local level, the empowerment of national and local institutions, and the strengthening of partnerships—in line with the Health Sector Strategic Plan, the strategies of national programs, and the country's international commitments, including the Sustainable Development Goals (SDGs) of the 2030 Agenda. A cross-cutting element is the **central role of the community level** as a key arena for intervention. By strengthening local services, the *brigadas* móveis[56] , prevention and awareness-raising activities, and mechanisms linking communities to health facilities, these interventions have helped improve access to prevention, diagnosis, treatment, and follow-up services; reduce geographic and social barriers to accessing

[56] *Mobile brigades* (mobile health units): itinerant health teams composed of health care personnel (often doctors, nurses, and support staff) who periodically travel to remote or hard-to-reach communities to provide prevention, diagnosis, treatment, follow-up, and health education services, helping to reduce geographical barriers to access to health services.

care; and promote greater community participation in health protection. The projects also share a component focused on **strengthening the capacities of health care personnel and public institutions** through training, technical assistance, the development of innovative tools, and support for national programs. Of particular importance is the **promotion of operational research**, the improvement of health information systems , and the generation of scientific evidence aimed at supporting planning and decision-making at the local and national levels. Taken together, the five initiatives have targeted population groups with different needs and vulnerabilities, including people living with HIV and TB, women (including pregnant women and mothers), adolescents and young people, rural populations and residents of remote areas, and people with NCDs. The interventions have also involved healthcare personnel, community stakeholders, and healthcare system institutions at various levels. The composition of the target groups varies across the initiatives and reflects the specific health and regional priorities addressed.

Table 2 summarizes the main characteristics of the five projects. The complete Project Fact Sheets are available as supporting documentation for the Report.

Table2 . Summary Table of Projects

Project, implementation status, type	Objectives	Areas of Intervention	Activities	Direct beneficiaries	Strategic Approach
Prevention and Control of Noncommunicable Diseases (AID 11375 - January 1, 2019 – December 31, 2022, completed) *Assigned to an NGO*	• **General**: To contribute to reducing morbidity and mortality in Mozambique from major noncommunicable diseases (NCDs) • **Specific**: Strengthen the response capacity of the National Health System and the Ministry of Health to the growing incidence of noncommunicable diseases, with a focus on diabetes, hypertension, and cervical cancer	Maputo, Sofala, and Zambézia provinces	• Diagnosis, treatment, and follow-up of diabetes and hypertension • Diagnosis and treatment of cervical cancer • Public awareness campaigns on risk factors and the prevention of NCDs and cervical cancer • Activities to strengthen epidemiological surveillance of NCDs	Healthcare personnel (medical staff, nurses, laboratory and pharmacy technicians, M&E staff, faculty at training institutions), community health workers, patients with diabetes/hypertension, women undergoing VIA/CACUM screening	A structural and systemic approach focused on strengthening human resources, service organization, primary care, early diagnosis, and health information systems
TILL THE END. Community-Based Strategies to Combat Tuberculosis and HIV in Inhambane Province (AID 11587/04/1 - June 1, 2019 - August 31, 2021, completed) *Global Fund 5%*	• **General**: To contribute to national and international efforts to combat tuberculosis and HIV in the province of Inhambane • **Specific**: To improve access to quality services for the prevention and diagnosis of tuberculosis and HIV for the most vulnerable populations in remote community districts, ensuring tuberculosis treatment at the community level	Inhambane Province (districts of Massinga, Funhalouro, Morrumbene, Homoine)	• TB/HIV prevention and diagnosis activities in rural communities • Activities for tuberculosis treatment and monitoring of treatment adherence • Capacity-building activities for healthcare workers and coordination • Conducting epidemiological analyses and disseminating the results	Women, boys, and girls in the rural target communities; the general population accessing basic health services; the population involved in TB and HIV prevention and diagnosis activities; health care personnel involved in capacity building and coordination; institutional and knowledge-based stakeholders involved in coordination, research, and dissemination	An integrated and decentralized approach, designed to overcome the geographic and structural barriers that limit access to health services in rural areas
Espaço Aberto. Strengthening Health Services for Adolescents and Young Women Living with HIV in Mozambique (AID 11817/04/06 - March 1, 2020 - September 30, 2022, completed) *Global Fund 5%*	• **General**: Reduce the risk and impact of HIV/AIDS on young women and adolescents in 4 provinces • **Specific**: Promote high-quality and effective health services; strengthen human resources through awareness-raising and training of health center staff; improve treatment adherence among patients receiving care; conduct operational research to collect sociodemographic data, data on retention and adherence to antiretroviral therapy, and data on the uptake of services offered	Provinces of Sofala, Maputo, Maputo City, Zambezia (districts of Matola, Machava, Maputo Center, Zimpeto, Beira, Manga	• Activities to strengthen health services for adolescents living with HIV • Activities to strengthen health services for young women living with HIV • Activities to increase public awareness of HIV among adolescents and young women	Adolescents and women living with HIV, *health workers, health educators (youth leaders),* individuals involved in awareness-raising activities, and people undergoing HIV testing (primarily adolescents and young women)	An integrated, *youth-friendly* care model for adolescents and young women (ages 10–24) living with HIV, strengthening access to services, the quality of care, and treatment adherence

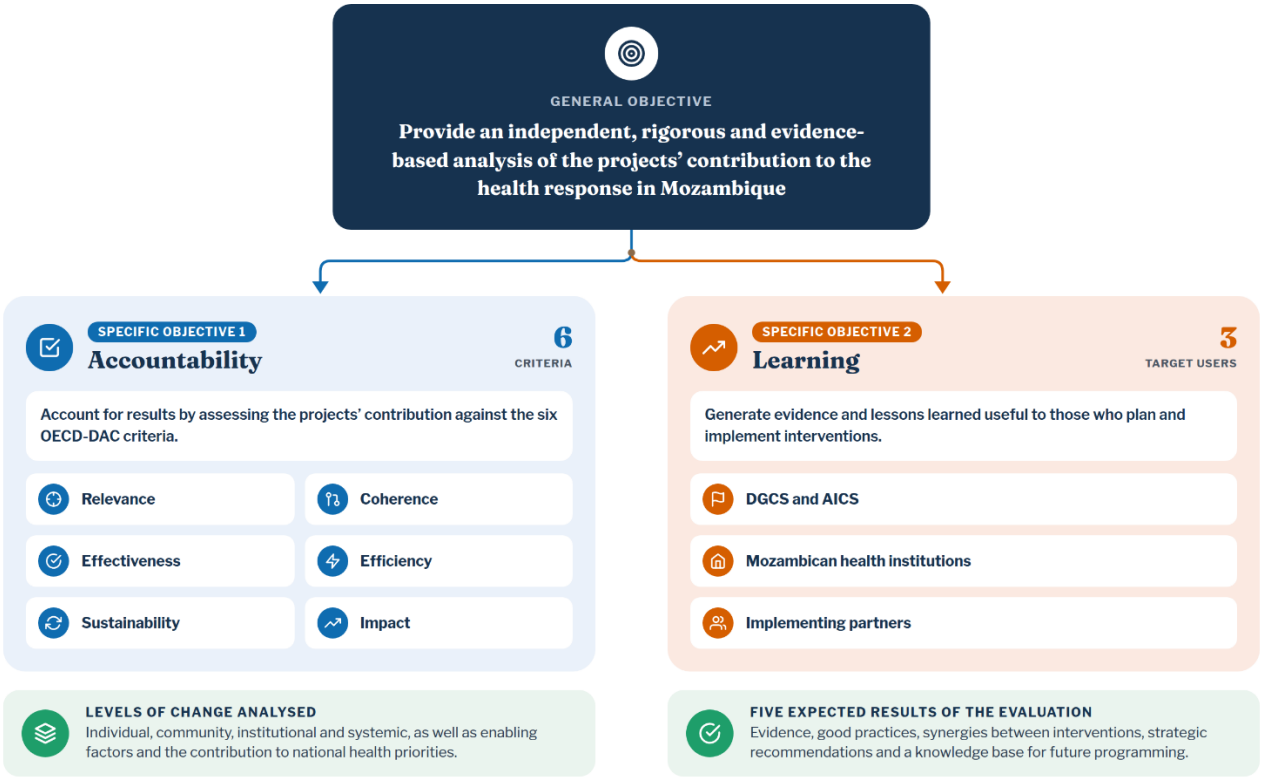
Project, implementation status, type	Objectives	Areas of Intervention	Activities	Direct beneficiaries	Strategic Approach
	to the young women and adolescents involved at the centers	Chingussura, Quelimane)			
PRoTeggiMI: Prevention of Mother-to-Child Transmission and Treatment of HIV and TB for Remote Communities (AID 012168/01/9 - 09/01/2021 – 08/31/2023, completed) *Global Fund 5%*	• **General**: Contribute to the effectiveness of national programs to combat the spread of HIV • **Specific**: Increase access to quality services for the prevention of mother-to-child transmission (PMTCT) of HIV and the treatment of HIV and TB in remote communities in Inhambane Province	Inhambane Province (districts of Massinga, Funhalouro, Morrumbene, Homoine)	• Provision of primary health care services to rural communities • Activities to prevent vertical transmission of HIV • Provision of services for HIV-positive patients at the community level	Population of the target rural communities (boys and girls, adolescents, adults—primarily women), community HIV activists, and local health workers (maternal and child health nurses)	A decentralized, community-based approach to improve access to primary health care services and the continuum of prevention, diagnosis, and treatment for HIV and tuberculosis in rural areas
Knowledge for Care: Mitigating the Impact of COVID-19 on HIV-Positive Adolescents and Young Adults Through Research and Improvements in Health Services (AID 12168/02/0 - November 1, 2021 - January 31, 2024, completed) *Global Fund 5%*	• **General**: To support Mozambican health authorities in achieving Sustainable Development Goal 3.3 and Strategic Objective 1 of the Global Fund (Maximize impact against HIV, TB, and malaria) in the context of the COVID-19 pandemic • **Specific**: To increase access to and improve the quality of prevention, early diagnosis, treatment, and follow-up services for HIV-positive adolescents and young adults at health centers (SAAJ) in the urban district of Beira through enhanced understanding of the impact of the COVID-19 pandemic	Sofala Province (Beira District)	• Collection, analysis, and dissemination of data on SARS-CoV-2 prevalence and risk factors among HIV-positive adolescents and young people • Collection and analysis of data on mental health and continuity of access to and treatment for HIV during the SARS-CoV-2 pandemic • Capacity-building activities for healthcare workers, community advocates, activists, and adolescents	Adolescents and young people undergoing serological testing for SARS-CoV-2, healthcare workers, community activists, *stakeholders* participating in outreach events, people reached through awareness-raising efforts, and patients receiving psychological care	An integrated approach to the collection, analysis, and systematic use of quantitative and qualitative data to strengthen the response to the health needs of HIV-positive adolescents and young people in the context of the COVID-19 pandemic

3.2 General and Specific Objectives of the Evaluation

The general objective of the evaluation is to provide the DGCS, the AICS, implementation partners, and other involved *stakeholders* with an independent, rigorous, and evidence-based analysis of the contribution of the evaluated projects to strengthening the health response in Mozambique. In line with the provisions of the Terms of Reference (ToR), the evaluation pursues a dual specific objective of *accountability* and learning. On the one hand, it aims specifically to assess the relevance, coherence, effectiveness, efficiency, sustainability, and impact of the interventions funded by Italian Cooperation, thereby contributing to transparency, *accountability*, and reporting on the use of public resources. On the other hand, it generates evidence, lessons learned, and operational recommendations useful to *the* various *stakeholders* involved. In particular, the DGCS and the AICS will be able to use the evaluation results to guide future planning and improve the design of similar initiatives in the health sector; Mozambican health institutions will be able to leverage the findings to strengthen processes for planning, coordinating, and implementing interventions; and implementing partners and other stakeholders will be able to use the lessons learned to improve approaches, tools, and operational methods.

This evaluation analyzes the changes brought about by interventions at the individual, community, institutional, and systemic levels, as well as the factors that have facilitated or limited the achievement of the observed results. It also examines the overall contribution of the projects to national health priorities. The main **expected outcomes** of the evaluation include: **i)** The production of credible and actionable evidence on the results and impacts of the projects; **ii)** The identification of best practices, innovative approaches, and potentially replicable success factors; **iii)** The analysis of synergies and complementarities among interventions; **iv)** The formulation of strategic and operational recommendations for the DGCS, AICS, and implementing partners; and **v)** The strengthening of the knowledge base on the local health system to inform future planning for Italian Cooperation in the health sector in Mozambique.

Figure7: General and Specific Objectives of the Evaluation



4 Theoretical and Methodological Framework

This section describes the evaluation criteria adopted for this evaluation, the methodology used and its application, and the information sources consulted.

4.1 Evaluation Criteria

The evaluation is structured around the **six criteria defined by the OECD-DAC**, prioritizing impact, sustainability, and effectiveness, and secondarily coherence, efficiency, and relevance, in accordance with the Terms of Reference (ToR). These criteria constitute the primary analytical framework for examining the projects and have guided the formulation of evaluation questions, the collection of evidence, and the interpretation of results. The analysis of the criteria was adapted to the specific characteristics of the projects and supplemented by a cross-cutting analysis of issues related to human rights, gender equality, equity in access to health services, and the *"Leave No One Behind"* principle. Particular attention was also paid to identifying the contextual, institutional, and operational factors that influenced the achievement of results and the sustainability of the observed changes.

The evaluation questions are detailed in the Evaluation Matrix (Appendix 2 to the Report), where they have been linked to specific evaluation criteria, indicators, information sources, and data collection tools.

4.2 Stages of the Evaluation

The evaluation proceeded through the following main phases.

- **Desk Analysis and Inception Report.** The evaluation began with an in-depth desk analysis phase aimed at systematically reviewing all available documentation related to the initiatives (project documents, logical frameworks, monitoring and evaluation reports, and secondary data). A kick-off meeting at the DGCS facilitated alignment with key institutional stakeholders, and based on these elements, the team drafted the Kick-off Report, which served as the reference document for the entire process.
- **Field visit.** The mission to Mozambique took place from July 20 to August 7, 2026. The team conducted interviews with institutional stakeholders, implementing partners, and beneficiaries; visited the intervention areas and health facilities; and collected qualitative and quantitative data. Finally, the team shared an initial summary of the findings with the stakeholders for preliminary validation.
- **Data analysis and drafting of the report.** The evidence underwent an integrated analysis and triangulation, on the basis of which the draft Evaluation Report was prepared.
- **Comments, feedback, and a seminar at the DGCS.** The draft was forwarded by the DGCS to the relevant stakeholders. The team reviewed the comments received, providing clarifications where appropriate while respecting the independence of the evaluation, and presented the preliminary results at the seminar held at the DGCS, gathering further input useful for finalizing the report.
- **Final report and on-site seminar.** The final report, prepared taking into account the comments received, was presented to local stakeholders at the on-site seminar, organized in coordination with the DGCS and with the support of the Embassy and AICS.

4.3 Methodology Used and Its Application

Consistent with the nature of the evaluation and the availability of existing evidence, the analysis does not seek **to measure counterfactual impact**. Adopting an integrated approach, it focuses on reconstructing and verifying the intervention logic and the theory of change underlying the projects (*Results-Based Approach)*, examining the plausibility of the interventions' contribution to the observed changes. By analyzing the relationships between activities, results, outcomes, and

expected impacts, the evaluation seeks to understand to what extent and through which mechanisms the projects contributed to the observed results (*Contribution Analysis)*, taking into account the operational context, external factors, and any competing influences. The Results-Based Approach (RBA) allows for the systematic reconstruction and verification of the degree to which expected results have been achieved, starting from the intervention's logic (inputs, activities, outputs, outcomes, and expected impacts), and for a critical assessment of the quality, completeness, and consistency of the data. The RBA can determine whether and to what extent the expected results have been achieved, but it cannot explain why this occurred, nor can it determine to what extent the observed changes are attributable to the interventions. For this reason, it is framed within a *theory-based* and contributory perspective, which uses the theory of change as a reference for verifying the plausibility of causal links and employs *contribution analysis* to weigh the role of external factors and alternative explanations and to identify unexpected effects, whether positive or negative.

Cross-cutting issues, including human rights, gender, and the environment, are systematically considered throughout the evaluation process. The evaluation, using a **Human Rights-Based Approach** (HRBA), examines the extent to which a human rights-based and gender equality approach has been incorporated into the design and implementation of interventions, and the extent to which the dimensions and objectives of gender equality and equity have been effectively pursued. The environmental dimension is considered from two complementary perspectives. First, in relation to the link between climate factors and health: the evaluation examines the extent to which extreme weather events (such as cyclones and floods) have affected access to services and the resilience of the health system in the intervention areas; and second, the extent to which the interventions have taken these factors into account in their design. These approaches are integrated across the board into the analysis, the evaluation questions, and the interpretation of the theory of change, so as to also examine the structural causes of inequalities and not merely their observable effects, with particular reference to access to services, equity, and the dynamics of inclusion and exclusion. The analysis also adopts an **intersectional perspective**, aimed at capturing the overlap of factors of vulnerability and discrimination—including gender, age, and geographic location—that generate cumulative forms of exclusion. Where possible, **data disaggregated by gender, age, and geographic location** are used; the evaluation also sought to be equity-centered, ensuring the genuine involvement of the most vulnerable groups through participatory processes.

The evaluation adopts a mixed-methods **approach**, combining **qualitative and quantitative tools** to ensure a rigorous analysis based on the integration of various sources of evidence, with the goal of gaining an in-depth understanding of both the results achieved and the processes that contributed to them.

The **quantitative component** is based on the analysis of available secondary data, including project documents (project logical frameworks, data from monitoring and reporting systems, narrative and final reports, and project databases) and statistical evidence produced by the implementing partners and Mozambican health institutions. The **qualitative component** (interviews with key informants and focus groups), on the other hand, allows for a deeper exploration of stakeholders' perceptions, the quality of implementation processes, the mechanisms that facilitated or hindered the achievement of results, the degree of institutional ownership, and the prospects for the sustainability of the interventions.

The preliminary **Theory of Change** outlined in the Inception Report was verified and refined through the triangulation of documentary, quantitative, and qualitative evidence collected during the evaluation. As outlined in the methodological framework, the verification was not intended to demonstrate a causal attribution of changes to individual initiatives, but rather to examine the plausibility of the links between activities, results, outcomes, and expected impacts, taking into

account contextual conditions, enabling and constraining factors, and competing influences, consistent with the *theory-based* and *Contribution Analysis* approach adopted by the evaluation.

Quantitative evidence is used to identify trends, results, and observable variations, while qualitative evidence helps interpret these results, verify the hypotheses formulated in the theory of change, and identify contextual factors, unexpected effects, and possible alternative explanations. The information collected (see Section 4.4) was **systematically organized and analyzed** based on the evaluation questions, the OECD-DAC criteria, and the reconstructed theory of change. The qualitative evidence underwent a thematic coding process that combines deductive categories—derived from the evaluation matrix, the OECD-DAC criteria, and the theory of change—with inductive categories emerging from the analysis of data collected in the field. This process allows for the identification of recurring patterns, convergences, divergences, and unexpected outcomes among the various stakeholder categories and across different territorial contexts. The quantitative analysis is based on available monitoring data, indicators from the logical frameworks, data from health information systems, and other accessible statistical evidence. Although it does not aim for a counterfactual measurement of impact, this data makes it possible to verify the achievement of expected results, the extent of intervention coverage, and the main trends observable during the implementation period.

To ensure the validity of the information collected, evidence triangulation is used:

- **Methodological triangulation:** This involves the combined use of different data collection methods to examine evaluation questions from different angles.
- **Triangulation of information sources:** Information from various sources—both primary and secondary—is consulted, including the broadest possible range of stakeholders, to gather multiple perspectives on the intervention from different local contexts.
- **Triangulation of evaluators:** This involves evaluators comparing and discussing the data they have collected, both individually and collectively. In the event of inconsistencies, verifications are conducted and, where necessary, further consultations are carried out.

4.4 Information Sources

The **data collection methods** used in this evaluation are listed below; the data collection tools are available as supporting documentation for the Report.

- **Document** analysis **(*desk review*).** Project documents (e.g., Single Project Document (DUP), Logical Framework (QL), interim and final reports) and secondary contextual sources (e.g., national and sectoral programs, studies, and statistical reports) in order to: i) gain a precise understanding of the interventions and the context in which they were developed, including the sources and conditions of access to information, and identify key informants; ii) define the evaluation questions and related indicators; iii) refine the methodological tools and assess their feasibility for data collection and processing. The desk review analyzed a total of 300 documents. For a list of the project documentation consulted, please refer to Annex 3 of the Report.
- **Semi-structured interviews.** The interviews were designed to gather the opinions of the various stakeholders involved in the interventions, to examine the actions undertaken by each, and to clarify any potential contradictions. The stakeholders included institutional actors, such as AICS Rome and AICS Maputo, MISAU, and relevant national programs; the Department of Public Health (DPS) and district health authorities; the lead CSOs for each intervention and their partners; as well as health care workers. A specific semi-structured guide was prepared for conducting the interviews; it was developed based on the Evaluation Matrix and its corresponding evaluation questions and subsequently adapted to the different categories of stakeholders involved and the target groups. The interview guides were tested and finalised at

the start of fieldwork; the updated version is available in the documentation accompanying the Report.

- ***Focus groups*.** The use of the *focus group* technique made it possible to gather a collective yet nuanced perspective from the various beneficiary groups regarding the relevance, effectiveness, impact, and sustainability of the initiative and, specifically, of the health and services offered as part of the interventions. Accordingly, depending on the context and characteristics of the interventions, the *focus groups* involved adolescents and young people, women who are beneficiaries of sexual and reproductive health services, people living with HIV, users of PMTCT and TB/HIV services, beneficiaries of services for noncommunicable diseases, community members, and caregivers. To facilitate the focus groups, a specific guide was developed and adapted for each type of beneficiary; this guide was also based on the evaluation matrix and designed to stimulate discussion among participants on the main topics covered by the evaluation. The guides used for the focus group discussions are available in the documentation accompanying the Report, together with the interview guides.
- **Direct observation during field visits.** Direct observations at health centers complemented consultations with stakeholders and documentary evidence, providing firsthand insight into the physical infrastructure, the availability and functionality of equipment, interactions among the various actors, and, more generally, the implementation of interventions. Direct observation also made it possible to assess the degree of *gender sensitivity* in the health infrastructure.

For data collection from primary sources, the evaluation approach was geared toward **the active participation of stakeholders**. The evaluation adopted a targeted sampling strategy. Field data collection focused on **the provinces of Maputo, Sofala**, **and Inhambane**, selected based on four criteria: (i) their relevance to the evaluation objectives and the thematic areas covered by the projects; (ii) the presence of multiple interventions and diverse beneficiary groups; (iii) the opportunity to observe different implementation models in urban, peri-urban, and rural contexts; and (iv) the availability of key actors at the institutional, operational, and community levels. Where possible, the sample includes both sites where interventions are considered particularly successful and sites where interventions have encountered implementation challenges, in order to better understand both enabling and limiting factors. Data for Zambezia were collected through document analysis, project monitoring data, and interviews with national-level stakeholders and implementing partners.

The data collection activities involved a wide range of stakeholders. **Fair, inclusive, and meaningful participation by the various beneficiary groups** was ensured**. Interviews** and **focus groups**, where appropriate, were conducted in groups homogeneous by gender, age, or beneficiary profile, in order to foster a climate of trust and the free expression of opinions, as well as to identify any gender-based barriers and differential impacts. The evaluation team employed **inclusive and culturally appropriate facilitation techniques**, ensuring that all participants had equal opportunities to contribute to the discussions without fear of discrimination, stigmatization, or negative consequences resulting from their participation. All consultation activities were conducted in accordance with the principles of informed consent, confidentiality, and personal data protection.

The following table provides an overview of the individuals consulted.

Table3. Overview of Consulted Individuals and Direct Observations

Category	No. of consultations	No. of stakeholders consulted	F	M	n/a	AID 11375	AID 11587/04/1	AID 11817/04/06	AID 012168/01/9	AID 12168/02/0
Semi-structured interviews (KII)										
Beneficiaries	9	9	6	2	1	5			4	1

Category	No. of consultations	No. of stakeholders consulted	F	M	n/a	AID 11375	AID 11587/04/1	AID 11817/04/06	AID 012168/01/9	AID 12168/02/0
Public Institutions / Government	8	10	5	2	3	7		5		2
Implementing Partners / CSOs	6	6	1	4	1	2		4		1
Universities / Scientific Partners	2	7	6	1			2			5
Italian Cooperation	1	1	1	0		all	all	all	all	all
Community Leaders	1	1	0	1					1	
Total KII	**27**	**34**	**19**	**10**	**5**	**14**	**2**	**9**	**5**	**9**
Focus groups (FGD)										
Beneficiaries (patients)	6	24	14	10		10			14	
Youth	6	77	45	32				75		2
Activists and Mentors	8	18	14	4		6		6	4	2
Healthcare professionals / nurses / psychologists	9	24	14	10		4	7		7	6
Public Institutions / Government	5	24	12	12		3	15		6	
Implementing Partners / CSOs	7	22	13	8	1	6	5	11		
Universities / Scientific Partners	1	2	0	2						2
Italian Cooperation	1	2	2	0		all	all	all	all	all
Total FGD	**43**	**193**	**114**	**78**	**1**	**29**	**27**	**92**	**31**	**12**
Direct Observations										
Sites, establishments, and services observed	19	n/a	n/a	n/a		5	1	5	5	3

4.5 Limitations

This assessment has certain limitations that must be taken into account when interpreting the results.

A first limitation concerns **the availability and comparability of quantitative data**. The monitoring systems and indicators used by the five initiatives vary in terms of completeness, frequency, and disaggregation, and do not always allow for the reconstruction of directly comparable baseline values, interim progress, and final outcomes. In particular, the inconsistent availability of data disaggregated by sex, age, geographic area, and other vulnerability factors limits the ability to uniformly analyze changes across different target groups and to conduct an intersectional analysis across all initiatives. The availability of updated data after the conclusion of the projects is also limited, making it possible primarily to verify the continuation of practices, capacities, and mechanisms, but not always to quantify the persistence of *the outcomes* achieved during implementation.

A second limitation concerns **the coverage and representativeness of the primary data collection**. The sampling of individuals and sites consulted was purposeful and designed to represent different initiatives, regions, stakeholder categories, and beneficiary groups; the qualitative evidence is therefore not statistically representative of the entire population reached. The field mission covered Maputo, Sofala, and Inhambane, while the analysis for Zambezia was based on available documentation, monitoring data, and consultations with relevant stakeholders. Furthermore, the involvement of partners and health facilities in identifying and mobilizing some of the interviewees may have favored the participation of individuals still connected to the services and initiatives, making it more difficult to reach people who were less involved, no longer in treatment, or who had less positive experiences.

The **ex-post nature of the evaluation** introduces a further limitation in the analysis of the projects. In the affected areas, some interventions occurred over time, and the same partners maintained a continuous presence, while public policies, other programs, and contextual factors contributed to the observed changes. It is therefore not possible to causally isolate the effects of individual initiatives. Instead, the evaluation analyzes the plausible contribution of the interventions to the observed changes , distinguishing—to the extent permitted by the evidence—the outcomes directly associated with specific services, tools, and practices from the institutional and systemic effects of a more cumulative nature.

These limitations were mitigated through the **systematic triangulation** of **sources** and **methods**, comparing project documentation and quantitative data with interviews, focus groups, and direct observation, and verifying convergences and divergences among different categories of stakeholders and regions. In cases where the evidence base does not allow for robust conclusions or comparisons between groups, these limitations are explicitly stated in the analysis, and the evaluative judgment is formulated with the corresponding level of caution.

5 Presentation of Results

5.1 Impact

The evaluated projects have contributed to significant and still observable changes, particularly at the individual, community, and institutional levels. The main changes concern improvements in the accessibility and continuity of care, capacity building, the development of more integrated care models tailored to different vulnerable groups, and the strengthening of the link between communities and the healthcare system. At the systemic level, signs of change are emerging, though supported by more limited evidence. The contribution of the initiatives is more clearly documented for changes directly associated with specific services, tools, and practices, whereas at the institutional and systemic levels, it takes on a more cumulative and concurrent character, partly due to the presence of public policies, subsequent interventions, and contributions from other actors.

Q1. What significant changes generated by the project persist after its conclusion for each beneficiary group?

The evidence indicates that important changes have endured, albeit with varying intensity and degrees of consolidation across initiatives, regions, and beneficiary groups. Several converging pathways of change emerge: greater proximity and continuity of services; the persistence of knowledge and practices related to prevention and care within communities; the strengthening of the capacities of the involved actors; the consolidation of relationships between communities and the healthcare system; and, for specific groups, a more integrated approach to addressing health, social, socioeconomic, and psychosocial needs.

Impact at the Individual and Community Levels

At the individual and community levels, the most evident changes concern four areas: 1. access to and continuity of care; 2. knowledge and practices related to prevention and treatment; 3. the relationship between communities and health services; 4. social, socioeconomic, and psychosocial care for adolescents and young people.

1. Effective access to services and continuity of care.

Evidence shows that community-based approaches and mechanisms linking individuals to care pathways—which the initiatives have helped to strengthen and expand—remain in place. In the rural communities of Inhambane, mobile health teams continue to serve as a vital channel for accessing services for populations living far from health facilities and are highly valued by both communities and health care providers. The visits and interviews conducted during the evaluation confirm their ongoing operation, although this remains dependent on the availability of vehicles, fuel, maintenance, and staff. The model's sustainability is further confirmed by its continuation and further consolidation within subsequent interventions.
AID 11587/04/1 – TILL THE END and AID 0
12168/01/9 – PRoTeggiMI have contributed to the gradual integration of HIV, TB, and PMTCT services into the mobile brigades and to strengthening the link between healthcare personnel and community stakeholders. The scale achieved during these interventions was significant: in 2022, the PRoTeggiMI brigades covered 104 communities in the four districts of Morrumbene, Funhalouro, Homoine, and Massinga, while AID 11587/04/1 – TILL THE END had further decentralized TB diagnosis through three mobile GeneXpert Edge units. The evidence gathered shows that this process did not end with the conclusion of the evaluated initiatives: mobile brigades and community-based services continue to be used in the affected areas, maintaining their role of bringing healthcare services closer to populations who would otherwise have to travel to healthcare facilities. Even within the context of NCDs, the approach of outreach and connection between communities and health services—developed through community actors—remains in place. AID 11375 – Prevention and Control of NCDs had trained a total of 353 people—including APEs, ACSs, ATPs,

and NCD activists—on NCDs and COVID-19, strengthening their role in raising awareness, referring patients to healthcare facilities, and accompanying patients. In the communities visited, these activities continue to be carried out, albeit with a smaller number of activists. In one of the facilities where it was possible to track the progress of the trained activists, 25% of those who had completed the training were still active. Although this is a specific figure that cannot be generalized to the entire network, it shows that community-based activities continue, albeit with fewer human resources available than during the project phase. The continuity of this approach is also reflected in subsequent interventions on DNTs, which have resumed and expanded activities related to awareness-raising, screening, case management, and referrals to healthcare facilities.

Mechanisms for patient follow-up and support also remain in place, including the active search for individuals who discontinue treatment. During AID 11375—Prevention and Control of Non-Communicable Diseases (NCDs)—treatment continuity had improved, particularly in Sofala and Zambézia, where the proportion of patients still on treatment rose from 35% to 43% and from 36% to 48%, respectively, while in Maputo it rose from 59% to 62%. The gradual expansion of active case-finding had contributed to this result: in the last year, out of 1,805 patients with diabetes and/or hypertension identified as *lost to follow-up*, 958 were located and 520 were reintegrated into care. Interviews conducted during the evaluation indicate that patient support continues through visits, active case-finding, and support for treatment continuity. However, the reduction in the number of active community workers following the project's conclusion suggests a diminished capacity for outreach, particularly with regard to identifying and supporting new patients. No updated data on *retention* or the number of patients reached are available to quantify this reduction or to verify whether the levels of treatment continuity achieved during the project have been maintained **or whether new patients have been included**.

Project data also highlighted a gender difference in treatment continuity: women accounted for 71% of those diagnosed, but 12-month *retention* was 35% among women compared to 47% among men. Unfortunately, in this regard as well, there are no updated data disaggregated by sex available to verify whether the improvement in treatment continuity subsequently continued for both groups or whether the gap observed at the end of the project has narrowed, remained the same, or widened.

2. Knowledge and Practices Regarding Prevention and Treatment

Healthcare knowledge and practices—stemming primarily from community awareness-raising and support activities—persist. In the communities visited, the persistence of these changes in practices and knowledge takes different forms depending on the groups and the health issues addressed: ranging from the adoption of healthier habits and greater attention to prevention, to a more informed management of chronic conditions and treatment continuity.

As part of AID 11375—Prevention and Control of Noncommunicable Diseases (NCDs)—implemented in the provinces of Maputo, Sofala, and Zambézia, community awareness-raising was a key component of the intervention, achieved through the involvement of activists and other community actors. In the third year alone, **324,097 people** were reached, **309,269** of whom were reached **through community visits**; repeated visits to households were used not only to reinforce messages but also to verify the adoption of healthy lifestyle practices and the use of screening and treatment. A specific evaluation of community activities conducted during the project also found, in the areas involved, increased awareness of NCDs and a link between community activities and the demand for care at health facilities.

The evidence gathered indicates that **some of these changes are still evident in the households and communities visited in Maputo**. Among the households interviewed, changes in dietary habits emerged that also involved other family members, along with greater attention to prevention and health checkups. The activists met in Moamba and Matola also demonstrated that they retained knowledge regarding hypertension and diabetes, the main risk factors and possible complications,

as well as the importance of screening and continuity of care. The persistence of this knowledge among community actors is particularly significant because some of them continue to carry out awareness-raising, home visits, and follow-up activities, thereby contributing to the transmission and reinforcement of these practices within the communities.

Among **adolescents and young people living with HIV**, the observed change primarily concerns awareness of their own condition and practices related to continuity of care. As part of **AID 11817/04/06 – Espaço Aberto**, the evaluation involved **75 adolescents and young people (44 females and 31 males) in five focus groups** conducted in Maputo and Sofala. The testimonies collected highlight the importance placed on knowing and accepting one's serostatus, adherence to and continuity of treatment, and the ability to cope with stigma and difficulties associated with HIV, including through the support of healthcare providers and peers. These changes are consistent with the intervention's approach, which combined clinical monitoring and antiretroviral therapy with programs aimed at increasing awareness of one's status and reducing the risk of treatment discontinuation.

For **AID 12168/02/0 – Conoscere per Curare**, the testimonies of the young people interviewed primarily reflect changes related to the ability to recognize and express distress, the search for support, and aspects of mental health and psychosocial well-being. Since the evaluation was able to directly involve only **two young people** linked to this intervention, these findings are indicative but do not allow for broader conclusions regarding the persistence of knowledge and practices among the target population.

Some of the knowledge and practices promoted by the interventions persist, particularly regarding healthy habits, prevention, management of non-communicable diseases (NCDs), and continuity of care for people living with HIV. However, no up-to-date quantitative data are available on the beneficiary population that would allow for measuring the prevalence of these changes or determining to what extent they have been maintained following the conclusion of the initiatives. Furthermore, for HIV/TB interventions in the communities of Inhambane, the evidence more clearly documents the persistence of mechanisms for accessing and receiving care than it does an independently measurable change in knowledge or behavior; for this reason, these results were primarily considered in the analysis of access to and continuity of care.

