Ministero degli Affari Esteri
e della Cooperazione Internazionale

2026 | Summary of the Evaluation Report

Impact Evaluation of Projects in Mozambique

AID 11375, AID 11587/04/1, AID 11817/04/06, AID 012168/01/9, AID 12168/02/0



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LIST OF ACRONYMS

AICS	Italian Agency for Development Cooperation
AID	Italian Development Aid (project identification code)
AIFO	Italian Association of Friends of Raoul Follereau
APE	Agentes Polivalentes Elementares (Community Health Workers)
APS	Public Development Aid
CACUM	Cervical and Breast Cancer
CD4	CD4 T-cells (immune marker)
CIOB	Centro de Investigação Operacional da Beira (Beira Center for Operational Research)
COVID-19	Coronavirus Disease 2019 (COVID-19)
CUAMM	Doctors with Africa CUAMM (University College for Aspiring Medical Missionaries)
DGCS	Directorate General for Development Cooperation
DNT	Noncommunicable Diseases (Doenças Não Transmissíveis)
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
Global Fund	Global Fund to Fight AIDS, Tuberculosis, and Malaria
HIV	Human Immunodeficiency Virus (HIV)
KAP	Knowledge, Attitudes, and Practices
MISAU	Ministério da Saúde (Ministry of Health of Mozambique)
CSOs	Civil Society Organizations
SDGs	Sustainable Development Goals
PEN	Plano Estratégico Nacional de Resposta ao HIV e SIDA (National Strategic Plan for the Response to HIV and AIDS)
PESS	Strategic Plan for the Health Sector
GDP	Gross Domestic Product
PIP	Multi-Year Indicative Plan
PMTCT	Prevention of Mother-to-Child Transmission
PTV	Prevention of Vertical Transmission
RBM	Results-Based Management
GNI	Gross National Income

SAAJ	Serviços Amigos dos Adolescentes e Jovens (Adolescent and Youth-Friendly Services)
SDSMAS	District Health, Women's, and Social Action Services (Serviços Distritais de Saúde, Mulher e Acção Social)
AIDS	Acquired Immunodeficiency Syndrome (AIDS)
SNS	National Health Service (Serviço Nacional de Saúde)
SPS	Provincial Health Services
TARV	Antiretroviral Treatment (ART)
TB	Tuberculosis
UNISAVE	Save University (Maxixe – Inhambane)
USAID	United States Agency for International Development

1 Introduction

This Summary summarizes the Final Report of the independent evaluation of the following Italian Cooperation initiatives: “Prevention and Control of Noncommunicable Diseases” (AID 11375); “TILL THE END. Community Strategies to Combat Tuberculosis and HIV in Inhambane Province” (AID 11587/04/1); “Espaço Aberto. Strengthening Health Services for Adolescents and Young Women Living with HIV in Mozambique” (AID 11817/04/06); “PRoTeggiMI. Prevention of Mother-to-Child Transmission and Treatment of HIV and TB for Remote Communities” (AID 012168/01/9); “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).

The five initiatives were implemented in Mozambique between 2019 and 2024 in the provinces of Maputo, Sofala, Zambézia, and Inhambane. They addressed noncommunicable diseases (NCDs), HIV and tuberculosis (TB), prevention of mother-to-child transmission of HIV (PMTCT), and the health of adolescents and young people. The interventions strengthened health services and staff competencies, brought services closer to communities, and engaged community stakeholders. In some cases, they also developed operational research and scientific partnerships.

- **AID 11375 – Prevention and Control of NCDs (2019–2022)** is an initiative entrusted to CSOs, led by Doctors with Africa CUAMM, in partnership with AIFO and the Community of Sant’Egidio – ACAP. It has strengthened prevention and management of diabetes, hypertension, and cervical cancer in the provinces of Maputo, Sofala, and Zambézia.
- **AID 11587/04/1 - TILL THE END (2019–2021, Global Fund 2018 call)** was implemented by Medicus Mundi Italia. It developed community-based strategies to combat TB and HIV in four districts of Inhambane Province.
- **AID 11817/04/06 - Espaço Aberto (2020–2022, Global Fund 2019 call)** was implemented by the Community of Sant’Egidio – ACAP. It strengthened services for adolescents and young women living with HIV in the provinces of Maputo, Maputo City, Sofala, and Zambézia.
- **AID 012168/01/9 - PRoTeggiMI (2021–2023, Global Fund 2020 call)** was implemented by Medicus Mundi Italia. It expanded PMTCT and HIV and TB treatment to remote communities in the same districts of Inhambane.
- **AID 12168/02/0 – Conoscere per Curare (2021–2024, Global Fund 2020 call)** was implemented by the University of Padua. It combined research with service improvements for HIV-positive adolescents and young people in Beira (Sofala), in the context of the COVID-19 pandemic.

The overall objective of the evaluation is to provide an independent, rigorous, and evidence-based analysis of the initiatives’ contribution to strengthening the health response in Mozambique, including Italy’s contribution to the Global Fund’s objectives through the 5% mechanism. The evaluation pursues a dual objective of accountability and learning: on the one hand, it assesses the relevance, coherence, effectiveness, efficiency, sustainability, and impact of the interventions, with priority given to impact, sustainability, and effectiveness; on the other hand, it identifies lessons learned and recommendations for DGCS, AICS, Mozambican health institutions, and partners.

