EVALUATION OF

DECENTRALISATION THROUGH MENTORSHIP

MSF BEIRA HIV PROJECT, MOZAMBIQUE

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ACRONYMS

AHD	Advanced HIV Disease
AIDS	Acquired Immunodeficiency
ART	Antiretroviral Therapy
CBO	Community-Based Organisation
DPS	Direcção Provincial de Saúde = Provincial Directorate of Health
FGDs	Focus Group Discussion
FSW	Female Sex Worker
GBV	Gender-Based Violence
HC	Healthcare Centre
HIV	Human Immunodeficiency Virus
KIIs	Key Informant Interviews
KP	KP(s): sex workers, MSM, people who use drugs, transgender people
MoH	Ministry of Health
MSM	Men who have Sex with Men
OIs	Opportunistic Infections
PAC	Post-Abortion Care
PEP	Post-exposure Prophylaxis
PLWHA	People Living With HIV/AIDS
PMTCT	Prevention of Mother-to-child Transmission
PrEP	Pre-exposure Prophylaxis
PWUD	People Who Use Drugs
SAC	Safe Abortion Care
SGBV	Sexual & Gender-based Violence
SOP	Standard Operating Procedures
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
WBL	Workplace-Based Learning

EXECUTIVE SUMMARY

CONTEXT

In Sub-Saharan Africa, Mozambique has the second-highest rate of HIV/AIDS prevalence; as of 2022, 11.6% of adults (ages 15–49) were infected. In the country, HIV continues to be the primary cause of morbidity and mortality. Although patient care has improved with the advent of CD4 testing in 2003 and the Test-and-Treat strategy in 2016, 25% of patients starting antiretroviral therapy (ART) in 2022 were diagnosed with advanced HIV disease (AHD). HIV prevalence rates are much higher in key population groups, such as female sex workers and men who have sex with men and transgender women. Access to vital healthcare treatments is nevertheless hampered by stigma and discrimination, even in Sofala province, where Médecins Sans Frontières (MSF) has been working since 2014. The MSF Beira HIV project aims to reduce HIV-related morbidity and mortality by enhancing access to integrated services of HIV/TB, sexual and reproductive health (SRH), and for Key Populations and other marginalised/stigmatised groups as well as the general population.

While basic HIV and SRH services were available in health centres (HCs), the quality and person-centred care was only available in a centralised model of care. To improve access to quality healthcare, MSF initiated the decentralisation through mentorship at the primary healthcare level in support of AHD, SRH, and KPs services at health centres in Beira. This decentralisation that involved the mentorship component as the core intervention, included also a logistic support comprising support to the laboratory.

The mentorship component of HIV decentralisation focused on several key objectives:

1. **Enhancing AHD treatment:** Ensuring timely diagnosis and management of advanced HIV disease at primary healthcare centres, reducing the need for patients to travel long distances to specialised facilities.
2. **Improving the quality of comprehensive SRH services:** This included safe abortion care, contraceptive services/, prevention and treatment of STIs and access to SGBV services and support for patients experiencing sexual and gender-based violence (SGBV), which are crucial for improving overall community health outcomes.
3. **Improving KP-friendly services:** By creating an environment that is welcoming and supportive of KP—such as sex workers, MSM, people who use drugs, and transgender people—the project aimed to reduce stigma and improve access to HIV/TB prevention, testing, and treatment services.

This evaluation of the mentorship component of HIV/TB and SRH services decentralisation at the primary healthcare facilities within the Beira HIV project provides critical insights into its relevance, coherence, effectiveness, impact, and replicability. Launched to strengthen healthcare delivery for marginalised populations in Beira, Mozambique, the mentorship component of the decentralisation focused on capacity building to improve HIV/TB care and SRH services, while simultaneously addressing barriers to healthcare access— particularly for key populations (KPs) such as sex workers,

men who have sex with men (MSM), transgender and gender non-conforming people, and individuals living with HIV.

METHODS

The evaluation of the decentralisation through mentorship utilised a mixed-method to gain a comprehensive understanding of the mentorship component. A case study methodology facilitated in-depth exploration of the mentorship implementation, while data were collected through online interviews, in-person interviews, focus group discussions, structured observations, and secondary data analysis. This rigorous framework combined qualitative insights with quantitative metrics, allowing for a nuanced assessment of the mentorship impact on HIV/TB healthcare and SRH services delivery. Ethical considerations ensured participant confidentiality and sensitivity, enhancing the reliability of the findings and offering actionable recommendations for future interventions.

The evaluation faced limitations, such as a restricted sample size and variability in data quality across facilities. Additionally, the focus on short-term outcomes made it difficult to assess the long-term impact of the mentorship component of AHD decentralisation, necessitating a more extended evaluation period to capture sustained effects.

KEY FINDINGS

1. ***Relevance***

   The mentorship component of AHD decentralisation, SRH, and KPs friendly services seems relevant and aligned with Mozambique's healthcare needs, especially given the country's high HIV prevalence and the healthcare challenges faced by vulnerable populations in accessing AHD and SRH services, including contraceptive care and SAC. Child rape cases in Beira were also raised as a concern as well as a need of support to health workers managing highly sensitive and stressful cases, such as GBV and rape. The mentorship component was tailored to the local context and showed promise in addressing some of the gaps in healthcare service delivery. Post-mentorship, healthcare workers demonstrated improvements in practices such as requesting CD4 tests and facilitating early diagnosis of opportunistic infections. However, persistent societal stigma and discrimination surrounding HIV and KPs remain considerable barriers to care, highlighting the ongoing need for advocacy and community education.

2. ***Coherence***

   The mentorship component of AHD decentralisation is generally aligned with Mozambique's national healthcare policies, particularly in supporting decentralisation efforts and improving access to HIV care. The mentorship component contributed to broader public health objectives and facilitated collaboration between MSF and local health authorities. However, there were challenges in maintaining consistent stakeholder commitment, and competing priorities within the health system made it difficult to fully integrate the mentorship component into long-term health system planning.

3. ***Effectiveness***

   In settings where the mentorship component for AHD/HIV, SRH, and KP-friendly services decentralisation was effectively sustained, there was an observable enhancement in

healthcare workers' skills, knowledge, and confidence in delivering HIV care and SRH services. The structured, phased approach significantly contributed to capacity building among health workers. However, in some healthcare clinics, challenges such as limited staffing, high turnover, and insufficient medical supplies and equipment have hindered the full implementation of training into practice. Addressing these resource gaps will be crucial for maximising the overall impact of the mentorship component in AHD, SRH, and KPs services decentralisation.

4. ***Impact***

   The mentorship component of AHD decentralisation had a positive influence on healthcare delivery, with some improvements in patient referrals, community engagement, and perceptions around HIV care. KPs appeared to experience better acceptance and access to services. However, sustaining these changes remains challenging due to ongoing stigma, discrimination, and inconsistent community engagement. The long-term durability of these impacts will likely depend on continued investment in sensitisation, capacity building, community awareness/education, policy support to reduce stigma, and efforts to ensure equitable access to healthcare, for KPs, alongside replication of mentoring and improved staff retention in health centres.