3. Relationship between communities and health services.

Qualitative evidence indicates that the relationship of trust between communities and health services remains strong, built in part through ongoing engagement with community stakeholders. As part of AID 11375—Prevention and Control of Non-Communicable Diseases (NCDs)—the project trained a total of 353 people, including APEs, ACSs, ATPs, and NCD activists, on NCDs and COVID-19, strengthening the role of community actors in raising awareness, referring patients to services, and providing follow-up care. The role of activists and other community actors was not limited to conveying information but also included home visits, guidance, dialogue about fears and beliefs, and accompanying people to health facilities. Testimonies collected in Moamba and Matola indicate that this relationship endures: activists who are still active (approximately 25% of those trained and who worked on the project) are well-known in their communities, which continue to turn to them, and they emphasized how ongoing contact helps maintain the trust built over time. In Moamba, one activist explicitly linked the continuity of follow-up to the building of greater trust and reported an increase in people's confidence in public services.

A similar relational dynamic emerges in Inhambane within the context of AID 11587/04/1 – TILL THE END and AID 012168/01/9 – PRoTeggiMI, where the community-based model had reached, in the case of PRoTeggiMI, 104 communities across four districts. The communities consulted expressed strong appreciation for the mobile brigades, community actors, and the relationship maintained with health services. In this case, however, the evidence more directly documents the

strengthening of the relationship between communities and services than an increase in trust in the strict sense. This aspect is also reflected in the testimonies of health sector stakeholders.

4. Social, Socioeconomic, and Psychosocial Care for Adolescents and Young People

For adolescents and young people, particularly those living with HIV, the changes observed go beyond the clinical dimension and also concern their ability to cope with their condition, stigma, and the social difficulties and relationships associated with it. This finding emerges primarily from AID 11817/04/06 – Espaço Aberto and AID 12168/02/0 – Conoscere per Curare, which integrated components of psychosocial support and specific approaches tailored to adolescents and young people into their care models.

Within the framework of AID 11817/04/06 – Espaço Aberto, this care model took the form of a combination of clinical care, individual counseling, support groups, mentors, and peer-led activities. The project established support groups in the seven participating centers and trained 58 young people as *health educators*, pairing them with healthcare staff and *expert clients*. Evidence indicates that this approach provided adolescents and young people with safe spaces and support figures to help them come to terms with their HIV status, address stigma, and cope with the personal and relational challenges associated with HIV. Additionally, pathways emerged for empowering young people within the services: among the four young people interviewed who transitioned from being service recipients to providing support to other adolescents, three were women and one was a man. This trend is reflected in the training of 10 *health educators* as VCT providers (6 women and 4 men).

For HIV-positive girls and young women, care management also included a component focused on socioeconomic autonomy, in response to gender-based vulnerabilities and barriers that could affect their access to services and continuity of care. Among other things, the project identified restrictions imposed by spouses on some young women's ability to visit health centers. A total of 93 HIV-positive girls benefited from vocational training courses, and 125 completed tailoring courses; 79 continued to use the workshops even after the courses ended. Testimonials collected during the evaluation indicate that training opportunities and meetings continue and that some participants have launched small income-generating activities, linking this experience to renewed personal motivation. However, it was not possible to directly verify these experiences or quantify the number of young women who continue to participate or who have developed an economic activity.

Even at the individual and community levels, the sustainability of the changes is not uniform. The knowledge and practices acquired, along with the relationships established with service providers, show greater sustainability, while the continuity of the mechanisms that support them—particularly community-based support, follow-up, and outreach services—is more severely affected by staff reductions and the limited availability of funds and other operational resources.

Impact at the Institutional Level

At the institutional level, evidence points to changes primarily in three areas: 1. the strengthening of the technical and operational capacities of health care personnel, activists, and other involved stakeholders; 2. the consolidation of collaboration models among health services, community stakeholders, and partners; 3. an increased capacity to generate and utilize data and evidence. The sustainability of these changes is most evident when skills, tools, and operational methods have been integrated into service practices, while it is more fragile for activities that rely heavily on external resources.

1. Strengthening technical and operational capacities.

This is a cross-cutting outcome across the initiatives, albeit with different focuses: NCDs and CACUM (*Cervical and Breast Cancer*) for AID 11375 – Prevention and Control of NCDs; HIV, TB, and PMTCT for AID 11587/04/1 – TILL THE END and AID 012168/01/9 – PRoTeggiMI; services for adolescents and young people, psychosocial support, and mental health for AID 11817/04/06 –

Espaço Aberto and AID 12168/02/0 – Conoscere per Curare. The evidence gathered indicates that skills were better consolidated when theoretical training was combined with on-site practice, access to the necessary equipment, and opportunities to share skills among colleagues.

As part of AID 11375 – Prevention and Control of Non-Communicable Diseases (NCDs), screening and management practices for NCDs—which had previously been more limited—were still in place at the facilities visited. In Sofala, the combined availability of equipment and skills within the CACUM program enabled trained staff to apply what they had learned and to continue providing on-the-job training to other healthcare workers. This aspect is particularly significant in light of reports from stakeholders, who noted that participation in training courses does not always translate into the ability to apply the acquired skills, as the facilities from which participants come may lack the necessary equipment. In the case of the facilities supported by the project, however, the integration of training, equipment, and practice has strengthened diagnostic and treatment capacity at the decentralized level.

The same mechanism is evident in Inhambane, within the framework of AID 012168/01/9 – PRoTeggiMI, where the availability of portable equipment has made it possible to transfer diagnostic capabilities directly to community-based services. Three PIM CD4 Analyzers were available for the TARV Móvel program in the four districts involved, enabling health care personnel to perform on-site CD4 counts in the communities and to apply national protocols at the community level. In this case, therefore, capacity building was not limited to staff training but resulted in the concrete ability to provide diagnostic services that were previously unavailable at that level.

2. Consolidation of Collaboration Methods and Institutional Integration

The projects contributed not only to strengthening collaboration between implementing partners and the public health system but, in some cases, to integrating partners into mechanisms for technical coordination, planning, and the definition of operational procedures at the national, provincial, and district levels.

As part of AID 11375—Prevention and Control of Non-Communicable Diseases (NCDs)—collaboration also extended to the health system's technical coordination mechanisms. CUAMM, ACAP, and AIFO, together with MISAU, contributed to the establishment of the first national Technical Working Group on diabetes and hypertension, tasked with coordinating activities related to the 2020–2029 Multisectoral Strategic Plan for NCDs and initiatives carried out across the country; CUAMM became a permanent member of this group. At the provincial level, supervision and on-the-job training within the CACUM framework were integrated into the supervision of the DPSs and coordinated by *the* provincial *focal points*, thereby incorporating skills transfer into the regular mechanisms of the healthcare system.

In Inhambane, AID 11587/04/1 – TILL THE END and AID 012168/01/9 – PRoTeggiMI have strengthened a delivery model based on integration among partners, district services, and community actors. This approach remains evident in the organization of community-based services observed during the evaluation: the mobile brigades continue to involve district health services and community actors, maintaining the integration of HIV, TB, and PMTCT components—which has been strengthened by the interventions.

In AID 11817/04/06 – Espaço Aberto, the integration of clinical, relational, and psychosocial care—built through the joint efforts of healthcare staff and youth and community workers—was still evident in the services visited.

The site visits and interviews confirm that some of these coordination methods continue to be used, particularly in linking community actors with healthcare facilities and in the organization of outreach services, although the extent of their use depends on the availability of staff and operational resources.

3. Greater Capacity to Generate and Utilize Data and Evidence

The Mozambican health system faces challenges in data collection, disaggregation, and quality control, which have made it difficult to establish a solid *baseline* against which to measure progress and changes. The projects have helped strengthen capacities for collecting, analyzing, and utilizing information, in some cases combining implementation with an operational research component. In Inhambane, the collaboration between Medicus Mundi and the University of Brescia linked operational research and data analysis to the mobile brigade model and to HIV, TB, and PMTCT services; as part of AID 12168/02/0 – "Conoscere per Curare" (Knowledge for Care), the collaboration between the University of Padua and CIOB integrated evidence generation, research, and the strengthening of services for HIV-positive adolescents and young people in Beira. These processes have contributed not only to the generation of new evidence but also to strengthening the capacity of individual and institutional actors to produce and utilize data and knowledge regarding health needs, the progress of interventions, and response strategies.

However, the sustainability of institutional changes is not uniform. Competencies, institutional relationships, and certain practices integrated into the day-to-day operations of facilities demonstrate greater sustainability, while activities requiring recurring resources, incentives for activists, transportation, materials, or other external inputs exhibit greater vulnerability. These aspects will be explored in greater depth in the sustainability analysis.

System-Level Impact

At the systemic level, the evidence is less robust than at the individual, community, and institutional levels and does not allow for the identification of fully consolidated systemic transformations. However, three main signs of change are emerging: 1. greater institutional attention to NSTs; 2. the gradual consolidation of community-based models and the decentralization of services in remote areas; 3. greater attention to tailoring the health response for adolescents and young people, including relational and psychosocial dimensions and, for girls and young women, specific gender-based vulnerabilities and barriers.

1. Greater Institutional Attention to NCDs

Within the framework of AID 11375—Prevention and Control of NCDs—the institutional stakeholders met in Maputo described greater visibility of hypertension, diabetes, and cancer prevention compared to a context that had previously been more focused on communicable diseases. The project helped strengthen this focus through collaboration with MISAU and participation in national technical coordination mechanisms on NCDs, including the establishment of the first national Technical Working Group on diabetes and hypertension. Project documentation also highlights contributions to the introduction and use of clinical and data collection tools for diabetes and hypertension, as well as the integration of related activities into public health services. These elements indicate a strengthening not only of institutional attention but also of operational capacities and management mechanisms for NCDs. However, the available evidence does not allow for a full assessment of the degree to which these tools have been formalized and disseminated at the national level, nor does it allow for attributing specific changes in health policies to the project. The observed contribution therefore pertains to increased institutional attention and a strengthening of the operational integration of DNTs into the healthcare system, while the consolidation of these results at the systemic level remains to be verified.

2. Gradual consolidation of community-based models and decentralization of services in remote areas

The experience developed in Inhambane through AID 11587/04/1 – TILL THE END and subsequently AID 012168/01/9 – PRoTeggiMI demonstrates a progressive integration of various health- s within the mobile brigades, involving staff from the public health system and adapting the

model to the evolution of the service network and the needs of the communities. The continuity and evolution of this model beyond the duration of individual initiatives are a significant indication of its gradual integration into the healthcare response mechanisms in the affected areas.

3. Greater Focus on Tailoring the Healthcare Response for Adolescents and Young People

Another notable factor of change concerns the growing attention to the need to tailor the health response for adolescents and young people, taking into account—in addition to clinical needs—relational and psychosocial dimensions and, for girls and young women, specific gender-based vulnerabilities and barriers. AID 11817/04/06 – Espaço Aberto structured the care of HIV-positive adolescents and young people by integrating relational, psychosocial, and social components into the clinical response, while AID 12168/02/0 – Conoscere per Curare focused in particular on the mental health and psychosocial distress of HIV-positive adolescents and young people. At the same time, AID 12168/02/0 used operational research to generate evidence on the mental health needs and psychosocial distress of HIV-positive adolescents and young people, linking research with health services. The involvement of health institutions and research stakeholders—including those at the national level—has fostered recognition of these needs and the availability of evidence that can be used to guide response strategies for this group.

Overall, these elements represent signs of change at the systemic level, rather than fully demonstrable systemic transformations. The evidence is more robust regarding the consolidation of practices and models in the regions and services involved, while it is more limited regarding their institutionalization on a national scale.

Q2. To what extent can these changes be attributed to the projects?

The extent to which the observed changes can be attributed to the initiatives varies depending on the nature of the effects and the level at which they occur. The link to the projects is stronger when it is possible to establish a coherent sequence between the activities and resources introduced, the changes in service delivery, and the changes subsequently observed. This relationship, however, becomes less clear-cut for institutional and, above all, systemic effects, which involve subsequent interventions, the long-term presence of partners, national health policies, and contributions from other actors.

At the community level, the case of the mobile brigades in Inhambane provides a particularly clear illustration of this relationship. As part of AID 11587/04/01 – TILL THE END, the strengthening of the TB component enabled community-based diagnosis using GeneXpert Edge[57] ; subsequently, AID 012168/01/9 – PRoTeggiMI integrated the PMTCT component into the community-based model. Healthcare workers and implementation partners interviewed in Inhambane noted that, prior to the introduction of community-based TB diagnostics, samples from suspected cases had to be transported to other facilities, resulting in longer turnaround times and the risk of losing track of patients along the diagnostic pathway. In this case, it is therefore possible to establish a sufficiently clear link between the contributions of the initiatives and the changes in service delivery methods.

A recognizable relationship between the intervention and change is also evident in AID 11375—Prevention and Control of NCDs. In the centers visited in Maputo and Sofala, the training of health workers and community activists, the availability of equipment, and the strengthening of screening, case management, and *referral* pathways are mechanisms directly linked to some of the changes observed. For example, community activists in Moamba and Matola attribute both the increase in knowledge about NCDs and the strengthening of guidance, active case-finding, and patient support activities to the project's efforts. Similarly, healthcare personnel interviewed in Sofala highlight the contribution of the equipment and skills acquired to strengthening diagnostic and therapeutic

[57] GeneXpert Edge is a portable molecular diagnostic system that enables rapid testing for the diagnosis of tuberculosis, including the identification of rifampicin resistance, even in decentralized settings with limited laboratory infrastructure.

capacities within the CACUM framework. The convergence of accounts from both the community level and service providers reinforces, in these areas, the plausibility of the initiative's contribution.

For AID 11817/04/06 – Espaço Aberto and AID 12168/02/0 – Conoscere per Curare, the initiative's contribution takes on different characteristics and is particularly evident in the integration of social and psychosocial dimensions into the care of adolescents and young people. For example, interviews and discussions with mentors and stakeholders involved in services for adolescents in Maputo revealed that the work carried out fostered relationship dynamics more focused on listening to and paying attention to young people, managing stigma and discrimination, and recognizing social and mental health issues. In some cases, as mentioned, young people initially involved as beneficiaries subsequently took on mentoring and support roles for other adolescents. Furthermore, in the case of the AID 12168/02/0 project—"Conoscere per Curare" (Knowledge for Care)—testimonies collected in Sofala indicate that the intervention carried out in the context of the COVID-19 pandemic helped maintain or restore the continuity of services for adolescents, while simultaneously strengthening the skills of staff and community actors. Participatory methodologies, a focus on mental health, and psychosocial support thus represent some of the mechanisms through which the contribution of the two initiatives can be assessed.

The relationship between the project and change becomes less linear when the time horizon is broadened. Several outcomes observed during the evaluation appear, in fact, to be the result of the layering of successive interventions. Inhambane offers a particularly significant example of this. The mobile brigades predate the initiatives under evaluation and have progressively evolved through different intervention cycles, expanding their territorial coverage and range of services over time. As highlighted, for example, in interviews with the implementing partner in Inhambane, AID 11587/04/1 – TILL THE END and AID 012168/01/9 – PRoTeggiMI introduced specific components into an existing model, contributing to its gradual evolution and strengthening. The model observed at the time of the evaluation therefore reflects not only the contributions of the two initiatives but also the experience accumulated over time, the partner's sustained presence, and collaboration with the public health system. The same interviewees emphasized the difficulty of separating the effects of individual projects within this trajectory.

At the institutional level, the five initiatives have helped consolidate expertise, coordination mechanisms, and relationships among implementing organizations, health facilities, and authorities at various levels; however, many of these relationships already existed and had developed through years of collaboration. For example, in discussions with health authorities in Maputo Province, it became clear that work on NDTs helped strengthen the link between the provincial and district levels, health facilities, activists, and communities. In other regions, the continuity of collaboration between partners and the health system played a similar role. The capital of trust and the methods of joint work observed during the mission should therefore be interpreted as the cumulative results of long-term collaboration, to which the evaluated initiatives contributed without necessarily being the sole determining factor.

At the systemic level, the increased focus on DNTs, the consolidation of community-based models, the attention to the needs of adolescents and young people, and the utilization of data and operational research are consistent with the mechanisms of change promoted by the initiatives. For example, the institutional stakeholders consulted as part of AID 11375 linked the intervention to an increased visibility of the DNTs, while in Inhambane, the succession of interventions coincided with the gradual development of the mobile brigade model. These developments, however, are part of MISAU's strategies, national programs, and the actions of other partners. At this level, therefore, it is possible to acknowledge a contribution by AICS initiatives to the observed processes, but not to isolate their impact from other concurrent factors.

As previously mentioned, the availability and level of disaggregation of data in Mozambique also limit the ability to accurately determine the contribution of individual initiatives. This problem arises,

for example, in Inhambane, where some of the health data available at the district or provincial level does not allow for a systematic distinction between the results of the mobile brigades and the overall results of health services. Consequently, some improvements reported during interviews (relating, for example, to access, continuity of care, or specific health outcomes) are consistent with the mechanisms supported by the projects and may contribute to the formulation of the evaluative judgment, but do not in themselves constitute proof of causality.

In conclusion, the degree to which changes can be attributed to the initiatives is higher for effects directly associated with the introduction or strengthening of specific services, tools, and practices; as we move toward institutional and systemic effects, the contribution becomes predominantly cumulative and concurrent. The evaluation therefore identifies a plausible and documented contribution of the initiatives to the observed processes of change, differentiating the degree of evidence, without extending this judgment to a causal attribution that the evaluation design and available data do not support.

Q3. Have any unexpected effects—positive or negative—emerged?

The unexpected effects identified by the evaluation are more limited in scope than the changes directly associated with the initiatives' objectives and are predominantly positive. The testimonies collected show, in particular, certain effects that have extended beyond the strictly health-related scope of the interventions, affecting social relationships, the protection and inclusion of adolescents, the behaviors of the community actors themselves, and, in some cases, the ways in which the involved parties collaborate. No unexpected negative effects of comparable magnitude emerged; however, some unforeseen consequences or tensions were identified, linked primarily to the creation of expectations within the communities and the capacity of services to meet the demand generated.

A first area concerns the **social and protective effects** produced by interventions targeting adolescents and young people. As part of AID 11817/04/06 – Espaço Aberto, the creation of safe spaces for listening and building trust has yielded results that went beyond mere health care. For example, in interviews conducted in Maputo with stakeholders involved in services for adolescents, cases were reported in which the relationships built with young people and adolescents made it possible to uncover situations of violence or abuse, as well as to address issues related to school retention and social inclusion. The space created by the intervention thus took on, in some cases, a broader role of protection and support, not limited to clinical conditions or adherence to treatment.

Also within the context of interventions aimed at young people, ***empowerment*** pathways emerged that transformed the role of some beneficiaries. Some adolescents initially reached as service recipients subsequently became mentors, points of reference for other young people, or, in some cases, continued to collaborate with the facilities and stakeholders involved. This evolution signals, in some cases, a transition from service utilization to an active role in peer support. Although it is not possible to determine the extent of this phenomenon, the testimonies collected highlight paths of youth leadership and participation that have developed through ongoing involvement in the activities.

A further effect, observed primarily within the context of AID 11375—Prevention and Control of Non-Communicable Diseases—concerns the changes brought about in the community activists themselves. Their training was intended to mobilize communities and connect them with services, but the testimonies show that the knowledge acquired was also applied to their own daily lives. For example, in the focus groups conducted with activists in Moamba and Matola, some participants described changes in their diets, greater attention to blood pressure and diabetes, a reduction in certain behaviors considered risky, and increased use of screening services. The activist thus emerges not only as a vehicle for the change intended by the intervention but also as an individual directly affected by processes of personal change.

Furthermore, certain **relational and institutional effects** emerged that appear to have extended beyond the immediate scope of the activities carried out. In particular, community-based work contributed in some areas to more frequent contact between communities, activists, health facilities, and health authorities. For example, in interviews with healthcare stakeholders in Maputo Province, respondents noted that communities had become more familiar with service representatives and were engaging in more direct dialogue with institutional authorities. While this outcome is difficult to quantify, it is significant because it suggests that the intervention also strengthened the relationship and trust between citizens and the healthcare system.

Another possible effect concerns the **creation of new opportunities for learning and collaboration** through operational research and partnerships with universities and research institutions, particularly evident in AID 12168/02/0 – Conoscere per Curare. Certain activities developed in the areas of mental health and participatory methodologies have fostered subsequent opportunities for discussion and exchange regarding community intervention strategies. In this case, the effect goes beyond the production of a single project outcome and concerns the dissemination of the experiences and methodologies developed. However, the available documentation does not allow us to determine to what extent these developments were actually unforeseen in the original design; they are therefore interpreted as additional or amplifying effects, rather than as unexpected effects in the strict sense.

The evaluation did not identify **any unexpected negative effects directly attributable to the initiatives.** However, a potential tension emerged between the increased awareness and demand for services generated by the outreach activities and the capacity of health facilities to respond to them. In particular, interviews with healthcare providers in Maputo Province highlighted that the referral of individuals to NCD services is not always matched by the availability of equipment, diagnostic materials, or medications. Based on the available evidence, this imbalance does not constitute an unexpected negative effect that has already been observed, but it represents a potential indirect effect of the interventions should the expectations and demand generated not be adequately met by the services.

5.2 Sustainability

The evidence points to generally positive but varied prospects for sustainability. Sustainability appears more robust for the competencies, practices, and operational procedures integrated into public health services and supported by institutional and community ownership. By contrast, the continuity of components that depend on recurring resources (staff, transportation, fuel, maintenance, supplies, incentives, and *outreach* activities)—for which full integration into standard funding mechanisms is not evident—is more fragile. Sustainability therefore depends less on the complete replication of project models than on the ability of institutions to preserve and adapt their essential functions to available resources. The evidence also shows greater ownership at the local and operational levels compared to financial ownership and institutionalization at the national level.

Q1. To what extent have the capacities developed been institutionalized and can they be sustained over time?

The **degree of institutionalization of the developed capacities is generally positive**, but varies across initiatives and sectors. Skills are more firmly established when training has been accompanied by practical application and integrated into the routine work practices of public health services. Continuing education, supervision, on-the-job learning, and the transfer of skills among practitioners contribute to the sustainability of the interventions, while staff mobility and the availability of the resources needed to apply what has been learned continue to represent factors of vulnerability.

Much of the capacity building took place within the public health system, in coordination with public institutions and with their direct participation, involving staff from health facilities, managers at various levels, activists, and other community actors. This reduced the risk that skills would remain confined to parallel mechanisms created by the projects. Ongoing collaboration between implementing partners and public institutions also appears to have fostered a gradual adoption of practices, skills, and working methods at the provincial, district, and individual health facility levels.

This process is particularly evident within the context of AID 11375—Prevention and Control of Non-Communicable Diseases (NCDs). For example, in the facilities visited in Maputo and Sofala, it was found that the skills related to screening, management of NCDs, and cancer prevention acquired during the project phase were still being used by healthcare workers at the time of the evaluation—and thus even after the conclusion of project activities. In Sofala, the combination of training, availability of equipment, and practical application of skills within the CACUM framework helped maintain diagnostic and therapeutic capabilities at the decentralized level, which were still operational at the time of the mission. In these cases, the training does not appear to have been limited to the individual acquisition of knowledge but has translated into capabilities that are effectively available within the service.

In Inhambane, capacity building has progressed gradually through a series of initiatives carried out by Medicus Mundi in close collaboration with provincial and district health services. As part of AID 11587/04/1 – TILL THE END, health care workers involved in community-based services strengthened their skills in the prevention, diagnosis, and management of HIV and TB, applying these skills through mobile teams and community-based TB screening. Subsequently, AID 012168/01/9 – PRoTeggiMI built upon the skills and operational methods already developed, further strengthening the staff involved and expanding the integration of community-based services through the PMTCT component. **The ongoing collaboration between Medicus Mundi and the health services has thus made it possible to leverage the expertise and experience gained from the previous intervention and apply them to a progressively more integrated model of response to HIV, TB, and PMTCT**.

For AID 11817/04/06 – Espaço Aberto and AID 12168/02/0 – Conoscere per Curare, healthcare personnel and other **stakeholders involved in the care of adolescents and young people have also developed skills in areas less strictly clinical, such as relationships with adolescents and young people, psychosocial support, mental health, and active listening**. In these cases, however, the need to distinguish between the persistence of skills and the continuity of activities becomes particularly clear. Some community-based and psychosocial support practices have in fact continued, though sometimes on a reduced scale or thanks to new funding. Professional capacity can therefore remain within the staff and facilities even when not all the resources necessary to fully replicate the project model are available.

The **issue of staff turnover** remains significant**.** The transfer of trained staff may result in a loss of capacity and knowledge for the individual facility, without necessarily leading to a complete loss for the healthcare system if the person continues to work in another public facility. However, the available evidence does not allow for a systematic reconstruction of the career paths of trained staff or the extent to which skills are disseminated and continue to be applied after any transfers within the public healthcare system.

The **recurring demand for new training programs highlights the importance** of viewing training as a continuous process: continuing education, supervision, on-the-job learning, and the transfer of skills among practitioners contribute to the sustainability of interventions, making it possible to maintain and renew over time the capabilities necessary for their implementation. Sustainability therefore depends not only on the number of people initially trained, but also on the existence of mechanisms that enable skills to be applied, updated, and transferred over time.

Academic and research partnerships between Italian and Mozambican institutions (such as the one developed under AID 12168/02/0—"Conoscere per Curare" [Knowledge for Care] through collaboration between the University of Padua, CIOB, and stakeholders in the Mozambican healthcare system) also represent an important factor in sustainability, helping to strengthen national capacities for training, research, and the production and use of evidence.

Q2. Can the innovations introduced be sustained or replicated?

The innovations introduced or strengthened by the initiatives show good potential for sustainability and replicability, though with significant variations depending on the resources required to support them. The outlook is more favorable when practices and operational procedures are integrated into existing services, rely primarily on public-sector staff, and can be adapted to available resources. Financial and operational sustainability, however, is the main challenge for models that depend on recurring costs, especially for interventions aimed at ensuring community-based services in remote areas.

Practices Integrated into Health Services. Within the framework of AID 11375—Prevention and Control of Non-Communicable Diseases (NCDs)—the integration of screening and early diagnosis into routine care pathways shows relatively favorable prospects for sustainability when skills have been transferred to facility staff and procedures have become part of standard service practice. Similarly, in Sofala, some diagnostic and therapeutic capabilities within the CACUM framework were still operational at the time of the mission. In these cases, the likelihood of sustaining the innovation stems primarily from its integration into the routine functions of the health facility, rather than from the continuation of a separate project-based initiative.

Adaptability of organizational models. The experience of the Cantinho—a dedicated space within the health facility for screening and follow-up of people with NCDs—offers a significant example of this capacity for adaptation. Some practices supported by the intervention appear to have been reinterpreted through organizational configurations different from those adopted during the project. As emerged from the interviews, the reconfiguration of the Cantinho made it possible to preserve certain functions of the service, adapting its operating procedures to the available resources. The key element for sustainability is therefore the preservation of the service's function, rather than the exact replication of the operational structure funded by the project.

Operational research and scientific collaborations. The knowledge, methodologies, scientific relationships, and research capabilities can continue to be utilized and generate new activities even after the conclusion of individual funding. The evaluated initiatives provide examples of collaborations that have combined research, training, and service strengthening. Examples include the collaboration between Medicus Mundi and the University of Brescia, which linked operational research on infectious diseases and community health to the training of healthcare workers, and the collaboration between the University of Padua and the CIOB under AID 12168/02/0 – "Conoscere per Curare," which combined the generation of evidence on the health needs of HIV-positive adolescents and young people with the strengthening of research capacities and services. As also highlighted in Q1, their value in terms of sustainability lies primarily in the ability to progressively consolidate national capacities for the production and use of evidence through lasting partnerships between Mozambican and Italian institutions.

Sustainability of equipment and technological innovations. The mere presence of equipment is not in itself sufficient to guarantee the sustainability of interventions. Tangible investments remaining in public facilities can continue to yield benefits, but their usability over time depends on the availability of maintenance, consumables, trained personnel, and financial resources. The replicability of a technological innovation must therefore be assessed by considering not only the initial investment but also the costs and conditions necessary for its continued operation over time.

Support Approaches for Adolescents and Young People. For services targeting adolescents and young people supported through AID 11817/04/06 – Espaço Aberto and AID 12168/02/0 – Conoscere per Curare, the evidence indicates the continuation of certain community-based and psychosocial support practices, though sometimes with reduced intensity or thanks to new funding. The continuity of methods for listening, building relationships, and providing care can be facilitated by the retention of skills among staff and mentors; however, it is more challenging to maintain the same intensity of *outreach*, accompaniment, and support activities when these require dedicated resources. Therefore, it is necessary to distinguish between the continuity of the approach and skills and the ability to fully maintain the level of activity guaranteed during the funding period.

Community-based mechanisms for linking with services. The skills developed by activists and the relationships built with communities and services can endure and constitute important social capital. However, activities such as active outreach, community visits, patient accompaniment, and *follow-up* require time, mobility, and, in some cases, incentives or other forms of support. For example, interviews conducted with activists and representatives of health institutions in Maputo revealed that gaps between funding cycles can lead to a reduction in community activities. The evidence therefore suggests a distinction between the sustainability of the capacities and relationships developed at the community level and the continuity of the operational functions carried out by activists, which is more dependent on the availability of resources and support. Strong social ownership of these mechanisms is therefore not sufficient, on its own, to ensure their operational continuity.

Community-based services in remote areas. The **mobile brigades** in Inhambane, strengthened through AID 11587/04/1 – TILL THE END and AID 012168/01/9 – PRoTeggiMI. The model features several elements that favor its replicability: it addresses a structural need of populations living in remote areas, is highly valued by communities, and is based on the integration of different services within a service delivery mechanism linked to the public health system. Over the course of the initiatives, the model has been progressively expanded and adapted, incorporating new components, including community-based TB diagnosis and PMTCT. The succession of interventions that have adopted and developed the model thus serves as an indication of its replicability and capacity for evolution. Furthermore, interviews conducted in Inhambane revealed that the mobile brigades continue to be regarded as a particularly important tool for reaching populations who, due to distance and transportation difficulties, face significant barriers to regular access to health facilities.

Conditions for Operational Sustainability. At the same time, the mobile brigades themselves clearly illustrate the difference between the model's validity and adoption and its autonomous financial sustainability. Their operations require vehicles, fuel, maintenance, staff availability, medicines, and other inputs that cannot be guaranteed by the institutionalization of competencies alone. The model's self-sustaining viability therefore remains contingent on the public health care system's ability to progressively incorporate its recurring costs into its planning and funding mechanisms.

Financial sustainability. Across all initiatives, evidence of the integration of innovations into standard funding mechanisms is more limited than that regarding their technical and operational adoption. The main challenges concern mobility and fuel, maintenance and consumables, outreach and follow-up, support for community stakeholders, and dedicated human resources. Continued support through new projects or external funding may confirm the ongoing relevance and usefulness of these functions, but does not, in and of itself, constitute evidence of their autonomous financial sustainability.

Overall, adaptability is particularly important in a context characterized by limited human and financial resources. A model may prove effective during implementation but prove difficult to sustain if it requires levels of staff, incentives, logistics, or resources that the system cannot guarantee on

its own. Sustainability and replicability therefore depend on the ability to preserve and transfer a model's essential functions, adapting its operational methods to the capacities and resources actually available, rather than on the identical reproduction of the original model.

Q3. Is there ownership by national and local institutions?

The evidence gathered indicates a significant level of institutional ownership, evident at the provincial and district levels as well as among the healthcare facilities directly involved. The initiatives were implemented through close collaboration with the public healthcare system, strengthening existing services and facilities rather than creating parallel structures. The continuity of relationships between partners and institutions appears to have fostered, over time, the adoption of skills, practices, and working methods developed through the projects.

However, the level of ownership observed is not uniform and must be distinguished along at least three dimensions: **strategic and institutional**, when the priorities or approaches promoted are recognized and adopted by the authorities; and **operational**, when practices and delivery methods are integrated into the functioning of services. These forms of ownership must be distinguished from financial sustainability, which depends on the availability of adequate resources to ensure the continuation of activities. In the Mozambican context, institutional support for interventions does not necessarily translate into the availability of domestic funding, as there remains a strong dependence on external resources. The evidence gathered therefore indicates varying levels of strategic-institutional and operational ownership, while financial sustainability constitutes one of the main areas of vulnerability. **Strategic and Institutional Ownership**. Within the framework of **AID 11375—Prevention and Control of NCDs**—the health authorities in Maputo Province interviewed associated the intervention with increased attention to NCDs and a strengthening of the link between the provincial and district levels, health facilities, and communities. This perception is reflected in the involvement of health institutions in training and supervision activities. Staff from the DPS and SDSMAS participated in training and subsequent supervision and refresher activities; in the third year alone, 271 internal supervision visits were conducted, in addition to joint supervision sessions with the DPS. **The training component aimed at community actors also reached a larger scale than initially anticipated: against a target of 174 APEs, a total of 353 APEs, ACSs, ATPs, and activists were trained on NTPs and COVID-19 and passed the final test, including 155 in the first year, 94 in the second, and 104 in the third.** The available documentation does not provide a gender breakdown of the cumulative data; among the documented activities, the exchange of experiences held in Sofala during the third year involved 30 activists, of whom 19 were women and 11 were men**.** The training sessions were facilitated by technical staff from the DPS and SDSMAS and accompanied by supervision and refresher activities. , the convergence between these data and the institutional testimonies gathered during the evaluation supports the **assessment that DNTs have been more fully integrated into the practices and dialogue among institutions, health facilities, and communities, although it does not allow for quantifying the degree of ownership**. At **the national level, elements of alignment and collaboration with MISAU and national programs have emerged;** however, the available evidence provides less certainty regarding the extent to which individual models developed by the projects have been formally incorporated into policies or protocols. It is therefore advisable not to equate alignment with national priorities with full institutionalization. **A further aspect of strategic and institutional ownership concerns the production and use of evidence.** The initiatives have fostered collaborations between Italian and Mozambican academic and research institutions, in some cases combining research, training, and service strengthening. These collaborations have helped develop relationships and research capacities that can promote greater production and utilization of evidence by national institutions. **However, the available evidence does not allow us to determine to what extent these capacities have already been institutionalized and used autonomously in routine planning and decision-making processes.**

Operational adoption. Ownership is evident when the practices introduced have been incorporated into routine service delivery procedures. This is the case, for example, with the skills and practices for *screening* and managing DNTs and, in Sofala, with certain capacities developed within the CACUM framework. The persistence of these practices in the facilities visited indicates that some components of the intervention have not remained exclusively tied to the project but have become part of the services' operational capacity. **The mobile brigades in Inhambane constitute a further example of operational ownership**. Within the framework of AID 11587/04/1 – TILL THE END and AID 012168/01/9 – PRoTeggiMI, the model was progressively integrated into service delivery procedures, directly involving personnel and programs within the public health system and incorporating new components over time. For AID 11817/04/06 – Espaço Aberto and AID 12168/02/0 – Conoscere per Curare, **ownership pertains to the integration of approaches targeting adolescents and young people, attention to the psychosocial dimension, and collaboration between services and community actors.** The available evidence shows that some of these practices have persisted, but it does not allow for equally robust documentation of their complete integration into the routine operations of the services for both initiatives. This indicates recognition of the value of the approaches developed, but makes it more difficult to determine to what extent they have been fully integrated into the institutions' routine resources and mechanisms. **The Cantinho experience** offers a further example of operational adoption, as it demonstrates the institution's ability to independently modify a model to make it compatible with its own operations and available resources.