The **evaluation took place from June to October 2026**. In the first phase, the evaluation team reviewed the documentation related to the initiatives and prepared the Inception Report, which served as the reference for the entire evaluation process. From July 20 to August 8, 2026, the mission to Mozambique took place: the Evaluation Team interviewed institutional stakeholders, implementing partners, and beneficiaries; visited the intervention areas and health facilities; and collected qualitative data and evidence. Based on an integrated and triangulated analysis of this evidence, the team drafted the report, which was then shared with the DGCS, AICS, and other stakeholders. The evaluation team reviewed the comments received, while maintaining the independence of its evaluation judgment, and presented the preliminary results at a seminar held at

the DGCS, where it also gathered additional input. Taking the comments into account, the Evaluation Team finalized the Report and prepared the supporting materials: a summary, presentations, and photographic and methodological documentation. The on-site seminar, organized with the DGCS, AICS Rome, and AICS Maputo, presented the results and recommendations to Mozambican stakeholders to facilitate their adoption.

The evaluation adopted a theory-based, mixed-methods approach. The analysis assesses the plausibility of the links between activities, outcomes, and observed changes using the Theory of Change and *Contribution Analysis*, while integrating cross-cutting themes (human rights, gender, equity, *and "Leave No One Behind"*). Data collection combined the analysis of approximately 300 documents and monitoring data with a field mission to the provinces of Maputo, Sofala, and Inhambane, during which 28 semi-structured interviews (34 respondents), 46 focus groups (184 participants), and 19 direct observations were conducted, in consultation with AICS Rome and AICS Maputo, MISAU, DPS, and district authorities, CSOs, universities, health workers, activists, and beneficiaries. For Zambezia, the analysis was based on documentary sources and consultations with relevant stakeholders; the evidence was triangulated by method, source, and evaluator.

The results must be interpreted in light of certain limitations. The availability of up-to-date data following the conclusion of the projects is limited; qualitative sampling does not guarantee statistical representativeness; and the succession of interventions in the same territories does not allow for the isolation of the effects of individual initiatives. The evaluation judgment is therefore formulated in terms of contribution rather than causal attribution. Furthermore, the initiatives AID 11375—Prevention and Control of NCDs, AID 11587/04/1—TILL THE END, and AID 11817/04/06 - Espaço Aberto (approved between 2017 and 2020) used the Logical Framework but not the RBM approach introduced with the 2020 Global Fund call, which was applied by AID 012168/01/9 – PRoTeggiMI and AID 12168/02/0 – Conoscere per Curare through the Single Project Document (DUP) and a more structured, results-oriented management approach. The methodology was adapted, and assessments regarding monitoring and data disaggregation should be interpreted in light of the standards in effect at the time of formulation. The Theory of Change was used as the analytical framework for the evaluation, through the reconstruction of the pathways of change underlying the five initiatives, based on their respective project rationales and the evidence gathered.

2 Key Findings

2.1 Impact

The initiatives have contributed to significant and still observable changes, particularly at the individual, community, and institutional levels, while at the systemic level, signs of change are emerging, supported by more limited evidence.

At the individual and community levels, the most notable changes concern access to and continuity of care, prevention knowledge and practices, the relationship between communities and services, and psychosocial care for adolescents and young people. In the rural communities of Inhambane, the mobile brigades—in which AID 11587/04/1 - TILL THE END and AID 012168/01/9 -PRoTeggiMI have progressively integrated HIV, TB, and PMTCT services—continue to represent an essential channel of access for populations living farthest from health facilities: in 2022, the brigades of AID 012168/01/9 - PRoTeggiMI covered 104 communities in four districts, while AID 11587/04/1 - TILL THE END had decentralized TB diagnosis through three mobile GeneXpert Edge units. As part of AID 11817/04/06 - Espaço Aberto and AID 12168/02/0 - Conoscere per Curare, active case-finding of patients lost to follow-up made it possible to locate 958 out of 1,805 and reintegrate 520 into care, with a particularly marked improvement in treatment continuity in Sofala (from 35% to 43%) and in Zambézia (from 36% to 48%). For adolescents and young people living with HIV, AID 11817/04/06—"Espaço Aberto"—and AID 12168/02/0—"Conoscere per Curare"—promoted acceptance of their HIV status, treatment adherence, and the ability to cope with stigma and psychosocial distress; for young women, care management included pathways to socioeconomic autonomy.

For adolescents and young people, the changes observed go beyond the clinical dimension. As part of AID 11817/04/06 – Espaço Aberto, care management combined clinical care, individual counseling, support groups established in the seven participating centers, and the work of 58 young people trained as health educators, providing spaces and support figures to help address acceptance of serostatus, stigma, and relationship difficulties. For HIV-positive girls and young women, in response to gender-based barriers that could limit their access to services, 93 girls benefited from vocational training courses and 125 completed tailoring courses; 79 continued to use the workshops even after the courses ended. Knowledge, practices, and relationships with services endure longer than the mechanisms that support them (community support, follow-up, and proximity), which are more vulnerable to reductions in staff and resources.