5. ***Replicability***

   The mentorship showed potential for replication in similar healthcare settings, particularly in low-resource environments. Its structured approach, emphasis on local ownership, and continuous support were positive factors that could facilitate replication. However, successful replication would require careful attention to resource availability, adapting the mentorship component to fit specific local contexts, and ensuring strong community engagement to address unique challenges in different settings.

CONCLUSION

The mentorship component of AHD, SRH, and KPs services decentralisation in the MSF Beira HIV Project presents a promising approach for improving healthcare delivery in Mozambique, particularly for marginalised populations. However, challenges related to resource constraints, stigma, and stakeholder engagement need to be considered in order to fully maximise its impact. Strengthening community engagement, ensuring adequate resources, and integrating the mentorship component within broader health system activities could enhance the initiative's sustainability and replicability. While the mentorship model holds potential for improving healthcare outcomes and contributing to public health goals in similar settings, its successful replication will depend on implementing an integrated approach that includes other components, such as logistical support and advocacy efforts.

KEY RECOMMENDATIONS

The evaluation resulted in several recommendations to enhance the sustainability and replicability of the mentorship component of the decentralisation:

Recommendations for Médecins Sans Frontières (MSF)

1. Recommendations regarding the current project in Beira – Mozambique

- Support advocacy led by CBO: Prior to MSF exit, ensure that CBO capacities are strengthened to continue advocacy to donors and the Government to support the integration of mentorship in routine quality improvement initiatives at the primary healthcare level. This capacity building should include training on advocacy, support in building advocacy plans, and organisation of advocacy activities / campaigns;
- Trauma-informed care support**:** Evaluate the need to provide trauma-informed care support for healthcare workers managing highly sensitive cases, such as GBV and rape, to help them handle the emotional impact of their work;
- Child rape cases in Beira**:** Consider conducting a new assessment to better understand the rising cases of child rape in Beira, which could help identify the scope of the issue and potential interventions;
- Exit strategy for SRH supplies**:** In order to ensure continuity and sustainability of services post-departure, MSF should explore alternative, local-managed sources for continuing essential life-saving SRH commodities such as Misoprostol and Mifepristone, AHD services, and KP friendly services.

2. Recommendations for future projects involving mentorship in decentralisation

- Improve and strengthen community awareness, engagement, and accountability: Consider implementing targeted outreach programs in collaboration with local organisations to help reduce stigma and discrimination against KPs. These efforts could focus on fostering supportive environments through education about HIV-related issues;
- Enhance mentorship follow-up system: Explore the possibility of establishing a structured follow-up and support system for mentors and mentees, including regular check-ins and refresher training sessions. This could help reinforce the skills and knowledge acquired during the mentorship;
- Support integration of the mentorship component in decentralisation: Consider working with local health authorities to explore ways to integrate the mentorship component into existing healthcare training programs. This could help promote its sustainability and alignment with local healthcare policies and needs;
- Develop a comprehensive monitoring and evaluation framework: Consider creating a framework to assess the long-term impacts of the mentorship component in the AHD decentralisation of AHD, SRH, and KPs friendly services, focusing on health outcomes, community engagement, and resource utilisation. This would help inform necessary adjustments and improvements over time.

Recommendations for the Ministry of Health (MoH) – MISAU

- Consider increasing resource allocation: Advocate for additional funding and resources for healthcare facilities to improve staffing, access to medical supplies, and essential equipment. This could support healthcare workers in providing comprehensive HIV and SRH care and may help improve staff retention;
- Strengthen policy support for KPs: Explore the participatory development and implementation of policies with the KP sector actors that address and uphold/ protect the rights of KPs and promote equitable access to healthcare services. Addressing stigma and discrimination within the healthcare system is one of the most important aspects to focus on;
- Facilitate stakeholder engagement: Consider organising regular stakeholder meetings to align priorities and foster collaboration among various health system actors. This could help maintain commitment to HIV/TB and SRH care and mentorship initiatives and support a shift from traditional supervision to a more effective and sustainable mentorship program.

INTRODUCTION

PROJECT BACKGROUND

CONTEXT OF HIV IN MOZAMBIQUE

Mozambique has the second-highest number of people living with HIV/AIDS (PLWHA) in Sub-Saharan Africa, with approximately 11.6% of the adult population (aged 15-49) living with the virus as of 2022 [1,2]. HIV remains the leading cause of morbidity and mortality in the country [3]. CD4 testing was first introduced in Mozambique in 2003, followed by the adoption of the Test-and-Treat approach in 2016. By 2022, the routine identification of Advanced HIV Disease (AHD) in patients became fully established. According to an internal assessment by the Ministry of Health (*Ministério da Saúde de Mozambique* - MISAU) in 2022, 25% of PLHIV newly initiated on Antiretroviral Therapy (ART) were AHD patients. This aligns with global estimates indicating that over 30% of PLHIV in low- to middle-income settings starting ART have a CD4 count below 200 cells/mm^3, necessitating specialised services.

HIV prevalence among key populations (KPs)—including sex workers (SW), people who use drugs (PWUD), people who are incarcerated, and men who have sex with men (MSM)—is significantly higher than among the general population. While the HIV prevalence in the general population is estimated at 13%, it rises to 24% among sex workers, with approximately 30% of new HIV infections occurring among women sex workers, their clients, and the partners of sex workers [4].

In Beira, MISAU estimates that the HIV prevalence is 24% among FSW and 9.1% among MSM. From 2014 to August 2023, MSF enrolled and followed up 7,080 individuals from KPs, with a self-reported overall HIV prevalence of 21.4%. Among these groups, HIV prevalence was 39.1% among FSW, 9% among MSM, and 29% among transgender persons. Despite ongoing efforts, HIV services for KPs remain inadequate. Stigma and discrimination continue to create significant barriers to accessing healthcare, further marginalising these groups [5].

MSF INTERVENTION IN SOFALA PROVINCE & BEIRA HIV PROJECT

Since 2014, MSF has been actively supporting HIV services in Sofala province, with a particular focus on addressing the high HIV prevalence and the additional barriers faced primarily by sex workers to access healthcare, and later it started engaging with transgender people. The Beira HIV project was launched to reduce HIV-related morbidity, mortality, and incidence among both KP and the general population.

The project emphasises improving access to integrated HIV, sexual and reproductive health (SRH), and tuberculosis (TB) services at primary healthcare facilities and hospitals for the general population. For KP, the focus was on providing tailored, community-based services that facilitate prevention, diagnosis, and linkage to HIV and SRH services. Additionally, efforts were made to ensure that healthcare services become more welcoming and accessible to KPs, thereby reducing the stigma and discrimination they face.