Financial ownership. The evidence is weaker than that for the strategic-institutional and operational dimensions. In fact, the integration of certain practices into the operation of services does not align with the institutions' ability to independently cover their recurring costs. In Inhambane, under AID 11587/04/1 – TILL THE END and AID 012168/01/9 – PRoTeggiMI, mobile brigades continue to be used and integrated into service delivery, but their operations remain dependent on the availability of vehicles, fuel, maintenance, personnel, medicines, and other resources. Similarly, under AID 11375 – Prevention and Control of Non-Communicable Diseases (NCDs), while expertise and certain screening and case management practices have been maintained, there has been a reduction in the number of community actors still active, along with constraints on the availability of resources needed to sustain outreach and follow-up activities; In Moamba, of the 12 activists initially identified, 8 had completed training, and only 2 were still active at the time of the evaluation—a finding limited to the site visited and not generalizable to the intervention as a whole. Even for services targeting adolescents and young people, the continuity of certain components does not necessarily equate to their full financial sustainability. Within the framework of AID 11817/04/06 – Espaço Aberto, some activities and functions developed through the initiative continued beyond its conclusion, but at a reduced intensity or through resources made available by subsequent interventions. The continuation through new external funding thus demonstrates the continuity and enduring relevance of certain functions, but not their full integration into the regular funding mechanisms of the public health system.

Continuity and Building on Previous Interventions. In Inhambane, the sequence between **AID 11587/04/1 – TILL THE END** and **AID 012168/01/9 – PRoTeggiMI** demonstrates how operational structures, expertise, and institutional relationships developed through one intervention can be leveraged in subsequent ones. The continuity of Medicus Mundi's presence and its collaboration with health institutions has made it possible to build upon an already consolidated foundation, progressively adapting and expanding the intervention model.

Overall, ownership is therefore better documented at the provincial, district, and healthcare facility levels, as well as in the strategic-institutional and operational dimensions; however, evidence of full institutionalization at the national level—and, above all, of the public healthcare system's independent assumption of recurring costs—is less robust.

Q4. Is there community-level ownership?

The evidence gathered indicates a **high level of community ownership**, although the intensity and methods vary across initiatives and territories. This is evident above all through recognition of the usefulness of the services, the participation of community actors, the strengthening of the link between communities and healthcare facilities, and, in some cases, the continuity of support practices and functions beyond the activities directly supported by the projects. Ownership is greater where interventions have removed concrete barriers to accessing services and have given community stakeholders an active role, rather than limiting their involvement to merely receiving information.

Community ownership is particularly evident in the mechanisms that foster proximity and connection between communities and health services. In Inhambane, the communities consulted expressed strong appreciation for the mobile health teams supported through **AID 11587/04/1 – TILL THE END** and **AID 012168/01/9 – PRoTeggiMI**, particularly valuing the ability to access services closer to home and to reduce the need to travel to distant health facilities. The high demand observed in the communities visited is a further sign of the population's acceptance of this model.

A similar dynamic emerges regarding the role of community health **workers and other community actors**, who have helped strengthen the link between the population and the health system. The evidence gathered shows that their role is not limited to raising awareness but also includes providing information, guidance, and support to help people access services. As part of **AID 11375—Prevention and Control of Noncommunicable Diseases** (**NCDs**)—the activists consulted in Moamba and Matola continue to be recognized by the communities as key points of reference; in Moamba, they also reported increased knowledge of hypertension, diabetes, and related risk factors, as well as changes in certain family practices, including dietary choices and greater attention to blood pressure monitoring and screening. At the same time, health authorities have highlighted the strengthening of relationships between health facilities and communities, as well as the involvement of health committees. **Community ownership is thus evident not only in the use of services but also in the recognition and sustainability of community mechanisms linking them to the health system**.

Community ownership can also be understood in terms of empowerment and, from a rights-based perspective, as a strengthening of communities' capacity to recognize and articulate their own health needs and to demand continuity of services. In focus groups with activists in Moamba, for example, it emerged that communities had learned to recognize their presence during health brigades and activities and that interruptions caused concern regarding the continuity of the support they received. The request to maintain community services and mechanisms deemed useful can therefore be interpreted not only as dependence on the services provided but also as a greater capacity to articulate demands to the health system and to assert access to services perceived as necessary. From this perspective, the recognition of and demand for these services represent a sign of community empowerment and greater awareness of the right to health. At the same time, discussions with healthcare institutions have highlighted that interruptions between projects have led to a reduction in the activities of community activists. However, this should not automatically be interpreted as a loss of community ownership, which primarily concerns greater awareness of health needs, trust in the National Health Service (SSN), and the communities' ability to access healthcare services. From this perspective, the continuity of activists' activities is not in itself the ultimate goal of the intervention; rather, the consolidation of the relationship between communities and health services—facilitated by the professional staff at health centers under the responsibility of MISAU—takes on particular importance.

One of the most significant manifestations of community ownership involves some young people who were previously beneficiaries and who have since taken on leadership or mentoring roles,

thereby contributing in turn to the support of other young people. Although this evidence is qualitative and limited in scope, this transition from recipients to active participants indicates that the skills, relationships, and value attributed to the experience have been at least partially replicated within the same target group.

However, community ownership and the capacity to sustain services independently are not one and the same. Communities may recognize the value of mobile teams, community actors, mentoring, and other community-based services and actively participate in their operation, without having the necessary resources to independently ensure their continuity. In particular, in remote areas, the high demand for mobile teams serves as both an indicator of their recognition by communities and of the vulnerability of the populations should such services be discontinued.

Q5. Have there been changes in health-related knowledge, attitudes, and practices among the beneficiary groups involved?

The qualitative evidence collected indicates positive changes, particularly in knowledge and, to a more limited extent, in attitudes and health practices. However, this assessment must be made with caution, as the initiatives do not uniformly include longitudinal measurements or KAP surveys that would allow for quantifying the extent and durability of these changes.

In the **AID 11375** project**—Prevention and Control of Non-Communicable Diseases** (**NCDs**)—the testimonies collected in Maputo and in the communities visited show greater knowledge of hypertension, diabetes, and cancer prevention, as well as greater awareness of the importance of screening and continuity of care. Community-based work also helped counter certain beliefs that hindered adherence to treatment, thereby facilitating connections with healthcare facilities.

Reported changes in individual and family practices also emerged. For example, some activists reported changes in diet, reduced alcohol consumption, greater attention to blood pressure and diabetes management, and participation in cancer screening. These accounts are significant because they suggest a shift from knowledge to practice. However, since these are self-reported changes from groups directly involved in the project activities, it is not possible to determine their prevalence among all beneficiaries or to attribute them exclusively to the intervention.

Signs of change are also emerging among adolescents and young people involved in AID 11817/04/06 – Espaço Aberto and AID 12168/02/0 – Conoscere per Curare. Peer support, *youth- -friendly* spaces, and psychosocial support have fostered greater trust in services, increased requests for support, and improved continuity of care. In this context, the change thus appears to stem not only from the acquisition of knowledge but also from a different attitude toward seeking help and engaging with services.

For the rural communities involved in TILL THE END and PRoTeggiMI, the evidence suggests greater familiarity with services and with prevention, diagnosis, and treatment pathways. However, the available evidence is less direct than that regarding individual behavioral changes; it would therefore be incorrect to automatically interpret the use of services as evidence of a stable change in health practices.

Across the board, the evidence indicates that changes were facilitated when community mobilization went beyond simply conveying information and instead combined knowledge, discussions about risks and possible solutions, support, and connections to services. The role of activists, mentors, and other community actors thus appears to have been significant in facilitating the transition from acquiring knowledge to applying it in health-related decisions.

However, the translation of knowledge into practice remains contingent on the accessibility and responsiveness of services: greater awareness and demand for services do not necessarily lead to lasting changes when shortages of medications, equipment, or staff persist, or when there are difficulties in accessing facilities.

5.3 Effectiveness

The initiatives evaluated show an overall positive level of effectiveness, albeit with differences among interventions, outcomes, and target groups. Quantitative and qualitative evidence indicates that significant results have been achieved in strengthening the competencies of healthcare personnel and community actors, expanding and decentralizing access to services, and improving care for specific vulnerable groups. Particularly noteworthy was the interventions' ability to adapt service delivery methods to different contexts and needs through community-based services, the involvement of community actors, and tailored approaches for adolescents and young people. However, the achievement of results was not uniform: some targets were met or exceeded, while constraints related to the availability of staff, resources, equipment, and other inputs—along with the effects of the COVID-19 pandemic and other contextual factors—limited or slowed the achievement of certain results.

Q1. To what extent were the expected results achieved for each of the beneficiary groups?

The evidence analyzed indicates an overall positive level of achievement of the expected results, although with differences across initiatives, outcomes, and beneficiary groups. The final documentation shows that numerous targets were met or exceeded, while the qualitative evidence collected during the evaluation confirms, in several cases, that the results were reflected in how services were delivered and used. However, the ability to quantitatively verify the achievement of results is not consistent across the five initiatives, partly due to the evolution of the design and monitoring approaches adopted in the various rounds of the Global Fund 5% program. In particular, the projects funded in the 2018 and 2019 rounds, although they had a Logical Framework, predate the introduction of the RBM approach—adopted starting with the 2020 round—and do not necessarily present the same level of definition and measurability for outcome indicators. For some initiatives, therefore, directly comparable final values and targets are available, while for others, the documentation primarily allows for a reconstruction of the activities carried out, the beneficiaries reached, and the qualitative outcomes. These differences, which are also attributable to the varying methodological requirements in place at the time the interventions were formulated, were taken into account in the assessment of effectiveness.

AID 11817/04/06 – Espaço Aberto was primarily aimed at adolescents and young people living with HIV, with a specific focus on girls and young women, and also involved healthcare personnel, mentors, and young health educators. For adolescents receiving treatment, the final report provides particularly robust quantitative evidence: at the end of the intervention, 2,728 adolescents were on antiretroviral therapy, compared to a target of 2,250, while 93% had undergone at least one annual viral load test, compared to a target of 80%. In the seven centers equipped with specific services for adolescents, median retention increased from 94.2% to 99.0%, and the average loss to follow-up per semester decreased from 1.5% to 0%. The gender dimension was explicitly incorporated into the intervention design: 52% of the 2,250 adolescents targeted were girls, and the project also included 1,250 young women with HIV aged 20 to 24, who were also recipients of specific components such as support groups, counseling, and vocational training programs. However, the main clinical indicators are not systematically disaggregated by sex; it is therefore not possible to verify whether the improvements observed in *retention* and continuity of care were equivalent for girls and boys.

The qualitative evidence gathered confirms the value placed on dedicated services, mentors, support groups, and psychosocial support. The adjustments made during the pandemic also strengthened ongoing psychological support, mentoring, individual counseling, and support groups; for young women, activities aimed at self-determination and economic independence were also expanded. However, the available documentation does not allow for a breakdown by sex of all the key clinical indicators listed above; this limitation is particularly significant given the specific

vulnerability of adolescent girls and young women to HIV and the intervention's explicit focus on gender-based barriers.

The achievement of these results is particularly significant given that the intervention was implemented during the COVID-19 pandemic, which required the restructuring of certain activities while still ensuring the continuity of key clinical services. The factors that facilitated this adaptability are analyzed in Q2.

AID 12168/02/0 – "Conoscere per Curare" (Knowledge for Care) was aimed at adolescents and young people, with a particular focus on HIV-positive youth, and also involved healthcare personnel and stakeholders engaged in SAAJ services, psychological support, and research. The final report and the corresponding evaluation conducted by AICS indicate that the project achieved largely positive results, with values exceeding the targets for nearly all indicators. The exceptions are two indicators: the percentage of HIV-positive adolescents and young adults among those tested at SAAJ centers and the percentage of HIV-positive adolescents and young adults with mental health issues among those accessing psychological support services.

In both cases, the deviation also appears to be linked to changes in the context and in the measurement systems. In the first case, the increase in service visits and the expansion of testing to a broader population after the most critical phase of the pandemic altered the denominator of the indicator; in the second, the nationwide adoption of the new *"Fica Bem"* mental health screening protocol changed the methods used to identify disorders. AICS notes, however, that these trends were already visible in the interim reports and that it would have been appropriate to formally adjust the target values. The failure to meet the two targets does not, therefore, indicate a lack of effectiveness in the activities, but rather highlights a weakness in adapting the monitoring system to the internal changes that occurred during implementation.

The qualitative evidence gathered in Beira from institutional stakeholders and service staff is consistent with this interpretation. The intervention helped maintain and improve services for HIV-positive adolescents and young people, introducing a greater focus on mental health and psychosocial support. In this case, therefore, the alignment between documented results and the testimonies gathered allows for a positive assessment, while explicitly acknowledging the exception represented by the two indicators that were not fully met.

AID 11587/04/1 – TILL THE END and AID 012168/01/9 – PRoTeggiMI targeted populations in remote communities in Inhambane, with a particular focus on people exposed to or living with HIV and TB and, in the second project, on pregnant women and the prevention of vertical transmission; both projects also involved healthcare personnel and community actors. The two projects are part of a sequential process to strengthen community-based services in Inhambane: AID 11587/04/1 – TILL THE END focused on access to prevention, diagnosis, and treatment of HIV and TB, while PRoTeggiMI subsequently expanded the model by integrating the PMTCT component.

For AID 11587/04/1 – TILL THE END, quantitative results document improved access to TB and HIV diagnosis in remote communities. Despite interruptions in outreach activities and clinical services provided by mobile teams during the pandemic, in the second year of the project, over **18,134 people** underwent clinical screening for TB; among suspected cases, **726 samples** were collected, and a total of **95 people received a TB diagnosis**, 34 of whom were confirmed by bacteriological testing. The use of GeneXpert Edge devices enabled **710 tests** to be performed, with **32 positive results**. Concurrently, as part of HIV counseling and testing services, a total of **12,715 HIV tests** were conducted, with **257 positive results (2.0%)**.

The project also strengthened the continuity of TB care: in the second year, **56 patients** received follow-up support, **18** received treatment through community point-of-care centers, and **116** were reached through active case finding and/or home-based counseling. Qualitative evidence

collected in Inhambane confirms the importance of these community-based approaches in bridging the gap between remote communities and health services and in promoting diagnosis and continuity of treatment. The availability of sex-disaggregated data varies across the five initiatives and therefore does not allow for a systematic comparison of results between women and men across the entire portfolio.

For AID 012168/01/9 – PRoTeggiMI, the final data document broad coverage of community-based services and the achievement or exceeding of several expected outcomes. Overall, activities related to Outcome 1 reached 206,476 direct beneficiaries; 2,214 awareness-raising sessions were held, with 57,563 participants, compared to the 1,600 sessions and 60,000 participants initially planned. In addition, 26,738 HIV tests were conducted in the ATS/UATS sector and 6,675 in the SMI sector.

The results are particularly relevant for pregnant and breastfeeding women and for children exposed to HIV. The project reached 489 direct beneficiaries under Outcome 2, compared to the projected 400: 276 HIV-positive pregnant or breastfeeding women received services through the Consulta Integrada program, and 213 children exposed to HIV received services through the CCR program[58] . The results thus demonstrate the intervention's specific ability to reach HIV-positive pregnant and breastfeeding women in remote communities—a group simultaneously exposed to geographical barriers and specific vulnerabilities related to the continuity of PMTCT. However, the available data do not allow for a female-to-male comparison for this component, as it is, by its nature, primarily aimed at women and children at risk.

Significant results also emerged regarding the care of HIV-positive individuals and HIV/TB integration, although not all targets related to the number of beneficiaries were met. Overall, **1,252 HIV-positive patients**—adults and children—underwent at least one visit through the mobile brigades/ART. A total of **6,657 consultations with HIV-positive patients** were conducted, compared to the 3,000 planned, and **610** follow-up **calls or home visits** were made, compared to the 500 planned. The percentage of HIV-positive individuals on ART who underwent TB screening reached **96.8%**, exceeding the final target of **95**%.

However, the total number of HIV-positive patients reached was lower than initial estimates. The documentation attributes this discrepancy primarily to the gradual expansion of ART services in health centers and to MISAU's introduction of additional community-based models for antiretroviral distribution, which reduced the number of people dependent on mobile teams. The failure to meet this target must therefore be viewed in conjunction with the high volume of services provided to the patients who were actually reached.

The qualitative evidence collected in Inhambane is consistent with these quantitative results: healthcare workers, community actors, and the communities consulted highlighted the importance of the mobile teams in bringing prevention, diagnosis, treatment, and follow-up to populations in remote areas. The evaluation also found that the integration of HIV, TB, and PMTCT components into the community-based model remained in place.

For AID 11375—Prevention and Control of NTPs—the main beneficiary groups included healthcare workers, community actors, and the population reached by prevention, screening, and case management activities, with a specific component targeting women through CACUM. For healthcare workers, the intervention strengthened competencies related to the screening, diagnosis, and management of NCDs and, within the CACUM framework, to the prevention and treatment of precancerous lesions. According to the project's final report, 413 healthcare workers were trained—equivalent to 154% of the target—and 14 healthcare facilities were equipped, fully meeting the

[58] Over the two-year period, 381 samples were also collected and analyzed for the early diagnosis of exposed children via PCR, of which 191 were analyzed using m-PIMA, and 1,106 samples were collected for viral load testing, of which 74 were analyzed using m-PIMA.

planned objective. At the facilities visited in Sofala, healthcare workers confirmed that the combination of acquired skills and the availability of equipment made it possible to provide services at the decentralized level that previously required referral to other levels of the system.

For the beneficiary population, the project recorded 58,902 diabetes screenings (140% of the target) and 563,581 blood pressure measurements (120% of the target). These figures refer to the services provided and not to the number of distinct individuals reached. In the area of cervical cancer prevention, 103,062 women underwent screening (98% of the target), and 4,283 treatments were performed using cryotherapy or thermocoagulation. Additionally, 218 LEEP procedures were performed. The data also highlight a gender difference in treatment continuity. Women accounted for 71% of those diagnosed, but 12-month retention was 35% among women compared to 47% among men. Women's greater access to diagnosis did not, therefore, translate into equivalent treatment continuity; however, the available data do not allow for identifying the causes of the observed gap.

For community stakeholders, the quantitative results exceeded initial expectations: Against an initial target of 174 APEs, the final report documents a total of 353 APEs/ACS/ATPs and activists trained on NCDs and COVID-19 who passed the final test. The project report also indicates that 724,097 people were reached by awareness-raising activities in the second and third years, including 4,675 people with disabilities in the third year. Qualitative evidence collected in Moamba and Matola further demonstrates the application of acquired skills in providing information on NCDs, referring individuals for screening, and accompanying them to services. However, the cumulative figure for the number of people trained is not disaggregated by sex, limiting the ability to analyze potential gender differences in the results of the community component.

As part of efforts to strengthen systems for collecting and monitoring data on NCDs, the final report documents the establishment of registries in 14 health facilities, meeting the target, and the training of 212 health workers on data collection, compared to a target of 200. In the third year, all participating health facilities were found to be transmitting the data required by the project. These results indicate a strengthening of NCD registration and monitoring capacities in the facilities supported by the intervention.

Beyond the quantitative results achieved, the evidence points to increased awareness of NCDs and the importance of prevention and screening, but it also reveals the limitations in translating the generated demand into actual access to diagnosis and treatment. As highlighted by institutional stakeholders and the project documentation, the increase in screening has not always translated proportionally into new diagnoses, partly due to the limited capacity of services to respond to the rise in demand. The effectiveness of the community-based approach therefore depends on the entire chain linking information, demand, screening, diagnosis, referral, and continuity of care.

Across all initiatives, capacity building produced more noticeable results when training was combined with supervision, the availability of tools, and the practical application of skills. The effectiveness of the investment in training is therefore evident not only in the number of people reached but, above all, in the translation of acquired skills into actual practices and services provided.

Q2. What factors, including climatic ones, have facilitated or hindered the achievement of results and access to services?

The evidence gathered shows that the achievement of results and access to services were influenced by external factors primarily attributable to the organizational characteristics of the healthcare system, the institutional context, territorial and infrastructural conditions, social and gender factors, and contextual factors.

Depending on the context, these conditions acted as either enabling or limiting factors, as summarized in the table below.

Table4. Enabling and Limiting Conditions by Type of External Factor

Type of external factor	Enabling conditions	Limiting conditions
Organizational / healthcare system	Availability and stability of healthcare personnel; opportunity to apply acquired skills; availability of resources necessary for service delivery	Staff shortages and turnover; workloads; intermittent availability of equipment, medications, supplies, vehicles, and fuel
Institutional	Support and collaboration from health authorities; continuity of institutional partners; coordination among the various levels of the system	Administrative and authorization timelines and procedures—including ethical review processes—which, in shorter-term initiatives, can significantly reduce the time actually available for implementation
Geographical and infrastructure-related	Greater accessibility of communities and facilities; availability of transportation and adequate conditions of access routes	Long distances; isolation of communities; transportation costs; logistical challenges and difficulties in accessing remote areas
Social and gender-related	Community acceptance of services; family and community support for access to and continuity of care	Poverty; stigma; gender norms and relationships that limit autonomy and mobility; other family and social barriers
Contextual	Conditions stable enough to ensure mobility, community activities, and the functioning of services	The COVID-19 pandemic; emergencies and other shocks; extreme weather events, which can exacerbate territorial and logistical challenges and lead to the reallocation of public resources toward emergency response

Organizational and healthcare system factors. The availability and stability of the staff and resources necessary for service delivery have broadly influenced the effectiveness of interventions. Evidence shows that the skills developed were more effectively applied in facilities where trained staff had access to the necessary equipment and resources, while staff turnover, transfers, and heavy workloads limited their use. Within the framework of **AID 11375—Prevention and Control of Non-Communicable Diseases** (**NCDs**)—for example, increased awareness and screening did not always translate into diagnosis and treatment when facilities lacked adequate equipment, diagnostic materials, or medications. Similarly, in Inhambane, the availability of staff, vehicles, and fuel affected how regularly services could reach remote communities.

Institutional factors. Support from health authorities and the continuity of relationships between partners and institutions facilitated implementation, especially where well-established collaborative relationships already existed. In Inhambane, **AID 11587/04/1 – TILL THE END** and **AID 012168/01/9 – PRoTeggiMI** benefited from the ongoing collaboration between Medicus Mundi and the provincial and district health services. Conversely, the time required for administrative and authorization procedures proved to be a limiting factor when combined with a relatively short project duration. In **AID 012168/01/9 – PRoTeggiMI**, a 24-month initiative, the preparation of the research protocol, two changes in the local coordinator during the first year, and the several months required to obtain approval from the MISAU Ethics Committee reduced the time actually available for the research component, contributing to the failure to complete the scientific publication planned by the end of the project. The impact of institutional timelines on effectiveness therefore also depends on

their proportion relative to the overall duration of the intervention: the same delay carries greater weight in short-term projects and in components—such as research—that require authorization processes that cannot be expedited.

Geographical and infrastructural factors. Distance, isolation, and transportation costs represented significant barriers to access, especially for rural and remote populations. Their impact is particularly evident in Inhambane, where **AID 11587/04/1 – TILL THE END** and **AID 012168/01/9 – PRoTeggiMI** had to rely on mobile services precisely to reach communities far from health facilities. Mobile teams reduced the geographic barrier, though they did not eliminate its causes: the ability to reach communities regularly remained constrained by distances, the condition of access roads, and the availability of transportation and resources for mobility.

Social and gender factors. Poverty, stigma, family dynamics, and sociocultural norms have influenced access, participation, and continuity of care in different ways, particularly in the context of HIV and PMTCT services and interventions targeting adolescents and young people. As part of AID 11817/04/06 – Espaço Aberto, it emerged that some young women faced obstacles to participating in activities due to restrictions imposed by their husbands, clearly demonstrating how decision-making autonomy and gender relations can limit access even when services are available. AID 012168/01/9 – PRoTeggiMI also identifies HIV-related stigma and the limited autonomy of some women in making decisions about their own health as barriers—factors that can affect access to and continuity of care. More generally, the evidence gathered indicates that family and community support facilitated the use of services, while stigma, economic vulnerability, and social constraints continued to pose barriers for certain groups. However, the available evidence does not allow us to identify with sufficient precision which services or activities men were systematically less likely to access, nor to determine the causes. Lower male participation cannot therefore be taken as a finding that can be generalized across the five initiatives.

Contextual factors. The COVID-19 pandemic was the main external shock common to all the initiatives, affecting mobility, community activities, and the organization of services. In **AID 11587/04/1 – TILL THE END**, *outreach* activities and clinical services provided by mobile teams were interrupted; in **AID 11817/04/06 – Espaço Aberto**, restrictions on group activities and school closures required a reworking of support strategies, while still allowing key clinical services to continue. Weather conditions and extreme events constitute another significant factor in the Mozambican context. In addition to exacerbating isolation, transportation difficulties, and challenges in accessing facilities, emergencies can indirectly impact the health system's ability to provide routine services, leading to the reallocation of public resources toward emergency response. Discussions with institutional stakeholders have highlighted how such pressure on resources can reduce those available for services and activities complementary to the evaluated initiatives. However, the evidence does not allow for quantifying the effect of specific climate events on the achievement of the five initiatives' outcomes; rather, it shows how climate shocks can amplify territorial, logistical, and financial vulnerabilities already present in the health system.

Overall, the effectiveness of the initiatives and access to services were strongly influenced by the context in which the interventions took place. The results were facilitated by the availability and stability of healthcare system resources, institutional support, more accessible territorial conditions, and social contexts conducive to service use; these same factors acted as limiting factors when characterized by staff and resource shortages, protracted institutional procedures, geographic isolation, poverty, stigma, or gender barriers. The COVID-19 pandemic constituted the main documented external shock. **Regarding climate factors, while it is not possible to quantify a specific effect on the outcomes of the initiatives, the evidence points to possible effects—both direct, on accessibility and logistics, and indirect, on the availability of resources—when emergencies lead to the reallocation of public funds from the continuity of routine services to the emergency response**.

Q3. How were the changes perceived by the various groups of beneficiaries and by healthcare providers?

The qualitative evidence gathered shows an overall positive perception of the changes associated with the initiatives, both on the part of communities and beneficiaries and on the part of the healthcare providers, activists, and institutional actors consulted. The aspects most highly valued differ depending on *the stakeholders'* position: beneficiaries and communities tend to emphasize above all the greater accessibility and proximity of services, the continuity of care, and the relationship of trust with providers; healthcare staff and activists place greater emphasis on the acquisition of skills, the availability of new tools, and improvements in organizational methods and patient management; institutional representatives and partners attach particular importance to the integration of interventions into the public health system and the strengthening of service capacities.

Beneficiaries and Communities. The perceptions gathered are generally positive and primarily concern the accessibility of services and the quality of the relationship with healthcare providers. In the remote communities of Inhambane, the ability to receive care closer to home was particularly valued, as it reduced the need to travel to distant healthcare facilities. Visits to the communities confirmed that distance, transportation costs, and limited availability of transportation constitute real barriers to access and that, in some rural contexts, these constraints also influence decisions regarding seeking maternal care and the location of childbirth. Within the framework of **AID 012168/01/9 – PRoTeggiMI**, this aspect takes on particular importance for HIV-positive women who are pregnant or breastfeeding, who are explicitly included among the target groups for community-based services and the PMTCT component. At sites involved in **AID 11375 – Prevention and Control of Non-Communicable Diseases (NCDs**), activists highlighted the knowledge gained regarding hypertension, diabetes, and prevention, as well as the strengthened links with healthcare facilities. Among adolescents and young people involved in **AID 11817/04/06 – Espaço Aberto**, active listening, psychosocial support, and the availability of trusted adults are particularly important; for girls and young women, the evidence gathered also highlights the importance of family and gender-based barriers that can affect access and continued participation.

Healthcare providers and community actors. Providers perceive changes primarily in terms of a greater ability to respond to the needs they encounter in practice. Within the framework of **AID 11375 – Prevention and Control of Non-Communicable Diseases (NCDs)**, healthcare staff particularly valued the combination of acquired skills and the availability of tools, which enabled them to apply what they had learned in practice. In services targeting adolescents and young people, however, the skills most frequently highlighted were active listening, guidance, and support, as well as the ability to recognize needs that go beyond the strictly clinical dimension. Community activists valued both the skills they acquired and the opportunity to use them in providing information, guidance, and support to help people access services.

Institutions and partners. Institutional stakeholders and implementation partners tend to place particular emphasis on strengthening service capacities and integrating skills and operational methods into existing structures. **Overall, there are no substantial disagreements regarding the direction of the changes, but there are differences in the aspects most highly valued:** accessibility and relationships with services for communities and beneficiaries; responsiveness for healthcare providers and community actors; and strengthening of services for institutions and partners. Alongside this positive assessment, there is a shared perception of vulnerability regarding the continuity of certain functions when staff, operational resources, or funding are lacking.

When comparing the different stakeholder groups, no substantial differences emerge regarding the direction of the changes, but rather differences in the aspects considered most important. Communities place greater value on accessibility, proximity, and service continuity; adolescents and young people also emphasize the quality of the relationship, active listening, and psychosocial support; activists to the ability to accompany and guide people; healthcare staff to the skills, tools,

and organization of care delivery; and institutions and partners to the integration of interventions and the overall strengthening of services. The convergence of these perspectives reinforces the positive assessment of effectiveness, while highlighting that the perceived quality of the changes remains contingent on the healthcare system's ability to ensure the continuity of resources and service provision.

The perceptions gathered are qualitative in nature and do not constitute a statistically representative measure of satisfaction among the entire beneficiary population. However, their recurrence across different stakeholder categories and regions allows for the identification of commonalities and differences in how the changes were perceived by the groups consulted.

5.4 Consistency

The five initiatives demonstrate a high degree of consistency with the priorities of the Mozambican health sector and with the guidelines of Italian Cooperation and the 2030 Agenda. The interventions are aligned both with the health priorities addressed (HIV, TB, PMTCT, adolescent and youth health, and noncommunicable diseases) and with the approaches promoted at the national level, particularly the strengthening of the public health system, decentralization and integration of services, capacity building, and linking communities with health facilities. For initiatives funded through the Italian 5% mechanism, there is also substantial alignment with the Global Fund's " " priorities. Coherence is therefore particularly strong at the strategic and programmatic levels, although the extent and methods of alignment vary among individual initiatives.

Q1. To what extent were the interventions consistent with the Mozambican government's national health sector policies, strategies, and plans? To what extent were they aligned with the guidelines of Italian Cooperation, the Global Fund's priorities, and the Sustainable Development Goals, particularly SDG 3 and other relevant SDGs?

Documentary and qualitative evidence indicates a high degree of strategic coherence among the five initiatives and the policies and programs of the Mozambican health sector, the guidelines of Italian Cooperation, and the 2030 Agenda. For the four initiatives funded through the Italian 5% mechanism, an additional level of coherence relates to the Global Fund. This alignment pertains both to the selected thematic areas (HIV, tuberculosis, prevention of vertical transmission, adolescent and youth health, noncommunicable diseases, and community health) and to the intervention approaches, which are primarily based on strengthening public services, decentralizing care, *capacity building*, and linking health facilities with communities.

National Level

At the national level, initiatives are consistent with the Strategic Plan for the Health Sector (PESS), which identifies as priorities the reduction of the burden of communicable diseases—including HIV and tuberculosis—the containment of the rising incidence of noncommunicable diseases, and the strengthening of primary health care. The evaluated portfolio translates these guidelines into differentiated yet complementary interventions focused on prevention, diagnosis, treatment, and continuity of care; on strengthening the competencies of healthcare personnel; and on reducing geographical and social barriers to accessing services.

More specifically, AID 11587/04/1 – TILL THE END and AID 012168/01/9 – PRoTeggiMI fall directly within the framework of the National HIV and Tuberculosis Control Program and, in the case of PRoTeggiMI, also within the Maternal and Child Health and Prevention of Vertical Transmission of HIV (PTV/PMTCT) programs. The documentation for AID 012168/01/9 – PRoTeggiMI explicitly identifies these ministerial programs as the national framework within which the project intended to strengthen and expand activities already planned. **AID 11587/04/1 – TILL THE END** and **AID 012168/01/9 – PRoTeggiMI** are consistent with the priorities and approaches of the national programs on HIV and TB and, in the case of PRoTeggiMI, also with those related to Maternal and

Child Health and the Prevention of Vertical Transmission of HIV (PTV/PMTCT). **This alignment is also evident at the operational level, through coordination with MISAU programs and structures at the provincial and district levels**.

AID 11817/04/06—Espaço Aberto—and AID 12168/02/0—Conoscere per Curare—are primarily situated at the intersection of the national response to HIV and services specifically targeting adolescents and young people. Espaço Aberto strengthened, within seven healthcare facilities, the clinical and diagnostic care of adolescents living with HIV, adherence to therapy, viral load monitoring, and the link between treatment and psychosocial support, operating in accordance with MISAU protocols. AID 12168/02/0 – "Conoscere per Curare" operated more directly through the SAAJ (Serviços Amigos dos Adolescentes e Jovens), strengthening access for HIV-positive adolescents and young people to prevention, early diagnosis, treatment, follow-up, and psychological counseling services in the context of the pandemic. The project also explicitly linked its objective to OSS 3.3 and Strategic Objective 1 of the Global Fund, regarding maximizing impact against HIV, TB, and malaria.

Initiative AID 11375—Prevention and Control of NCDs—is consistent with MISAU's Multisectoral Strategic Plan for the Prevention and Control of Noncommunicable Diseases 2020–2029. The intervention addressed some of the key components of this agenda—diabetes, hypertension, and cervical cancer prevention—through staff training, screening and early diagnosis, the organization of care pathways, and community mobilization.

AID 11817/04/06 – "Espaço Aberto" and **"AID 12168/02/0 – Conoscere per Curare"** are consistent with the national response to HIV targeting adolescents and young people and with the approach of **the SAAJ (Serviços Amigos dos Adolescentes e Jovens**), which promotes services tailored to the needs of this population group. This alignment stems from the integration of interventions into existing public facilities and services, the application of MISAU protocols, and a focus on treatment continuity and the psychosocial factors that may influence access to and adherence to care. **Consistency therefore pertains not only to the health priority being addressed but also to the national model for delivering services to adolescents and young people.**

Global Fund.

Four of the five initiatives were funded through Italy's 5% mechanism, which aims to implement interventions that are synergistic and complementary to the programs supported by the Fund. The HIV/TB initiatives are particularly consistent with several recurring priorities of the Global Fund's strategy: increasing access to essential services; reducing vertical transmission of HIV; integrating TB and HIV care; focusing on adolescent girls and young women; removing barriers related to gender and human rights; and strengthening resilient and sustainable health systems through workforce capacity, diagnostics, and support systems. PRoTeggiMI also explicitly provided for coordination with Principal Recipients, Sub-Recipients, and the Country Coordinating Mechanism (CCM). AID 11817/04/06 – Espaço Aberto also maintained direct liaison with the CCM during implementation.

Italian Cooperation

Consistency is also high with respect to the guidelines of Italian Cooperation. The Mozambican PIP 2022–2026 identifies health as one of the main priority sectors and integrates gender equality and the reduction of inequalities across all areas. The Italian approach in the health sector prioritizes strengthening the National Health System, consolidating institutional and professional capacities, improving access to essential health services, and implementing integrated care models focused on the most vulnerable populations. This orientation finds a direct counterpart in the evaluated portfolio: integration with public structures, strengthening of personnel, decentralization and proximity of

services, focus on vulnerable groups, and the building of partnerships with national and local institutions.

SDGs

The evaluated interventions are primarily consistent with SDG 3—Good Health and Well-being—and with several of its targets. Target **3.3**, concerning the fight against AIDS, tuberculosis, and other communicable diseases, is directly relevant to the four initiatives focused on HIV and/or TB and is explicitly referenced in **AID 12168/02/0—Knowledge for Treatment**. **AID 11375 – Prevention and Control of NCDs**, on the other hand, relates to Target **3.4**, which concerns reducing premature mortality from noncommunicable diseases through prevention and treatment. Also relevant are Target **3.1**, concerning the reduction of maternal mortality, and Target **3.7**, concerning access to sexual and reproductive health services, in relation to the maternal and child health and PMTCT components. Finally, the portfolio is linked to **SDG 5—Gender Equality**—due to its focus on the barriers affecting girls' and young women's access to services, and to **SDG 10—Reducing Inequalities**—due to its focus on vulnerable populations and regional disparities in access to health services.

Q2. To what extent were the various projects included in the evaluation complementary and/or consistent with one another?