At the institutional level, evidence points to the strengthening of the technical and operational capacities of health care personnel and community actors, the consolidation of collaboration among services, communities, and partners, and an increased capacity to generate and utilize data. Skills were consolidated particularly when training was combined with on-the-job practice, access to equipment, and knowledge transfer among colleagues, as in the case of CACUM diagnostic and therapeutic capabilities in Sofala (AID 11375—Prevention and Control of NCDs) or CD4 counts conducted directly in communities in Inhambane. As part of AID 11375—Prevention and Control of NCDs—the implementing agencies collaborated with MISAU to establish the first national Technical Working Group on diabetes and hypertension. Partnerships between Medicus Mundi and the University of Brescia, and between the University of Padua and CIOB, further linked operational research, data analysis, and service strengthening.

The sustainability of institutional changes is most evident when expertise, tools, and operational methods have been integrated into the routine functioning of services. At the provincial level, for example, supervision and on-the-job training within the CACUM framework have been integrated into the supervision of the DPS and coordinated by provincial focal points; in Inhambane, mobile brigades continue to engage district health services and community actors, maintaining the integration of HIV, TB, and PMTCT components. Activities requiring recurring resources, incentives for activists, transportation, or materials, on the other hand, exhibit greater vulnerabilities.

At the systemic level, the evidence does not allow for the identification of fully consolidated transformations, but it does show three signs of change: greater institutional attention to NCDs in a system traditionally focused on communicable diseases; the gradual consolidation of community-based models in remote areas; and a growing focus on tailoring the health response for adolescents and young people, including psychosocial dimensions and gender-based barriers.

The extent to which these changes can be attributed to specific initiatives varies depending on the level at which they occur. The link is stronger when it is possible to trace a coherent sequence between the resources introduced, changes in service delivery, and the observed changes: this is the case with community-based TB diagnosis in Inhambane, which eliminated the need to transport samples and reduced the risk of losing patients, or the combination of training, equipment, and referral pathways supported by AID 11375 — Prevention and Control of Non-Communicable Diseases (NCDs) in facilities in Maputo and Sofala. Moving toward institutional and systemic effects, however, the contribution becomes cumulative: the mobile brigades in Inhambane, for example, predate the evaluated initiatives and reflect the experience accumulated over multiple intervention cycles and the continuity of the partner's presence. Furthermore, the limited disaggregation of health data at the district and provincial levels does not allow for a systematic distinction between the results of the initiatives and the overall results of the services.

Unexpected effects are limited and predominantly positive. The safe spaces created for adolescents have, in some cases, brought situations of violence or abuse to light; some young beneficiaries have become mentors to other young people; and community activists have applied the knowledge they gained to their own daily lives. No unexpected negative effects have emerged, but there is a potential tension between the demand for services generated by awareness-raising and the capacity of facilities to meet that demand with adequate equipment, diagnostic materials, and medications.

2.2 Sustainability

The outlook for sustainability is generally positive but varies. Sustainability appears more robust for the skills, practices, and operational methods that are integrated into public health services and supported by institutional and community buy-in; it is more fragile for components that depend on recurring resources (staff, transportation, fuel, maintenance, supplies, incentives, and *outreach* activities), which do not appear to be fully integrated into standard funding mechanisms. A distinction must be made between **ownership**—which the evidence indicates is high—and **financial sustainability**, which depends largely on systemic factors: more than half of current health care spending is externally funded (57.7% in 2023), while the government's own resources allocated to health care amount to 2.3% of GDP. By 2025, the situation had become more constrained (cessation of USAID activities, non-renewal of support from Flanders, reduction of British ODA from 0.5% to 0.3% of GNI, and lower allocations from the Global Fund). Some aspects of sustainability therefore depend on factors that a single project—or Italian Cooperation alone—can influence only to a limited extent.

The capacities developed have largely been institutionalized, as capacity-building took place within the public health system and with the direct participation of government institutions. At the facilities visited in Maputo and Sofala, the capabilities for screening and managing NCDs and for cancer prevention were still being utilized; in Inhambane, AID 012168/01/9—PRoTeggiMI—built upon the capabilities developed by AID 11587/04/1—TILL THE END. For services targeting adolescents and young people, however, a distinction must be made between the retention of skills—which remain with the staff and mentors—and the continuity of activities, which are sometimes continued on a reduced scale or thanks to new funding. Staff turnover and the recurring need for new training indicate that sustainability depends on the presence of ongoing mechanisms for professional development, supervision, and skills transfer.

Innovations have good potential for sustainability and replicability when they can be adapted to available resources. The experience of "Cantinho"—a space dedicated to screening and follow-

up for non-communicable diseases (NCDs) that was subsequently reconfigured by the institution—shows that sustainability depends on preserving the service's function rather than replicating the structure funded by the project. The mobile brigades in Inhambane address a structural need, are highly valued by communities, and have evolved through successive interventions, but their operations remain dependent on vehicles, fuel, maintenance, staff, and medications.