The table below shows the MSF intervention history.

Table 1. History of the MSF HIV/AIDS Intervention in Mozambique and Beira project

YEAR	INTERVENTION
2014	▪ Starting of the MSF HIV intervention in Sofala province, Mozambique with the "Corridor Project".
2015	▪ MSF started to intervene in two Primary Health Centres (PHC) - Munhava and Ponta Gêa - supporting MISAU in the implementation of specific HIV- related activities including routine Viral Load (VL) monitoring and pharmacy management, targeting KP.
2017	▪ "Corridor Project" evolved to deliver a quality and tailored package of HIV prevention and treatment, as well as SRH services to KP; ▪ Starting of activities related to AHD in the observation room of Beira Central Hospital (BCH); ▪ Starting of support to Munhava PHC on advanced HIV activities.
2018	▪ Introduced workshop training as part of a capacity-building initiative. The mentorship project, initially started by the project, was scaled up over several years to involve multiple PHC. However, MISAU faced challenges in incorporating these services.
2019	▪ On job training for the MISAU clinicians in the one stop shop for AHD (less engagement); ▪ Starting of support to Ponta Gêa (PG) PHC on AHD activities; ▪ Community mobilisation and community clinics to improve linkage of KP to PHC; ▪ Starting of clinical, laboratory and pharmacological support for TB-MR patients.
2020	▪ Starting a Light approach intervention in Ponta Gea, leading to a pilot AHD mentorship in Ponta Gêa and Chingussura.
2021	▪ Change of project name from Corridor project to Beira project- Key Vulnerable Population and General Population for HIV/TB and SRH services; ▪ Expansion of the mentorship project, planning to include additional 9 health centres and integration of the mentorship as an integral part of the decentralisation project of AHD, SRH, and KP friendly services.
2024	▪ Evaluation of the mentorship component of HIV decentralisation of the Beira project.

DECENTRALISATION OF THE BEIRA PROJECT

Conceptual framework of decentralisation

a. Definition of decentralisation

Decentralisation can be understood in two ways: as a static state of being decentralised, or as a dynamic process of becoming decentralised. Broadly, it refers to the transfer of authority and responsibility for public functions from a central government to lower-level or quasi-independent government bodies, or even the private sector. Traditionally, decentralisation focuses on shifting power, responsibility, and resources from central to local governments, playing a crucial role in shaping the relationship between the two. In a more modern context, decentralisation involves transferring administrative authority—such as planning, decision-making, and revenue collection—from central governments to provincial institutions, local authorities, federal units, semi-autonomous public institutions, professional bodies, and voluntary organisations outside the formal administration [6].

b. Decentralisation in the health sector

In the health sector, decentralisation involves redistributing planning, management, decision-making, and resources from the national level to regional, district, or local levels. This often includes delegating responsibilities for healthcare delivery, resource allocation, and policy implementation to subnational or community-based entities. The goal is to enhance the responsiveness, efficiency, and equity of healthcare systems.

c. Decentralisation of HIV/AIDS services

When applied to HIV/AIDS, decentralisation refers to transferring key services—such as HIV testing, treatment, and care—from specialised, centralised facilities to more accessible primary healthcare settings and community-based organisations. This often involves "task-shifting," where specialised providers hand over certain responsibilities to general practitioners, nurses, or community health workers. The objective is to improve access to essential HIV services, particularly in resource-limited or hard-to-reach areas.

Examples of decentralisation in HIV services include:

- Offering HIV testing, counselling, treatment initiation and ongoing ambulatory care at primary health care clinics;
- Moving stable HIV patient monitoring and medication refills to community-based settings;
- Empowering and training community health workers to provide HIV education, support, and linkage to care;
- Integrating HIV services with other primary healthcare services, such as reproductive health, and maternal and child health.

d. Purpose of the decentralisation on the Beira project

In Mozambique, there is a high prevalence of HIV both among the general population and especially within KP. Until 2020, most HIV diagnoses occurred at the stage of AHD, resulting in high morbidity

and mortality due to late-stage detection. Several factors contributed to this situation, including a health system weakened by decades of civil war, the devastation caused by Cyclones Idai and Kenneth, and severe flooding in 2019. The COVID-19 pandemic further strained the already fragile health infrastructure, significantly limiting access to essential health services.

At the peripheral level, specific services faced limitations, leading to delays in diagnosing and managing AHD cases. These delays often resulted in patients arriving at health centres too late for effective treatment. Services most impacted included those related to AHD care, healthcare for KP, and comprehensive SRH services, including safe abortion care and support for women surviving sexual violence.

In addition to the purpose of the mentorship in decentralising of AHD, SRH, and KPs services at the primary health centres, the exit strategy and hand-over planning was also part of the purpose of implementing mentorship.

The Beira project decentralisation strategy

The mentorship component decentralisation primarily focuses on transferring technical expertise, empowering healthcare centre (HC) staff, and raising their awareness of how services impact patients' lives. Rather than providing direct medical services, MSF concentrated on capacity building and offering targeted logistical and medical supply support to 10 selected HCs in Beira: Cerâmica, Chingussura, Inhamizua, Macurungo, Manga Loforte, Marrocanhe, Mascarenhas, Nhaconjo, Nhangau, and Ponta-Gea.

Capacity building has been a core focus across all mentorship components to ensure the ongoing delivery of high-quality services. However, earlier efforts to enhance healthcare workers' skills and performance through traditional classroom-based methods saw limited success. In response, the project shifted towards a decentralised model, focusing on workplace-based learning (WBL). Evidence increasingly shows that learning in the workplace is significantly more effective than conventional education methods [7 – 10].

Workplace learning integrates real-world scenarios that promote active engagement, problem-solving, and reflective practices. Studies consistently demonstrate that WBL leads to greater retention of knowledge and skills, as it encourages "learning by doing" and applying theoretical concepts directly in practical settings. This method fosters critical skills like decision-making, collaboration, and adaptability—skills that are challenging to develop in classroom settings [11].

For example, health-worker performance improvement strategies, particularly in low- and middle-income countries, have shown that traditional methods, such as simply distributing written guidelines, often fall short in enhancing real-world application and skills. Instead, approaches that combine training, supervision, and group problem-solving can yield more substantial and lasting improvements. Reflective practices within workplace-based learning (WBL) further enhance these

outcomes by continuously engaging learners in integrating their experiences and fostering a more dynamic, inclusive, and effective learning process [7-10].

The mentorship component of decentralisation was designed with this approach in mind, integrating training, mentorship, and supervision to enhance the knowledge, skills, and attitudes of healthcare workers using an adult-learning, staff-centred methodology. The mentorship component was implemented between May 2021 and September 2023 in all 10 HCs and consisted of training packages focusing on KP-friendly services, SRH, and AHD care. It was structured to span six months in each HC, passing through five phases and targeting clinical staff as well as patient support workers. Since the inception of the mentorship component of HIV decentralisation, 124 healthcare workers have fully participated as mentees.