The evidence gathered indicates a high level of substantive complementarity among the initiatives, particularly evident when projects were implemented sequentially in the same territories, carried out by the same actors, or reinforced different components of the same health response. However, this complementarity appears more clearly as the result of territorial, institutional, and thematic continuity than as the effect of coordinated planning of the five initiatives considered as a single portfolio: the available evidence, in fact, does not indicate the existence of a systematic mechanism for strategic coordination among all five projects.

The most relevant example of complementarity resulting from temporal, geographic, and thematic continuity is provided by the projects AID 11587/04/1 – TILL THE END and AID 012168/01/9 – PRoTeggiMI in Inhambane Province. The two initiatives share the same geographic area, a significant portion of the institutional partners, and an approach based on the decentralization of services through mobile teams and community-based mechanisms. AID 11587/04/1 – TILL THE END focused on improving access to HIV and tuberculosis prevention, diagnosis, and treatment in remote communities, with particular attention to TB diagnosis and the possibility of initiating treatment at the community level. AID 012168/01/9 – PRoTeggiMI subsequently expanded on this approach by further integrating the prevention of vertical HIV transmission, maternal and child health services, and the HIV/TB continuum into the mobile teams.

Interviews conducted in Inhambane confirm a complementary relationship—including in terms of timing—between the interventions: the components developed through **AID 11587/04/1 – TILL THE END** were progressively expanded upon in **AID 012168/01/9 – PRoTeggiMI** and in subsequent interventions, leveraging already established operational structures, expertise, and institutional relationships. Medicus Mundi's ongoing presence and the relationships built with DPS, SDSMAS, HIV/TB program managers, and healthcare facility staff have enabled subsequent interventions to build upon an existing operational and relational foundation, progressively expanding functions and services—particularly within the mobile brigades, the community-based component, and research. **This complementarity therefore stems not only from working in the same sector and territory but also from the gradual evolution of an intervention model in which subsequent projects have consolidated existing functions and introduced new ones in response to changing needs and priorities**.

Thematic complementarity also applies to AID 11817/04/06 – Espaço Aberto and AID 12168/02/0 – Conoscere per Curare, both of which target adolescents and young people in the context of HIV

prevention and care, with a focus on psychological and psychosocial dimensions as well, albeit through different objectives and intervention methods. AID 11817/04/06 – Espaço Aberto has strengthened a *youth-friendly* care model centered on therapeutic continuity, clinical monitoring, adherence, counseling, support groups, and the role of young *health educators*. AID 12168/02/0 – Conoscere per Curare, on the other hand, focused more on the effects of the COVID-19 pandemic on services for HIV-positive adolescents and young people, integrating research, strengthening of SAAJ, mental health, psychological support, and community mobilization.

However, the available evidence does not allow us to conclude that this complementarity stemmed from joint planning or structured operational coordination between the two initiatives; rather, it appears to be a convergence of interventions that addressed, at different times and in different contexts, related needs of the same population group.

In Sofala Province, where several initiatives overlapped geographically, an even broader complementarity emerges among different components of the health response. AID 11375 focused on strengthening prevention and care for DNT and CACUM; AID 11817/04/06 – Espaço Aberto focused on services for adolescents and young people living with HIV; AID 12168/02/0 – Conoscere per Curare focused on service continuity, mental health, and research in the context of COVID-19. Preliminary evidence has identified a convergence in Sofala of interventions addressing non-communicable diseases ( ), HIV, adolescent and youth health, mental health, and operational research, creating opportunities for complementarity within the same provincial health system.

The complementarity between the initiatives is particularly evident in certain specific cases. In Inhambane, **AID 11587/04/1 – TILL THE END** and **AID 012168/01/9 – PRoTeggiMI** demonstrate clear complementarity in the areas of the response to HIV and TB and community-based services. AID 12168/01/9 – PRoTeggiMI built upon components already developed through AID 11587/04/1 – TILL THE END, expanding the model by integrating PMTCT and leveraging existing operational structures, expertise, and coordination mechanisms with provincial and district health services.

A thematic complementarity also emerges between AID 11817/04/06 – Espaço Aberto and AID 12168/02/0 – Conoscere per Curare, both of which target adolescents and young people in the context of HIV prevention and care, with a focus on psychological and psychosocial dimensions as well, albeit through different objectives and intervention methods.

Q3. Did synergies emerge among the various initiatives evaluated? And with interventions by other actors?

The presence of multiple actors and funders in the health sector requires distinguishing between strategic alignment, operational complementarity, and actual synergy. The evidence gathered shows specific examples of synergy both among some of the evaluated initiatives and with interventions supported by other actors, but does not allow for extending the same assessment to the entire portfolio or to all interventions funded through the Italian 5% mechanism of the Global Fund. Synergies are most evident in cases where interventions shared territories, facilities, and institutional partners or were linked through the healthcare system’s coordination mechanisms.

Synergies Among the Evaluated Initiatives

Among the evaluated initiatives, internal synergies are particularly evident in Inhambane, where subsequent interventions were able to utilize operational structures, institutional relationships, expertise, and working methods developed in previous cycles. In this sense, **AID 11587/04/1 – TILL THE END** and **AID 012168/01/9 – PRoTeggiMI** not only exhibit sequential complementarity—already analyzed in Q2—but also demonstrate an ability to capitalize on previous resources and lessons learned in the evolution of the community-based model.

A thematic complementarity also emerges between AID 11817/04/06 – Espaço Aberto and AID 12168/02/0 – Conoscere per Curare. The two initiatives addressed complementary aspects

of the response aimed at adolescents and young people, linking HIV care, therapeutic continuity, and attention to psychological and psychosocial dimensions. **The available evidence thus shows a convergence of approaches but does not allow for the identification of systematic forms of operational coordination between the two interventions.**

In Sofala, AID 11375 – Prevention and Control of STIs, AID 11817/04/06 – Espaço Aberto, and AID 12168/02/0 – Knowledge for Care operated within the same provincial health system, focusing on different areas. However, the evidence gathered does not show any joint activities or systematic mechanisms for coordination and exchange among the three initiatives.

Synergies with Other Actors

Four of the five projects were designed as initiatives that would work in synergy with programs supported by the Global Fund, with the goal of strengthening complementary components of the national response, particularly in the HIV and TB sectors and in areas and among groups facing greater difficulties in accessing care.

For the four initiatives funded through the Italian 5% mechanism of the Global Fund, alignment with the Fund's priorities went beyond mere strategic alignment and, in some cases, translated into concrete forms of operational coordination.

In Inhambane, coordination between MMI, DPS, national programs, and other partners made it possible to link activities funded through different sources. As part of AID 11587/04/1 – TILL THE END, for example, collaboration with the Centro de Colaboração em Saúde (CCS) made it possible to use the GeneXpert Edge installed in mobile brigades to analyze samples collected by CCS activists in densely populated areas, reducing the distances and time required to obtain a tuberculosis diagnosis. This represents a concrete example of synergy in which resources and capabilities supported by different initiatives were combined within the same diagnostic pathway.

In the same region, a collaboration with the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF)—a DPS partner in the HIV program—has been documented. During 2020, amid the restrictions caused by the pandemic, the experience developed by MMI with the TARV Móvel piqued EGPAF's interest and led to the piloting of mobile treatment visits in the Massinga district, integrating the distribution of antiretroviral therapy into mobile teams serving three rural communities. This is a significant example because it demonstrates a synergy that goes beyond administrative coordination: a model developed by one organization was utilized and scaled up through collaboration with another partner operating within the same health program.

In Inhambane, moreover, synergies were facilitated by the existence of institutional coordination mechanisms. The DPS organizes meetings with national and international NGOs to compare activity planning and take stock of implemented interventions; MMI has also participated in strategic meetings and discussions on data related to HIV, TB, and clinical services. PRoTeggiMI's documentation also includes coordination with the Global Fund's Principal Recipients and Sub-Recipients and with the *Country Coordinating Mechanism*, as well as periodic meetings on the HIV, PTV, and PNCT programs.

Coordination also extends to civil society organizations and sector-specific networks. The PRoTeggiMI documentation refers, for example, to exchanges with organizations involved in HIV and TB programs, such as MONET Plus, KUYAKANA, Movimento para a Luta contra a Tuberculose, and ADPP, as well as participation in provincial forums of health NGOs and the NAIMA+ network. These forums served as potential mechanisms for both operational coordination and the sharing of experiences and best practices.

Public health institutions played a central role in fostering synergies. In a context characterized by the simultaneous presence of multiple donors, NGOs, and technical partners, MISAU, DPS, and SDSMAS serve as the main point of coordination among interventions. Preliminary findings from the

mission identified coordination with public authorities as the primary mechanism for coordinating interventions and reducing the risk of overlap. This is consistent with what was observed during the mission: initiatives generally operated through public structures and programs, facilitating connections with other actors active in the same territory or sector.

The observed synergies have some limitations. First, they are more consistently documented in certain regions and initiatives (particularly Inhambane) than in others.

Second, although the AICS calls for proposals already provided, during the selection phase, for the consideration of applicants' prior experience and complementarities with previous interventions, the evidence gathered does not document a systematic mechanism for coordination and mutual learning among the five initiatives during implementation. The observed synergies therefore appear to have developed primarily through specific collaborations and territorial complementarities, rather than through a structured process of sharing results, tools, and lessons learned among all the initiatives.

Q4. Did the interventions avoid duplication among themselves and with other interventions?

Even with regard to interventions by other actors, the risk of overlap was mitigated primarily through coordination with health authorities and the integration of activities into public programs and services. MISAU, DPS, and SDSMAS served as the primary link between different partners and funding sources; for initiatives funded through the 5% mechanism, specific coordination mechanisms with Global Fund structures were also in place. In the case of PRoTeggiMI, the documentation explicitly refers to coordination as a tool for avoiding overlaps and duplication in HIV, PTV, and TB programs.

For the four initiatives funded through the Italian 5% mechanism of the Global Fund, there is also clear alignment with priorities related to the response to HIV and TB and the strengthening of health systems. In the case of PRoTeggiMI, coordination mechanisms with Principal Recipients, Sub-Recipients, and the CCM are explicitly mentioned.

Overall, no evidence of significant duplication emerged among the evaluated initiatives or with other interventions, and integration into the public health system and institutional coordination mechanisms helped reduce this risk. However, this assessment must be made with caution: in the absence of a comprehensive mapping—by region and time period—of all health-related funding and interventions active at the same time, the evaluation can conclude that no significant duplication was identified, but cannot prove its absence in absolute terms.

5.5 Efficiency

The evaluated initiatives show generally positive levels of efficiency, albeit with differences across interventions and implementation phases. Available resources were generally translated into activities and outcomes consistent with the intended objectives, including through organizational and operational adjustments necessitated by the context. Efficiency was, however, affected by delays and external constraints, including the COVID-19 pandemic, administrative and authorization procedures, logistical difficulties, and the availability of personnel, equipment, and supplies. In some cases, extensions and adjustments made it possible to catch up on activities and outcomes that had initially been delayed. The available financial documentation allows for an analysis of the budget execution rate for individual initiatives, while differences in objectives, operational models, and monitoring systems limit the ability to conduct a comparative assessment of the relationship between resources used and results achieved across the five initiatives.

Q1. Were resources used appropriately, taking into account the different needs of the beneficiaries?

The evidence indicates an overall appropriate use of resources in relation to the objectives and beneficiary groups, with differences among intervention models and some limiting structural factors.

The integration of activities into existing health facilities and programs made it possible to leverage existing capacities, while project resources were primarily used to address specific gaps through training, equipment, technical assistance, mobility, and support for community-based activities.

The allocation of resources to diagnostic tools and equipment appears effective in reducing barriers to access. The availability of equipment at peripheral facilities or mobile teams has made it possible to decentralize certain diagnostic capabilities and reduce the need to transport patients or samples to more distant facilities. However, the value of these investments depends on the subsequent availability of maintenance, consumables, and trained personnel, as already highlighted in the sustainability analysis.

In rural and remote areas, a significant portion of resources has necessarily been allocated to transportation and logistics (DNT, TILL THE END, and PRoTeggiMI). This approach is consistent with reducing barriers to access to services for beneficiary groups, but it entails high, variable, and difficult-to-forecast operating costs. The evidence gathered also indicates the need to define more clearly, already during the planning phase, who is responsible for recurring operational costs when resources and services are used jointly by partners and health authorities. The higher unit cost of community-based services must, however, be interpreted in light of the characteristics of the beneficiaries. In the most remote communities, providing services exclusively at healthcare facilities—while seemingly less expensive—would not necessarily have guaranteed a level of access equivalent to that ensured by mobile teams.

Another important issue concerns the training of healthcare personnel and community stakeholders. The evidence confirms the value of this investment but also reveals a trade-off between training and the availability of staff to provide services. In the DNT project, for example, the documentation indicates that it was not always possible to organize intensive courses because they would have drawn staff away from healthcare units that were already understaffed. Continuing education, *on-the-job training*, and workplace *follow-up* may therefore be more efficient than a series of residential courses, especially when they allow for simultaneous verification of the application of the skills acquired.

Q2. Were the operational models adopted adequate and efficient for achieving the expected results?

The evidence consistently shows that the operational models were substantially appropriate given the characteristics of the beneficiary groups and the constraints of the Mozambican healthcare system. Integrating activities into existing public facilities and services made it possible to leverage existing personnel, skills, and care pathways while limiting the creation of parallel mechanisms.

The combination of mobile brigades, health facilities, and community actors proved particularly effective in rural and hard-to-reach areas, as demonstrated by the experiences of AID 11587/04/1 – TILL THE END, AID 012168/01/9 – PRoTeggiMI, and AID 11375 – Prevention and Control of NCDs, where mobile brigades made it possible to provide screening and diagnosis for hypertension and diabetes in areas characterized by greater difficulties in accessing services.

The effectiveness of these models is also linked to the ability to combine multiple functions within the same operational framework. Community actors contributed to informing, identifying, and referring people to services and, in some contexts, to *follow-up*, while mobile brigades made it possible to decentralize various health services. The combination of community and health components thus strengthened the services' ability to reach populations that would have been unlikely to use the available services on their own.

This approach, however, presents a clear *trade-off* between accessibility and efficiency. Bringing services to remote communities requires vehicles, fuel, maintenance, and staff availability—recurring costs that can affect the frequency and regularity of activities. The cost of mobile brigades must therefore be weighed against the model's ability to reach populations for whom the alternative (service delivery exclusively through fixed facilities) would have resulted in substantially lower coverage. In the Mozambican context, efficiency also depends on the ability to integrate multiple services into a single outreach visit and to plan routes based on needs and geographical dispersion.

In the AID 11375 project—Prevention and Control of Non-Communicable Diseases (NCDs)—the integration of NCD screening and early diagnosis into the routine workflows of health units made it possible to utilize existing points of contact between the population and the health system, thereby avoiding the creation of a separate circuit. However, the efficiency of this solution is closely linked to the functionality of the entire care chain. Identifying a suspected case yields limited benefit if diagnostic confirmation, referral, treatment, and *follow-up* are not subsequently available. The project report highlighted, for example, the persistent difficulty in ensuring that individuals identified by mobile brigades as suspected cases of NCDs are referred to health facilities.

The methods used to strengthen competencies also affect the efficiency of the models. Since staff shortages in healthcare facilities hinder participation in intensive training, integrated training programs and on-the-job follow-up appear to be more efficient, as demonstrated by AID 11375—Prevention and Control of DNT—with its combination of theoretical training, *on-the-job training*, and ongoing support.

The evaluation of models that combine implementation with operational research is more complex. Collaboration among CSOs, universities, research centers, and public institutions has made it possible to combine different areas of expertise and generate useful evidence in addition to carrying out the activities.

Q3. What organizational factors among institutional *stakeholders* and implementing agencies influenced implementation?

The implementation of the five initiatives was significantly influenced by the capacity for coordination among implementing agencies, health authorities, and the facilities involved. Among the enabling factors, the presence of organizations with established knowledge of the local areas and pre-existing collaborative relationships with MISAU, DPS, SDSMAS, and health units stands out. This relational capital facilitated the launch and adaptation of activities and, in several cases, reduced coordination burdens.

The continued presence of partners proved particularly important in Inhambane, where the experience accumulated by Medicus Mundi and the collaboration with health authorities allowed **AID 11587/04/1 – TILL THE END** and subsequently **AID 012168/01/9 – PRoTeggiMI** to integrate into an already well-established framework for the development of mobile brigades and community services. The integration of public sector staff into project activities and the involvement of healthcare facility staff and authorities facilitated the incorporation of these activities into routine services.

At the same time, the limited availability and high turnover of healthcare personnel have been among the main organizational constraints, especially in terms of organizing training, as already mentioned in relation to the AID 11375 project—Prevention and Control of Non-Communicable Diseases. This aspect is particularly significant because staff turnover may make it necessary to repeat training activities that have already been conducted, thereby increasing the need for resources.

Collaboration between CSOs, public institutions, universities, and research centers, on the other hand, has made it possible to bring together complementary expertise. This arrangement has provided added value, particularly in initiatives with an operational research component, but it has

also increased managerial complexity. Differences in timelines, procedures, and working methods among the cooperation sector, the healthcare system, and the research sector have required a clear definition of responsibilities and adequate communication and coordination mechanisms.

5.6 Relevance

The five initiatives are highly relevant to the health needs of the local areas and target groups. The interventions addressed significant priorities—HIV, TB, PMTCT, DNT, adolescent and youth health, and mental health—by adapting services and operational methods to varying degrees to the territorial, social, and gender-based barriers that affect access to and continuity of care. This relevance is particularly evident for the most vulnerable populations and in areas with greater difficulties in accessing services. The evidence also shows an ability to adapt to evolving needs and contexts, albeit with differences among the initiatives.

Q1. To what extent have the interventions addressed the needs of vulnerable populations, particularly women, young people, and vulnerable/discriminated-against groups?

Overall, the initiatives' response to the needs of vulnerable populations was highly relevant, both in terms of the target groups selected and the methods used to make services accessible. The five initiatives targeted people living with HIV and TB, women and mothers, adolescents and young people, rural and remote populations, and people with NCDs, addressing health needs often associated with geographic, economic, and social vulnerability.

The relevance in addressing territorial barriers is particularly evident in the initiatives carried out in Inhambane. AID 11587/04/04 – TILL THE END and AID 012168/01/9 – PRoTeggiMI addressed the needs of rural and remote populations through outreach services and community-based mechanisms, tackling access barriers related to distance from health facilities, transportation costs, and limited availability of transportation. AID 012168/01/9 – PRoTeggiMI also addressed the specific needs of HIV-positive pregnant and breastfeeding women by integrating the PMTCT/PTV component into community-based services. The intervention thus simultaneously addressed geographical barriers and specific gender-based vulnerabilities that can affect access to HIV and maternal and child health services.

A different dimension of vulnerability was addressed by AID 11817/04/06 – Espaço Aberto and AID 12168/02/0 – Conoscere per Curare. For adolescents and young people living with HIV, needs extend beyond access to treatment to include support in disclosing their HIV status, guidance on treatment adherence and retention, the impact of stigma on daily life, mental health, and building trust with service providers. *Youth-friendly* approaches, psychosocial support, support groups, and participatory methodologies are therefore relevant given the multidimensional nature of this population's needs.

The evidence gathered and direct observations confirm the importance of an approach that considers clinical, psychosocial, and relational dimensions together when providing care for adolescents and young people. This importance also has a clear gender dimension. In Mozambique, girls and young women are particularly vulnerable to HIV, a vulnerability also linked to economic and social inequalities, stigma, and gender-based barriers that can affect prevention, access to services, and continuity of care. AID 11817/04/06 – Espaço Aberto has addressed these vulnerabilities by providing, alongside clinical care, components specifically tailored to girls and young women living with HIV, including support groups, counseling, and programs aimed at strengthening autonomy. However, the available evidence does not allow for a systematic comparison of clinical outcomes between girls and boys, as the main indicators of *retention* and treatment response are not fully disaggregated by sex.

The AID 11375 initiative—Prevention and Control of Non-Communicable Diseases (NCDs)—has, on the other hand, addressed a growing public health need within a system traditionally focused on communicable diseases. Strengthening prevention, screening, and management of hypertension, diabetes, and cardiovascular diseases (CACUM) responds to the growing importance of chronic diseases in the country's epidemiological profile. The increased attention subsequently given to NCDs by health institutions further supports the strategic relevance of this investment. In this case as well, the combination of services in health centers, mobile teams, and community-based activities sought to reach people who would have faced greater difficulties in accessing prevention and diagnosis on their own.

The importance of these efforts for vulnerable groups was further put to the test by the COVID-19 pandemic. The initiatives in question adapted their activities and operating procedures to ensure continuity of care and respond to emerging needs. This aspect is particularly evident in AID 12168/02/0 – *Conoscere per Curare*, whose intervention strategy directly addressed the effects of the pandemic on HIV-positive adolescents and young people, including the mental health dimension.

However, there remain needs that individual initiatives have not been able to fully address. The communities consulted highlighted problems related not only to health services but also to transportation, infrastructure, water, electricity, and connectivity. The persistence of these barriers does not diminish the relevance of the interventions; rather, it highlights the structural nature of certain determinants of access and the need to situate health projects within broader institutional responses.

Q2. To what extent did the interventions take into account the various factors that limit access to health services (gender, age, poverty, geographic distance, stigma, disability, extreme weather events, etc.)?

The initiatives took the main barriers affecting actual access to services into account to a significant extent, although the level of detail varied depending on the target groups and regions. Particular attention was paid to geographic, economic, age- and gender-related barriers, and stigma; in contrast, evidence regarding disability and the systematic integration of climate risks into the design of the interventions was more limited.

Geographic distance and the cost of travel are the barriers most explicitly addressed. Visits to communities have confirmed that the mere presence of a health facility does not in itself guarantee the ability to use its services: distance, availability of transportation, and related costs can make access particularly difficult for rural populations. AID 11587/04/1 – TILL THE END and AID 012168/01/9 – PRoTeggiMI have directly addressed this problem through mobile teams, *outreach*, and coordination between communities and healthcare facilities. In this sense, the community-based model has simultaneously addressed the geographic barrier and, at least in part, the economic barrier, reducing the need for users to bear transportation costs.

Age and stigma, on the other hand, take on particular significance in initiatives targeting adolescents and young people. AID 11817/04/06 – Espaço Aberto and AID 12168/02/0 – Conoscere per Curare have recognized that access to and retention in services for HIV-positive youth also depend on the quality of the relationship with service providers, confidentiality, how serostatus is communicated, psychosocial support, and the ability to address mental health issues. The use of *youth-friendly* services, mentors, support groups, and participatory methodologies has therefore sought to reduce barriers that are not exclusively physical or economic, but also relational and social.

The gender dimension has been incorporated primarily into initiatives related to HIV, PMTCT, and maternal and child health. AID 012168/01/9 – PRoTeggiMI, for example, addressed the specific needs of women in rural communities through sexual and reproductive health services, prevention of mother-to-child transmission, support for HIV-positive women, and psychosocial support. The

project documentation itself acknowledges the influence of gender relations and sociocultural norms on women's ability to make decisions regarding their own health and highlights the persistence of stigma and discriminatory behaviors. **However, the focus on gender is predominantly concentrated on the vulnerabilities and barriers faced by women and girls, while the analysis of differences in access and participation within the various target groups—and among segments that may be under-served—is less systematic.** Systematic consideration of those who remain excluded or underserved is therefore still inconsistent across the initiatives, even in light of the *"Leave No One Behind"* principle.

As for disability, the evidence gathered is more limited and does not allow for the conclusion that it has been addressed systematically across all five initiatives. Specific examples emerged during the mission—including regarding the physical accessibility of certain facilities—but there is no sufficiently documented cross-cutting strategy to allow for an assessment similar to that made for gender, age, stigma, or geographic distance.

Extreme weather events also influenced the implementation context and the accessibility of services, but the available evidence does not show that they were systematically integrated as a specific vulnerability factor in the design of all the initiatives. It is therefore appropriate to distinguish between the projects' capacity to adapt to shocks and emergencies and the existence of a genuine preventive strategy for climate risk management. On this latter aspect, the available information base is weaker.

Q3. How were the target groups and their characteristics identified?

Target groups were identified primarily based on epidemiological and health priorities, guidance from the relevant authorities, and the implementing agencies' knowledge of the local areas. The ongoing presence of certain partners in the regions (particularly evident in the work of Medicus Mundi in Inhambane, CUAMM within the DNT program, and DREAM/ACAP in services for adolescents and young people in Sofala and Maputo) helped build operational knowledge of needs, barriers to access, and approaches to engaging with communities. The ongoing collaboration with DPS, SDSMAS, health units, and community actors has made it possible, in several cases, to progressively refine the identification of needs and the most vulnerable populations.

The selection clearly reflects the specific characteristics of the initiatives: people living with HIV and TB and hard-to-reach rural communities for **AID 11587/04/1 – TILL THE END** and **AID 012168/01/9 – PRoTeggiMI**, the latter with a specific focus **on HIV-positive pregnant and breastfeeding women and children exposed to HIV**; HIV-positive adolescents and young people, with particular attention **to girls and young women** and to clinical, psychological, and social vulnerabilities, for **AID 11817/04/06 – Espaço Aberto** and **AID 12168/02/0 – Conoscere per Curare**; people with hypertension, diabetes, and cancer prevention needs for **AID 11375 – Prevention and Control of Non-Communicable Diseases**. In some cases, operational research has also helped generate new evidence on target groups and guide subsequent interventions.

The identification of target groups appears relevant and consistent with the primary health needs and vulnerabilities of the affected areas. A key strength lies in the combination of health data and priorities with the operational knowledge gained through continuous presence in the communities.

Q4. How were beneficiary groups, as rights-holders, involved in identifying their specific needs and in designing solutions?

Beneficiaries were involved primarily during implementation and in adapting operational procedures, through activists, APEs, *mentors*, support groups, and other community mechanisms. These actors served as a link between communities and services, helping to identify needs, barriers to access, and response strategies best suited to the various contexts. In rural areas, ongoing dialogue with

communities and local stakeholders helped adapt community-based services to the actual conditions of access.

However, the available evidence is less robust than that regarding the direct participation of beneficiaries in the initial design phase. The design of the interventions appears to have been guided primarily by health priorities, engagement with institutions, and the experience of implementing agencies in the local areas—through which the needs of local communities were also identified and represented. It is therefore not possible to assert that a systematic co-design process with beneficiary groups was applied across all five initiatives.

Q5. Were the planned strategies appropriate for the socioeconomic context? And for environmental risk factors?

Overall, the strategies adopted were appropriate for the socioeconomic context of the intervention areas, particularly in their ability to account for conditions that effectively limit access to services: poverty, transportation costs, geographical dispersion, weak infrastructure, and limited availability of healthcare resources. Community visits confirmed that actual access to care depends heavily on these conditions.

The community-based strategies adopted by AID 11587/04/04 – TILL THE END, AID 012168/01/9 – PRoTeggiMI, and, in part, by the AID 11375 project – Prevention and Control of Non-Communicable Diseases—directly addressed this context by bringing services and prevention activities closer to rural populations. Similarly, integration into public structures and the involvement of community actors made it possible to adapt interventions to a system characterized by limited human and financial resources, avoiding the creation of parallel services as much as possible.

Adaptability was also evident in the face of external shocks, particularly during the COVID-19 pandemic. Several initiatives modified their activities and delivery methods to ensure service continuity; in the case of AID 12168/02/0 – Conoscere per Curare, addressing the pandemic's impact on HIV-positive adolescents and young people was a central component of the intervention itself.

Evidence regarding the adequacy of strategies in relation to environmental and climate risks is, however, more limited. Although a capacity to adapt to shocks and extreme events has emerged, there is no evidence across all five initiatives of a systematic integration of climate risk into the design phase.

6 Final Theory of Change

The preliminary Theory of Change outlined in the Inception Report was verified and refined through the triangulation of documentary, quantitative, and qualitative evidence collected during the evaluation[59] . As outlined in the methodological framework, the verification was not intended to demonstrate a causal attribution of changes to individual initiatives, but rather to examine the plausibility of the links between activities, results, outcomes, and expected impacts, taking into account contextual conditions, enabling and constraining factors, and competing influences. This approach is consistent with the *theory-based* and *Contribution Analysis* perspective adopted by the evaluation.

[59] None of the five initiatives evaluated had an explicitly formulated Theory of Change (ToC) at the design stage. The ToC used in the evaluation was therefore reconstructed by the Evaluation Team, based on the intervention logic and available project documentation, as part of the preparation of the Inception Report and subsequently verified in the Final Report.

The evidence confirms the plausibility of the logic of change identified in the Inception Report, according to which strengthening the institutional and professional capacities of the health care system—combined with improving the accessibility and quality of services, developing care models tailored to different groups, and strengthening ties with communities—can help improve the health care system's response to the needs of vulnerable populations. However, the evaluation made it possible to clarify the nature of these relationships, highlighting their nonlinear character and their dependence on certain critical conditions.

6.1 Long-Term Impact

The long-term impact identified in the preliminary Theory of Change remains relevant as the direction of change toward which the initiatives aim to contribute, but it must be reformulated to distinguish this perspective from the effects that can actually be verified through this evaluation:

To contribute to strengthening the Mozambican health system so that it becomes progressively more resilient, equitable, inclusive, and capable of responding to the needs of the most vulnerable populations, thereby promoting, in the long term, improvements in the population's health status and reductions in morbidity and mortality associated with the main national health priorities.

The available evidence does not allow for verification of the achievement of this impact in its entirety, nor does it allow for establishing the contribution of the five initiatives to changes in morbidity and mortality at the population level. Instead, it allows for the identification of plausible contributions toward the expected impact, through observed changes in services, institutional and professional capacities, access to care, and the link between communities and the health system. The evaluation also highlighted that, in areas characterized by a succession of multiple interventions and the prolonged presence of the same partners, these changes frequently take on a cumulative nature and cannot be attributed to a single initiative.

6.2 Intermediate States of Change

The two intermediate states identified in the preliminary Theory of Change are essentially confirmed, albeit with varying degrees of consolidation.

The first—**strengthened local and community health services that are better equipped to provide prevention, diagnosis, treatment, and follow-up services to vulnerable populations**—is reflected in the following achievements: strengthening of community-based services; integration among healthcare facilities, mobile teams, and community actors; development of tailored care pathways for adolescents and young people; and enhanced screening, diagnosis, and management of non-communicable diseases (NCDs). The evidence suggests, however, that increased accessibility and the ability to identify health needs yield more robust results when accompanied by the effective functioning of the entire care chain, including referral, diagnostic confirmation, treatment, availability of medications and supplies, and follow-up.

The second objective—**national and provincial health institutions equipped with greater technical, organizational, and decision-making capacities to plan, implement, and sustain interventions in priority public health sectors**—is reflected in the following achievements: capacity building, integration of practices and activities within public services, collaboration among institutions and partners, and, in some areas, the development of knowledge and tools to support health processes. However, the consolidation of these capacities varies and is affected by staff shortages and turnover, the availability of operational resources, and the institutions' ability to sustain the functions supported by the projects over time.

6.3 Pathways of Change

The four pathways of change identified in the preliminary analysis are generally reflected in the evidence gathered on the activities carried out and their implementation methods. The evaluation, however, has provided a better understanding of the mechanisms through which these pathways produce results and the conditions under which these results tend to become consolidated.

1. **Strengthening the skills and capacities of healthcare personnel and public institutions.** This approach is reflected in various initiatives, but the mission has shown that training alone is not sufficient. The results appear more solid when training activities are followed by practical application, on-the-job training, supervision, and ongoing support. Conversely, staff turnover and transfers, combined with a lack of adequate equipment, materials, or organizational conditions, can limit the application and retention of acquired skills. The continuity of capacity-building therefore depends not only on the training provided but also on the conditions that enable staff to use and pass on what they have learned.
2. **Expanding access through decentralized and community-based models.** This is one of the approaches that finds the clearest support in the evidence gathered. In particular, mobile teams and *outreach* activities have made it possible to bring services closer to rural and remote communities that faced greater difficulties in accessing permanent facilities, thereby reducing certain barriers related to distance and transportation costs. Community actors have also played a role that goes beyond providing information and mobilizing the community, facilitating referral, connecting individuals with healthcare facilities, providing support, and ensuring follow-up. However, this approach presents a critical challenge: bringing services closer to the community and identifying new needs produce lasting results only if the system has the necessary resources to sustain outreach activities and to ensure *referrals*, case management, treatment, and continuity of care.
3. **Development of integrated and tailored services for vulnerable groups.** This approach is particularly evident in interventions targeting adolescents and young people, women, and remote populations. The evaluated experiences demonstrate the relevance of care models that consider not only clinical needs but also psychosocial and relational dimensions, as well as the specific barriers that may affect access to and continuity of care. This is particularly evident in services for adolescents and young people, where active listening, psychosocial support, accompaniment, and community linkages have complemented the health care component. However, the ability to recognize and address multiple and intersectional vulnerabilities—including disability—as well as to identify the least-reached segments within these priority groups remains less systematic.
4. **Production and Use of Scientific Evidence and Data.** The initiatives have generated knowledge and strengthened collaborations among healthcare institutions, CSOs, universities, and research centers. In some cases, the evidence generated has helped identify new needs or guide subsequent activities. The transition from knowledge production to its use in decision-making, however, is less straightforward. This process therefore yields greater value when research is linked from the outset to the knowledge needs of the health care system and when there are established timelines, stakeholders, and institutional forums in which the results can be discussed and utilized.

6.4 Critical Assumptions and Enabling Factors

An assessment of the assumptions made in the preliminary Theory of Change reveals a mixed picture. The continuity of institutional commitment and coordination among partners and health authorities have been largely confirmed and have been important conditions for integrating activities into the public system and for consolidating certain capabilities and practices.

The assumption regarding the availability of qualified and sufficiently stable human resources, however, is only partially confirmed. Staff shortages and high turnover have affected service

delivery, participation in training activities, the application of acquired skills, and the continuity of certain practices.

The assumption that communities can access and use available services also requires qualification. The evidence shows that the formal availability of a service does not automatically determine its use: distance, transportation costs, stigma, age, gender- , and other social conditions can continue to limit its accessibility. Proximity models and community linkages have addressed precisely some of these critical issues.

The assumption regarding sufficiently stable operating conditions has been only partially verified. The availability of vehicles, fuel, equipment, supplies, and medications, as well as recurring costs and external shocks, have affected the continuity of activities. The COVID-19 pandemic represented the main cross-cutting shock observed, while climate events affected the context of some interventions without being systematically integrated into the planning as a specific risk factor.

Among the enabling factors hypothesized in the preliminary ToC, the following have been confirmed: the integration of interventions into the public health system, coordination with health authorities, the experience of implementing agencies, and the continuity of institutional and community relationships. The evaluation also brought greater focus to a factor that was less explicit in the preliminary formulation: continuity over time. In areas where subsequent interventions were able to build upon previously developed capacities, relationships, structures, and operational methods, the evidence points to more consolidated pathways of change. However, this continuity does not imply that the changes should be attributed to a single initiative; rather, it reinforces the interpretation that the contribution is cumulative.

6.5 Overall Validation of the Theory of Change

In general, the evaluation confirms the plausibility of the main causal pathways identified in the preliminary Theory of Change, but qualifies its assumptions and highlights its conditional and cumulative nature. Capacity building alone does not guarantee better services if staff and operational resources are not available; bringing services closer to the community does not guarantee continuity of care if the referral, treatment, and follow-up chain does not function; community participation yields greater value when it is concretely linked to services; the generation of evidence contributes to change when it can be effectively utilized; and integration into the public system promotes sustainability but does not automatically resolve the issue of recurring costs.

The final Theory of Change can therefore be summarized as follows: **the coordinated strengthening of the health system's capacity, service accessibility and quality, community engagement, and the use of scientific evidence helps improve the ability to respond to the needs of vulnerable populations when supported by institutional and operational continuity, the availability of resources, and the ability to adapt interventions to the conditions of the Mozambican context.**

It is through the interaction of these mechanisms—rather than through individual activities considered in isolation—that the five initiatives have made a plausible contribution to the long-term direction of change identified by the evaluation.