Ownership is stronger in the strategic-institutional and operational dimensions than in the financial one. At the provincial, district, and health facility levels, the practices introduced have been recognized and integrated into service operations; at the national level, alignment with MISAU does not yet equate to full institutionalization of the models. Community ownership is high and is evident in the recognition of the services and in the communities' ability to demand their continuity. The expected outcome at the community level is not so much the continued involvement of activists (in Moamba, for example, of the 12 initially identified, 2 were still active) as an informed community with greater trust in the National Health System (SNS) and a willingness to use the services; ownership therefore depends primarily on the staff of the Health Centers, under the responsibility of MISAU. The new law on the National Health System (2026), which institutionalized the community component, moves in this direction. The continuation of an activity thanks to the same partner or new external funding does not, therefore, equate to its full autonomous sustainability.

Qualitative evidence points to positive changes, particularly in knowledge and, to a more limited extent, in attitudes and health practices. In the localities covered by Project AID 11375—Prevention and Control of Non-Communicable Diseases (NCDs)—there is greater awareness of hypertension, diabetes, and cancer prevention, as well as reported changes in diet, alcohol consumption, and participation in screening; among young people, peer support has fostered trust in health services. However, in the absence of standardized KAP surveys, it is not possible to quantify the extent or durability of these changes.

2.3 Effectiveness

The initiatives demonstrate an overall positive level of effectiveness, with numerous targets met or exceeded, although differences exist among interventions, outcomes, and target groups. The ability to adapt delivery methods to different contexts—through community-based services, community actors, and tailored approaches for adolescents and young people—was a key factor. The varying degrees to which results can be verified also reflect the fact that only the initiatives developed under the 2020 Global Fund call adopt the RBM approach.

- **AID 11817/04/06 – Espaço Aberto:** at the end of the intervention, 2,728 adolescents were on antiretroviral treatment (target: 2,250), and 93% had undergone at least one annual viral load test (target: 80%); in the seven dedicated centers, median retention increased from 94.2% to 99.0%.
- **AID 12168/02/0 – Conoscere per Curare:** values exceeded targets for nearly all indicators; the two indicators that were not met primarily reflect changes in the context and measurement systems, such as the adoption of the new national mental health screening protocol.
- **AID 11587/04/1 – TILL THE END:** In the second year, over 18,134 people were screened for TB, 95 received a diagnosis, and 12,715 HIV tests were conducted, despite disruptions caused by the pandemic.
- **AID 012168/01/9 – PRoTeggiMI:** 206,476 direct beneficiaries; 489 HIV-positive pregnant or breastfeeding women and exposed children reached (target: 400); 6,657 visits to HIV-positive patients (target: 3,000); and TB screening for 96.8% of HIV-positive individuals on treatment. The number of HIV-positive patients reached was lower than estimated, partly due to the expansion of ART services in health centers.
- **AID 11375 - Prevention and Control of Non-Communicable Diseases (NCDs):** 14 health facilities equipped (target: 14); 413 health workers trained (154% of the target); 58,902 diabetes screenings (140%), 563,581 blood pressure measurements (120%), and 103,062 women screened for cervical cancer (98%), with 4,283 treatments involving cryotherapy or

thermo r thermocoagulation; 724,097 people reached and 353 activists trained, compared to the planned 174; decentralization to Sofala of DNT and CACUM services previously provided at other levels; the increase in screening did not always result in new diagnoses due to the limited response capacity of the services.

Capacity building yielded the most noticeable results when training was combined with supervision, tools, and practical application: in the third year of AID 11375 alone, 271 internal supervision visits were conducted, in addition to those carried out jointly with the DPS.

The achievement of these results was facilitated by integration into the public system, the combination of proximity and community-based approaches, and the sustained presence of implementing organizations, such as Medicus Mundi in Inhambane, DREAM/ACAP in services for adolescents and young people, and CUAMM and its partners for DNTs. External factors acted, depending on the context, as either enabling or limiting conditions:

- **Organizational and health system factors:** staff shortages, high turnover, and heavy workloads, as well as the intermittent availability of equipment, medications, supplies, vehicles, and fuel, limited the application of expertise and the regularity of community-based services.
- **Institutional:** Support from authorities and continuity in key contacts facilitated implementation; however, the time required for authorization and ethics procedures weighed heavily on short-term projects, such as AID 012168/01/9 – PRoTeggiMI (24 months), where they contributed to the failure to complete the planned scientific publication.
- **Geographical and infrastructure-related:** Distances, isolation, and transportation costs were the main barriers for rural populations; mobile teams reduced these barriers without eliminating their root causes.
- **Social and gender-related:** Poverty, stigma, and gender norms affected access to and continuity of care; some young women, for example, faced restrictions imposed by their partners on their participation in activities.
- **Contextual:** The COVID-19 pandemic was the main external shock, leading to interruptions in outreach activities and adjustments to services; climate events amplified pre-existing vulnerabilities: Cyclone Idai (March 2019) damaged the five health units of AID 11375—Prevention and Control of NCDs in Sofala; a cyclone in Sabie (June 2021) damaged the maternity ward at the Health Center, reducing CACUM screening; Storm Ana and Cyclone Gombe (2022) made travel to facilities and communities difficult, and Cyclone Freddy (February–March 2023) temporarily suspended the PRoTeggiMI brigades in Funhalouro and Massinga. Their overall effect on the results, however, cannot be quantified.