According to MSF, following the conclusion of the mentorship component of AHD decentralisation, in September 2023, the decentralisation of the project was fully completed by mid-2024. Ongoing, on-demand support for the 10 health centres (HCs) will continue, with sustained collaboration with community actors. Additionally, MSF will provide continued assistance to MISAU in implementing AHD, SRH and KP guidelines at the primary healthcare level, ensuring the ongoing integration of these critical services into the health system.

The five phases of the mentorship component of AHD decentralisation included:

1. **Pre-mentorship phase (2-4 weeks)**: An assessment of needs and available resources was conducted to tailor the mentorship to the specific context of each HC.
2. **Classroom training phase (3-5 days)**: Targeted training sessions on SRH, KP-friendly care, AHD, and laboratory services were delivered to equip staff with essential knowledge.
3. **Mentorship phase (4-14 weeks)**: Daily mentorship (side-by-side in a consulting room with an experienced clinician/mentor) was available to help mentees apply their newly acquired knowledge in practice, thus creating a supportive, hands-on learning environment.
4. **Follow-up phase (3-6 months)**: Ongoing supervision was provided through weekly case discussions, monthly feedback sessions, and remote support as needed.
5. **Replication phase**: In this final phase, promising mentees were selected to participate in a 'Training of Trainers 'workshop. These new mentors will then replicate the mentorship process in other healthcare facilities.

Activities included in the Beira project decentralisation

The decentralisation was structured around the following core activities:

- **Training, supervision, and mentorship of health staff:** Health workers at the 10 selected centres received continuous training and on-site mentorship, helping them build skills in AHD management, SRH services, and KP-friendly care. Ongoing supervision ensured that quality standards were maintained, and staff were supported in implementing new practices.
- **Logistical Support:** In addition to training, the project provided essential logistical support, including:

- Rehabilitation of healthcare facilities to create safe, hygienic, and functional environments for service delivery;
- Effective procurement and supply chain management to ensure consistent availability of medical supplies, including diagnostics and treatments for opportunistic infections (OIs), antiretroviral therapy (ART), and SRH commodities;
- Water, sanitation, and hygiene (WASH) activities to ensure basic infrastructure improvements for clean water and proper sanitation, which are vital for maintaining health service quality.

This approach aimed to decentralise health services, improve access to care, and alleviate pressure on centralised healthcare facilities by making essential services more available at the primary healthcare level. One interesting strategy was the use of mobile clinics ('brigadas móveis'), which provided medical care to KPs and those living in remote /hard-to-reach areas. These mobile clinics offered an additional way for healthcare professionals to work with members of KP as community health workers and reach individuals who might otherwise face barriers to accessing care in health centres. Over time, the consistency of these mobile clinic visits helped foster a sense of trust between KP and healthcare professionals. Some patients, recognising the welcoming nature of these professionals, later sought care at health centres to reconnect with the staff they met through the mobile units. This was a key part of 'mentoring' health care professionals, by immersing them in the reality of the lives that sex workers and other KP live in Beira. Peer educators played an essential role in connecting communities with health services/professionals for trust building.

EVALUATION SCOPE

This evaluation assesses the mentorship component of AHD, SRH, and KPs services decentralisation implemented across ten primary healthcare facilities in Beira City, Mozambique, from 2021 to 2023. The focus is on understanding the effectiveness and impact of the mentorship component in enhancing service delivery for AHD, SRH, and friendly services for KP, alongside logistics support.

The **evaluand is the mentorship component of the decentralisation of HIV and SRH services at primary healthcare facilities.** The definition of the evaluand required deep discussions between the evaluation team and the consultation group. Discussions with the evaluation consultation group (CG) were thorough and collaborative, reflecting a commitment to achieving a shared understanding of the evaluand. These discussions involved multiple meetings where the CG members and the evaluation team engaged in open dialogues, sharing their insights and perspectives on the mentorship component of the decentralisation of HIV and sexual and reproductive health (SRH) services at primary healthcare facilities (health centres). The group also briefly considered the logistics component of decentralisation, although this received less emphasis. Initial interviews with consultation group members during the inception phase played a crucial role in clarifying the evaluand, helping to align everyone's perspectives and expectations for the evaluation. Through iterative dialogue, the evaluation team refined the definition of the evaluand, ensuring that it accurately captured the core focus of the evaluation while addressing the diverse viewpoints of all

stakeholders involved in discussions. This process not only fostered consensus but also strengthened the foundation for a comprehensive and meaningful evaluation process.[1]

The evaluation was guided by the following key questions, derived from the logic model outlined above:

EQ 1: To what extent was the mentorship component of HIV decentralisation relevant and appropriate?

EQ 2: To what extent was the mentorship component of HIV decentralisation effective?

EQ 3: To what extent has the mentorship component of HIV decentralisation influenced larger contributions, perceived by different stakeholders?

EQ 4: To what extent was the mentorship component of HIV decentralisation coherent within its broader context?

EQ 5: To what extent is the mentorship component of HIV decentralisation replicable?

The Evaluation Matrix (Annex II) elaborates the evaluation questions in more depth and presents sub-questions (investigation questions that help answer the main evaluation questions).

The logic model of the evaluation shown below describes the initial situation justifying the mentorship implementation as well as the entire decentralisation process and its results chain.

[1] The mentorship in the Beira HIV project decentralisation process is referred to throughout this document as the mentorship component of HIV decentralisation, or just the "mentorship component''.