The infographic on the Theory of Change is included in the supplementary documentation.

7 Conclusions

The evaluation of the five projects yields an overall positive assessment of Italian Cooperation's contribution to the health sector in Mozambique. Despite the diversity of intervention areas, regions, and beneficiary groups, a common thread emerges based on strengthening the public health system, bringing services closer to the hardest-to-reach populations, developing the capacities of

staff and community actors, and—in some initiatives—generating knowledge through operational research. These processes were supported by collaboration among health institutions, implementing agencies, civil society organizations, and— ly in some interventions—universities and research centers, which contributed technical expertise, local knowledge, and sustained support.

The most robust results do not necessarily stem from isolated individual activities, but rather from the combination and continuity over time of interventions, institutional relationships, and progressively built capacities. This aspect is particularly evident in areas where implementing agencies have maintained a prolonged presence and stable collaboration with health authorities. At the same time, the evaluation highlights some recurring vulnerabilities: shortages and high turnover of healthcare personnel, inconsistent availability of equipment and supplies, logistical costs of community-based services, dependence on external funding, and difficulties in ensuring continuity for components involving recurring costs.

7.1 Impact

The evidence gathered shows changes at the individual, community, and institutional levels and, in some areas, signs of a broader impact on the health care system. Of particular note are the improved access to and continuity of care for remote and vulnerable populations, the strengthening of health care providers' competencies, the evolution of services for adolescents and young people, and the growing institutional focus on DNTs.

Some of these changes persist beyond the conclusion of individual initiatives through the skills gained, practices integrated into services, relationships between institutions and partners, and models that have subsequently been adapted or developed.

The research component has also contributed, in some initiatives, to documenting and better understanding the changes brought about by the intervention models. In PRoTeggiMI, the collaboration between Medicus Mundi and the University of Brescia complemented the implementation of mobile brigades with operational research on access to HIV and PMTCT services and on the follow-up of women and children in remote communities, strengthening the link between on-the-ground intervention and evidence generation. The analysis must be framed in terms of contribution, since the evaluation design and available evidence do not allow for isolating the effects of individual initiatives from other factors and interventions that contributed to the observed changes. This is particularly true in areas characterized by a succession of interventions and the long-term presence of the same partners, as seen in the experiences of Medicus Mundi in Inhambane, of DREAM/ACAP in services targeting adolescents and young people, and—with different characteristics—in the continuity of the work carried out by CUAMM and its partners within the DNT framework. In these cases, the observed effects often appear to be cumulative and associated with a trajectory of cooperation rather than with a single initiative.

7.2 Sustainability

The most robust prospects for sustainability stem from the capabilities embedded in staff and institutions, the well-established relationships between partners and the health system, certain practices integrated into services, and the body of knowledge generated. The ongoing presence of certain implementing agencies has facilitated, in various regions, the gradual consolidation of expertise, relationships, and operational procedures; at the same time, the continuation of certain functions—whether due to the presence of the same partner or new external funding—should not be confused with the system's capacity to sustain them independently. Institutional and community ownership is generally strong, and there have been instances where practices introduced by the projects have been maintained, adapted, or further developed.

The financial and operational sustainability of components dependent on recurring costs, however, is more fragile. Furthermore, the continuation of an activity through new external funding does not equate to its full autonomous sustainability.

Another dimension of sustainability concerns research and knowledge-generation capacities. The collaboration developed through AID 12168/02/0 – “Conoscere per Curare” between the University of Padua and the CIOB in Sofala has helped consolidate scientific expertise and relationships within a Mozambican institution, creating favorable conditions for the continuation of research activities and the generation of new evidence beyond the duration of the individual funding.

An important finding from the evaluation is that sustainability does not necessarily require a complete replication of the project model. In some cases, institutions have maintained the essential functions of the innovations while adapting their organization, distribution of tasks, and operational methods to the resources actually available. This capacity for adaptation is itself a significant aspect of sustainability.

7.3 Effectiveness

The overall assessment of effectiveness is positive, although the extent to which results were achieved varies across the different initiatives and relative to their respective indicators. The available quantitative evidence documents the achievement of numerous targets and, in some cases, their exceeding; qualitative evidence also confirms the effectiveness of the services and operational methods adopted.

Effectiveness was greater where interventions combined integration into the public system, community-based services, a community component, and continuity in relationships with beneficiaries and institutions. In some areas, the prolonged presence of implementing organizations further facilitated this process, allowing them to build upon established relationships, contextual knowledge, and operational methods. In Inhambane, Medicus Mundi’s ongoing collaboration with health institutions accompanied the gradual evolution of the mobile brigades; in services targeting adolescents and young people, DREAM/ACAP helped integrate clinical care, guidance, and psychosocial support; in the intervention addressing neglected tropical diseases (NTDs), CUAMM and its partners supported the strengthening of capacities and protocols for screening, diagnosis, and management.

Effectiveness was also influenced by structural factors (e.g., human resources, distances, availability of transportation, medications, and equipment) and by external shocks, particularly the COVID-19 pandemic. The adaptability demonstrated by implementing agencies and institutions has, however, made it possible to maintain a significant portion of activities and, in some cases, to develop responses to emerging needs.

7.4 Consistency

The interventions are consistent with the priorities of the Mozambican health sector in their respective areas (HIV, TB, PMTCT, adolescent and youth health, NCDs, and health system strengthening) and with the guidelines of Italian Cooperation and the 2030 Agenda. For the four projects funded through Italy’s 5% mechanism of the Global Fund, there is also clear alignment with priorities related to the response to HIV and TB and the strengthening of health systems.

Among the five initiatives, there is a strong thematic, geographical, and temporal complementarity, particularly evident in the sequence of interventions in Inhambane and in the various components developed within the Sofala health system. Concrete synergies have also been identified with public authorities, Global Fund programs, CSOs, universities, and other partners.

However, this complementarity appears to stem more frequently from the continuity of relationships, the prolonged presence of certain implementing agencies in the regions, and their ability to build on

previous experiences—together with health institutions—rather than from the explicit management of the five initiatives as a unified portfolio. No significant duplications emerged; however, the evidence shows that opportunities for joint planning, exchange of experiences, and cross-initiative learning were only partially exploited.

7.5 Efficiency

The assessment of efficiency is positive, particularly regarding the adequacy of operational models and the utilization of capacities already present within the healthcare system. Integration into public " " facilities has reduced the need to create parallel systems, while the combination of fixed facilities, mobile teams, and community-based actors has made it possible to tailor resources to the access conditions of the various beneficiary groups.

Efficiency must, however, be interpreted in light of the characteristics of each region. Local services entail high logistical costs, but in the most remote areas they represent a particularly important means of reducing geographic and economic barriers to access. Similarly, training and operational research generate added value, but require time and resources that must be adequately factored into the planning process.

The evaluation lacks sufficiently consistent data to make a comparative assessment of cost-efficiency among the five initiatives. The evidence does indicate, however, that operational efficiency is closely tied to the alignment between available resources, the intervention model, project duration, and the operational capacity of the public system, as well as to the proper consideration of the recurring costs necessary for the activities to function.

7.6 Relevance

The relevance is high.

The initiatives addressed priority health needs and diverse vulnerabilities, including people living with HIV and TB, women and mothers, adolescents and young people, rural and remote populations, and people with NCDs. The relevance of the interventions was also confirmed by community visits, which highlighted how distance, poverty, transportation, stigma, and social conditions concretely affect the ability to access services. In Inhambane, for example, long distances and transportation costs make mobile teams particularly important for rural communities; in HIV services, stigma continues to affect access to and continuity of care; among young women, cases also emerged in which family dynamics and restrictions imposed by partners limited participation in activities.

Mobile teams, community actors, youth-friendly services, psychosocial support, and the integration of NSTs into care pathways represented responses consistent with the specific barriers encountered by the various groups.

Beneficiary participation was more evident in the implementation and adaptation of activities than in the initial planning phase. There is also room for a more systematic consideration of multiple and intersectional vulnerabilities, disability, and climate and environmental risks.

Cross-cutting Issues and Concluding Assessment

The evaluation highlights a focus—albeit varying across initiatives—on equitable access and the specific vulnerabilities of target groups. This focus is particularly evident in interventions targeting women and young women, adolescents and young people living with HIV, and populations in rural and remote areas, through measures aimed at reducing territorial, economic, social, and gender-based barriers. However, differences remain in the initiatives' ability to systematically analyze who is least reached and to document results disaggregated by gender and other vulnerability factors. The "Leave No One Behind" perspective is particularly evident in community-based models and in interventions targeting groups facing specific barriers to access. By contrast, the cross-cutting

integration of gender and disability dimensions, multiple and intersectional vulnerabilities, and climate resilience into program design appears less systematic.

Taken together, the five initiatives show that the contribution of Italian Cooperation is most valuable when it strengthens and supports the public system over time, combines institutional capacity with community outreach, and fosters ongoing relationships between health institutions, implementing agencies, community actors, and, where relevant, scientific and academic partners. It is through these relationships that experiences, skills, and knowledge can be progressively capitalized upon and utilized in subsequent interventions. Continuity thus emerges as one of the key factors linking effectiveness, impact, and sustainability.

In general, the evaluation highlights a discrepancy between the strong continuity and complementarity observed among certain initiatives and their management, which still largely follows the logic of individual projects. The opportunities offered by a portfolio approach—in terms of capitalizing on innovations, ensuring complementarity among interventions, planning for institutional and financial absorption, and using evidence to guide future programming—depend not only on the programming and coordination methods of Italian Cooperation but also on the priorities, the commitment, and the responsiveness of Mozambican institutions, whose involvement is crucial for the consolidation and sustainability of the results.

8 Recommendations

R1. Strengthen strategic planning for the health portfolio in Mozambique by capitalizing on lessons learned and leveraging complementarities among interventions

Level: Strategic

Recipients: DGCS/AICS

Strengthen strategic planning for the health portfolio in Mozambique through the systematic use of evidence and lessons learned from funded interventions, in order to identify experiences, capacities, and models to be consolidated, developed, or adapted, in line with national and subnational health priorities and the specific needs of local areas. To this end, establish periodic opportunities for cross-cutting analysis and capitalization of funded initiatives in the health sector in Mozambique, aimed at identifying results and models to be leveraged, lessons to be shared, synergies to be developed, and any gaps or overlaps between interventions.

This analysis should contribute to the development of a more integrated and coherent planning framework for the health portfolio, fostering thematic, territorial, and operational complementarities among initiatives and leveraging the capacities, services, and mechanisms already developed and integrated into the public health system. Future planning should therefore prioritize the consolidation and development of existing experiences, avoiding the automatic replication of project models and verifying their relevance and adaptability to the priorities and capacities of Mozambican health institutions.

R2. Ensure that the duration of funded projects—particularly Global Fund calls for proposals—is aligned with the nature and timing of expected changes

Level: Strategic-programmatic

Recipients: DGCS/AICS

For interventions aimed at strengthening the health system, introducing or consolidating new service models, building capacity, and changing professional and community practices, ensure that project durations are appropriate to the nature and timing of expected changes, accompanied by funding consistent with the objectives and geographical scope of the intervention. The extension to 36 months introduced starting with the 2024 Global Fund Call for Proposals represents a positive step

in this direction; it will be important to assess its suitability for the various types of interventions and the outcomes sought. Shorter durations may be appropriate when justified by the nature of the action or when the intervention constitutes a clearly defined phase within a broader and ongoing programmatic framework.

The project duration should allow for the inclusion, within the intervention cycle, of sufficient time to test and adapt the models, build capacity, and support their institutional and community adoption, as well as time buffers and mitigation strategies to manage any administrative or institutional delays. This is particularly important for the operational research components, especially given the time required for approvals from ethics committees, which can significantly impact the time actually available for conducting research activities and utilizing the results.

R3. Strengthen shared planning for sustainability and the exit strategy, progressively verifying their feasibility

Level: Strategic-Programmatic

Target Audience: DGCS/AICS and implementing agencies, in coordination with MISAU and the relevant provincial and district health institutions

Strengthen, from the very outset of project formulation, the shared definition of sustainability and exit strategies between implementing agencies and relevant health institutions, building on the emphasis already placed by AICS procedures on aspects of sustainability and institutional ownership. These strategies should identify the essential functions to be preserved, the responsibilities to be transferred or shared, the necessary capacities, and the recurring costs associated with sustaining benefits after funding ends, taking into account the priorities, resources, and actual response capacities of the Mozambican health system

Planning should also explicitly identify the main risk factors and external conditions on which sustainability depends, distinguishing between aspects that the project can address directly and those that require decisions, resources, and commitments from national and local institutions. In this regard, the exit strategy should define, where possible, realistic and phased approaches to transferring or consolidating functions, without assuming that capacity building alone is sufficient to ensure their continuity.

During implementation—and particularly in the final year—the strategy should be jointly and periodically reviewed by the implementing agencies and relevant institutions, including within the framework of existing coordination mechanisms, to verify the feasibility of the planned approaches in light of the resources actually available, identify any critical issues, and make any necessary adjustments. This process should facilitate a gradual transition toward the conclusion of funding, recognizing that long-term sustainability also depends on institutional choices and the partner country’s capacity to respond.

R4. Promote and improve mechanisms for evaluating the effectiveness, adaptability, and institutionalization of practices tested through projects

Level: Institutional – national

Primary Recipient: MISAU

Support: AICS and, as appropriate, implementing agencies, DPS/SPS, and academic and research institutions

Systematically use the evidence generated by cooperation initiatives to identify which organizational models, care practices, and tested solutions have proven effective and are well-suited to be adapted, consolidated, or integrated into the health system, taking into account available resources and the local context.

The decision to consolidate or expand a practice should include a specific assessment of its adaptability, taking into account regional differences in terms of population needs, geographic accessibility, the capacity of healthcare facilities, the availability of staff, logistical and financial resources, and the presence of community stakeholders. On this basis, the relevant institutions should define their own implementation and follow-up procedures, sustainable within the limits of the capacities and resources actually available, rather than assuming that the project model should continue in the form in which it was funded and managed by the implementing agency. This involves identifying which essential functions must be preserved, which can be reorganized or simplified, at which levels of the system the relevant responsibilities should be assigned, and through which routine mechanisms their monitoring over time can be ensured. In this process, AICS could play a role in facilitating institutional dialogue and providing technical support, building on practices that have already yielded positive results during the implementation of the interventions. Promoting roundtable discussions with MISAU, involving experts, and providing specialized technical assistance could help clarify the conditions necessary to adapt these practices to the characteristics and capacities of the Mozambican health system, working with the relevant authorities to identify the most appropriate ways to consolidate them and potentially integrate them into public programs and services.

R5. Consolidate integrated community-based models, strengthening the role of community actors

Level: Institutional—provincial, district, and operational

Primary beneficiaries: MISAU, DPS/SPS, and SDSMAS

Support: AICS and implementing agencies

In areas where geographic distance, transportation costs, and other barriers limit effective access to health services, consolidate integrated community-based models that combine decentralized services with the role of community actors, adapting their methods, frequency, and composition to the needs of the population, local characteristics, and the resources actually available.

Planning should take into account health, community, and logistical aspects collectively: the frequency and routes of outreach activities, team composition, transportation and fuel, personnel, equipment, diagnostics, medications, and supplies, as well as the availability and distribution of community stakeholders. APE, ACS, *community activists*, and other liaison figures should be progressively integrated into the planning of services and care pathways, with clearly defined roles regarding information and mobilization, needs assessment, referrals, accompaniment, and follow-up. Strengthening their capacity should include initial and ongoing training, field supervision, skills development, and sustainable support mechanisms. Planning should encompass the entire care pathway, ensuring consistency between the demand generated by outreach activities and the capacity of referral facilities in terms of staffing, diagnostics, medications, *referrals*, case management, and follow-up. The organization of the model should preserve its essential functions while avoiding operational models that are sustainable only through external funding.

At the national and provincial levels, MISAU and DPS/SPS should promote the consolidation of community actors' functions, training standards, and supervision and support mechanisms, as well as coordination among programs and the identification of priority areas. At the district level, the SDSMAS should translate these guidelines into the operational planning of community-based services, adapting their organization and frequency to local conditions and available resources, and ensuring coordination between communities, healthcare facilities, and referral services.

AICS could assist national and local health authorities in strengthening community-based services by providing specific technical expertise to address the organizational and operational challenges that have emerged during project implementation. This support could focus, in particular, on the

territorial planning of services, the organization of mobile activities, coordination between healthcare facilities and community actors, and the establishment of systems for supervising and supporting community workers. Regular dialogue among the institutions involved—facilitated in part through dedicated working groups—would enable the identification of shared, solutions to maintain and adapt the intervention methods already tested, taking into account the resources and capacities available at the provincial and district levels.

R6. Promote the ongoing development of the healthcare system's capabilities through training, practical application, and supervision

Level: Institutional-operational

Primary Recipients: MISAU, DPS/SPS, and SDSMAS

Support: AICS and implementing agencies

Further integrate training activities supported by projects into the regular capacity-building mechanisms of the healthcare system, providing—in addition to initial training—practical application, periodic supervision, refresher training, and the transfer of skills within facilities.

Develop mechanisms to identify and leverage the skills already acquired by transferred staff and to facilitate the transfer of these skills to their new facilities.

At the provincial and district levels, training planning should take into account the distribution and mobility of staff, identifying the essential skills that must be available in the various facilities and establishing sustainable ways to maintain them over time. Cooperation initiatives could support the launch and strengthening of these mechanisms, prioritizing approaches that can subsequently be utilized by institutions using their available resources and capacities.

R7. Expand and strengthen services for adolescents, young people, and women, reducing barriers to access, and promoting and adapting the practices that have proven most effective

Level: Programmatic-institutional

Primary Recipients: MISAU and AICS

Involvement: DPS/SPS, SDSMAS, implementing agencies, health facilities, and community actors

Systematically integrate a differentiated analysis of the barriers affecting effective access into the design of interventions and service planning, with particular attention to adolescents, young people, girls, and women. This analysis should consider the interplay between distance and transportation costs, socioeconomic conditions, gender and age, stigma and discrimination, family dynamics, disabilities, and, where relevant, climate and environmental risks.

Leverage lessons learned from past interventions by identifying and adapting practices and intervention methods that have yielded positive results, such as dedicated reception services, psychosocial support, peer support, assistance with treatment continuity, and coordination between services and communities. The feasibility of such integration should be assessed by considering the organization of existing services, staff competencies and workload, available resources, the characteristics and needs of different groups of adolescents and young people, and opportunities for collaboration with community stakeholders, identifying approaches that can be progressively adopted by the public system and sustained over time.

Specific attention should continue to be paid to girls and young women, taking into account their health needs, sexual and reproductive health, HIV, mental health, and social and family factors that may affect access to and continuity of care. Here as well, response strategies should be tailored to the characteristics of different regions and groups, avoiding standardized solutions and directly involving adolescents, young people, and women in identifying barriers and designing responses.

Their experience should be valued as rights-holders and experts on their own contexts, and not merely as recipients of services.

R8. Strengthen operational research, scientific partnerships, and the use of evidence in the health care system

Level: Strategic-programmatic

Primary Recipients: MISAU and AICS

Support: Mozambican and Italian universities and research institutions, other scientific institutions, and implementing agencies

Strengthen the research component of health cooperation interventions by promoting both the development of national capacities for the production and use of evidence and the application of operational research to evaluate and consolidate proven practices.

To promote structured, medium- to long-term scientific partnerships between MISAU, Mozambican universities and research institutions, and Italian and international scientific partners, building on existing successful experiences—including the partnership with UNIPD—as a model for developing similar collaborations tailored to the priorities and capacities of the institutions involved. These partnerships should strengthen the role of Mozambican institutions in defining research priorities, generating evidence, and using it to guide decisions within the health system.

Further integrate operational research into the design and implementation of interventions, identifying key research questions from the outset and establishing mechanisms for sharing and utilizing the results in health planning, service adaptation, and the potential institutionalization of effective practices. Planning should account for the time required for ethical approvals, data collection and analysis, and the dissemination of results, in accordance with the guidelines set forth in R2.

AICS could support these processes by promoting scientific partnerships, engaging specialized expertise, and facilitating dialogue between research institutions and health authorities, thereby fostering the utilization of the evidence generated. MISAU should continue to play a central role in identifying research priorities and in applying the results to inform decisions within the health care system.

R9. Strengthen adaptive management of interventions and operational continuity in the face of risks and changes in the context

Level: Programmatic-operational

Primary recipients: AICS and implementing agencies

Involvement: MISAU, DPS/SPS, and SDSMAS

Strengthen, from the very outset of intervention planning, risk analysis and the definition of operational measures to ensure the continuity of activities and services in the face of external shocks, institutional delays, or changes in the context. By leveraging the planning tools and flexibility for adjustment already provided for in AICS procedures, projects should proactively identify key risk factors, build realistic buffers into timelines, and, where possible, identify alternative implementation methods, while clarifying decision-making responsibilities for their activation.

Particular attention should be paid to the timelines of institutional procedures and ethical approvals, in accordance with R2 and R8, as well as to climate and environmental risks. The effects of extreme events documented in some of the evaluated initiatives—including cyclones that damaged healthcare facilities and temporarily disrupted community-based activities—highlight the need to integrate mitigation and business continuity measures into planning, especially in the most vulnerable areas.

During implementation, risk analysis should be periodically updated in collaboration with the relevant health institutions, utilizing information generated by monitoring and operational research to promptly identify critical issues and possible adjustments. AICS could support this process through technical dialogue with implementing agencies and health authorities and, when necessary, by utilizing the flexibility and adjustment tools already available, thereby facilitating timely responses consistent with operational conditions and the resources actually available.

The recommendations are also outlined in the infographic included in the supplementary documentation.

9 Lessons Learned and Best Practices

The lessons learned presented below stem from a cross-sectional analysis of the five initiatives and the triangulation of documentary evidence and data collected during the mission. They concern not only the individual solutions adopted but, above all, the conditions that fostered their effectiveness, ownership, and sustainability, and can therefore provide useful guidance for the design and implementation of future Italian Cooperation interventions in the health sector.

LA1. A sustained presence and institutional relationships enable the achievement of cumulative results that are difficult to produce through isolated interventions

The experience of the evaluated initiatives shows that some of the most significant results do not stem exclusively from activities carried out within a single project, but from progressive processes of building relationships, expertise, knowledge of the local context, and trust among institutions, implementing agencies, health facilities, and communities.

Continuity does not necessarily imply repeated funding of the same project or the same model. Rather, the lesson concerns the value of process continuity: a new initiative can generate greater value when it recognizes and leverages previously established capacities, relationships, lessons learned, and solutions, adapting them to new priorities and contextual conditions.

This lesson also explains an apparent contradiction that emerged in the evaluation: some relatively short-term interventions produced appreciable results precisely because they did not start from scratch. Instead, they were embedded in trajectories of collaboration and institutional presence that were much longer than the formal duration of the individual funding period.

LA2. Integration into the public health care system promotes the adoption of models but does not automatically guarantee financial sustainability

The experiences evaluated show that the solutions most likely to endure beyond the funding period are those developed within the regular structures, programs, and mechanisms of the healthcare system, utilizing and strengthening—as much as possible—existing staff, expertise, and organizational arrangements.

Institutional integration does not automatically guarantee financial sustainability. A practice may be recognized and incorporated into the institutions' working methods yet remain vulnerable when it requires recurring costs, additional staff, maintenance, materials, or logistical support that are not available after the project's conclusion.

The lesson learned, therefore, is that integration into the public system is a necessary but not sufficient condition for sustainability: the chances of continuity increase when, in addition to institutional ownership, the essential functions introduced by the project can be adapted to the organizational capacities and resources actually available within the health care system.

LA3. For adolescents and young people, proximity to services is also relational

Experiences targeting adolescents and young people show that the availability and physical proximity of services are not sufficient to encourage their use and the continuity of care. Active listening, trust, confidentiality, psychosocial support, peer support, and delivery methods appropriate to the age and specific circumstances of young people are important components of service accessibility.

The evaluated initiatives highlight, in particular, the value of integrating the clinical dimension with the relational and psychosocial dimensions, creating spaces and care models in which adolescents and young people can express needs that go beyond their health condition alone to include stigma, family and social relationships, and difficulties in maintaining continuity of care.

The lesson learned is that, in interventions targeting adolescents and young people, “proximity” should also be understood as the service’s ability to adapt the relationship, spaces, and care delivery methods to the specific characteristics and needs of this group. The integration of clinical care, psychosocial support, and peer relationships can help make services more accessible and appropriate for adolescents and young people.

LA4. Sustainability depends on the ability to preserve and adapt essential functions, not on the exact replication of project models

The evaluated experiences show that sustainability is promoted when the essential functions and benefits of interventions can be progressively integrated and adapted to the capacities, resources, and standard mechanisms of the health care system. Models that are effective during implementation may require adaptations to be compatible with the organizational, financial, and human capacities of the health care system.

When assessing sustainability, it is helpful to distinguish between the design model and the functions it has introduced. A particular operating model may not be fully sustainable, while the function it serves (for example, bringing a service closer to the population, ensuring follow-up, improving screening, or guaranteeing an appropriate reception for young people) can continue through different organizational solutions.

Sustainability must therefore be assessed in terms of the ability to preserve, over time, the functions that have generated value, through operational approaches adapted to available resources, the system’s capabilities, and the context.

LA5. Community actors are an integral part of the care pathway, not merely a tool for raising awareness

The experiences evaluated show that the contribution of community actors—including *Agentes Polivalentes Elementares (APE)*, *Agentes Comunitários de Saúde (ACS)*, *community activists,* and other figures present in various contexts—goes beyond the dissemination of health information. In several interventions, these figures played an essential role as a bridge between the community and the health system, contributing to the mobilization, identification, and guidance of users; *referrals*; accompaniment; and, in some cases, the follow-up and re-engagement of people who had interrupted their treatment pathways.

Their proximity to communities also allows them to understand and interpret barriers that may be less visible from the perspective of healthcare facilities, including economic and geographic difficulties, family and gender dynamics, stigma, and health-related knowledge, perceptions, and practices. Community mobilization therefore takes on greater value when it is not conceived as mere one-way awareness-raising, but as a process of sharing knowledge, understanding the context, identifying needs, and building a connection between communities and services.

The recognition of the community component within Mozambique’s national health system serves as an important institutional framework for enhancing these functions. However, the experiences evaluated show that the effective integration of community actors into care pathways depends on a clear definition of their tasks and responsibilities, operational linkages with health facilities, and the availability of training, supervision, and ongoing support. The lesson learned, therefore, concerns the need to translate the institutional recognition of the community component into operational procedures that enable its effective and ongoing contribution to access to services and the care of service users.

LA6. Training produces more lasting effects when accompanied by practical application, supervision, and the transfer of skills

Capacity building represents one of the most cross-cutting outcomes of the evaluated initiatives and one of those most likely to endure beyond the conclusion of funding. The evidence gathered shows, however, that the implementation of training activities alone does not guarantee the application and long-term retention of the skills acquired.

The most promising outcomes emerged when training was linked to the actual duties performed by staff and accompanied by practical application, on-the-job supervision, refresher training, and peer exchanges among professionals. In some interventions, for example, periodic supervisory visits, mentoring, and exchanges among staff made it possible to progressively consolidate technical and communication skills and to address the challenges encountered in applying them.

The continuity of skills is also influenced by staff turnover and mobility. When knowledge remains concentrated among individuals directly trained through the project, its transfer may result in a loss of capacity for the individual facility; however, if staff remain within the healthcare system, mobility can contribute to the circulation of skills across facilities and regions. The system's ability to recognize, utilize, and facilitate the transfer of skills already acquired thus becomes a key factor in maximizing the long-term value of the investment made in training.

It has also emerged that the ability to apply what has been learned depends on operational conditions. Technical skills acquired through training can be used only partially when equipment, materials, and supplies are unavailable, when the organization of the service does not allow for the application of new practices, or when adequate supervision is lacking.

Capacity building must be viewed as a process rather than a one-time training activity. Its effectiveness and sustainability increase when training, practical application, supervision, and refresher training—along with the availability of the conditions necessary for the application and transfer of skills within the system—are conceived as components of the same process.

LA7. Research and the production of up-to-date data generate the data management system and the evidence base necessary for informed decision-making

The evaluated experiences show that applied research produces greater value when it is closely linked to implementation and the needs of the health care system and built through partnerships between research and implementation. Collaboration among universities, research centers, implementing agencies, and health care institutions can link knowledge production to concrete problems in service delivery. The value of these partnerships lies not only in the scientific outputs produced, but also in the exchange of expertise and methodologies, the ability to analyze needs, and technical support in creating systems for data collection, monitoring, and analysis to be used for decision-making at the project, strategic, and national policy levels.

The knowledge generated through a project can itself constitute a lasting outcome of the intervention. Its value increases when the research addresses shared knowledge priorities, is linked to concrete problems in service delivery, strengthens national capacities, and produces evidence, methodologies, and results that can be utilized by the health care system and in subsequent interventions. This potential, however, requires timeframes compatible with research processes and mechanisms that facilitate the transfer of the evidence generated into decision-making processes.

LA8. The direct involvement of beneficiaries can transform vulnerable groups from recipients of interventions into protagonists and agents of change

Vulnerability and exclusion should not be viewed as static characteristics of individuals. When appropriate conditions for listening, trust, support, and participation are created, people initially

regarded primarily as beneficiaries can develop capabilities, assume new roles, and actively contribute to reaching and supporting others facing similar circumstances.

This process can produce ripple effects that go beyond individual access to services: those who have directly experienced certain barriers possess specific knowledge of the problems and the strategies needed to address them and can become important partners for communities and service providers.

The lesson learned is that beneficiary participation is not merely a tool for improving the relevance of interventions, but can itself become a process of empowerment and change. When people—including those previously marginalized or excluded—have genuine opportunities for participation and recognized roles, they can transition from being recipients of activities to becoming agents and drivers of change in their own communities.

The lessons learned and best practices are also outlined in the infographic included in the supplementary documentation.

10 Attachments to the Report

In accordance with the Terms of Reference, this Report includes only the ToR, the Evaluation Matrix, and the list of documents consulted during the desk review. The remaining documentation produced during the evaluation is submitted separately as supplementary documentation to the Report.

10.1 ToR

Ministero degli Affari Esteri
e della Cooperazione Internazionale

MINISTERO DEGLI AFFARI ESTERI E DELLA COOPERAZIONE INTERNAZIONALE

DIREZIONE GENERALE PER LA COOPERAZIONE ALLO SVILUPPO

Ufficio VII

TERMINI DI RIFERIMENTO

PER LA VALUTAZIONE INDIPENDENTE DELLE INIZIATIVE:

***"Prevenzione e controllo delle malattie non trasmissibili"* AID 11375**

***"TILL THE END. Strategie comunitarie di contrasto alla tubercolosi e all'HIV nella provincia di Inhambane"* - AID 11587/04/1**

***"Espaço Aberto. Rafforzamento dei servizi sanitari per adolescenti e giovani donne con HIV in Mozambico"* - AID 11817/04/06**

***"PROTEGGIMI. Prevenzione della trasmissione Materno – Infantile e trattamento di HIV e TB per le comunità remote"* - AID 012168/01/9**

***"Conoscere per curare: mitigare l'impatto del COVID-19 su adolescenti e giovani HIV+ attraverso la ricerca e il miglioramento dei servizi sanitari"* - AID 12168/02/0**

MOZAMBICO

Valutazione d'impatto

1. Oggetto della valutazione

1.a. Contesto

Le presenti iniziative di cooperazione allo sviluppo in ambito sanitario, realizzate in Mozambico, si inseriscono in un contesto comune segnato da profonde fragilità strutturali del sistema sanitario nazionale e da una vulnerabilità socio-economica diffusa, che incide in modo significativo sulle condizioni di salute della popolazione.

Il Paese presenta una struttura demografica estremamente giovane, con una larga maggioranza della popolazione sotto i 25 anni, elevati livelli di povertà, bassi tassi di alfabetizzazione e una speranza di vita tra le più basse a livello globale. In questo quadro, l'accesso equo ai servizi sanitari di base risulta fortemente limitato, in particolare nelle aree rurali e peri-urbane, a causa dell'estensione geografica del territorio, delle grandi distanze dai centri di salute, della carenza e distribuzione disomogenea delle risorse umane qualificate, nonché di persistenti barriere socio-culturali e di genere che ostacolano l'utilizzo dei servizi da parte delle fasce più vulnerabili, in particolare donne, adolescenti e bambini.

Dal punto di vista epidemiologico, il Mozambico è caratterizzato da un elevato carico di malattie trasmissibili, in particolare HIV/AIDS, tubercolosi e malaria, che continuano a rappresentare le principali cause di mortalità, soprattutto nella popolazione giovane e materno-infantile.
Allo stesso tempo, il Paese ha affrontato una progressiva transizione epidemiologica, con una crescita rilevante delle malattie non trasmissibili (MNT), come patologie cardiovascolari, diabete, malattie respiratorie croniche e tumori, che il Sistema Sanitario Nazionale fatica a intercettare e gestire in modo sistematico, soprattutto a livello di cure primarie.
Tale situazione si innesta su un sistema sanitario sottofinanziato, fortemente dipendente dal settore pubblico e dal sostegno dei partner internazionali, con limitate capacità di pre-pagamento e protezione finanziaria della popolazione e con sistemi di informazione sanitaria ancora deboli, che ostacolano la pianificazione basata su evidenze e l'uso efficiente delle risorse.

Le crisi recenti hanno ulteriormente aggravato questo contesto già fragile. La pandemia di COVID-19 ha avuto un impatto trasversale e profondo, determinando l'interruzione o la riduzione di servizi sanitari essenziali, l'aumento delle difficoltà di accesso alle cure, problemi di approvvigionamento di farmaci salvavita e un rafforzamento dello stigma associato a determinate patologie, in particolare l'HIV. A ciò si aggiungono gli effetti di eventi climatici estremi, come cicloni e inondazioni, che hanno colpito duramente diverse regioni del Paese, ampliando le disuguaglianze territoriali, indebolendo ulteriormente le infrastrutture sanitarie e riducendo la capacità di risposta dei servizi, soprattutto nelle comunità più remote.

In questo scenario, la Cooperazione Italiana ha finanziato iniziative che condividono un approccio strategico orientato al rafforzamento del Sistema Sanitario Nazionale e all'allineamento con le politiche e le priorità definite dal Ministero della Salute mozambicano. Esse si fondano su principi comuni quali l'equità, il diritto alla salute, la qualità e l'efficienza dei servizi, il decentramento dell'assistenza a livello locale, la responsabilizzazione delle istituzioni locali e il rafforzamento delle partnership, in coerenza con il Piano Strategico del Settore Salute, con le strategie dei programmi nazionali e con gli impegni internazionali assunti dal Paese, inclusi gli Obiettivi di Sviluppo Sostenibile dell'Agenda 2030 e le strategie del Fondo Globale.
Un elemento trasversale a tutte le iniziative è **l'attenzione al livello comunitario come spazio privilegiato di intervento**, sia per migliorare l'accesso ai servizi di prevenzione, diagnosi, trattamento e follow-up, sia per ridurre lo stigma, promuovere comportamenti salutari e rafforzare il ruolo delle comunità come attori chiave della salute pubblica. In tale ottica, assumono particolare rilevanza i modelli di assistenza decentrata, l'integrazione dei servizi per diverse patologie, l'impiego di equipe mobili, il coinvolgimento di attivisti comunitari e il rafforzamento del legame tra comunità e strutture sanitarie di riferimento.
Le iniziative condividono inoltre una forte componente di **rafforzamento delle capacità del personale sanitario** attraverso la formazione iniziale e continua, l'aggiornamento delle competenze in risposta ai mutamenti del profilo epidemiologico, il sostegno ai programmi nazionali e lo sviluppo di strumenti innovativi, come la ricerca operativa e la telemedicina, per migliorare la qualità dell'assistenza e la resilienza del sistema sanitario a shock esterni. La produzione e l'utilizzo di evidenze scientifiche per informare le politiche sanitarie,

migliorare la pianificazione e orientare le decisioni a livello locale e nazionale, rappresentano un ulteriore elemento comune, così come l'attenzione agli aspetti di salute mentale e di benessere psicosociale, emersi con maggiore forza a seguito delle crisi recenti.
Nel loro insieme, queste iniziative si collocano quindi all'interno di un quadro unitario di cooperazione allo sviluppo che mira a rispondere in modo integrato e sostenibile alle sfide sanitarie del Mozambico, contribuendo a ridurre le disuguaglianze, migliorare la qualità e la continuità delle cure e rafforzare la capacità del sistema sanitario di garantire, nel lungo periodo, il diritto alla salute per tutta la popolazione.