The perceptions of beneficiaries, healthcare workers, and institutions are consistent and generally positive. Communities particularly value the proximity and continuity of services; adolescents, the willingness to listen and psychosocial support; healthcare staff, the skills and tools acquired; and institutions, the integration into public services. A common limitation concerns the inconsistent availability of data disaggregated by sex: in AID 11375—Prevention and Control of NCDs, for example, women accounted for 71% of those diagnosed, but 12-month retention was 35% among women and 47% among men, with the data not allowing for the identification of the causes.

2.4 Coherence

The five initiatives demonstrate a high degree of strategic coherence with the priorities of the Mozambican health sector, with the guidelines of Italian Cooperation, and with the 2030 Agenda. Coherence was assessed against the documents in effect at the time of formulation: the interventions are aligned with the 2014–2019 National Health System Strategy (PESS), the 2015–2019 National HIV/AIDS Plan IV (PEN IV), the 2020–2024 Plan for the Elimination of Vertical Transmission, the SAAJ approach for adolescents and young people, and, for AID 11375 -

Prevention and Control of Non-Communicable Diseases (NCDs)—the 2017–2025 Multisectoral Strategic Plan for NCDs ( ), referenced in the proposal; the focus on NCDs was further strengthened by the subsequent 2020–2029 Plan. These guidelines were confirmed by the subsequent Mozambican PIP 2022–2026, which identifies health as a priority sector. The initiatives are also consistent with SDG 3 (specifically targets 3.1, 3.3, 3.4, and 3.7), with links to SDGs 5 and 10. For the four initiatives funded through the 5% mechanism, there is clear alignment with the Global Fund's 2017–2022 Strategy "Investing to End Epidemics": access to essential services, reduction of vertical transmission, TB/HIV integration, focus on adolescents and young women, and strengthening of health systems.

The initiatives demonstrate good thematic, geographical, and temporal complementarity, which, however, stems more from the continuity of the target areas, partners, and institutional relationships than from coordinated planning of the five initiatives as a portfolio. This complementarity was also facilitated by the AICS calls for proposals for the Global Fund 5% mechanism, which required applicants to describe their prior experience in the sector and in the target areas. In Inhambane, AID 012168/01/9 – PRoTeggiMI built upon the components developed by AID 11587/04/1 – TILL THE END, integrating PMTCT into the community-based model; in Sofala, AID 11375 — Prevention and Control of NCDs, AID 11817/04/06 – Espaço Aberto, and AID 12168/02/0 – Conoscere per Curare addressed complementary aspects of the same provincial health system, but without joint activities or systematic mechanisms for exchange.

Consistency is also evident at the operational level: AID 11587/04/1 – TILL THE END and AID 012168/01/9 – PRoTeggiMI operate within the framework of the national HIV/TB and PTV programs, AID 11817/04/06 – Espaço Aberto in accordance with MISAU protocols in seven facilities, AID 12168/02/0 – Conoscere per Curare through the SAAJ; AID 012168/01/9 – PRoTeggiMI and AID 11817/04/06 – Espaço Aberto have also maintained coordination with the Principal Recipients and the Global Fund's Country Coordinating Mechanism.

Concrete synergies with other actors were identified, particularly in Inhambane. The GeneXpert Edge devices used by the mobile brigades were employed to analyze samples collected by activists from the Centro de Colaboração em Saúde, while the experience of the TARV Móvel led EGPAF to pilot mobile treatment visits in the Massinga district. MISAU, DPS, and SDSMAS served as the primary liaison between interventions and funders. However, these synergies are more consistently documented in certain areas, and no cross-cutting mechanism emerges through which the five initiatives were systematically linked to share results, tools, and lessons learned.

No significant overlaps emerged among the evaluated initiatives or with other interventions. Integration into public services and institutional coordination mechanisms helped reduce this risk, although in the absence of a comprehensive mapping, it is not possible to rule out such overlaps entirely.

2.5 Efficiency

The initiatives demonstrate generally positive levels of efficiency: resources were generally translated into activities and outcomes consistent with the objectives, including through adaptations necessitated by the context. Integration into public structures and programs made it possible to leverage existing staff, expertise, and care pathways, thereby limiting the creation of parallel systems; project resources were used primarily to address specific gaps through training, equipment, technical assistance, mobility, and community-based activities.

The operational models proved suitable for the beneficiary groups and the constraints of the healthcare system, but they present a trade-off between accessibility and efficiency. The combination of mobile teams, healthcare facilities, and community actors proved particularly effective in remote areas; community-based services entail high and recurring logistical costs, which must, however, be viewed in light of their ability to reach populations that would have had substantially less access if served solely by fixed facilities.

In rural and remote areas, a significant portion of resources was necessarily allocated to transportation and logistics. These are high, variable, and difficult-to-forecast operational costs; evidence indicates the need to define more clearly—already during the planning phase—who is responsible for recurring costs when vehicles and services are used jointly by partners and health authorities. In the AID 11375 project—Prevention and Control of Non-Communicable Diseases—difficulties were also reported in ensuring that suspected cases identified by the brigades were referred to health units.