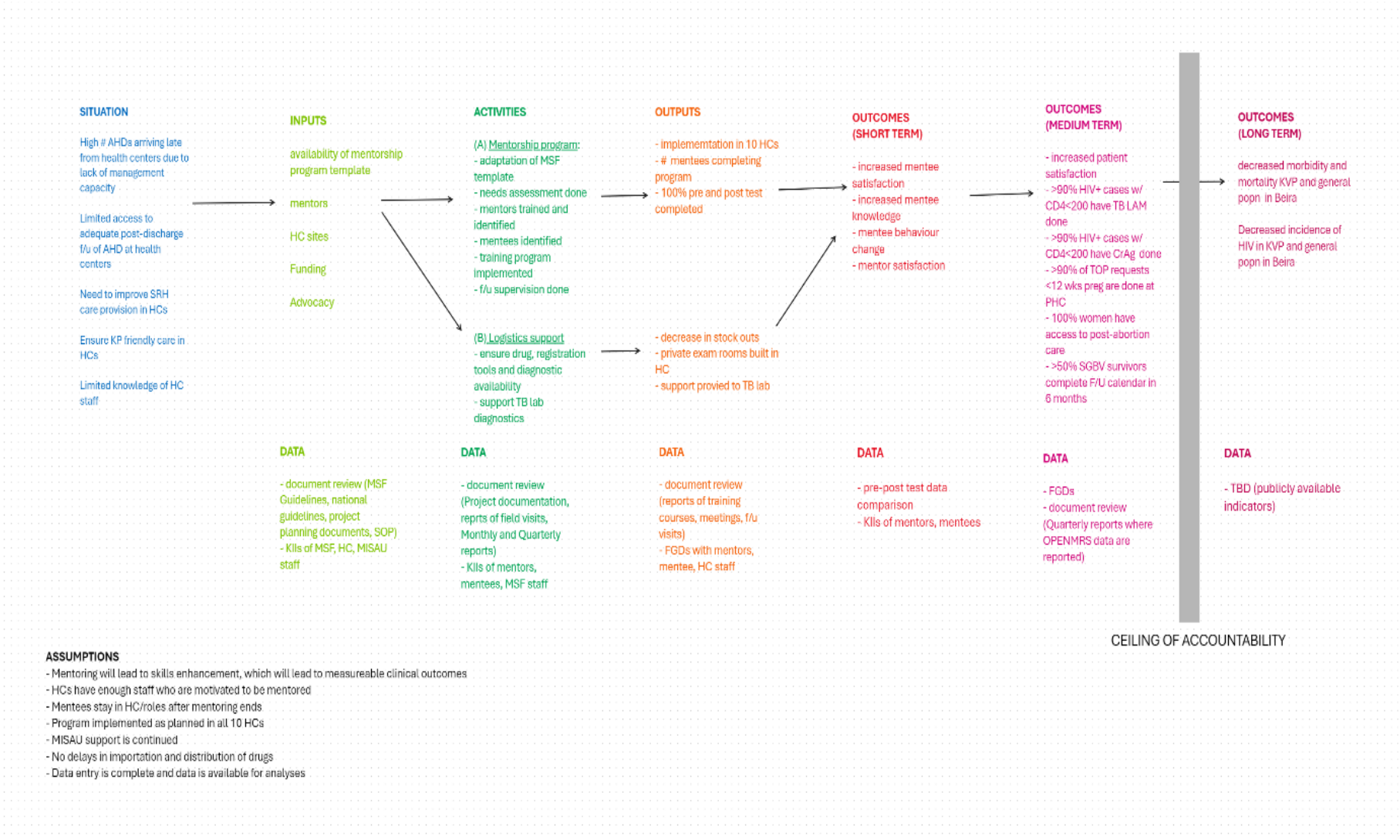

Figure 1. Logic model of the mentorship component of HIV decentralisation

METHODOLOGY

The evaluation of the mentorship component of HIV decentralisation in Beira, Mozambique, employed a mixed-methods approach, combining both quantitative and qualitative data collection and analysis. This approach was selected to provide a well-rounded understanding of the effectiveness of the mentorship component within the broader decentralisation strategy.

A case study approach was specifically chosen to explore the complexities of implementing the mentorship component of HIV decentralisation, providing deep insights into the "how" and “why" behind its implementation. This method enabled a richer understanding of real-world experiences, allowing the evaluation team to identify factors that influenced some positive feedback and results in diverse healthcare facilities, as well as the challenges encountered in each different context. Such depth of exploration would have been difficult to achieve through other methods, such as contribution analyses or outcome harvesting. Additionally, the case study approach benefited from the integration of qualitative data with quantitative analysis of secondary data, which allowed for the assessment of whether established targets had been met. This combination of qualitative and quantitative data also facilitated triangulation with other data sources, enhancing the robustness of the findings.

DATA COLLECTION

Data collection was conducted both online and on-site in Beira, Mozambique.

Online data collection

During the evaluation, nine online interviews were conducted to gather valuable insights from participants, primarily from the project and strategic levels within MSF (OCB HQ and SAMU). These interviews were held via a secure video conferencing platform (MS Teams), offering flexibility in scheduling and ensuring participants ’comfort. Each session lasted between 40 to 60 minutes, focusing on participants' perspectives and experiences regarding the design, implementation, and performance of the mentorship component of HIV decentralisation. The semi-structured interview format encouraged open discussions while allowing for in-depth exploration of key topics. The online format also enabled access to a diverse group of participants who could not be reached during field visits, ultimately contributing to a richer and more comprehensive dataset for analysis.

On-field data collection

From August 10 to 26, 2024, a member of the evaluation team collaborated with MSF representatives in Beira to conduct in-person data collection.

a. Primary goals of the field visit

- **Understanding the mentorship component of HIV decentralisation**: We aimed to gain a comprehensive understanding of how the mentorship component was implemented in Beira. This included analysing the strategies and adaptations implemented to fit the local context.

We also focused on how mentorship facilitated skill transfer and delegated responsibilities to local clinics, improving both the effectiveness and accessibility of care.

- **Gathering diverse perspectives and feedback**: We sought to collect feedback from a broad range of stakeholders, including MSF and MISAU representatives, mentors, mentees, community members, and healthcare professionals. By gathering insights into their expectations, experiences, and challenges, we aimed to assess the mentorship project's overall impact through first-hand accounts of its successes, obstacles, and potential areas for improvement.

b. Field visit activities

- **In-depth key (IDIs)**: 43 IDIs were conducted with key stakeholders, including MSF and MISAU representatives, and mentors involved in areas such as AHD care, sexual and reproductive health (including safe abortion care), gender-based violence interventions, laboratory best practices, and strategies to improve healthcare access and retention in care for KPs. These interviews provided valuable insights into the mentorship strategies used across various domains of healthcare.
- **Focus Group Discussions (FGDs):** Four FGDs were conducted with mentees from local health centres, including Nhaconjo, Macurungo, Chingussura, Manga Loforte, Ponta Gêa, and Manga Mascarenhas. Each FGD brought together mentees from different clinics and professional backgrounds, such as lab technicians, nurses providing safe abortion care, and AHD care providers, fostering a space for collaborative dialogue. A total of 28 mentees participated, sharing diverse perspectives on their mentorship experiences, the integration of services, and the broader impact on healthcare delivery. Additionally, one FGD was held with 11 community activists from the NGO Takaezana, a local MSF partner that works with KPs, advocating for their rights and supporting their access to and retention in healthcare services.
- **Structured observations**: Observations were conducted at 10 health centres (e.g., Chingussura, Nhaconjo, Macurungo, Marrocanhe, Inhamizua, Ceramica, Nhangau, Ponta Gêa, Manga Loforte, and Manga Mascarenhas) during weekday mornings. Following a structured approach, we assessed the physical environment, patient flow, and the integration of mentorship practices into daily operations. These observations offered an on-the-ground assessment of how the mentorship component of HIV decentralisation was integrated—or, in some cases, not fully integrated—into the daily activities of each health centre. A brief report from each observation is included at the end of this report.

Secondary data analysis

Included the following datasets: (a) **Mentee Database** – This database contains detailed information on each mentee who participated in the mentorship, including enrolment details, pre-and post-test scores, and mentor observations recorded at three key time points; (b) **Project Monitoring Data** – This data is compiled from project monitoring tools and reported in the Quarterly Reports, offering additional insights into mentorship implementation and progress.