1. **"Prevenzione e Controllo delle Malattie Non Trasmissibili" (AID 11375)**

Intervento di carattere strutturale e sistemico, volto a rafforzare la risposta del Sistema sanitario nazionale, attraverso il Ministero della Sanità, alla crescente transizione epidemiologica verso le malattie non trasmissibili. Il progetto agisce su formazione delle risorse umane, organizzazione dei servizi di cura delle patologie croniche e sistemi informativi, con particolare attenzione alle cure primarie e alla diagnosi precoce (diabete, ipertensione, cancro della cervice). L'iniziativa funge da incubatore di modelli replicabili a livello nazionale e contribuisce al consolidamento dei Programmi Nazionali sulle MNT.
Aree di intervento: Province di Maputo, Sofala e Zambezia.

2. **"TILL THE END - Strategie comunitarie di contrasto alla tubercolosi e all'HIV" - AID 11587/04/1**

Progetto focalizzato sulla Provincia di Inhambane, che mira a rafforzare l'accesso a servizi di prevenzione e diagnosi di HIV e tubercolosi nelle comunità rurali più remote. Attraverso il potenziamento delle *Brigadas Móveis* (le équipe sanitarie mobili del Sistema Sanitario Nazionale del Mozambico, pensate per portare i servizi sanitari direttamente nelle comunità), e l'erogazione di servizi decentrati, l'intervento contribuisce alla diagnosi precoce, al miglioramento della presa in carico dei pazienti e alla riduzione delle barriere geografiche e sociali all'accesso alle cure.
Aree di intervento: Provincia di Inhambane (Massinga,Funhalouro, Morrumbene e Homoine).

3. **"Espaço Aberto - Rafforzamento dei servizi sanitari per adolescenti e giovani donne con HIV" - AID 11817/04/06**

Il progetto opera in quattro province del Mozambico per ridurre l'impatto dell'HIV su adolescenti e giovani donne, uno dei gruppi più vulnerabili. Punta a rafforzare i servizi sanitari attraverso un approccio **youth-friendly**, migliorando qualità, accesso e continuità delle cure. La formazione di personale sanitario e giovani health educators sostiene campagne mirate di Voluntary Test and Counselling e promuove l'aderenza ai trattamenti. Attività dedicate e iniziative comunitarie mirano a incrementare la retention nei programmi di cura. L'intervento coinvolge direttamente circa 3.500 beneficiari e e genera dati utili a orientare strategie future di prevenzione e cura dall'HIV.
Aree di intervento: Maputo città, Province di Maputo, Sofala e Zambezia.

4. **"PRoTeggiMI - Prevenzione della trasmissione materno-infantile e trattamento di HIV e TB" - AID 012168/01/9**

Intervento comunitario e decentrato nella Provincia di Inhambane, fortemente orientato al potenziamento delle cure materno-infantile e alla prevenzione della trasmissione verticale dell'HIV. Attraverso il rafforzamento delle Brigadas Móveis e l'integrazione dei servizi di HIV, tubercolosi e cure primarie, il progetto migliora l'accesso, la continuità delle cure e la qualità dell'assistenza per donne, bambini e gruppi vulnerabili nelle aree rurali.
Aree di intervento: Provincia di Inhambane - Distretti di Morrumbene, Homoine, Massinga e Funhalouro.

5. **"Conoscere per curare - Mitigare l'impatto del COVID-19 su adolescenti e giovani HIV+" - AID 12168/02/0**

Progetto di ricerca-intervento nel distretto urbano di Beira, volto a rafforzare la risposta all'HIV durante la pandemia di COVID-19. L'iniziativa riunisce insieme produzione di evidenze scientifiche, monitoraggio della salute mentale, rafforzamento dei servizi e *capacity building* del personale sanitario. Il valore aggiunto risiede nell'approccio *evidence-based*, che supporta il miglioramento dei servizi e il processo decisionale a livello locale e nazionale.
Aree di intervento: Provincia di Sofala, Distretto di Beira.

Le allegate schede descrittive contengono le informazioni relative ai documenti previsionali. I documenti di progetto relativi alle iniziative da valutare sono allegati alla Richiesta di preventivo inviata tramite la piattaforma Traspare. Nella fase di Desk Analysis descritta nelle disposizioni gestionali e piano di lavoro, a seguito della comunicazione ufficiale di avvio ai lavori, verrà inoltre fornita ulteriore documentazione.

1.b. Utilità della valutazione

L'obiettivo è di valutare i risultati conseguiti dalle iniziative e, soprattutto il loro impatto, al fine di garantire trasparenza e *accountability,* nonché di produrre evidenze utili a orientare le future strategie di cooperazione allo sviluppo e la programmazione, contribuendo al miglioramento della formulazione e della qualità degli interventi della Cooperazione italiana.

La valutazione d'impatto delle iniziative consentirà, nello specifico, di:

- Analizzare i cambiamenti, intenzionali e non intenzionali, positivi o negativi, prodotti dalle iniziative sulle condizioni di salute delle popolazioni beneficiarie e sul funzionamento del sistema sanitario. In tale prospettiva, la valutazione esaminerà il contributo degli interventi alla riduzione della mortalità associate a HIV, tubercolosi e trasmissione materno-infantile, al miglioramento degli esiti di salute per adolescenti e giovani, nonché al rafforzamento della resilienza dei servizi sanitari locali di fronte a crisi sanitarie. L'analisi dell'impatto terrà conto delle dinamiche di contesto, del contributo di altri attori e delle principali ipotesi causali sottostanti le teorie del cambiamento delle iniziative.

- Esaminare la pertinenza delle stesse rispetto ai bisogni sanitari del contesto mozambicano e alle priorità nazionali in materia di HIV, tubercolosi, salute materno-infantile, salute degli adolescenti e giovani, nonché prevenzione e gestione delle malattie non trasmissibili. La valutazione analizzerà la coerenza interna ed esterna degli interventi, con un focus sulla strategia del Fondo Globale, valutando il grado di allineamento tra obiettivi, strategie e modalità di attuazione, nonché la complementarità e le sinergie tra iniziative accomunate da un approccio integrato ai servizi sanitari e da un forte orientamento comunitario.

- Valutare l'efficacia delle strategie adottate nel migliorare l'accesso, la qualità e l'appropriatezza dei servizi sanitari per i gruppi target - in particolare adolescenti, giovani donne, donne in gravidanza e popolazioni residenti in aree remote - analizzandone l'impatto in termini di empowerment delle comunità beneficiarie, riduzione delle diseguaglianze nell'accesso ai servizi, promozione e rispetto dei diritti umani e superamento delle barriere di genere.

- Valutare la sostenibilità dei risultati conseguiti, analizzando in che misura il rafforzamento delle strutture sanitarie nazionali e locali, risulti sostenibile nel medio-lungo periodo, nonché il livello di ownership locale e il grado di integrazione sistemica dei risultati nella struttura di governance sanitaria. In linea con l'approccio tematico, si valuterà in che misura gli interventi abbiano favorito l'integrazione dei servizi (per quanto concerne HIV, TB, salute sessuale e riproduttiva, MNT) e la continuità delle cure, anche in contesti caratterizzati da vulnerabilità strutturali e da shock esterni, come l'emergenza COVID-19.

1.c. Obiettivi generali della valutazione

La presente valutazione si configura come una valutazione condotta nel settore sanitario in Mozambico, in conformità ai criteri OCSE-DAC (2019), con particolare enfasi sul criterio dell'**impatto**.

La valutazione dovrà esprimere un giudizio generale, adeguatamente motivato, sulla rilevanza degli obiettivi delle iniziative da valutare rispetto alle esigenze e alle priorità dei contesti di intervento, nonché sulla loro coerenza interna ed esterna, sia con le altre iniziative della Cooperazione italiana che con quelle promosse dagli altri donatori.

In base ai risultati raggiunti, tenendo conto anche degli indicatori elencati nel quadro logico, si valuteranno l'efficacia degli interventi, l'efficienza nell'utilizzo delle risorse a disposizione e la sostenibilità dei benefici conseguiti anche sotto il profilo istituzionale, economico, sociale e ambientale.

Particolare attenzione dovrà essere dedicata all'impatto di natura qualitativa delle iniziative valutate, nel loro complesso, e descrivere pertanto quali cambiamenti esse abbiano contribuito a determinare, o si possa ipotizzare che contribuiranno a determinare, in via diretta o indirettamente, nell'ambito del contesto sociale, economico e ambientale. L'analisi dovrà mettere in relazione tali effetti con il livello di conseguimento degli obiettivi indicati nelle schede descrittive allegate e con gli altri indicatori di sviluppo pertinenti, privilegiando una valutazione argomentata e qualitativa dell'impatto complessivo prodotto (per gli indicatori consultare il documento "*Modular framework handbook"* del Global Fund.

In particolare, l'analisi dell'impatto dovrà evidenziare gli effetti, prodotti o emergenti, su benessere collettivo, diritti umani, eguaglianza di genere e ambiente e sottolineare il contributo ad eventuali cambiamenti di carattere strutturale e duraturo nei sistemi di riferimento, nelle norme, nelle politiche pubbliche e/o nelle capacità istituzionali. Si dovrà anche analizzare in che misura e secondo quali meccanismi gli interventi abbiano contribuito a tali cambiamenti, come pure l'influenza di fattori esterni quali il contesto politico, le condizioni economiche e finanziarie.
La valutazione dovrà tenere conto degli eventuali effetti sinergici, sia positivi che negativi, tra i vari progetti oggetto della valutazione, al fine di evidenziare possibili effetti complementari derivanti dalla loro attuazione congiunta.
La valutazione esaminerà anche il grado di logicità e coerenza del design dei progetti e ne valuterà la validità complessiva.

Le conclusioni della valutazione saranno basate su evidenze oggettive, credibili, affidabili e adeguatamente triangolate, tali da permettere alla DGCS di elaborare misure di *evaluation management response,* processo volto ad assicurare che le lezioni apprese e le buone pratiche emerse, nonché le raccomandazioni elaborate, siano tradotte in cambiamenti concreti sia in termini di scelte strategiche, che di modalità operative al fine di migliorare la qualità, la programmazione, la formulazione e la gestione degli interventi di cooperazione allo sviluppo.
Eventuali azioni di follow up alle raccomandazioni, saranno elaborate da AICS e dagli attori destinatari delle raccomandazioni stesse.

La diffusione dei risultati della valutazione contribuirà al rafforzamento dell'*accountability* istituzionale nei confronti del Parlamento - circa l'utilizzo dei fondi stanziati per l'Aiuto Pubblico allo Sviluppo - e dell'opinione pubblica italiana, in relazione alla validità dell'allocazione delle risorse governative disponibili in attività di cooperazione. I risultati della valutazione e le esperienze acquisite saranno condivisi con le principali Agenzie di cooperazione e con i partner locali. La valutazione favorirà anche la *mutual accountabilty* tra partner in relazione ai reciproci impegni.
Infine, mediante il coinvolgimento dei Paesi partner in ogni fase del suo svolgimento, la valutazione contribuirà al rafforzamento della loro capacità in materia di valutazione, favorendo l'appropriazione dei risultati e promuovendo una cultura della valutazione orientata all'apprendimento e al miglioramento continuo delle politiche e degli interventi di sviluppo.
Il team di valutazione potrà suggerire e includere altri aspetti che siano congrui con lo scopo della valutazione.

2. Metodologia della valutazione

2.a. Principi generali e approccio

a) La valutazione deve essere in linea con i più elevati standard internazionali di riferimento, in particolare di integrità e rispetto delle regole civili, degli usi e costumi, dei diritti umani e dell'uguaglianza di genere e del principio del "non nuocere".

Le valutazioni realizzate dalla DGCS tengono conto delle linee guida della cooperazione italiana, si basano sui principi: utilità, credibilità, indipendenza, imparzialità, trasparenza, eticità, professionalità, diritti umani, parità di genere e sul principio del *leave no-one behind.*

La valutazione deve essere condotta con i più elevati standard di integrità e rispetto delle regole civili, degli usi e costumi, dei diritti umani e dell'uguaglianza di genere e del principio del "non nuocere".

Le tematiche trasversali (tra cui diritti umani, genere, ambiente) dovranno avere la dovuta considerazione ed i risultati della valutazione in questi ambiti dovranno essere adeguatamente evidenziati con una modalità trasversale.

b) Per valutare quanto gli interventi abbiano inciso sulla capacità, da un lato di concedere i diritti umani e dall'altro di pretenderne la fruizione, si utilizzerà lo *Human Rights Based Approach*.

Più in generale, il team di valutazione userà un *Results-based approach* (RBA) che costituirà la base per l'analisi di varie fonti informative e di dati derivanti da documentazione di progetto, del quadro logico - laddove disponibile, relazioni di monitoraggio, interviste con le controparti governative, con lo staff del progetto, con i beneficiari diretti, sia a livello individuale sia aggregati in focus group. Tale approccio sarà tuttavia integrato in un quadro valutativo più ampio, orientato all'analisi causale, al fine di verificare non solo il grado di raggiungimento dei risultati attesi, ma soprattutto di valutare l'attribuzione dei cambiamenti osservati agli interventi e l'emergere di effetti inattesi, positivi o negativi.

Il team dovrà in ogni caso considerare il design progettuale degli interventi. Qualora gli interventi non siano stati strutturati secondo una piena logica RBM (*results-based management*) o vi siano lacune in termini di teoria del cambiamento, indicatori o dati di baseline, il team procederà ad integrare o adattare l'approccio metodologico.

A questo scopo, il team di valutazione intraprenderà una missione in **Mozambico**.

Il processo di valutazione dovrà essere "*utilisation focused*", vale a dire che l'enfasi principale verrà posta sull'uso specifico che dei suoi risultati dovrà essere fatto.

c) Il team di valutazione potrà adottare metodologie sia qualitative che quantitative in modo tale da poter triangolare i risultati ottenuti con l'utilizzo di ciascuna di esse. Nella scelta delle metodologie da utilizzare, il team di valutazione dovrà tenere conto degli obiettivi che la valutazione si propone nonché delle dimensioni e caratteristiche degli interventi. Si dovrà esplicitare quali metodi si utilizzano sia per la valutazione che per la raccolta dei dati e la loro analisi, motivando la scelta e chiarendo le modalità di applicazione degli stessi.

In ogni caso, le metodologie utilizzate dovranno essere in accordo con tutti i principi enunciati in precedenza nei punti a e b. In particolare, la prospettiva di genere dovrà sempre essere integrata (alla luce del tipo di intervento valutato) e con modalità che dovranno essere indicate nella proposta tecnica presentata (ad esempio, la presenza nel team di personale di sesso femminile o comunque esperto in materia di genere, raccolta ed analisi dei dati in maniera disaggregata per genere etc.).

Nella fase di avvio della valutazione, i valutatori dovranno:

- proporre le principali domande di valutazione e le domande supplementari, in maniera puntuale e tenendo conto delle caratteristiche specifiche degli interventi;
- elaborare la matrice di valutazione, che, per ciascuna delle domande di valutazione e domande supplementari che si è deciso di prendere in considerazione, indichi le tecniche che si intendono utilizzare per la raccolta dei dati e fornisca altre informazioni quali i metodi di misura, eventuali indicatori, la presenza o meno di *baseline* e quanto altro opportuno in base alle esigenze della valutazione;
- stabilire le modalità di partecipazione degli stakeholder alla valutazione con particolare attenzione ai beneficiari e ai gruppi più vulnerabili.
- ricostruire la teoria del cambiamento, compatibilmente con le modalità di impostazione progettuale degli interventi.

2.b. Qualità

Il team di valutazione userà diversi metodi (inclusa la triangolazione) al fine di assicurare che i dati rilevati siano validi.

La valutazione dovrà conformarsi ai *Quality Standards for Development Evaluation* dell'OCSE/DAC.[1]

[1] https://www.oecd.org/en/publications/dac-quality-standards-for-development-evaluation_9789264083905-en.html

2.c. Criteri

I criteri di valutazione da adottare, recentemente ridefiniti in ambito OCSE-DAC insieme ai principi di riferimento per il loro utilizzo, costituiscono la base per l'analisi complessiva dell'intervento. Pur rimandando alle fonti OCSE-DAC[2] per un approfondimento dettagliato, si invitano i valutatori a porre particolare attenzione ai primi tre criteri – Impatto, Sostenibilità, Efficacia - in quanto rappresentano gli aspetti prioritari per questa valutazione. Di seguito se ne evidenziano i principali elementi, seguiti dagli altri criteri di riferimento.

Criteri prioritari

- **Impatto**: si analizzeranno gli effetti significativi degli interventi – positivi o negativi, previsti o imprevisti – in un ambito più ampio rispetto ai risultati immediati. L'analisi includerà gli effetti sociali, economici e ambientali, nonché le ricadute su temi chiave quali benessere delle comunità, diritti umani e uguaglianza di genere. La valutazione, pertanto, non si limita a verificare il raggiungimento formale degli obiettivi dichiarati, ma mira a comprendere come gli interventi abbiano inciso sul funzionamento complessivo del sistema sanitario e in che misura abbiano contribuito, direttamente o indirettamente, al miglioramento degli esiti di salute e agli obiettivi di sviluppo più generali.
- **Sostenibilità**: si valuterà la possibilità che i benefici dell'iniziativa si mantengano nel medio e lungo termine, sia per quanto riguarda quelli già realizzati sia per quelli potenzialmente futuri.
- **Efficacia**: la valutazione misurerà il grado e l'entità in cui gli obiettivi dell'iniziativa, intesi in termini di risultati diretti ed immediati, siano stati raggiunti o si prevede lo saranno, con attenzione ai diversi risultati ottenuti nei vari gruppi di beneficiari. Occorrerà analizzare, pertanto, non solo in che misura le azioni realizzate abbiano generato cambiamenti concreti e pertinenti nel contesto di riferimento, ma anche l'effettivo miglioramento dell'accesso, della qualità e della continuità dei servizi sanitari per le popolazioni target.

Altri criteri di valutazione

- **Coerenza**: la valutazione analizzerà la coerenza intesa come la congruenza tra gli interventi proposti e le priorità e le strategie del *Global Fund*, così da assicurare che le azioni finanziate siano allineate sia agli obiettivi del bando, sia alle politiche e ai piani nazionali di salute.
- **Efficienza**: verrà analizzato se l'utilizzo delle risorse sia stato, o si preveda sarà, ottimale per il conseguimento dei risultati, in termini economici, temporali e gestionali.
- **Rilevanza**: il team di valutazione verificherà in che misura gli obiettivi e il disegno dell'iniziativa rispondano ai bisogni, alle politiche e alle priorità dei beneficiari, del Paese e delle istituzioni partner, anche in contesti mutevoli.

2.d. Quesiti valutativi

I quesiti valutativi dovranno essere formulati soprattutto in funzione dell'utilità e degli obiettivi della valutazione. Anche l'interpretazione specifica dei criteri OCSE-DAC, nonché di eventuali criteri aggiuntivi, dipenderà da cosa la valutazione mira ad evidenziare e dall'utilizzo che della valutazione stessa si intende fare. Le domande sull'efficacia e sull'impatto dovranno basarsi sul livello degli *outcome* e degli impatti specifici generati, anziché su specifici output e sull'impatto globale, difficilmente quantificabile.

[2] Per le definizioni dei Criteri OCSE si rinvia al seguente link: https://www.oecd.org/en/topics/sub-issues/development-co-operation-evaluation-and-effectiveness/evaluation-criteria.html

Per meglio valutare l'impatto, una parte dei quesiti dovranno essere del tipo causa-effetto. Alcune domande dovranno essere indirizzate a tematiche trasversali (povertà, diritti umani, questioni di genere o ambientali etc.).

In ogni caso, i quesiti (principali e supplementari) dovranno essere formulati quanto più possibile in maniera dettagliata, facendo riferimento alle specifiche caratteristiche degli interventi, in forma chiara e con un taglio operativo che tenga anche conto della concreta possibilità di darvi una risposta.

2.e. Coinvolgimento degli stakeholder locali

I metodi utilizzati dovranno essere il più partecipativi possibile, prevedendo in tutte le fasi il coinvolgimento dei destinatari "istituzionali" della valutazione, del Paese partner, dei beneficiari degli interventi ed in generale di tutti i principali *stakeholders*.

Il team di valutazione dovrà coinvolgere gli *stakeholders* locali nella realizzazione della valutazione realizzando attività formative di *capacity building* volte alla promozione di una cultura della valutazione orientata all'apprendimento e al miglioramento continuo delle politiche e degli interventi di sviluppo.

Inoltre, al termine della visita sul campo, le informazioni utili alla valutazione raccolte saranno condivise dal team con gli *stakeholders* locali.

Di seguito, sono riportati i principali *stakeholders* locali:

- Ministero della Sanità

- Autorità provinciali e distrettuali di competenza, direzione e personale dei centri di salute oggetto degli interventi di cooperazione,

- gli enti esecutori in loco (OSC, Università), comitati di salute relativi ai centri di salute;

- donatori di settore attivi nel Paese e rappresentanti delle OO.II.

2.f. Profilo del team di valutazione

Il servizio di valutazione dovrà essere svolto da un team di valutazione, composto da almeno 3 membri, incluso il *team leader*, il quale sarà il referente della DGCS per l'intera procedura e parteciperà alle riunioni ed ai seminari previste dal piano di lavoro.

I membri del *team* dovranno avere i seguenti requisiti:

FIGURA	REQUISITI MINIMI	REQUISITI PREFERENZIALI
EXPERT (Team Leader)	• Diploma di laurea triennale; • Padronanza della lingua **italiana** e **inglese**, parlata e scritta; • Esperienza in attività di valutazione di iniziative di cooperazione allo sviluppo (**almeno 5 anni**); • Esperienza in coordinamento di team multidisciplinari (**almeno 3 anni**); • Conoscenza approfondita della metodologia RBM e degli strumenti e modalità di intervento della Cooperazione italiana.	• Padronanza della lingua **portoghese**, parlata e scritta. • Esperienza in attività di valutazione di iniziative di cooperazione allo sviluppo **in ambito sanitario.** • Conoscenza del Paese e del contesto istituzionale.
MID LEVEL / JUNIOR LEVEL	• Diploma di laurea triennale; • Padronanza della lingua **italiana** e **inglese**, parlata e scritta;	• Padronanza della lingua **portoghese**, parlata e scritta.

	• Esperienza in attività di valutazione di iniziative di cooperazione allo sviluppo (**almeno 1 anno JL; almeno 3 anni ML**);	• Esperienza in attività di valutazione di iniziative di cooperazione allo sviluppo **in ambito sanitario.** • Conoscenza del Paese e del contesto istituzionale.
LOCAL (facoltativo, ma consigliato)	• Conoscenza della lingua **portoghese** come lingua veicolare; • Conoscenza del Paese e del contesto istituzionale. • Conoscenza della gestione del ciclo del progetto e dei progetti di cooperazione allo sviluppo.	

Il team di valutazione **dovrà** inoltre disporre delle seguenti competenze, che potranno essere possedute da uno o più membri obbligatori o aggiuntivi:

- Competenze nel settore sanitario e sui fenomeni epidemici, in particolare sulle malattie trasmissibili e non;
- Conoscenza del Paese e del contesto istituzionale;
- Competenza in interviste, ricerche documentate, raccolta e analisi dei dati;
- Competenza adeguata in tematiche trasversali, in particolare in un approccio gender-responsive;
- Competenze relazionali in virtù del contatto con le comunità locali;
- Ottime capacità analitiche, redazionali e di presentazione dei dati.

Nel caso in cui la conoscenza della lingua veicolare non risulti posseduta da alcun candidato, i valutatori sono tenuti a predisporre un adeguato servizio di interpretariato, assicurando la piena comprensione reciproca durante tutte le fasi delle attività di valutazione.

3. Prodotti dell'esercizio di valutazione

Si elencano di seguito gli output dell'esercizio.

- Un **Rapporto d'Avvio in lingua italiana** (intorno alle 20 pagine), da trasmettere alla Stazione Appaltante entro la scadenza concordata in occasione dell'incontro di avvio della valutazione presso la DGCS (generalmente 20 giorni). Il documento dovrà includere la descrizione dell'ambito della valutazione, dei quesiti valutativi principali e supplementari, dei criteri e degli indicatori che verranno utilizzati per rispondere alle domande, delle metodologie che si intendono utilizzare per la raccolta e l'analisi dei dati e per la valutazione in generale, della definizione del ruolo e delle responsabilità di ciascun membro del team di valutazione, del piano di lavoro comprensivo del cronoprogramma delle attività e delle modalità di svolgimento delle visite sul campo.

- Un **Rapporto finale** (max 50 pagine allegati esclusi) **in lingua italiana e tradotto in inglese e portoghese**. Oltre che in formato Word e Pdf (max 3Mb), i rapporti nelle 3 lingue dovranno essere forniti alla stazione appaltante, **in formato cartaceo rilegato in brossura, nella misura di 3 copie per ciascuna delle 3 lingue (9 copie complessivamente).** La redazione e la traduzione in lingua dovranno essere di un livello qualitativo professionale. Il Rapporto dovrà inoltre contenere elementi di infografica che facilitino la lettura e diano immediata evidenza delle risultanze della valutazione. Ulteriori indicazioni in merito al formato e alla struttura del rapporto sono fornite nella relativa scheda descrittiva.

- Una **Sintesi del Rapporto Finale** (max 15 pagine), **in lingua italiana e tradotto in inglese e portoghese**. Oltre che in formato Word e Pdf (max 3Mb), le sintesi dei rapporti nelle 3 lingue dovranno essere fornite alla stazione appaltante, **in formato cartaceo rilegato in brossura, nella misura di 3 copie per ciascuna delle 3 lingue (9 copie complessivamente).** Le copie cartacee dovranno essere dotate di copertina plastificata. La redazione e la traduzione in lingua dovranno essere di un livello qualitativo professionale. Nella versione sintetica del rapporto si dovranno necessariamente includere l'ambito e gli obiettivi della valutazione, l'approccio metodologico, le principali conclusioni e le raccomandazioni.

- **Documentazione fotografica** (in alta definizione) sull'iniziativa valutata e sul suo contesto, a sostegno delle conclusioni della valutazione, fornita su supporto informatico.

- **Due presentazioni Power Point**, rispettivamente in italiano e in portoghese, per illustrare le principali risultanze della valutazione (da utilizzare anche a supporto dei seminari programmati).

- **Seminario di presentazione della bozza di rapporto finale presso il MAECI-DGCS.**

- **Seminario di presentazione del rapporto finale in loco.**

Seguono:

- **Schede descrittive dei progetti;**
- **Disposizioni gestionali e piano di lavoro;**
- **Scheda relativa a formato e struttura del Rapporto di valutazione.**

SCHEDA DESCRITTIVA PROGETTO

TITOLO DEL PROGRAMMA	**"*Prevenzione e Controllo delle Malattie Non Trasmissibili"* AID 11375**
LUOGO DEL PROGRAMMA	Città di Maputo, Nampula, Tete e Zambézia
LINGUA DEL PROGRAMMA	Portoghese
DURATA PREVISTA	36 mesi
DURATA EFFETTIVA	gennaio 2019 – dicembre 2022 (VNO di 12 mesi)
CANALE DI FINANZIAMENTO	Bilaterale
TIPOLOGIA	Affidato OSC
BUDGET TOTALE	7.073.000 Euro
ENTE ESECUTORE	Medici con l'Africa Cuamm (Capofila); Associazione Italiana Amici Di Raoul Follereau (AIFO); Comunità di Sant'Egidio ACAP ONLUS (ACAP)

OBIETTIVI DI SVILUPPO SOSTENIBILE (SDGs): 3 (T 3.4 e 3.c)

Contesto dell'iniziativa

L'iniziativa nasce dalla richiesta del Governo del Mozambico alla Cooperazione Italiana di finanziare un programma di contrasto alle malattie non trasmissibili (MNT), con l'obiettivo di ridurne morbilità e mortalità. A fronte di una storica focalizzazione sulle malattie trasmissibili, il Paese ha vissuto una transizione epidemiologica caratterizzata dal crescente peso delle MNT e ha aderito alle strategie globali e regionali per la loro prevenzione e controllo. Pur avendo definito programmi specifici, il Ministero della Salute ha incontrato difficoltà nella loro integrazione e, nonostante i progressi normativi, il Sistema Nazionale di Sanità (SNS) presenta ancora capacità limitate nella prevenzione, diagnosi e trattamento delle MNT, in particolare a livello delle cure primarie. Persistono debolezze nella sorveglianza epidemiologica, nel Sistema di Informazione Sanitaria e nella disponibilità e distribuzione equa di risorse umane e infrastrutture, soprattutto nelle aree periferiche. In risposta, il Governo ha riconosciuto le MNT come priorità nazionale, istituendo Programmi Nazionali dedicati (malattie cardiovascolari, diabete, malattie respiratorie croniche, tumori prioritari e traumi) e promuovendo il rafforzamento della formazione del personale sanitario. In questo contesto, l'intervento si configura come una risposta integrata volta a rafforzare le capacità del SNS attraverso lo sviluppo delle competenze delle risorse umane, il miglioramento dell'organizzazione dei servizi e il consolidamento dei programmi nazionali, contribuendo a una risposta più equa, efficace e sostenibile ai bisogni di salute della popolazione.

Obiettivo generale e specifico

L'obiettivo generale è di contribuire alla riduzione della morbi-mortalità in Mozambico a causa delle principali malattie non trasmissibili (in particolare diabete, ipertensione e cancro alla cervice).

L'obiettivo specifico è sviluppare capacità locali per la decentralizzazione dell'erogazione di servizi di assistenza sanitaria integrata per le malattie non trasmissibili (MNT) a livello periferico del Servizio Sanitario Nazionale (SSN):

- Rafforzare la formazione continua dei professionisti sanitari per la prevenzione, il controllo e la sorveglianza epidemiologica delle MNT, utilizzando strategie innovative di formazione a distanza e tecnologie dell'informazione e della comunicazione;
- Implementare incubatori di un modello di consultazione per le malattie croniche nel SSN, con un focus iniziale sulla diagnosi precoce e sulla gestione appropriata dei fattori di rischio delle malattie croniche;
- Ampliare la diagnosi precoce del cancro attraverso il rafforzamento delle competenze dei tecnici di patologia, la creazione di algoritmi di riferimento adeguati al contesto e il potenziamento delle attrezzature dei laboratori di riferimento.

Descrizione strategia di intervento

La strategia di intervento si articola in un approccio graduale e integrato, volto al rafforzamento delle capacità del Sistema Nazionale di Salute attraverso investimenti infrastrutturali, sviluppo di competenze e consolidamento dei sistemi informativi e di riferimento clinico, con il supporto di partner di implementazione.

In una **fase iniziale** è previsto il rafforzamento delle basi strutturali e organizzative dell'intervento, attraverso il miglioramento delle infrastrutture, la produzione di materiali didattici, l'introduzione e il potenziamento dei registri ospedalieri, nonché la formazione di formatori e il training del personale sanitario. Questa fase include attività di sviluppo curriculare, assistenza tecnica e supporto logistico-amministrativo alle Direzioni e ai Programmi Nazionali competenti, con il coinvolgimento attivo delle istituzioni di formazione e delle ONG partner. Parallelamente, vengono costituite équipe di supervisione incaricate del monitoraggio e della valutazione delle attività implementate nelle strutture sanitarie e nelle istituzioni formative.

La **seconda fase** si concentra sull'implementazione operativa e sulla sperimentazione di modelli di servizio, attraverso l'attivazione delle consultazioni per i fattori di rischio, il rafforzamento dei sistemi di riferimento oncologico e lo sviluppo di attività di formazione continua in aree selezionate, concepite come incubatori per una successiva estensione a livello nazionale. In questa fase viene rafforzata la formazione in servizio dei professionisti maggiormente coinvolti nella gestione delle patologie croniche, a diversi livelli di competenza. Contestualmente, sono previste attività di ricerca operativa e di sorveglianza epidemiologica, finalizzate a produrre evidenze utili al miglioramento dei servizi e al processo decisionale.

Nel suo complesso, la strategia mira a integrare formazione, organizzazione dei servizi, sistemi informativi e partenariati istituzionali, garantendo il coordinamento tra i diversi attori coinvolti e ponendo le basi per la sostenibilità e la replicabilità degli interventi nel medio-lungo periodo.

Risultati da conseguire

L'intervento mira a rafforzare le capacità istituzionali e formative del sistema sanitario, migliorando il Sistema di Informazione Sanitaria per una pianificazione più efficace e basata su evidenze. Attraverso modelli pilota replicabili, formazione continua e uso della telemedicina, il progetto intende migliorare la qualità dei servizi, aumentare la motivazione e la permanenza del personale sanitario, in particolare nelle aree periferiche. Nel complesso, l'intervento contribuirà al miglioramento degli indicatori sanitari nazionali e alla riduzione dell'impatto delle malattie non trasmissibili, in coerenza con gli Obiettivi di Sviluppo Sostenibile.

Elenco dei beneficiari

Beneficiari diretti:

- oltre 5.000 professionisti sanitari, tra cui clinici (medici, tecnici di medicina curativa, tecnici della nutrizione, tecnici di fisioterapia, tecnici di psichiatria, tecnici di salute materno-infantile, agenti di medicina curativa), infermieri, tecnici di laboratorio, tecnici di patologia, tecnici di farmacia, tecnici di medicina preventiva, tecnici di radiologia e personale amministrativo. I professionisti sanitari sono distribuiti tra le Direzioni Nazionali, le Istituzioni di Formazione e le Unità Sanitarie su tutto il territorio nazionale.

- I docenti delle Istituzioni di Formazione (IdF) del MISAU, beneficiari del progetto in quanto costituiscono il gruppo target della formazione sin dall'inizio del progetto.
- 2600 pazienti visitati nel primo anno di implementazioni; circa 4000 donne sottoposte al test visuale con acido acetico per rilevare sospetto di cancro al collo dell'utero.

Beneficiari indiretti: gli abitanti di tutte le province di intervento nel Paese che hanno beneficiato dei risultati dell'implementazione del progetto, in particolare del miglioramento delle condizioni infrastrutturali delle unità sanitarie e/o della riduzione delle malattie non trasmissibili.

Finanziamento

Il finanziamento è stato erogato in tre tranches rispettivamente da: € 2.397.575,40 (prima rata), € 2.224.424,60 (seconda rata), € 2.451.000,00 (terza rata).

Variazioni intervenute

- Il periodo della prima annualità comprende due estensioni non onerose, la prima di quattro mesi fino al 30 aprile 2020 e la seconda di due mesi fino al 30 giugno 2020. Le due estensioni non onerose sono state approvate dalla sede AICS di Maputo in data 14 maggio 2020 (prot. n. 0379).
- Il secondo rapporto (prot. n.01667.14-12-2020) relativo alla seconda annualità comprende una VNO e una proroga temporale di ulteriori 3 (tre) mesi fino al 30/09/2021, approvate dalla Sede AICS Maputo in data 24/02/2021 con prot.n. 04746.
- Con l'invio del rapporto relativo alla terza e ultima annualità (prot. n. 020394.01-07-2022) la OSC capofila ha inoltrato la richiesta di VNO e proroga di ulteriori 3 (tre) mesi, ovvero fino al 31/12/2022, approvate da AICS Maputo con prot. n. 024187 del 05/08/2022.