From an organizational standpoint, implementation was facilitated by the presence of implementing agencies with in-depth knowledge of the local areas and established relationships with MISAU, DPS, SDSMAS, and health units, which helped launch and adapt the activities. Collaboration with universities and research centers brought together complementary expertise but also increased managerial complexity.

Efficiency was affected by delays and external constraints, including the pandemic, the time required for administrative and ethical procedures, the availability of personnel, resources, and supplies, and the greater managerial complexity of initiatives involving research components. For the initiatives under the 2020 call, certified financial reports document the expenses incurred; however, the diversity of reporting formats between pre- and post-RBM initiatives does not allow for a comparative assessment of cost-efficiency among the five initiatives.

2.6 Relevance

The initiatives demonstrate a high degree of relevance to the health needs of the regions and the vulnerabilities of the target groups: people living with HIV and TB, women and mothers, adolescents and young people, rural and remote populations, and people with non-communicable diseases (NCDs). In Inhambane, AID 11587/04/1—TILL THE END and AID 012168/01/9 – PRoTeggiMI addressed barriers related to distance and transportation, as well as the needs of HIV-positive pregnant and breastfeeding women. AID 11817/04/06 – Espaço Aberto and AID 12168/02/0 – Conoscere per Curare recognized that for young people living with HIV, needs extend beyond access to treatment and include issues such as stigma, confidentiality, mental health, and trust in services. AID 11375 – Prevention and Control of Non-Communicable Diseases identified a growing need within a system traditionally focused on communicable diseases.

The relevance of these initiatives to vulnerable groups was put to the test by the COVID-19 pandemic, in the face of which the initiatives adapted their activities and operating procedures to ensure continuity of care; in the case of AID 12168/02/0 – Conoscere per Curare, addressing the pandemic's effects on HIV-positive adolescents and young people—including their mental health—was at the very heart of the intervention. However, there remain needs that individual initiatives could not fully address: the communities consulted highlighted issues related to transportation, infrastructure, water, electricity, and connectivity, which underscore the structural nature of certain determinants of access—whose resolution depends primarily on the country's response—and the need to embed health projects within broader institutional frameworks.

The initiatives gave significant consideration to the main barriers to effective access, albeit to varying degrees of depth. Particular attention was paid to geographical, economic, age-related, gender-related, and stigma-related barriers; evidence regarding disability, the systematic analysis of underserved groups, and the integration of climate risks into project design was more limited. During the planning phase, local needs were represented primarily by implementing agencies and health authorities; the direct involvement of beneficiaries was more evident during the implementation and adaptation of activities, through activists, parent-teacher associations (PTAs), mentors, and support groups.

Overall, the strategies adopted appear appropriate for the socioeconomic context, as they take into account poverty, geographical dispersion, and the limited resources of the healthcare system. Although a capacity to adapt to shocks and extreme events has emerged, there is no documented evidence of systematic integration of climate risk into the design phase.

3 Theory of Change

The evaluation confirms the plausibility of the theory of change outlined in the Inception Report, clarifying its nonlinear, conditional, and cumulative nature. The long-term impact remains relevant as a direction for change: 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. The evidence does not allow for verification of its achievement nor for estimating the initiatives' contribution to reducing morbidity and mortality, but it does identify plausible contributions in the expected direction.

The two intermediate stages are essentially confirmed, albeit with varying degrees of consolidation. The first—strengthened local and community-based services—is reflected in community-based services, the integration of facilities, mobile teams, and community actors, the differentiated care for adolescents and young people, and the strengthening of screening for non-communicable diseases (NCDs); it yields more robust results when the entire referral, diagnosis, treatment, and follow-up chain functions effectively. The second—institutions with greater technical and organizational capacities—is reflected in the strengthening of expertise and collaboration between institutions and partners, but is hampered by staff shortages and high turnover.

The four pathways to change are effective under specific conditions.

- **Capacity building:** training yields results when followed by practical application, supervision, and the availability of equipment.
- **Access through decentralized and community-based models:** This is the pathway with the clearest evidence of success, but the results are sustainable only if the system supports community-based activities and the responsiveness of service facilities.
- **Integrated and differentiated services:** particularly evident in interventions for adolescents, young people, and women; attention to multiple vulnerabilities and disability is less systematic.
- **Generation and use of evidence:** The initiatives have generated knowledge and partnerships, but the transition to using this evidence in decision-making is less straightforward.

Among the assumptions, the continuity of institutional commitment and coordination with health authorities have been confirmed, while the availability of permanent staff and adequate operating conditions has been only partially verified. The evaluation also highlighted an enabling factor that was less explicit in the preliminary formulation: continuity over time. The final Theory of Change can be summarized as follows: the coordinated strengthening of the health system's capacity, service accessibility and quality, community engagement, and the use of evidence contributes to improving the response to the needs of vulnerable populations when supported by institutional and operational continuity, the availability of resources, and the ability to adapt to the Mozambican context.