SAMPLING TECHNIQUES

Purposive and snowball sampling methods were employed to ensure the inclusion of participants with the most relevant experiences and insights. Purposive sampling was used to strategically identify key individuals who could offer critical perspectives on the mentorship, while snowball sampling facilitated the identification of additional participants through referrals from initial informants. This combined approach allowed for the collection of diverse, in-depth data, enhancing the richness and credibility of the qualitative findings while ensuring a comprehensive understanding of the mentorship impact. Respondents were gradually added until the theoretical saturation of information was obtained.

DATA ANALYSIS

For **qualitative** data analysis, a thematic analysis approach was employed to identify, analyse, and report patterns within the data. First, all interviews, focus group and observational notes were systematically reviewed and coded to identify recurring themes and sub-themes. Both inductive and deductive coding techniques were used, with some codes emerging directly from the data (inductive) and others based on pre-established frameworks related to mentorship, healthcare delivery, and service integration (deductive). The data were then organised into categories that aligned with the study's objectives, allowing for deeper insights into the effectiveness of the mentorship and its impact on patient outcomes. Throughout the process, triangulation was applied by cross-referencing data from different sources (interviews, focus groups, and observations) to ensure validity and reliability. This rigorous analysis provided a rich, nuanced understanding of the mentorship implementation and outcomes, contributing to actionable recommendations for future interventions.

Quantitative data was used to construct the following indicators to assess specific outputs and outcomes of the mentorship component of HIV decentralisation.

Output: The mean participation by mentees in the mentorship component, reported by each health centre and by specific mentorship: KP, AHD, SRH.

Short-term outcome – change in mentee knowledge: This was evaluated using two key indicators. The first was a gain score, calculated as the percentage difference between the pre-test administered before the starting of the mentorship and the post-test taken after the training concluded. The second indicator was the global impact score, which represented the percentage improvement in a mentee's performance across multiple topics, as assessed by a mentor at various points throughout the training (based on the evaluation grids). These scores were further analysed by health centre and mentorship type (KP, AHD, SRH) to capture specific trends and insights.

Medium-term Outcomes: The five medium-term outcomes are based on the original log frame indicators of the Beira project and correspond to the expected result. These outcomes include:

- Percentage of HIV (+) cases with CD4 <200 that have TB LAM done;
- Percentage of HIV (+) cases with CD4 <200 that have CrAg done;

- Percentage of SAC requests < 12 weeks of pregnancy that are performed at the PHC;
- Percentage of women who seek post-abortion care who have access to the service;
- Percentage of SGBV survivors who complete the follow-up calendar within 6 months.

ETHICAL CONSIDERATIONS

Ethical considerations were central to the evaluation process, ensuring that the rights, dignity, and confidentiality of all participants were protected. Evaluators adhered to the SEU Ethical Guidelines, emphasising the importance of ethical integrity, particularly when engaging with vulnerable groups such as survivors of sexual violence.

Several ethical safeguards were implemented:

- **Informed consent**: All participants were fully informed about the purpose of the evaluation, their role in the process, and their right to withdraw at any point without penalty. Verbal consent was obtained before any data collection activities starts;
- **Confidentiality**: Measures were taken to ensure that participants' identities and the information they shared remained confidential. Data was anonymised during the analysis process, and access to sensitive information was restricted to authorised evaluation team members only;
- **Sensitivity in data collection**: Given the nature of the topics discussed—especially those related to vulnerable populations such as KP and survivors of sexual violence—special care was taken to create a safe and respectful environment during IDI and FGD. To enhance the 'do-no-harm' principle, the types of questions asked were carefully designed to avoid re-traumatisation or distress. This involved avoiding intrusive or graphic details of traumatic events, using neutral and empathetic language, and allowing participants to skip any questions they found uncomfortable. Additionally, the professional responsible for IDI and FGDs is a clinical psychologist with training in trauma-informed approaches, enabling her to recognise signs of distress and provide appropriate support or ask for referrals when necessary. These measures ensured that participants felt comfortable sharing their experiences without fear of judgment or repercussion and that their emotional well-being was prioritised throughout the data collection process.

In summary, the mixed-methods approach, integrating both qualitative insights and quantitative metrics, offered a comprehensive evaluation of effectiveness of the mentorship component of HIV decentralisation. The case study approach facilitated a more detailed examination of its implementation, while key informant interviews, focus group discussions, and site observations contributed to a broader understanding of its influence on healthcare delivery. This methodological framework provided credible findings and useful insights for stakeholders seeking to improve, refine, or potentially scale similar interventions in the future.

LIMITATIONS

Despite the robust mixed-methods approach used in this evaluation, several limitations in data collection and analysis may influence the overall findings and could introduce potential biases.

DATA COLLECTION LIMITATIONS

Sampling bias: The use of purposive sampling, while effective for targeting knowledgeable participants, may introduce selection bias. If certain perspectives are over- or under-represented, it could skew the findings, limiting the generalisability of results. A diverse recruitment strategy was implemented, incorporating multiple referral pathways to ensure a wide range of perspectives and backgrounds among participants. These included referrals from MSF teams, which provided access to individuals already engaged with MSF activities in Beira; referrals from healthcare professionals, who could identify participants with specific experiences relevant to the mentorship component of HIV decentralisation, and referrals from KP and NGO representatives, who acted as trusted intermediaries to reach marginalised groups such as sex workers, MSM, and people who use drugs. Additionally, random data collection was conducted at each clinic visited, selecting participants from diverse backgrounds and clinic attendees to capture broader community experiences. By combining these methods, the recruitment process aimed to minimise selection bias and enhance the generalisability of the results, ensuring that a comprehensive range of voices was represented.

Self-reported data: Relying on self-reported data in interviews and focus groups can lead to social desirability bias, where participants may provide answers, they perceive as favourable rather than reflecting their true experiences. This could affect the accuracy of insights on service quality and client-provider interactions. Anonymised data collection has been done alongside interviews to encourage honesty, reducing social desirability bias and improving the accuracy of participant responses.

DATA QUALITY LIMITATIONS

Inconsistencies in data entry: Variability in data entry into the mentee database could affect data integrity. Errors during data entry or cleaning, and incomplete data entry may result in inaccuracies in the quantitative analysis. This can hinder the ability to fully assess the effectiveness of the mentorship component of HIV decentralisation. To minimise bias, we used the complete case analysis approach, wherein observations with incomplete information were not included in the analytic dataset.

ACCESS TO DATA SOURCES

Restricted access to vulnerable groups: Difficulty accessing certain vulnerable populations, such as survivors of sexual violence, or KP may result in a lack of diverse perspectives, potentially skewing the findings. Collaborating with local community organisations leaders helped establishing trust and offered an opportunity of talking to KP members. In these kinds of difficult situations, collaborating with KP sector CBOs leaders can facilitate access and promote participation in the evaluation.