Rapporti di monitoraggio o valutazione effettuati

Supervisioni congiunte con il Ministero della Sanità:
21/04/2022 e 04/05/2022: Provincia di Maputo
25/04/2022-28/04/2022: Provincia di Zambezia
09/05/2022-13/05/2022: Provincia di Sofala
14/11/2022-18/11/2022: Provincia di Sofala

Nel periodo 5-17 marzo 2023 l'Ufficio IV Sviluppo Umano di AICS ha effettuato una missione di monitoraggio congiunto con AICS Maputo in Mozambico

SCHEDA DESCRITTIVA PROGETTO

TITOLO DEL PROGRAMMA	***"TILL THE END. Strategie comunitarie di contrasto alla tubercolosi e all'HIV nella provincia di Inhambane"* AID 11587/04/1**
LUOGO DEL PROGRAMMA	Provincia di Inhambane
LINGUA DEL PROGRAMMA	Portoghese
DURATA PREVISTA	24 MESI
DURATA EFFETTIVA	29 mesi (1/06/2019 - 31/08/2021)
CANALE DI FINANZIAMENTO	Bilaterale
TIPOLOGIA	Global Fund 5%
BUDGET TOTALE	EURO 405.000,00
ENTE ESECUTORE	MEDICUS MUNDI ITALIA ONG

OBIETTIVI DI SVILUPPO SOSTENIBILE (SDGs): SDG 3 (T 3.3)

Contesto dell'iniziativa

Il Mozambico presenta livelli di sviluppo umano tra i più bassi a livello globale, con forti disuguaglianze nell'accesso ai servizi sanitari, in particolare nelle aree rurali. Nella Provincia di Inhambane, l'ampia estensione territoriale, la dispersione della popolazione e le carenti infrastrutture di trasporto limitano fortemente l'accesso ai Centri di Salute, incidendo negativamente sulla prevenzione, diagnosi e trattamento delle principali patologie. In questo contesto, le *Brigadas Móveis* rappresentano uno strumento chiave di decentramento dei servizi sanitari, sebbene la loro implementazione risulti spesso irregolare. La situazione epidemiologica è aggravata dall'elevata incidenza di HIV e tubercolosi, nonché dalla frequente co-infezione TB/HIV, associate a ritardi diagnostici, bassa conferma batteriologica e difficoltà di aderenza terapeutica nelle zone più remote. Nonostante i progressi nell'espansione dei servizi di terapia antiretrovirale, persistono significative barriere di accesso per la popolazione rurale. L'iniziativa si inserisce pertanto nella necessità di rafforzare modelli di intervento integrati e decentrati, in grado di garantire diagnosi precoce, continuità delle cure e monitoraggio dei pazienti direttamente nelle comunità più vulnerabili.

Obiettivo generale e specifico

Obiettivo generale: contribuire agli interventi nazionali e internazionali di lotta contro la tubercolosi e l'HIV nella Provincia di Inhambane.

Obiettivo specifico: migliorare l'accesso a servizi di qualità nella prevenzione e diagnosi della tubercolosi e dell'HIV per la popolazione più vulnerabile delle comunità remote dei Distretti di Massinga, Funhalouro, Homoine e Morrumbene, garantendo il trattamento della tubercolosi a livello comunitario.

Descrizione strategia di intervento

La strategia di intervento adotta un approccio integrato e decentrato, pensato per superare le barriere geografiche e strutturali che limitano l'accesso ai servizi sanitari nelle aree rurali. Il fulcro dell'azione è rappresentato dalle *Brigadas Móveis*, equipe sanitarie multidisciplinari che portano regolarmente nelle comunità più remote servizi di prevenzione, educazione sanitaria, screening e diagnosi precoce di tubercolosi e HIV, insieme alle principali prestazioni di salute pubblica. L'utilizzo di metodologie partecipative e il

coinvolgimento attivo dei leader comunitari favoriscono la fiducia della popolazione, aumentano l'adesione ai servizi e rafforzano la consapevolezza sui rischi e sulle modalità di prevenzione delle due patologie.

Parallelamente, la strategia rafforza la continuità delle cure attraverso l'introduzione di tecnologie diagnostiche innovative e mobili, come il GeneXpert Edge, e la creazione di point of care comunitari per il trattamento della TB, strettamente collegati ai Centri di Salute. Questo modello consente di ridurre i tempi di diagnosi, prevenire la perdita dei pazienti nel percorso di cura e migliorare l'aderenza terapeutica, anche grazie ad attività di supervisione, follow-up e ricerca attiva domiciliare. Il progetto agisce inoltre sul rafforzamento del sistema sanitario locale mediante formazione mirata degli operatori, coordinamento strutturato tra i diversi livelli istituzionali e produzione di evidenze scientifiche, con l'obiettivo di garantire sostenibilità, qualità dei servizi e allineamento con i Programmi Nazionali di Controllo della TB e dell'HIV.

Risultati da conseguire

L'intervento mira ad aumentare significativamente l'accesso ai servizi di salute, migliorando la prevenzione e la diagnosi precoce di TB e HIV, inclusa la TB multiresistente, e riducendo le perdite nel percorso di cura. Si prevede un incremento dei casi diagnosticati e trattati, una maggiore aderenza terapeutica grazie ai point of care e alla ricerca attiva domiciliare, e una riduzione dell'abbandono del trattamento. Al contempo, il rafforzamento delle competenze degli operatori e del coordinamento istituzionale contribuirà a sistemi sanitari più efficaci, mentre le attività di ricerca e divulgazione produrranno evidenze utili a orientare politiche e buone pratiche a livello locale, nazionale e internazionale.

Nel dettaglio:

- **R1**: Rafforzare la prevenzione e la diagnosi precoce di tubercolosi e HIV, nelle comunità rurali dei Distretti target (Morrumbene, Homoine, Funhalouro, Massinga).
- **R2**: Garantire il trattamento della tubercolosi e l'aderenza al trattamento dei pazienti delle comunità rurali.
- **R3**: Rafforzare le competenze delle figure sanitarie di riferimento in ambito di TB e HIV e favorire il coordinamento a livello provinciale e nazionale.
- **R4**: Condurre analisi epidemiologiche, realizzare evidenze scientifiche e diffondere i risultati a livello provinciale, nazionale e internazionale.

Elenco dei beneficiari

Beneficiari diretti
Sono le persone e i gruppi che partecipano direttamente alle attività del progetto o ne ricevono i servizi:

- **Donne e bambini delle comunità rurali** raggiunte dalle Brigadas Móveis:
  - 6.000 donne beneficiarie di visite pre e post-natali
  - 8.000 donne seguite nella pianificazione familiare
  - 6.500 bambini vaccinati
- **Popolazione generale** che accede ai servizi sanitari di base:
  - 22.400 adulti e bambini trattati per la malaria
  - 90.000 pazienti sottoposti a screening clinico
- **Beneficiari delle attività di prevenzione e diagnosi TB e HIV**:
  - 111.000 adulti e bambini partecipanti a sessioni di educazione sanitaria
  - 5.000 pazienti sottoposti a test TB con GeneXpert Edge
  - 22.400 persone sottoposte a test HIV
  - 500 pazienti diagnosticati e trattati per TB nei point of care
  - 1.000 pazienti con TB monitorati durante il trattamento
  - 350 beneficiari della ricerca attiva e del counselling familiare
- **Operatori e personale sanitario** coinvolti nel rafforzamento delle competenze e nel coordinamento:
  - 15 tecnici di laboratorio e 80 clinici formati su GeneXpert e PNCT
  - 80 operatori sanitari formati sulla gestione dell'HIV

    - 100 operatori sanitari partecipanti alle riunioni distrettuali HIV/TB
- **Attori istituzionali e della conoscenza** coinvolti nelle attività di coordinamento, ricerca e diffusione:
    - 20 partecipanti alle riunioni provinciali e nazionali con il Fondo Globale
    - Enti pubblici locali (SDSMAS, DPSI, MISAU)
    - 80 partecipanti al workshop provinciale
    - 300 partecipanti a congressi
    - 1.200 lettori di riviste scientifiche specializzate
    - 2.000 partecipanti a eventi pubblici
    - 3.000 persone raggiunte dalle campagne media

Totale beneficiari diretti: 117.780 persone.

Beneficiari indiretti

Sono i soggetti che traggono beneficio dagli effetti sistemici e di lungo periodo del progetto:

- **Popolazione delle 98 comunità rurali** servite dai servizi comunitari in Mozambico: circa **170.000 persone**, che beneficiano di un miglioramento complessivo dell'accesso, della qualità e della continuità dei servizi sanitari.
- **Popolazione in Italia** raggiunta indirettamente dalle attività di sensibilizzazione e divulgazione: circa **5.000 persone**.
- **Sistema sanitario locale e nazionale**, che beneficia di operatori più formati, dati epidemiologici più solidi, migliore coordinamento istituzionale e modelli replicabili di intervento.
- **Stakeholder istituzionali e comunitari**, tra cui responsabili provinciali e distrettuali dei programmi TB e HIV, responsabili dei Centri di Salute, leader comunitari, direttori dei servizi distrettuali, CCM, Principal e Sub-Recipients del Fondo Globale, coinvolti nel rafforzamento della governance e della programmazione sanitaria.

Finanziamento

L'erogazione del finanziamento è avvenuta in un'unica tranche pari a € 405.000,00.

Variazioni intervenute

Richiesta del 2019 di VNO del Piano Finanziario e proroga temporale di tre mesi

Richiesta del 2021 di VNO del Piano Finanziario

Rapporti di monitoraggio o valutazione effettuati

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SCHEDA DESCRITTIVA PROGETTO

TITOLO DEL PROGRAMMA	**"*Espace Aberto. Rafforzamento dei servizi sanitari per adolescenti e giovani donne con HIV in Mozambico"* AID 11817/04/06**
LUOGO DEL PROGRAMMA	Province di Sofala, Maputo, Maputo città, Zambezia
LINGUA DEL PROGRAMMA	Portoghese
DURATA PREVISTA	24 mesi
DURATA EFFETTIVA	34 MESI (01/03/2020 - 30/09/2021**)**
CANALE DI FINANZIAMENTO	Bilaterale
TIPOLOGIA	Global Fund 5%
BUDGET TOTALE	EURO 450.000,00 (contributo AICS su un budget totale e di € 736.250,00)
ENTE ESECUTORE	ACAP - COMUNITÀ DI S. EGIDIO ONLUS

OBIETTIVI DI SVILUPPO SOSTENIBILE (SDGs): SDG 3 (T 3.3)

Contesto dell'iniziativa

Il Mozambico presenta un contesto sanitario fragile, segnato da forti disuguaglianze territoriali e da una grave carenza di risorse. Nel 2017 la popolazione era di circa 27,9 milioni di persone, con un'aspettativa di vita ancora bassa (57 anni per le donne e 51 per gli uomini) e una disponibilità di personale sanitario pari a 1,74 operatori ogni 1.000 abitanti, inferiore agli standard OMS. La spesa sanitaria pro capite è tra le più basse della regione e l'accesso ai servizi di qualità resta particolarmente limitato nelle aree rurali, rendendo il Paese fortemente dipendente da finanziamenti esterni.

Il Paese affronta una tripla epidemia di HIV, tubercolosi e malaria, con l'HIV come principale emergenza. Nel 2018 la prevalenza dell'HIV nella popolazione adulta era del 12,6%, con un forte impatto su bambini, adolescenti e giovani donne. Solo il 72% delle persone con HIV conosceva il proprio status e il 56% era in trattamento, lontano dagli obiettivi 90-90-90. Particolarmente critica è la situazione di adolescenti e giovani (15-24 anni), caratterizzata da bassa conoscenza sulla prevenzione (30,8%), alti tassi di abbandono delle cure e marcate disuguaglianze di genere. In questo contesto emerge la necessità di rafforzare servizi sanitari più accessibili e mirati, in particolare per adolescenti e giovani donne, migliorando diagnosi, presa in carico e continuità delle cure.

Obiettivo generale e specifico

Obiettivo generale: massimizzare l'impatto delle azioni contro l'HIV in Mozambico, contribuendo alla realizzazione di due obiettivi di sviluppo sostenibile:

- Obiettivo di Sviluppo Sostenibile 3: Benessere e Salute. Il progetto vuole contribuire ad accrescere il benessere e le condizioni di salute della popolazione del Mozambico Centrale e Meridionale attraverso i servizi di prevenzione, Voluntary Test and Counselling e trattamento dell'HIV in modo da rinforzare un sistema sanitario debole che non riesce a rispondere ai bisogni della popolazione
- Obiettivo di Sviluppo Sostenibile 5: Parità di genere, la maggior parte dei beneficiari composta da donne e ragazze che sono maggiormente colpite da HIV e dallo stigma che lo accompagna a causa di disparità culturali, sociali ed economiche.

Il progetto vuole dunque:

- promuovere servizi sanitari di qualità ed efficacia (prevenzione e cura)
- rafforzare le risorse umane attraverso sensibilizzazione e formazione del personale dei centri di salute
- migliorare la compliance del trattamento nei pazienti in cura
- effettuare ricerca operativa per acquisire dati socio-demografici degli adolescenti e giovani donne coinvolti nei 7 centri, dati sulla retention e aderenza alla terapia antiretrovirale, dati di adesione ai servizi proposti.

Obiettivo specifico: ridurre il rischio e l'impatto dell'HIV/AIDS su giovani donne e adolescenti in 4 province in Mozambico (province di Sofala, Maputo, Maputo città e Zambezia).
A tal fine, l'iniziativa intendeva agire su diverse carenze del sistema sanitario, con l'obiettivo di aumentare la compliance di adolescenti e giovani ai programmi di cura. Infine, l'iniziativa mira a contribuire all'eliminazione degli ostacoli che non permettono di raggiungere le mete prefissate dalla Strategia 90-90-90 che entro il 2020 voleva raggiungere il:

1. 90% di persone con HIV che conoscono il loro status
2. 90% delle persone con una diagnosi HIV che ricevono terapia antiretrovirale
3. 90% delle persone che ricevono terapia antiretrovirale raggiungono la soppressione della carica virale.

Descrizione strategia di intervento

La strategia si concentra su un modello integrato di presa in carico *youth-friendly* per adolescenti e giovani donne (10–24 anni) con HIV, rafforzando l'accesso ai servizi, la qualità delle cure e l'aderenza al trattamento. L'intervento mira a superare i limiti delle campagne di Voluntary Test and Counselling (VCT) esistenti, attraverso la formazione di 14 health educators adolescenti e giovani, per supportare il personale sanitario nella realizzazione di campagne mirate e più efficaci.

Il progetto prevede servizi sanitari gratuiti per circa 3.500 adolescenti e giovani donne per due anni, con attività dedicate due giorni al mese e un approccio *life-cycle* che accompagna le giovani persone nell'affrontare le sfide legate a una malattia cronica. Sono previste inoltre attività aggregative per migliorare l'aderenza terapeutica e la *retention* nel programma, supportando il personale sanitario nella gestione di pazienti HIV in modo continuativo e mirato.

La qualità delle cure è garantita dal personale formato, dal monitoraggio routinario della carica virale secondo le linee guida OMS e dall'integrazione con la diagnosi e il trattamento della tubercolosi, spesso non rilevata e ad alto impatto sulla morbidità e mortalità prevenibile. Questo approccio integrato mira a garantire una presa in carico completa, migliorando sia gli esiti clinici sia la continuità dei servizi per adolescenti e giovani donne nelle comunità target.

Risultati da conseguire

I risultati attesi e le attività del progetto sono:
R1. Rafforzamento del servizio sanitario disponibile per adolescenti con HIV in sette centri di salute:
R1.A1. Monitoraggio clinico e diagnostico pazienti adolescenti con HIV
R1.A2. Supporto all'aderenza e alla retention di adolescenti
R2. Rafforzamento del servizio sanitario disponibile per giovani donne con HIV in 7 centri di salute:
R2.A1. Monitoraggio clinico e diagnostico di giovani donne con HIV
R2.A2. Supporto all'aderenza e alla retention di giovani donne
R3. Sono accresciute le conoscenze della popolazione sull'HIV in adolescenti e giovani donne:
R3.A1. Campagna di voluntary test and counselling

Elenco dei beneficiari

I **beneficiari diretti** del progetto sono:

- 2.250 adolescenti con HIV (per il 52% femmine) tra i 10 e i 19 anni
- 1.250 giovani donne con HIV tra i 20 e i 24 anni
- 22 *health workers* beneficiari di un corso di formazione per l'approfondimento di tematiche riguardanti l 'HIV negli adolescenti e nelle giovani donne.
- 14 giovani tra i 18-24 anni beneficiari di una formazione come *health educators* che rappresentano gli youth leader nei 7 centri di salute.
- 5.000 persone coinvolte in attività di sensibilizzazione su prevenzione e cura dell'HIV nei due anni di pr ogetto, di queste, 8.000 persone beneficiarie di test HIV, per la maggior parte adolescenti (10-19 anni) e giovani donne (20-24 anni).

Sono persone che vivono nelle Province di Maputo Città, Sofala, Zambesia e Maputo Provincia, in particolare nelle aree di Maputo, Matola, Beira, Manga Chingussura, Quelimane e Zimpeto. L'obiettivo è di far ricevere a circa 3.000 beneficiari già entro il primo anno cure di qualità specifiche per questi gruppi particolarmente vulnerabili, godendo di personale di riferimento, giorni dedicati. Grazie alle campagne di sensibilizzazione si prevede un aumento dei beneficiari delle cure gratuite di circa il 15% entro la fine del progetto.

I **beneficiari indiretti** del progetto sono le famiglie degli adolescenti e delle giovani donne coinvolte nel progetto nelle 4 province interessate, intorno ai centri di salute inclusi, beneficiari di una migliore salute dei pazienti che saranno più aderenti. Si include, tra i beneficiari indiretti, anche la comunità scientifica e tutta la popolazione mozambicana, che vedrà i benefici della ricerca operativa realizzata dalla Scuola Superiore Sant'Anna.

Finanziamento

Erogazione del finanziamento in un'unica tranche da 450.000 €.

Variazioni intervenute

- Nel 2020: I richiesta di estensione non onerosa di quattro mesi della prima annualità di progetto con termine al 30 giugno 2021 e VNO del Piano Finanziario
- Nel 2021: II richiesta di estensione non onerosa di tre mesi con termine della prima annualità al 30 settembre 2021 e relativa VNO del Piano Finanziario
- Nel 2022: III richiesta di VNO del Piano Finanziario

Rapporti di monitoraggio o valutazione effettuati

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SCHEDA DESCRITTIVA PROGETTO

TITOLO DEL PROGRAMMA	***"PRoTeggiMI: prevenzione della trasmissione materno-infantile e trattamento di HIV e TB per le comunità più remote"* AID 012168/01/9**
LUOGO DEL PROGRAMMA	Provincia di Inhambane, Distretti di Morrumbene, Homoine, Massinga, Funhalouro
LINGUA DEL PROGRAMMA	Portoghese
DURATA PREVISTA	24 mesi
DURATA EFFETTIVA	38 mesi **(**1/09/2021 - 31/08/2023)
CANALE DI FINANZIAMENTO	Bilaterale
TIPOLOGIA	Global Fund 5%
BUDGET TOTALE	EURO 455.000,00
ENTE ESECUTORE	MEDICUS MUNDI ITALIA ONG

OBIETTIVI DI SVILUPPO SOSTENIBILE (SDGs): SDG 3 (T 3.3)

Contesto dell'iniziativa

L'intervento si colloca nella Provincia di Inhambane, in Mozambico, caratterizzata da vaste aree rurali e da significative difficoltà di accesso ai servizi sanitari di base, in particolare per le fasce più vulnerabili della popolazione, come donne e bambini. La distanza dai Centri di Salute, la scarsità di personale sanitario e fattori socio-culturali ed economici limitano l'accesso e la fruizione delle cure, mentre eventi recenti, come la pandemia da SARS-CoV-2 e i cicloni Dineo e Idai, hanno ulteriormente peggiorato gli indicatori di salute materna e infantile e quelli relativi alle tre grandi pandemie – HIV, malaria e tubercolosi. Tali emergenze hanno inoltre interrotto per diversi mesi servizi essenziali, come le Brigadas Móveis, aumentando il divario tra aree semi-urbane e rurali e accentuando le disuguaglianze. In questo contesto, le comunità più remote necessitano di interventi mirati per migliorare la prevenzione, la diagnosi e il trattamento di HIV e tubercolosi, con particolare attenzione alla salute di donne e bambini, rafforzando l'accesso ai servizi e la qualità delle cure.

Obiettivo generale e specifico

L'intervento ha come **obiettivo generale** quello di contribuire all'efficacia dei programmi nazionali di contrasto alla diffusione dell'HIV, misurabile attraverso la riduzione del tasso di incidenza dell'infezione nella popolazione, disaggregato per sesso, età e gruppi vulnerabili.

In coerenza con questo, l'**obiettivo specifico** del progetto è aumentare l'accesso a servizi sanitari di qualità per la prevenzione della trasmissione verticale dell'HIV e per il trattamento dell'HIV e della tubercolosi nelle comunità remote della Provincia di Inhambane, in particolare nei distretti di Massinga, Funhalouro, Homoine e Morrumbene. L'iniziativa mira a raggiungere le popolazioni più vulnerabili attraverso l'impiego delle Brigadas Móveis, equipe sanitarie mobili che forniscono servizi di Primary Health Care integrati, garantendo prevenzione, diagnosi e trattamento dell'HIV e della tubercolosi direttamente nelle comunità isolate. In questo modo, il progetto intende migliorare la qualità e l'efficacia dei servizi sanitari, promuovere l'accesso universale alla diagnosi e al trattamento, e ridurre la trasmissione dell'HIV da madre a figlio.

Descrizione strategia di intervento

La strategia di intervento adotta un approccio decentrato e comunitario per migliorare l'accesso ai servizi di salute primaria e al continuum di prevenzione, diagnosi e trattamento di HIV e tubercolosi nelle aree rurali della Provincia di Inhambane. L'azione si fonda sul rafforzamento delle Brigadas Móveis, che consentono di raggiungere regolarmente le comunità più remote, integrando i servizi di base con interventi mirati su HIV, TB e salute materno-infantile, con particolare attenzione alla prevenzione della trasmissione verticale dell'HIV. La strategia combina l'erogazione diretta dei servizi sanitari con attività di sensibilizzazione ed educazione socio-sanitaria, finalizzate a ridurre lo stigma e promuovere comportamenti preventivi, e con il coinvolgimento attivo di attori comunitari, formati per facilitare il collegamento tra popolazione e sistema sanitario e sostenere il follow-up dei pazienti. Parallelamente, il progetto rafforza le competenze del personale sanitario locale e introduce servizi di trattamento e diagnosi a livello comunitario, inclusi strumenti point of care, per garantire una presa in carico tempestiva, continua e di qualità dei pazienti, in coordinamento con il Sistema Sanitario Nazionale.

Risultati da conseguire

- **Miglioramento dell'accesso ai servizi di salute primaria** per le comunità rurali più isolate della Provincia di Inhambane, grazie al rafforzamento e alla regolarità delle Brigadas Móveis. Questo consente a una quota crescente di popolazione, in particolare donne, bambini e gruppi vulnerabili, di ricevere servizi sanitari essenziali senza dover percorrere lunghe distanze verso i Centri di Salute.
- **Potenziamento della prevenzione e della diagnosi precoce dell'HIV**, attraverso attività sistematiche di counselling e test nelle comunità, con un aumento delle persone consapevoli del proprio stato sierologico. In particolare, le donne in gravidanza e in età fertile beneficiano di un accesso più continuo ai servizi di prevenzione della trasmissione verticale, con effetti diretti sulla riduzione delle nuove infezioni pediatriche.
- **Incremento significativo dell'accesso al trattamento antiretrovirale** e un miglioramento della continuità terapeutica, grazie all'estensione dei servizi TARV a livello comunitario e al rafforzamento del follow-up dei pazienti. Questo contribuisce ad aumentare l'aderenza alla terapia e a ridurre l'abbandono, soprattutto nelle aree rurali.
- **Rafforzamento della diagnosi, del trattamento e del monitoraggio della tubercolosi**, inclusa la TB-HIV coinfezione. L'introduzione di screening più tempestivi e di servizi integrati direttamente nelle comunità permette di intercettare un numero maggiore di casi, migliorare la presa in carico e ridurre mortalità e fallimenti terapeutici.
- Consolidamento di un **modello operativo efficace di sanità territoriale**, in sinergia con il MISAU, migliorando l'organizzazione dei servizi decentrati, le competenze del personale sanitario e il coinvolgimento degli attori comunitari, con un impatto duraturo sulla resilienza del sistema sanitario locale.

Elenco dei beneficiari

I **beneficiari diretti** dell'iniziativa sono stimati in 216.000 individui, raggiunti attraverso le attività delle Brigadas Móveis. Essi includono principalmente la popolazione delle comunità rurali target, con una forte prevalenza femminile. In particolare, i beneficiari diretti comprendono 70.000 bambini tra 0 e 5 anni, 26.000 bambini e adolescenti tra 5 e 14 anni e 120.000 persone di età superiore ai 14 anni, per un totale di circa 74% donne e 26% uomini. Rientrano inoltre tra i beneficiari diretti anche gli attivisti comunitari HIV e gli operatori sanitari locali, in particolare le infermiere di Salute Materno-Infantile, che beneficiano delle attività formative e di rafforzamento delle competenze. La selezione dei beneficiari avviene sulla base di criteri di vulnerabilità, difficoltà di accesso ai servizi sanitari e bisogni di salute, in coordinamento con i Servizi Distrettuali di Salute e con il coinvolgimento diretto delle comunità.
I **beneficiari indiretti** sono costituiti dall'insieme della popolazione rurale dei Distretti di Morrumbene, Homoine, Massinga e Funhalouro, pari a circa 561.000 abitanti (dati del Censimento 2017), che beneficiano in modo indiretto del miglioramento complessivo dell'offerta sanitaria, del rafforzamento dei servizi decentrati e dell'aumento della capacità del sistema sanitario locale. A questi si aggiungono circa 5.000 persone in Italia, raggiunte dalle attività di comunicazione, sensibilizzazione e diffusione dei risultati dell'iniziativa, contribuendo ad accrescere la consapevolezza sui temi della salute globale e della cooperazione sanitaria.

Finanziamento

Il finanziamento totale pari a € 455.000,00 è stato erogato in due rate. La prima rata di € 318.500 corrisposta nel 2021. La seconda rata di € 136.500,00 nel 2023.

Variazioni intervenute

N/A

Rapporti di monitoraggio o valutazione effettuati

Nel periodo 5-17 marzo 2023 l'Ufficio IV Sviluppo Umano di AICS ha effettuato una missione di monitoraggio congiunto con AICS Maputo in Mozambico.

SCHEDA DESCRITTIVA PROGETTO

TITOLO DEL PROGRAMMA	***"Conoscere per curare: mitigare l'impatto del COVID-19 su adolescenti e giovani HIV+ attraverso la ricerca e il miglioramento dei servizi sanitari"* AID 12168/02/0**
LUOGO DEL PROGRAMMA	Distretto di Beira; Provincia di Sofala (Mozambico)
LINGUA DEL PROGRAMMA	Portoghese
DURATA PREVISTA	24 mesi
DURATA EFFETTIVA	1/11/2021 - 31/01/2024 (tre mesi di proroga)
CANALE DI FINANZIAMENTO	Bilaterale
TIPOLOGIA	Bando AICS Global Fund 5% del 2020
BUDGET TOTALE	EURO 275.000,00
ENTE ESECUTORE	Università di Padova

OBIETTIVI DI SVILUPPO SOSTENIBILE (SDGs): SDG 3 (T 3.3)

Contesto dell'iniziativa

Il Mozambico presenta una struttura demografica fortemente giovane, con quasi la metà della popolazione sotto i 15 anni, e affronta una sfida sanitaria rilevante legata all'HIV tra adolescenti e giovani. Nonostante i progressi globali nella riduzione di infezioni e mortalità correlate all'AIDS, gli adolescenti rappresentano l'unico gruppo in cui i decessi non sono in diminuzione. Nel contesto mozambicano, tale criticità è aggravata dall'inizio precoce dell'attività sessuale e da una bassa copertura dei servizi di test HIV, in particolare tra i giovani. La situazione è ulteriormente peggiorata dalla pandemia di COVID-19, che ha aumentato lo stigma, limitato le attività di prevenzione comunitaria e ostacolato l'accesso ai servizi di screening e ai trattamenti antiretrovirali, anche a causa delle restrizioni alla mobilità e di carenze locali di farmaci. In questo quadro, emerge il rischio concreto di un arretramento rispetto agli obiettivi nazionali e internazionali di controllo dell'HIV, rendendo necessario un intervento mirato a rafforzare la resilienza dei servizi sanitari e a migliorare l'accesso e la qualità delle cure per adolescenti e giovani HIV+ nel distretto urbano di Beira.

Obiettivo generale e specifico

Obiettivo generale: contribuire al mantenimento e al miglioramento della risposta all'HIV in Mozambico durante la pandemia di COVID-19, riducendo il rischio di peggioramento degli esiti di salute e garantendo la continuità di prevenzione, diagnosi e trattamento, in particolare tra adolescenti e giovani, anche attraverso il rafforzamento della conoscenza dello status HIV e del sistema informativo sanitario.

Obiettivo specifico: incrementare l'accesso e migliorare la qualità dei servizi di prevenzione, diagnosi precoce, trattamento e follow-up dell'HIV per adolescenti e giovani (10–24 anni) nei SAAJ del distretto urbano di Beira, attraverso: una migliore conoscenza dell'impatto del COVID-19 su HIV e salute mentale, il rafforzamento dei servizi e del monitoraggio, il mantenimento della continuità delle cure durante la pandemia, con particolare attenzione a ragazze e giovani donne, gruppo maggiormente vulnerabile.

Descrizione strategia di intervento

La strategia di intervento si basa su un approccio integrato di raccolta, analisi e utilizzo sistematico di dati quantitativi e qualitativi per rafforzare la risposta ai bisogni sanitari degli adolescenti e giovani HIV+ nel distretto urbano di Beira nel contesto della pandemia di COVID-19. L'iniziativa prevede, da un lato, la produzione di evidenze scientifiche sull'epidemiologia del SARS-CoV-2 e sui principali fattori di rischio socio-demografici e clinici attraverso test sierologici, questionari strutturati e analisi comparate; dall'altro, il rafforzamento della continuità di accesso ai servizi HIV e TARV e il monitoraggio dello stato di salute mentale degli utenti dei SAAJ. Parallelamente, la strategia include azioni di capacity building rivolte al personale sanitario e agli attivisti comunitari, nonché attività di sensibilizzazione e l'attivazione di servizi di supporto psicologico, al fine di migliorare la qualità dei servizi offerti, ridurre l'impatto della pandemia sull'aderenza alle cure e promuovere risposte istituzionali più efficaci, basate su dati concreti e condivisi con le autorità sanitarie competenti.

Risultati da conseguire

- Il progetto mira a **migliorare la disponibilità di dati** sulla prevalenza anticorpale SARS-COVID-2 e sui fattori di rischio associati negli adolescenti e giovani HIV+ del distretto urbano di Beira. Questo risultato dovrebbe essere raggiunto attraverso test sierologici, raccolta di dati socio-demografici e clinici, e analisi approfondita dei risultati, con la produzione di ricerche scientifiche validate e la condivisione dei dati con le autorità sanitarie locali.
- L'iniziativa intende **valutare e monitorare l'impatto della pandemia sulla salute mentale** dei giovani HIV+, mediante questionari standardizzati e analisi comparativa con dati precedenti, producendo ulteriori ricerche scientifiche approvate e pubblicate.
- Il progetto si propone di **rafforzare le competenze e conoscenze di personale sanitario, attivisti comunitari e giovani**, migliorando la prevenzione e gestione di HIV e COVID-19. A tal fine sono organizzate sessioni di formazione, attività di sensibilizzazione comunitaria e l'attivazione di un servizio di consulenza psicologica dedicato agli adolescenti e giovani HIV+.

In sintesi, i principali risultati attesi riguardano: raccolta e analisi dati epidemiologici, produzione di evidenze scientifiche, rafforzamento delle capacità locali e miglioramento dei servizi di supporto psicologico e prevenzione.

Elenco dei beneficiari

Il progetto coinvolge **14.215 beneficiari diretti**, tra adolescenti e giovani sottoposti a test sierologici per SARS-COVID-2, personale sanitario e attivisti comunitari formati, stakeholder partecipanti a eventi di divulgazione, e persone sensibilizzate su HIV e COVID-19, oltre a pazienti che ricevono assistenza psicologica. La selezione dei beneficiari rispetta le fasce d'età e garantisce equità di genere, privilegiando chi non ha partecipato ad altre attività formative e una distribuzione omogenea sul territorio. Gli **effetti indiretti** interessano l'intera popolazione del distretto urbano di Beira, stimata in circa 592.000 abitanti, con particolare attenzione a adolescenti e giovani adulti, nonché al personale e ai policy makers coinvolti nella gestione epidemiologica. Le stime si basano sui dati del **Censimento 2017** e sulle proiezioni demografiche per il 2020.

Finanziamento

Totale di € 260.000,00 corrisposto in due rate da € 182.000,00 (prima) e € 78.000,00 (seconda).

Variazioni intervenute

Nel 2023 nella trasmissione del RI2 l'Università ha richiesto una proroga temporale di tre mesi, con termine del progetto al 31 gennaio 2024 e ha presentato le modifiche unilaterali al Piano Finanziario

Missioni di monitoraggio o valutazione effettuati

Nel periodo 5-17 marzo 2023 l'Ufficio IV Sviluppo Umano di AICS ha effettuato una missione di monitoraggio congiunto con AICS Maputo in Mozambico.