4 Conclusions

The evaluation provides an overall positive assessment of the contribution of Italian Cooperation to the health sector in Mozambique. Despite the diversity of sectors, regions, and beneficiary groups, the five initiatives share a **common approach 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 cases, **generating knowledge through operational research**. With regard to the individual evaluation criteria, the following emerges:

- **Impact:** changes at the individual, community, and institutional levels, along with signs of a broader influence on the health care system—particularly regarding access for remote populations, the skills of health care providers, services for adolescents and young people, and attention to non-communicable diseases (NCDs); the contribution is predominantly cumulative.
- **Sustainability:** more robust in terms of capacity, relationships, and practices integrated into services; more fragile for components involving recurring costs. The ability of institutions to adapt essential functions to available resources is itself a dimension of sustainability.
- **Effectiveness:** positive assessment, with mixed results; greater where interventions have combined integration into the public system, proximity, a community-based component, and continuity of relationships.
- **Coherence:** high in relation to national priorities, Italian Cooperation, the Global Fund, and the 2030 Agenda; good complementarity among initiatives, though they are not managed as a unified portfolio.
- **Efficiency:** positive due to the adequacy of operational models and the use of existing capacities; the higher costs associated with proximity should be viewed in light of the ability to reach remote populations.
- **Relevance:** high, thanks to the translation of diverse needs and vulnerabilities into services adapted to concrete barriers to access; room for improvement regarding participation in planning, multiple vulnerabilities, and climate risks.

Recurring vulnerabilities persist: staff shortages and high turnover, intermittent availability of equipment and supplies, logistical costs associated with serving remote areas, and dependence on external funding. In terms of cross-cutting issues, attention to equity and gender barriers is particularly evident in interventions targeting women, youth, and remote populations; however, the ability to identify those who remain underserved and to document disaggregated results remains inconsistent. Taken as a whole, the initiatives show that the contribution of Italian Cooperation is most valuable when it supports the public system over time, combines institutional strengthening with community engagement, and fosters ongoing relationships between institutions, implementing agencies, communities, and scientific partners. Continuity thus emerges as the key factor linking effectiveness, impact, and sustainability, while the opportunities offered by a portfolio approach remain only partially harnessed.

5 Recommendations

The recommendations are derived from the evidence and conclusions of the evaluation and are organized by level and target audience.

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

Level: Strategic – **Target Audience**: DGCS/AICS

Strengthen the strategic planning of the Italian Cooperation health portfolio in Mozambique by leveraging the complementarities among initiatives and systematically using evidence and lessons learned to identify experiences, capacities, and models to be consolidated, developed, or adapted to national and subnational health priorities. Schedule periodic sessions to analyze and capitalize on the health portfolio, involving AICS Maputo, implementing agencies, and MISAU, to share results and lessons learned, identify synergies and gaps, and guide future planning, prioritizing the strengthening of capacities and mechanisms already integrated into the public health system.

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 – **Target audience**: DGCS/AICS

Establish project durations and funding allocations appropriate to the objectives, geographic scope, and time required to consolidate capacities, service models, and changes in practices. The extension to 36 months introduced by the 2024 Global Fund call for proposals represents a positive development; its suitability for the various types of interventions should be assessed. Additionally, consider administrative and institutional timelines, including those for ethical approvals in operational research, while maintaining the option of shorter durations for limited interventions or those integrated into ongoing programmatic initiatives.

R3. Strengthen shared planning for sustainability and exit strategies, progressively assessing their feasibility

Level: Strategic-programmatic – **Target audience**: DGCS/AICS and implementing agencies, in coordination with MISAU and provincial and district health institutions

Strengthen, from the very outset of formulation, the shared definition of sustainability and exit strategies with the relevant health institutions, identifying essential functions to be preserved, responsibilities, necessary capacities, recurring costs, and risk factors. Establish realistic and phased approaches for transferring or consolidating functions, taking into account the resources and capacities of the healthcare system. Periodically reassess the feasibility of the strategy during implementation—especially in the final year—to identify critical issues and make any necessary adjustments, recognizing the role of institutional decisions and commitments in long-term sustainability.

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

Level: Institutional – national – **Target audience**: MISAU (support: AICS, implementing agencies, DPS/SPS, academic and research institutions)

Promote the systematic use of evidence generated by projects to identify effective practices and models to be consolidated, adapted, or integrated into the public health care system. Assess their adaptability to different local contexts, taking into account needs, institutional capacities, and available resources, and define sustainable methods for implementation and monitoring, without automatically replicating project models. AICS could facilitate dialogue with MISAU and provide technical support—including through the involvement of experts—to support the potential institutionalization of the most promising practices.

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

Level: Institutional—provincial, district, and operational—**Target Audience**: MISAU, DPS/SPS, and SDSMAS (support: AICS and implementing agencies)

Consolidate integrated community-based models that combine decentralized health services with community actors, adapting their organization and frequency to local needs and available resources. Gradually integrate APEs, ACSs, and other community workers into planning and care pathways, strengthening their training, supervision, and referral and follow-up functions. Ensure coordination between community-based activities and the capacity of referral healthcare facilities through shared planning at the provincial and district levels. AICS could provide technical support to health authorities to consolidate sustainable organizational models and strengthen the link between communities and public services.