Limited availability of documentation: Although a document library was established, challenges in obtaining all relevant documents or reports may have hindered a comprehensive analysis of the context and implementation of the mentorship component of HIV decentralisation. This limitation was low as most of the project's documents were provided by MSF.

POTENTIAL BIAS LINKED TO INTERPRETATION

These limitations could introduce biases that affect the evaluation's conclusions:

- **Over-representation of positive outcomes**: Participants with favourable experiences may be more likely to participate in interviews or focus groups, leading to an overly optimistic view of the effectiveness of the mentorship component of HIV decentralisation. Additionally, key informants from the government sector were not interviewed, as fieldwork coincided with an election period. During this time, many government leadership positions were in transition, with acting leaders engaged in election-related activities or involved in meetings with incoming officials. As a result, it was challenging to secure their participation, and it is assumed that some divergent perspectives, particularly those that may not align with the favourable outcomes, could have been missed, constituting a limitation.
- **Under-reporting of challenges**: Participants may be reluctant to discuss negative experiences or difficulties encountered during the mentorship, resulting in an incomplete understanding of areas that require improvement. A safe space for participants was always created, emphasising confidentiality, and targeted prompts were used to encourage open discussions about negative experiences and challenges faced.
- **Data interpretation bias**: Variability in how evaluators interpret qualitative data could introduce subjectivity, particularly if there are no standardised protocols for coding and analysing responses. We implemented standardised coding protocols and utilised a regular crosscheck between the evaluation team members to enhance objectivity in qualitative data analysis, ensuring a more consistent interpretation of responses.

Despite the identified limitations, we believe that the overall findings remain robust due to the mixed-methods strategy, which integrated both qualitative and quantitative data, enhancing the credibility of the results. The use of diverse data sources—such as interviews, focus groups, site observations, and quantitative metrics—allowed for triangulation, ensuring that potential biases from any single method or source were mitigated. This methodological rigor, combined with the strong variability of participants and perspectives, provides confidence that the evaluation's conclusions accurately reflect the effectiveness and impact of the mentorship component of HIV decentralisation

FINDINGS

RELEVANCE

IDENTIFIED CAPACITY GAPS

Several gaps in access to quality healthcare services at the primary level (health centres) were identified, highlighting the need for the mentorship component as part of the decentralisation of AHD services. This mentorship, the core element of the intervention, was implemented to support healthcare staff, alongside logistical improvements. Key gaps include:

- **Delayed AHD diagnosis:** A significant number of advanced HIV disease (AHD) patients arrived at health facilities that were not adequately equipped to manage these cases and were referred to the Beira Central Hospital;
- **High workload at BCH:** Beira Central Hospital (BCH) faced overwhelming demand in managing AHD, HIV-related comorbidities
- **Limited post-discharge services:** BCH struggled to provide sufficient post-discharge services for AHD patients;
- **SRH services needing improvement:** Primary healthcare centres required quality care enhancements in SRH services, particularly in providing safe abortion care SAC) , post abortion care (PAC), and support for SGBV survivors.
- **Need for improved patient-provider relationships:** Strengthening the patient-provider relationship was essential to making healthcare services more inclusive / friendly and accessible particularly for KPs;
- **Low capacity at health centres:** Health centres faced limitations in managing AHD, SRH issues (e.g., safe abortion care), and services for KPs. These limitations included gaps in staff training, laboratory services, supply chain management for commodities for AHD and SRH and confidentiality.

A gap analysis conducted before implementing the mentorship in Beira underscored the relevance of this approach, a view further reinforced by MISAU representatives, as we can see on the quote below:

"We faced significant challenges in Mozambique's national HIV response, especially with so many patients arriving at Beira's Hospital Central da Beira (HCB) in advanced stages of HIV. The mortality rate was alarmingly high, with many dying just days after their admission. This situation was a major concern for us at MISAU, as well as for healthcare professionals. To address this, we partnered with MSF, launching a pilot mentorship program at HCB and Munhava Health centre. The goal was to strengthen our ability to detect early signs of advanced HIV and manage opportunistic infections more effectively. The program was successful, and we saw the potential to expand it to local clinics. By doing so, we aimed to improve early diagnosis and treatment, making tests like CD4 count, HIV viral load, and TB screenings more accessible at the community level. We believe that this early intervention approach can help patients manage their HIV before it progresses to advanced stages. For those already in advanced stages, better local management of opportunistic infections could reduce hospitalisations and lower the risk of death. Decentralising these critical services would also relieve the heavy patient load at HCB, reducing wait times and easing the strain on healthcare workers."

MISAU Representative

MENTORSHIP COMPONENT OBJECTIVES AND ACTIVITIES

The mentorship component of HIV decentralisation focused on transferring technical expertise and empowering HC staff. The aim was to enhance their awareness of the vital impact their services have on patients' lives. Rather than providing direct medical care, MSF shifted its focus towards capacity building, offering targeted training, logistical support, and ensuring a consistent supply of medical resources to 10 selected healthcare centres in Beira: Nhaconjo, Chingussura, Inhamizua, Ponta-Gea, Macurungo, Manga Loforte, Mascarenhas, Cerâmica, Nhangau, and Marrocanhe.

The mentorship component aimed to equip local healthcare professionals with the necessary skills and resources to independently deliver high-quality care to their communities. The mentorship component specifically addressed the needs of KPs and the general population seeking HIV and sexual and reproductive health (SRH) services. By empowering HC staff, the mentorship component sought to create sustainable improvements in healthcare delivery, ensuring that critical services could continue to meet local needs effectively.

ENGAGEMENT AND OWNERSHIP BY LOCAL HEALTH AUTHORITIES

Engagement and ownership by local health authorities are critical for the success of the mentorship component. Involving key stakeholders, such as the provincial reproductive health department, the provincial health department, and the national HIV control project, fosters a shared sense of responsibility and commitment. However, the current evaluation only reflects the perspective of two individuals from MISAU involved in the mentorship component, leaving a gap in understanding the broader engagement and ownership across other health authorities.

While the mentorship was largely based on MSF (SAMU) guidelines and implemented in a substitution mode, this approach may have limited opportunities for genuine co-construction and collaboration with local entities. Given that mentorship in AHD management at the primary healthcare level is relatively new, even globally, building robust partnerships that emphasise skill development and competency enhancement is essential. A blended approach, combining practical and theoretical training in infectious diseases would help ensure that health personnel are well-prepared and deeply invested in the success of the mentorship component of HIV decentralisation.

Strengthening these partnerships will not only enhance the effectiveness of the mentorship initiative but also promote sustainable health outcomes within the community. Engaging a broader range of stakeholders is key to fostering a sense of ownership and ensuring that the overall project and the mentorship component is responsive to local needs and contexts, ultimately contributing to long-term success.