DISPOSIZIONI GESTIONALI E PIANO DI LAVORO	
Desk Analysis	In questa prima fase i valutatori esamineranno la documentazione riguardante il progetto. Dopo la firma del contratto la DGCS fornirà al team di valutazione ulteriore documentazione relativa all'iniziativa oggetto della valutazione. Nella riunione d'avvio, il team incontrerà i rappresentanti degli uffici della DGCS, gli esperti/funzionari dell'Agenzia ed altri stakeholder rilevanti.
Rapporto d'avvio	Il team dovrà predisporre il Rapporto d'avvio (vedi pag. 9), che sarà soggetto ad approvazione da parte della DGCS, entro la scadenza concordata in occasione dell'incontro di avvio della valutazione presso la DGCS (generalmente 20 giorni).
Visita sul campo	Coordinandosi con il MAECI, l'Ambasciata d'Italia e la Sede dell'AICS Maputo, il team di valutazione visiterà i luoghi dell'iniziativa, intervisterà e parti interessate, i beneficiari e raccoglierà ogni informazione utile alla valutazione. Il team di valutazione si recherà sul campo per un periodo stimato di circa **20 giorni complessivi e continuativi** (la durata effettiva sarà determinata dall'offerente). Il suddetto periodo dovrà essere coperto da almeno uno dei membri obbligatori. La presenza in loco del team leader, anche per un periodo circoscritto, è incentivata con l'attribuzione di relativo punteggio in sede di valutazione dell'offerta tecnica (Piano di lavoro). Al termine della visita sul campo, le informazioni utili alla valutazione raccolte saranno condivise dal team con gli stakeholder locali.
Bozza del rapporto di valutazione	Il team predisporrà la bozza del rapporto di valutazione, che dovrà essere inviata per l'approvazione da parte della DGCS.
Commenti delle parti interessate e feedback	La bozza di rapporto sarà sottoposta ai soggetti interni alla DGCS, ai rappresentanti dell'Agenzia e altri eventuali stakeholder individuati dalla DGCS per questa finalità. Commenti e feedback saranno comunicati ai valutatori invitandoli a dare i chiarimenti richiesti e fare eventuali contro-obiezioni, nel pieno rispetto dell'indipendenza delle risultanze della valutazione.
Seminario presso la DGCS	La DGCS organizzerà un seminario per la presentazione da parte del team della bozza del rapporto di valutazione, per l'acquisizione di eventuali commenti e feedback da parte dei soggetti di cui al paragrafo precedente, utili alla stesura del rapporto definitivo.
Rapporto finale e documentazione accessoria	Il team di valutazione, tenendo conto dei commenti ricevuti, definirà il rapporto finale e lo trasmetterà alla DGCS, per l'approvazione. Il rapporto può includere i commenti degli stakeholder. Al rapporto saranno allegati i ToRs, la lista completa dei quesiti valutativi con relativi indicatori e fonti e l'elenco della documentazione consultata. Assieme al rapporto dovrà essere fornito il materiale fotografico e l'ulteriore documentazione prodotta nel corso della valutazione: i questionari, i documenti specifici prodotti per gli approfondimenti di particolari tematiche o linee di intervento, le fonti informative secondarie utilizzate, le tecniche di raccolta dei dati nell'ambito di indagini ad hoc, le modalità di organizzazione ed esecuzione delle interviste, la definizione e le modalità di quantificazione delle diverse categorie di indicatori utilizzati, le procedure e le tecniche per l'analisi dei dati e per la formulazione delle risposte ai quesiti valutativi, inclusa la Matrice di Valutazione etc.
Seminario in loco	Il team di valutazione organizzerà, in coordinamento con la DGCS, un seminario per la presentazione alle controparti del rapporto finale di valutazione. I risultati della valutazione verranno presentati ai principali interlocutori locali: soggetti istituzionali, enti esecutori, rappresentanti dei beneficiari etc. I costi organizzativi del seminario (incluso affitto della sala, catering, eventuali rimborsi per lo spostamento dei partecipanti locali) saranno integralmente a carico dell'offerente. Le modalità organizzative di massima del seminario dovranno essere illustrate nell'offerta del concorrente e concordate in tempo utile nel dettaglio con la DGCS. Per il seminario in loco, è fortemente consigliato fornire il documento "rapporto finale della valutazione" tradotto e stampato in lingua locale.

FORMATO E STRUTTURA DEL RAPPORTO DI VALUTAZIONE

Rilegatura	In brossura con copertina plastificata recante l'indicazione del titolo dell'iniziativa anche nella parte laterale.
Carattere	Arial o Times New Roman, corpo 12 minimo
Copertina	Il file relativo alla prima pagina sarà fornito dall'Ufficio VII della DGCS assieme ai contenuti da inserire nella prima pagina (modalità di aggiudicazione, disclaimer etc.)
Lista degli acronimi	Sarà inserita una lista degli acronimi utilizzati
Localizzazione degli interventi	Inserire una carta geografica relativa alle aree oggetto dell'iniziativa.
Sintesi iniziale	Quadro sintetico di contesto, ambito ed obiettivi della valutazione, metodologia di raccolta e analisi dati, principali conclusioni e raccomandazioni. Segnalare che del rapporto finale è disponibile una versione sintetica.
Contesto	- Situazione Paese, basata su informazioni rilevate da fonti internazionali accreditate. - Breve descrizione delle politiche di sviluppo attive nel Paese, con particolare riferimento alla cooperazione italiana, e della sua situazione politico-istituzionale, socio-economica e culturale.
Ambito ed obiettivo	- Descrizione delle iniziative valutate che includa logica e strategia di base, obiettivi generali e specifici, risultati previsti e stato di realizzazione dei singoli progetti - Obiettivi generali e specifici della valutazione.
Quadro teorico e metodologico	- I criteri di valutazione. - La metodologia utilizzata e la sua applicazione, segnalando le eventuali difficoltà incontrate. - Le fonti informative e il loro grado di attendibilità.
Presentazione dei risultati	La presentazione dei risultati della valutazione dovrà articolarsi sulla base dei quesiti formulati dall'offerente e delle relative risposte (adeguatamente documentate).
Conclusioni	Le conclusioni, fondate sui risultati della valutazione, includeranno un giudizio chiaro e motivato in merito a ciascuno dei criteri di valutazione e dovranno tenere conto di quanto richiesto nella sezione "Utilità" dei ToRs e delle tematiche trasversali.
Raccomandazioni	Le raccomandazioni, relative ad aspetti specifici delle iniziative valutate o a carattere generale, devono comunque essere fondate sulle risultanze e le conclusioni della valutazione. Sono indirizzate ai destinatari istituzionali e finalizzate al miglioramento delle strategie della cooperazione italiana e dei progetti futuri. Per facilitare il *management response* devono essere limitate nel numero (indicativamente non più di 10 raccomandazioni principali) e prevedere una formulazione sintetica che evidenzi chiaramente l'azione da svolgere, accompagnata da un eventuale ulteriore testo esplicativo.
Lezioni apprese e buone pratiche	Sono fondate sulle risultanze della valutazione e possono andare al di là del ristretto ambito del progetto.
Allegati inseriti nel rapporto	In calce al rapporto devono essere inseriti i ToRs (Allegato 1), la lista completa dei quesiti valutativi con relativi indicatori e fonti e l'elenco della documentazione consultata. Ulteriori allegati possono essere inseriti se non contengono dati potenzialmente sensibili (nominativi individuali ed altre informazioni che possono essere usate per identificare individui). Nel rapporto può anche essere inserito l'elenco di tutta la documentazione accessoria prodotta (questionari etc.), inclusa quella non allegata.

10.2 List of Evaluation Questions and Related Indicators and Sources (Evaluation Matrix)

Evaluation Criteria	Evaluation Questions	Data Collection Techniques	Stakeholders Involved	Indicators
Impact: Analyze the plausible contribution of the projects to the changes observed at the individual, community, institutional, and systemic levels.	1. Which significant changes generated by the project persist after its conclusion for each beneficiary group?	Desk review Interviews Focus groups	All stakeholder groups, with a particular focus on beneficiaries and health institutions	▪ Mortality and morbidity trends for HIV, TB, and maternal and child health in the intervention areas ▪ Changes in regulations, public policies, institutional capacity, and service models attributable to the interventions ▪ Institutionalization of introduced tools and approaches ▪ Adoption or replication of models by institutions outside the project areas ▪ Plausibility of the causal link between interventions and outcomes ▪ Assessment by institutional actors of systemic changes
	2. To what extent can these changes be attributed to the projects?	Desk review Interviews	All stakeholder groups, with a particular focus on beneficiaries and health institutions	▪ Type and extent of unintended effects—positive or negative—documented in progress and monitoring reports ▪ Unanticipated effects reported by beneficiaries, communities, and healthcare providers, broken down by gender and age ▪ Plausibility of the link between the interventions and the identified unintended effects
	3. Have any unexpected effects—positive or negative—emerged?	Desk review Interviews Focus groups	All stakeholder groups, with a particular focus	

Evaluation Criteria	Evaluation Questions	Data Collection Techniques	Stakeholders Involved	Indicators
		Direct observation	on beneficiaries and healthcare institutions	▪ Stakeholders' assessment of the significance and management of unexpected effects
Sustainability: Examines the likelihood that the benefits and changes generated can be sustained over time.	4. Have the capacities developed been institutionalized?	Desk review Interviews	MISAU, DPS, health facilities, implementing partners	▪ Integration of strengthened facilities and services into routine health governance ▪ Existence of the technical, financial, and regulatory conditions to replicate and scale up the approaches at the district, provincial, and national levels ▪ Assessment by institutions and communities of the sustainability of the benefits
	5. Can the innovations introduced be sustained or replicated?	Desk review Interviews	MISAU, DPS, health facilities, implementing partners	▪ Availability or projected financial resources to sustain the benefits ▪ Retention of trained staff ▪ Existence of defined and agreed-upon exit/transition strategies and sustainability plans ▪ Assessment by agencies and institutions of the current adequacy and future availability of financial and human resources to support innovations
	6. Is there ownership by national and local institutions? Is there ownership at the EU level?	Desk review Interviews	MISAU, DPS, health facilities, implementing partners	▪ Assumption of managerial and financial responsibilities by local institutions and communities ▪ Participation of community-based organizations in the management and oversight of services

Evaluation Criteria	Evaluation Questions	Data Collection Techniques	Stakeholders Involved	Indicators
				▪ Assessment by institutions and communities of the level of ownership and the capacity to independently continue activities
	7. Have there been changes in knowledge, attitudes, and practices related to health care among the beneficiary groups involved?	Desk review Interviews Focus groups	DPS, healthcare facilities, implementing partners, beneficiaries	▪ Documented changes in beneficiaries' knowledge ▪ Documented changes in health-related attitudes and behaviors reported by beneficiaries, broken down by gender and age ▪ Changes in the use of health services by target groups in the intervention areas ▪ Assessments by healthcare providers and partners regarding the changes in knowledge, attitudes, and practices observed among beneficiaries
Effectiveness: Analyze the extent to which the intended objectives and outcomes were achieved and the factors that facilitated or limited their achievement.	8. To what extent were the expected outcomes achieved for each of the beneficiary groups?	Desk review Interviews Focus groups Direct observation	Implementing partners, healthcare personnel, beneficiaries, community stakeholders	▪ Outcome indicator values achieved relative to targets ▪ Concrete, observable changes in the target contexts that can plausibly be attributed to the interventions ▪ Extent and reasons for discrepancies between planned and actual results ▪ Stakeholders' assessment of the achievement of results ▪ Users' assessment of the quality, continuity, and accessibility of services, broken down by gender and age
	9. What factors, including climatic ones, have facilitated or hindered the success of the projects and access to services in relation to each beneficiary group?	Desk review Interviews Focus groups Direct observation	Implementing partners, healthcare personnel, beneficiaries,	

Evaluation Criteria	Evaluation Questions	Data Collection Techniques	Stakeholders Involved	Indicators
			community stakeholders	
	10. How were the changes perceived by the different groups of beneficiaries and by the staff?	Interviews Focus groups Direct observation	Implementing partners, healthcare staff, beneficiaries, community stakeholders	▪ Type and extent of unintended effects, positive or negative, documented or reported ▪ Nature and extent of bottlenecks and barriers to access and use of services for adolescents and women ▪ Identification of groups excluded from or less well-served by the services compared to the rest of the target population ▪ Users' assessments of the quality, continuity, and accessibility of services, broken down by gender and age
Consistency: Examines the degree to which projects align with the Global Fund's priorities and strategies, with national health sector policies and	11. To what extent were the interventions consistent with the Mozambican government's national health sector policies, strategies, and plans? To what extent were they aligned with the guidelines of Italian Cooperation, the Global Fund's priorities, and the Sustainable	Desk review Interviews	AICS, MISAU, implementing partners	▪ References in project documents to MISAU's objectives and strategic plans ▪ References in project documents to the SDGs ▪ Explicit references to the objectives, areas of intervention, and principles of the *Global Fund* and Italian Cooperation in project documents ▪ Use of national and international standard indicators in project logframes

Evaluation Criteria	Evaluation Questions	Data Collection Techniques	Stakeholders Involved	Indicators
plans, as well as with the synergies and guidelines of Italian Cooperation.	Development Goals (in particular SDG 3 and other relevant SDGs)?			▪ Stakeholder assessment of the degree of alignment with the strategies of the *Global Fund* and Italian Cooperation
	12. To what extent were the interventions complementary and/or consistent with one another? Did synergies emerge among the various initiatives covered by the evaluation? And with interventions by other actors? Did the interventions avoid duplication among themselves and with other interventions?	Desk review Interviews	AICS, MISAU, implementing partners	▪ Documented complementarity with interventions by other partners by area, target group, or service ▪ Participation in mechanisms for coordinating the healthcare system and sharing tools and data ▪ Division of roles with other actors operating in the same contexts ▪ Examples of concrete operational synergies among implementing agencies ▪ Assessments by agencies and partners regarding the level of coordination of interventions
Efficiency: Assess the relationship between resources used, activities carried out, and results achieved.	13. Were resources used appropriately, taking into account the different needs of the beneficiaries?	Desk review Interviews	AICS, implementing partners, DPS	▪ Ratio of available resources to requirements for achieving results ▪ Rate of financial execution and utilization of planned resources ▪ Stakeholders' assessment of the adequacy and timeliness of resources
	14. Were the operational models adopted adequate and efficient for achieving the expected results?	Desk review Interviews	AICS, implementing partners, DPS	▪ Discrepancy between the planned timeline and activities actually carried out ▪ Existence and functionality of management and monitoring systems

Evaluation Criteria	Evaluation Questions	Data Collection Techniques	Stakeholders Involved	Indicators
	15. What organizational factors among institutional stakeholders and implementing agencies influenced implementation?	Desk review Interviews	AICS, implementing partners, DPS	▪ Extent and causes of delays and management measures adopted ▪ Impact of delays on results and mitigation measures ▪ Stakeholders' assessment of the timeliness of implementation
Relevance: Analyzes the relevance of the intervention to the actual needs of the beneficiaries identified during the design phase and to the policies and priorities of the Government of Mozambique.	16. To what extent have the interventions addressed the needs of vulnerable populations— , in particular, women, youth, and vulnerable/discriminated-against groups?	Desk review Interviews Focus groups	MISAU, DPS, implementing partners, health workers, beneficiaries	▪ Selection of geographic areas and target groups based on epidemiological data ▪ Inclusion in the logframe of indicators and targets related to priority groups in the areas of HIV, TB, maternal and child health, adolescents, and NCDs ▪ Stakeholders' assessment of the relevance of the objectives to priorities and needs
	17. To what extent did the interventions take into account the various factors that limit access to health services (gender, age, poverty, geographic distance, stigma, disability, extreme weather events, etc.)?	Desk review Interviews	MISAU, DPS, implementing partners, health workers	▪ Inclusion of a gender and equity analysis and targeted actions in the needs assessment and program design ▪ Availability of data disaggregated by gender, age, and geographic area, and documented use of such data in the formulation of interventions ▪ Type of beneficiary involvement in the various phases of the interventions ▪ Beneficiaries' assessment, broken down by gender and age, of how well the interventions meet their specific needs
	18. How were the target groups identified, and what are their characteristics? How were the beneficiary groups, as	Desk review Interviews Focus groups	MISAU, DPS, implementing partners, healthcare	

Evaluation Criteria	Evaluation Questions	Data Collection Techniques	Stakeholders Involved	Indicators
	rights-holders, involved in identifying their specific needs and in designing solutions?		providers, beneficiaries	
	19. Were the planned strategies appropriate for the socioeconomic context? And for environmental risk factors?	Document review Interviews	MISAU, DPS, implementing partners, health workers	▪ Inclusion, in the project documents, of an analysis of the socioeconomic context of the intervention areas ▪ Inclusion in project documents of an analysis of environmental risk factors ▪ Inclusion of adaptation measures or contingency plans for managing environmental risks ▪ Stakeholder assessment of the adequacy of strategies in light of the socioeconomic context and environmental risk factors

10.3 List of documents consulted

(Sub) Folder	File name	Content
AID11375_CUAMM_NCD		
AID11375_Proposal_Contract	AID11375_Proposal.pdf	Project proposal
AID11375_Proposal_Contract	AID11375_Proposal_Annex A1_MoH letter.pdf	Request of financing by MoH
AID11375_Proposal_Contract	AID11375_Proposal_Annex A2_MoH concept note.pdf	Concept note by MoH
AID11375_Proposal_Contract	AID11375_Proposal_Annex B_Financial plan.xlsx	Project proposal budget
AID11375_Proposal_Contract	AID11375_Proposal_Annex C_Logframe.pdf	Project proposal logframe
AID11375_Proposal_Contract	AID11375_Proposal_Annex D_Workplan.pdf	Project proposal workplan
AID11375_Proposal_Contract	AID11375_Proposal_Annex F_Markers.pdf	Project proposal markers
AID11375_Proposal_Contract	AID11375_Contract.pdf	Contract between AICS Maputo and CUAMM
AID11375_Reporting_Y1	AID 11375_Reporting Y1_letter.pdf	Report presentation letter
AID11375_Reporting_Y1	AID 11375_Reporting Y1_A1_tech report.pdf	Technical report
AID11375_Reporting_Y1	AID 11375_Reporting Y1_A2_fin report.pdf	Financial report
AID11375_Reporting_Y1	AID 11375_Reporting Y1_A3_fx rate.pdf	Declaration on exchange rate
AID11375_Reporting_Y1	AID 11375_Reporting Y1_A4_expense list.pdf	Expense list
AID11375_Reporting_Y1	AID 11375_Reporting Y1_A5_exp list_by budget line.pdf	Expense list by budget line
AID11375_Reporting_Y1	AID 11375_Reporting Y1_A6_exp reconciliation_CUAMM.pdf	Expense reconciliation for CUAMM
AID11375_Reporting_Y1	AID 11375_Reporting Y1_A7_exp reconciliation_ACAP.pdf	Expense reconciliation for ACAP
AID11375_Reporting_Y1	AID 11375_Reporting Y1_A8_exp reconciliation_AIFO.pdf	Expense reconciliation for AIFO
AID11375_Reporting_Y1	AID 11375_Reporting Y1_A9_admin costs decl.pdf	Declaration on administrative costs
AID11375_Reporting_Y1	AID 11375_Reporting Y1_A10_VAT decl.pdf	Declaration on VAT payment
AID11375_Reporting_Y1	AID 11375_Reporting Y1_A11_2nd install request.pdf	Request for 2nd installment
AID11375_Reporting_Y1	AID 11375_Reporting Y1_A12_audit report.pdf	Certified audit report
AID11375_Reporting_Y1	AID 11375_Reporting Y1_A13_all fin data.xlsx	All financial data in Excel
AID11375_Reporting_Y1	AID 11375_Reporting Y1_A14_financial plan Y1.pdf	Financial plan for year 1
AID11375_Reporting_Y1	AID 11375_Reporting Y1_A15_tech report signed.pdf	Signed technical report
AID11375_Reporting_Y1	AID 11375_Reporting Y1_A16_photos.pdf	Photographic report
AID11375_Reporting_Y1	AID 11375_Reporting Y1_A17_fin report signed.pdf	Signed financial report
AID11375_Reporting_Y2	AID 11375_Reporting Y2_annex list.doc	List of annexes to report
AID11375_Reporting_Y2	AID 11375_Reporting Y2_A1_tech report signed.pdf	Signed technical report
AID11375_Reporting_Y2	AID 11375_Reporting Y2_A2_tech report.pdf	Technical report
AID11375_Reporting_Y2	AID 11375_Reporting Y2_A3_photos.pdf	Photographic report
AID11375_Reporting_Y2	AID 11375_Reporting Y2_A4_fin report.pdf	Financial report
AID11375_Reporting_Y2	AID 11375_Reporting Y2_A5_financial plan Y2.pdf	Financial plan for year 2
AID11375_Reporting_Y2	AID 11375_Reporting Y2_A6_fx rate.pdf	Declaration on exchange rate
AID11375_Reporting_Y2	AID 11375_Reporting Y2_A7_expense list.pdf	Expense list
AID11375_Reporting_Y2	AID 11375_Reporting Y2_A8_exp list_by budget line.pdf	Expense list by budget line
AID11375_Reporting_Y2	AID 11375_Reporting Y2_A9_exp reconciliation_CUAMM.pdf	Expense reconciliation for CUAMM
AID11375_Reporting_Y2	AID 11375_Reporting Y2_A10_exp reconciliation_ACAP.pdf	Expense reconciliation for ACAP
AID11375_Reporting_Y2	AID 11375_Reporting Y2_A11_exp reconciliation_AIFO.pdf	Expense reconciliation for AIFO
AID11375_Reporting_Y2	AID 11375_Reporting Y2_A12_admin costs decl.pdf	Declaration on administrative costs
AID11375_Reporting_Y2	AID 11375_Reporting Y2_A13_VAT decl.pdf	Declaration on VAT payment
AID11375_Reporting_Y2	AID 11375_Reporting Y2_A14_3rd install request.pdf	Request for 3rd installment
AID11375_Reporting_Y2	AID 11375_Reporting Y2_A15_audit report.pdf	Certified audit report
AID11375_Reporting_Y2	AID 11375_Reporting Y2_A16_all fin data.xlsx	All financial data in Excel
AID11375_Reporting_Y3	AID 11375_Reporting Y3_letter.pdf	Report presentation letter
AID11375_Reporting_Y3	AID 11375_Reporting Y3_A1_tech report.pdf	Technical report
AID11375_Reporting_Y3	AID 11375_Reporting Y3_A10_exp list_by budget line.pdf.pdf	Expense list by budget line
AID11375_Reporting_Y3/AID 11375_Rep Y3_Cla	AID11375_Reporting Y3_clarification request.pdf	Clarification request on financial report
AID11375_Reporting_Y3/AID 11375_Rep Y3_Cla	AID 11375_Reporting Y3_A1_bank statement_CUAMM.pdf	Bank statements for CUAMM
AID11375_Reporting_Y3/AID 11375_Rep Y3_Cla	AID 11375_Reporting Y3_A2_account closing_CUAMM.pdf	Receipt of account closing request for CUAMM

AID11375_Reporting_Y3/AID 11375_Rep Y3_Cla	AID 11375_Reporting Y3_A3_bank statement_AIFO.pdf	Bank statements for AIFO
AID11375_Reporting_Y3/AID 11375_Rep Y3_Cla	AID 11375_Reporting Y3_A5_exp reconciliation_AIFO Y2.pdf	Expense reconciliation for AIFO - Y2
AID11375_Reporting_Y3/AID 11375_Rep Y3_Cla	AID 11375_Reporting Y3_A8_exp reconciliation_AIFO.xlsx	Expense reconciliation for AIFO - all years
AID11375_Reporting_Y3/AID 11375_Rep Y3_Cla	AID 11375_Reporting Y3_final certificate.pdf	Certificate of completion by AICS
AID11587_MMI_Till the End		
AID11587_Proposal_Contract	AID11597_Proposal.pdf	Project proposal - includes workplan, logframe, financial plan
AID11587_Proposal_Contract	AID11597_Award ranking.pdf	Ranking and award of GF financing
AID11587_Proposal_Contract	AID11597_Contract.pdf	Contract between AICS and MMI
AID11587_Reporting_Y1	AID11597_Interim tech report.pdf	Technical report
AID11587_Reporting_Y1	AID11597_Fin report_Y1.xlsx	Financial report
AID11587_Reporting_Y1	AID11597_No cost var and ext 2019.pdf	Approval of no cost variation and extension by AICS
AID11587_Reporting_Y2	AID11597_Final tech report.pdf	Technical report
AID11587_Reporting_Y2	AID11597_Final report_all annexes.pdf	Final report - including technical report, financial report, VAT declaration, expense list, monitoring missions reports, comms between MMI and AICS, report on delivery of movable and immovable property, auditing report
AID11587_Reporting_Y2	AID11597_Financial report email.pdf	Email presenting financial report
AID11587_Reporting_Y2	AID11597_Final fin report.xlsx	All financial data in Excel
AID11587_Reporting_Y2	AID11597_No cost variation 2021_request.pdf	Request for no cost variation
AID11587_Reporting_Y2	AID11597_No cost variation 2021.pdf	Approval of no cost variation by AICS
AID11587_Reporting_Y2	AID11597_Tech note on final report.docx	Technical note approving final report by AICS
AID11587_Reporting_Y2	AID11597_Tech note on final report.pdf	Technical note approving final report by AICS
AID11817_ACAP_Esp Aberto		
AID11817_Proposal_Contract	AID11817_Proposal.pdf	Project proposal - includes workplan, logframe, financial plan
AID11817_Proposal_Contract	AID11817_Contract and bank guarantee_email.pdf	Email sending signed contract and bank guarantee
AID11817_Proposal_Contract	AID11817_Activities start_email.pdf	Email communicating date of activity start
AID11817_Reporting_Y1	AID11817_No cost extension 2021_request.pdf	Request for no cost extension #1
AID11817_Reporting_Y1	AID11817_No cost extension 2021_approval.pdf	Approval of no cost extension #1
AID11817_Reporting_Y1	AID11817_No cost variation and extension 2021_request.pdf	Request of no cost variation and extension #2
AID11817_Reporting_Y1	AID11817_No cost variation and extension 2021_request_email.pdf	Email sending request of no cost variation and extension #2
AID11817_Reporting_Y1	AID11817_No cost variation and extension 2021_request_email_2.pdf	Correction to email sending request of no cost variation and extension #2
AID11817_Reporting_Y1	AID11817_No cost variation and extension 2021_request_signed.pdf	Signed request of no cost variation and extension #2
AID11817_Reporting_Y1	AID11817_Interim tech and fin report_email.pdf	Email sending technical and financial report
AID11817_Reporting_Y1	AID11817_Interim tech report.pdf	Technical report
AID11817_Reporting_Y1	AID11817_Audit report Y1.pdf	Audit report
AID11817_Reporting_Y2	AID11817_Final report email.pdf	Email sending final report
AID11817_Reporting_Y2	AID11817_Final report email_2.pdf	Email sending final report
AID11817_Reporting_Y2	AID11817_Interim tech and fin report.pdf	Interim technical and financial report
AID11817_Reporting_Y2	AID11817_Final tech and fin report.pdf	Final technical and financial report
AID11817_Reporting_Y2	AID11817_Fin report.xlsx	All financial data in Excel
AID11817_Reporting_Y2	AID11817_Fin report Y2_variation.xlsx	Request for budget variation
AID11817_Reporting_Y2	AID11817_Financial summary_Y1Y2.pdf	Financial summary data
AID11817_Reporting_Y2	AID11817_Financial summary_Y1Y2.xlsx	Financial summary data
AID11817_Reporting_Y2	AID11817_No cost variation 2022_request.pdf	Request of no cost variation
AID11817_Reporting_Y2	AID11817_No cost variation 2022_email.pdf	Email sending request of no cost variation
AID11817_Reporting_Y2	AID11817_No cost variation 2022_clarification.pdf	Response to AICS clarification request on no cost variation
AID11817_Reporting_Y2	AID11817_No cost extension 2022_clarification_email.pdf	Email sending response to AICS clarification request on no cost variation
AID11817_Reporting_Y2	AID11817_No cost variation 2022_approval.pdf	AICS approval of no cost variation
AID11817_Reporting_Y2	AID11817_Final tech report_approval.pdf	AICS approval of final technical report
AID11817_Reporting_Y2	AID11817_Tech note on final report.pdf	Technical note approving final report by AICS
AID11817_Reporting_Y2	AID11817_Audit report Y2.pdf	Audit report
	AID11817_Research paper.pdf	Research paper on DREAM program
AID012168_MMI_Protect Me		

AID012168_Proposal_Contract	AID012168_Application.pdf	Letter of application
AID012168_Proposal_Contract	AID012168_Application_email.eml	Email sending application
AID012168_Proposal_Contract	AID012168_Application_email.pdf	Email sending application
AID012168_Proposal_Contract	AID012168_Application_Proposal.pdf	Project proposal
AID012168_Proposal_Contract	AID012168_Application_Admin checklist.docx	Admin checklist
AID012168_Proposal_Contract	AID012168_Application_civil works value estim.pdf	Civil works value estimate
AID012168_Proposal_Contract	AID012168_Application_MCP endorsment.pdf	Endorsement by Global Fund Country Coordination Mechanism
AID012168_Proposal_Contract	AID012168_Application_Partnership DPSI.pdf	Partnership agreement with DPSI
AID012168_Proposal_Contract	AID012168_Application_Partnership UNIBS.pdf	Partnership agreement with UNIBS
AID012168_Proposal_Contract	AID012168_Application_SA1_Dipl mission assessment.docx	Model for risk management assessment by diplomatic mission
AID012168_Proposal_Contract	AID012168_Application_SA1_Dipl mission assessment.pdf	Model for risk management assessment by diplomatic mission
AID012168_Proposal_Contract	AID012168_Application_SA2_Decl operat capacity.pdf	Declaration of operational capacity
AID012168_Proposal_Contract	AID012168_Application_SA3_Decl operat capacity_assessment.docx	Declaration of operational capacity assessment form
AID012168_Proposal_Contract	AID012168_Application_SA4_logframe.pdf	Project proposal logframe
AID012168_Proposal_Contract	AID012168_Application_SA5_workplan.pdf	Project proposal workplan
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AID12168_Reporting P3/AID12168_Rep P3_fin r	AID12168_Rep P3_fin rep_financial appr.xlsx	AICS approval of final financial report

BIBLIOGRAPHY RELATED TO THE FINAL REPORT

Italian Agency for Development Cooperation (2022). Multi-Year Indicative Plan (PIP) Italy–Mozambique 2022–2026. https://maputo.aics.gov.it/wp-content/uploads/2023/02/AICS-Maputo-PIP-2022-2026.pdf

Italian Agency for Development Cooperation – Maputo (n.d.). Official website. https://maputo.aics.gov.it/home-ita/sede/profilo/

Azevedo-Fernandes, F., Chilundo, B. (2026). Navigating cervical cancer care in Maputo: a mixed-methods analysis of socioeconomic inequities in patient pathways and health system barriers. BMC Women's Health, 26, 353. https://doi.org/10.1186/s12905-026-04550-8

Bruni L., Albero G., Serrano B., Mena M., Collado J.J., Gómez D., Muñoz J., Bosch F.X., de Sanjosé S. (2023). Human Papillomavirus and Related Diseases in Mozambique. Summary Report, ICO/IARC Information Centre on HPV and Cancer (HPV Information Centre). https://hpvcentre.net/statistics/reports/MOZ.pdf

Committee for Development Policy – UN DESA (2021). Country Profile: Mozambique (Least Developed Countries). https://policy.desa.un.org/sites/default/files/2025-06/ldc_profile_mozambique.pdf

de Oliveira, C.M., Rangeiro, R., Osman, N., et al. (2025). Evaluation of HPV risk groups among women enrolled in the Mulher cervical cancer screening study in Mozambique. Infectious Agents and Cancer, 20, 24. https://doi.org/10.1186/s13027-025-00655-1

Ervik M., Laversanne M., Lam F., Colombet M., Ferlay J., Filho A.M., Bray F. (2026). Global Cancer Observatory: Cancer Today (2024 estimates, version 1.0) – Mozambique Factsheet. International Agency for Research on Cancer (IARC). https://gco.iarc.who.int/media/globocan/factsheets/populations/508-mozambique-fact-sheet.pdf

National Institute of Health – Mozambique, ICAP at Columbia University (2023). Mozambique Population-based HIV Impact Assessment 2021 (INSIDA 2021): Final Report. https://phia.icap.columbia.edu/wp-content/uploads/2023/10/050324_INSIDA_ENG_RR5.pdf

International Diabetes Federation (2025). Diabetes Atlas, 11th edition. https://media.idf.org/media/uploads/sites/3/2025/10/IDF_Diabetes_Atlas_11th_Edition_2025_WEB.pdf

World Health Organization (2019). Mozambique Hypertension Profile 2023. https://cdn.who.int/media/docs/default-source/country-profiles/hypertension/hypertension-2023/hypertension_moz_2023.pdf

World Health Organization (2025). Global Tuberculosis Report 2025. https://iris.who.int/server/api/core/bitstreams/e97dd6f4-b567-4396-8680-717bac6869a9/content

World Health Organization (2025). Noncommunicable Diseases Progress Monitor 2025. https://iris.who.int/server/api/core/bitstreams/7a228681-a190-4c29-b2a8-9d4255dc49d1/content

World Health Organization (2026). NCD Portal – Mozambique Country Profile. https://ncdportal.org/CountryProfile/GHE110/MOZ

World Health Organization (2026). Tuberculosis Profile: Mozambique. https://worldhealthorg.shinyapps.io/tb_profiles/?_inputs_&tab=%22tables%22&lan=%22EN%22&iso3=%22MOZ%22&entity_type=%22country%22

World Health Organization (n.d.). Mozambique – Country Data Portal. https://data.who.int/countries/508

Republic of Mozambique (2024). National Development Strategy 2025–2044. https://mef.gov.mz/index.php/publicacoes/estrategias/2184-estrategia-nacional-de-desenvolvimento-2025-2024/file

Republic of Mozambique, Ministry of Health – Directorate of Planning and Cooperation (2024). Strategic Plan for the Health Sector – PESS 2014–2019 (Extension 2020–2024). https://docs.bvsalud.org/biblioref/2023/12/1519224/final_pess-revisao-extensao_07-marco-2021_3082022.pdf

Salcedo, M.P. et al. (2023). The Mulher Study: cervical cancer screening with primary HPV testing in Mozambique. International Journal of Gynecological Cancer, 33(12), 1869–1874. https://doi.org/10.1136/ijgc-2023-004958

United Nations Development Programme, Human Development Report Office (n.d.). Specific Country Data – Mozambique. https://hdr.undp.org/data-center/specific-country-data#/countries/MOZ

United Nations Population Fund (2025). Mozambique – World Population Dashboard. https://www.unfpa.org/data/world-population/MZ

World Bank (2023). Mozambique Country Climate and Development Report. https://openknowledge.worldbank.org/server/api/core/bitstreams/2b9fa284-479a-4f38-9cd8-b39a569b4e7b/content

World Bank (2025). Climate Risk Profile: Mozambique. https://climateknowledgeportal.worldbank.org/sites/default/files/country-profiles/17258-WB_Mozambique%20Country%20Profile-WEB.pdf

World Bank (n.d.). Mozambique | World Bank Group. https://www.worldbank.org/ext/en/country/mozambique#tab-about

World Bank Data Help Desk (n.d.). World Bank Country and Lending Groups. https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups

World Bank, Poverty and Inequality Platform (n.d.). Mozambique Country Profile. https://pip.worldbank.org/country-profiles/MOZ

World Bank, World Development Indicators (n.d.). Current health expenditure (% of GDP) – Mozambique https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=MZ

World Bank, World Development Indicators (n.d.). GDP per capita (current US$) – Mozambique [NY.GDP.PCAP.CD]. https://data.worldbank.org/indicator/NY.GDP.PCAP.CD?locations=MZ

World Bank, World Development Indicators (n.d.). Incidence of tuberculosis (per 100,000 people) – Mozambique [SH.TBS.INCD]. https://data.worldbank.org/indicator/SH.TBS.INCD?locations=MZ

World Bank, World Development Indicators (n.d.). Life expectancy at birth, female (years) – Mozambique [SP.DYN.LE00.FE.IN]. https://data.worldbank.org/indicator/SP.DYN.LE00.FE.IN?locations=MZ

World Bank, World Development Indicators (n.d.). Life expectancy at birth, male (years) – Mozambique [SP.DYN.LE00.MA.IN]. https://data.worldbank.org/indicator/SP.DYN.LE00.MA.IN?locations=MZ

World Bank, World Development Indicators (n.d.). Life expectancy at birth, total (years) – Mozambique [SP.DYN.LE00.IN]. https://data.worldbank.org/indicator/SP.DYN.LE00.IN?locations=MZ

World Bank, World Development Indicators (n.d.). Mortality from NCDs, female (% probability between exact ages 30 and 70) – Mozambique [SH.DYN.NCOM.FE.ZS]. https://data.worldbank.org/indicator/SH.DYN.NCOM.FE.ZS?locations=MZ

World Bank, World Development Indicators (n.d.). Mortality from NCDs, male (% probability between exact ages 30 and 70) – Mozambique [SH.DYN.NCOM.MA.ZS]. https://data.worldbank.org/indicator/SH.DYN.NCOM.MA.ZS?locations=MZ

World Bank, World Development Indicators (n.d.). Rural population (% of total population) – Mozambique [SP.RUR.TOTL.ZS]. https://data.worldbank.org/indicator/SP.RUR.TOTL.ZS?locations=MZ