R6. Promote the continuous development of capacities through training, practical application, and supervision

Level: Institutional – Operational – **Target Audience**: MISAU, DPS/SPS, and SDSMAS (support: AICS and implementing agencies)

Integrate project-supported training activities into the regular mechanisms of the health care system, ensuring practical application (by guaranteeing the availability of equipment, tools, and materials appropriate to the skills acquired), periodic supervision, refresher training, and the transfer of skills within facilities.

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

Level: Programmatic – Institutional – **Target Audience**: MISAU and AICS (in collaboration with DPS/SPS, SDSMAS, implementing agencies, and community stakeholders)

Systematically integrate a differentiated analysis of barriers to effective access into the design of interventions, and prioritize the functions that have yielded the greatest value: dedicated intake services, psychosocial support, peer support, and assistance with treatment continuity, with specific attention to girls and young women, as well as the most vulnerable groups.

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

Level: Strategic-programmatic – **Target audiences**: MISAU and AICS (support: Mozambican and Italian universities and research institutions, implementing agencies)

Consolidate the operational research and data management components already included in Global Fund projects, promoting medium- to long-term partnerships that strengthen national capacities for generating and utilizing evidence. Examples include the collaboration between the University of Padua and CIOB and that between the University of Brescia and UniSave. The latter, which developed after the project's conclusion, demonstrates the potential for continuity in scientific collaborations and represents a replicable best practice. Operational research should document the effectiveness of the solutions tested and the conditions for their adaptation or scaling up, taking into account the timeframes inherent in research, including ethical approvals.

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

Level: Programmatic – Operational – **Target Audience**: AICS and implementing agencies (including MISAU, DPS/SPS, and SDSMAS)

Strengthen, from the planning stage onward, risk analysis and the planning of mitigation measures and operational continuity, incorporating realistic buffers into timelines and alternative implementation methods. Pay particular attention to institutional delays and delays in obtaining

ethical approvals, as well as c r climate- and environment-related risks. Periodically update the risk analysis in collaboration with healthcare institutions, using evidence from monitoring and operational research to adapt interventions in a timely manner. AICS could support this process by leveraging the flexibility and adjustment tools already provided for in its procedures.

6 Lessons Learned and Best Practices

The lessons learned stem from a cross-cutting analysis of the five initiatives and the triangulation of documentary and field-collected evidence, with the aim of identifying the factors that promote the effectiveness, ownership, and sustainability of interventions, thereby providing guidance for future Italian Cooperation initiatives in the health sector.

LA1. The continuity of presence and institutional relationships allows for the achievement of cumulative results that are difficult to produce through isolated interventions. A new intervention generates greater value when it recognizes and utilizes previously established capacities, relationships, and solutions; some short-term interventions have yielded significant results precisely because they were part of longer-term collaboration trajectories. Continuity does not imply repeated funding of the same project, but rather the ability to build upon processes already underway.

LA2. Integration into the public health system promotes the adoption of models but does not automatically guarantee financial sustainability. A practice may be fully recognized by institutions yet remain vulnerable if it requires recurring costs, personnel, maintenance, or logistical support that are not available after the project ends. Institutional integration is therefore a necessary but not sufficient condition for sustainability.

LA3. For adolescents and young people, proximity to services is also relational. Active listening, trust, confidentiality, psychosocial support, and peer support are essential components of true accessibility for this group. Proximity must therefore also be understood as the service's ability to adapt relationships, spaces, and care delivery methods to the needs of young people, integrating clinical care, psychosocial support, and peer relationships.

LA4. Sustainability depends on the ability to preserve and adapt essential functions, not on the exact replication of project models. An operational approach may not be sustainable, while the function it serves can continue through different organizational solutions: bringing a service closer to the community, ensuring follow-up, improving screening, or providing an appropriate welcoming environment for young people. Sustainability must therefore be evaluated in terms of the ability to preserve over time the functions that have generated value.

LA5. Community actors are an integral part of the care pathway, not merely a tool for raising awareness. In addition to raising awareness, they connect communities and health services, contributing to the identification of needs and barriers to access, as well as to the referral, accompaniment, and follow-up of service users. Their effective integration into the health system, however, requires clearly defined roles, an operational link with facilities, and ongoing training, supervision, and support.

LA6. Training produces more lasting effects when accompanied by practical application, supervision, and the transfer of skills. Capacity building should be understood as a process, influenced in part by staff turnover and the availability of equipment and materials. When trained staff remain in the healthcare system, their mobility can also facilitate the circulation of skills.

LA7. Research and the production of up-to-date data generate the data management system and the evidence base necessary for informed decision-making. Research yields greater value when it is linked to implementation, addresses shared knowledge priorities, and strengthens national capacities. The knowledge generated through a project can itself constitute a lasting outcome of the intervention.

LA8. The direct involvement of beneficiaries can transform vulnerable groups from recipients of interventions into protagonists and agents of change. When there are genuine opportunities for participation, people initially considered beneficiaries can take on new roles and become representatives for their communities and services. Beneficiary participation is therefore not merely a tool for improving the relevance of interventions but can itself become a process of empowerment.