APPROPRIATENESS BY MENTORSHIP PARTICIPANTS

The majority of mentees and mentors found the mentorship both relevant and aligned with the specific challenges they encountered in delivering SRH and AHD services. It deepened their understanding of SRH and advanced HIV care and enhanced their ability to address the unique needs of key populations (KPs). The mentorship fostered a mindset and skills that improved the gathering of patients' medical history, complaints, and symptoms, enabling healthcare providers to gain deeper insights into their health status. This, in turn, facilitated earlier diagnoses and more timely treatment or referrals when necessary.

When healthcare professionals faced uncertainty in diagnosis, they were encouraged to consistently request CD4 tests and refer patients with low counts for further testing, such as TB and CrAg screenings, to ensure proper diagnosis of AHD and timely treatment of opportunistic infections. These efforts supported a more individualised care and fostering trust between patients and healthcare providers, as reflected in the quote below.

> “Before the mentorship, our focus was on clearing the waiting room as quickly as possible to avoid patient complaints about long waits. However, the mentorship on advanced HIV disease (AHD) showed us this was a big mistake. We were missing critical opportunities to truly listen to patients, understand their symptoms, and identify if they might be experiencing AHD. Now, after the mentorship, we know what to look for, and we're much more attentive when assessing patients who might be in this stage of HIV. When we detect it, we immediately request their Visitec to see if their CD4 is low and initiate the full protocol for opportunistic infections screening. This change is thanks to the mentorship—before, I didn’t even know AHD existed. I used to think all HIV patients were treated the same. Now, thanks to the MSF mentorship, I know better.”
>
> Mentee, Health Centre of Manga Loforte

Most of the mentees who received training to better understand the unique needs of key populations (KPs) reported an improvement in their ability to deliver more sensitive and personalised care. The mentorship program also enhanced their capacity to provide services such as counselling, HIV testing, PrEP, and other targeted support. The hands-on training approach, coupled with the immediate availability of supervisors for guidance, played a crucial role in helping participants effectively apply their newly acquired skills in clinical settings.

> "The mentorship was exactly what we needed. It helped us dig deeper into advanced HIV care and also understand the needs of KPs better. We've completely changed how we assess patients now—spending more time with them, asking the right questions, and knowing when to refer a woman who is a sex worker for specific sexual and reproductive care. We try to make their appointment more welcoming, you know? Sometimes they just need someone to talk to… It doesn't matter if they are a sex worker or not, they are here and need care. Here, most of the women looking for safe abortion are either sex workers or adolescents who were raped. It is really sad. But the mentorship, the hands-on practice and having a supervisor just a call away made a huge difference. It really improved our clinic's approach, and I just wish it could keep going to train new staff since people come and go so often.".
>
> Mentee, Health Centre of Manga Mascarenhas

According to many mentees, the mentorship program also facilitated the reorganisation of care processes in many clinics, with separate areas and patient flows based on specific needs, such as advanced HIV disease (AHD), pregnant women, and children. This restructuring allowed for more time dedicated to clinical evaluations and patient engagement and prescription ensuring that the unique circumstances of each patient were considered.

> "What really stood out to me was the open dialogue—it was a two-way learning experience. I wasn't just being taught; I was also sharing insights with my mentor about my reality, my community, the services we provide, and the specific needs of my patients. They were receptive and even adjusted the mentorship to better address my particular needs as a professional working with this community. Together, we developed a strategy to group patients with HIV based on their unique needs: adolescents in one area, pregnant women in another, and those with advanced disease in another. This way, each group received the specialised care they required."
>
> Mentee, Health Centre of Ponta Gêa

The quote below highlights the lasting impact of the MSF mentorship program, emphasising its difference from other donor-driven initiatives. Unlike external interventions that often leave no sustainable results after funding ends, the mentee reflects on how the MSF mentorship was tailored to the local team and healthcare system, equipping them with skills and knowledge that will continue to benefit their practice long-term. The participant underscores the value of this approach in fostering self-reliance and continuity in healthcare services, ensuring that the benefits of the training remain even after external partners depart. This type of perception was less frequently reported by participants.

> "The MSF mentorship was different. It was not something implemented by an external donor or another organisation. It was for us—for me, for our team, for my service, for MISAU staff. We were the ones being trained, and the skills and knowledge we gained will stay with us in our practice. With other strategies brought in by external donors or organisations, once the funding dries up or the partners leave, we're left with nothing. We end up back at square one, with no new testing, no new diagnoses—nothing remains, nothing stays with us…"
>
> Mentee, Health Centre of Ponta Gêa

According to the vast majority of mentors, their perception as mentors and healthcare professionals is that the mentorship program significantly enhanced health staff's ability to provide comprehensive and effective care for people living with HIV/AIDS (PLWHA). Specifically, health staff have gained skills to better address the complex needs of PLWHA, ensuring that patients receive timely, accurate diagnosis, appropriate treatment, and continuous monitoring of their condition.

In laboratories, technicians have improved their technical skills and can now perform crucial tests, such as CD4 counts, TBLam, Crag, and viral load collection, directly on-site. This capability not only reduces patient travel time but also enables faster clinical decision-making and enhances service efficiency. Furthermore, following the mentorship program, some clinics adopted a "one-stop-shop" model for HIV services, which integrates various services in a single visit. This model streamlines patient care, minimising the need for multiple appointments and enhancing overall accessibility and continuity of care for PLWHA.

"I believe this mentorship program has significantly improved the flow of care for people living with HIV/AIDS. In many clinics, patients can now access multiple services—such as blood work, prescription refills, and clinical appointments—all in a single visit. For clinics that haven't yet adopted this 'one-stop-shop' model, efforts are underway to schedule all necessary appointments on the same day, easing the burden of repeated trips for patients. This shift in approach came directly from the mentorship, where we, mentors, reinforced over and over again the importance of retaining patients in care, ensuring early diagnosis, and intervening quickly when advanced HIV disease is detected."

Mentor

Some mentors in the SRH mentorship program also observed a positive impact when comparing the care provided to sexual violence survivors before and after the mentorship. Previously, care for these patients was primarily limited to post-rape services focused on STI/HIV prophylaxis. After the mentorship, care became more comprehensive, continuing to include STI/HIV prophylaxis while also offering psychological support during the initial consultation and follow-up visits to help patients address trauma. Before the mentorship, there was no follow-up support available. Additionally, many healthcare centres introduced safe spaces for child survivors of sexual violence after the mentorship, further enhancing the quality of care provided.

"I honestly believe that this mentorship program changed how we approach post-rape care and safe abortion services. Previously, many healthcare professionals were uncomfortable treating sex workers and adolescents who were victims of repeated sexual violence, often facing stigma and discrimination. Victims, especially sex workers and adolescents living in unsafe environments, would frequently request safe abortions, but healthcare professionals would sometimes respond with prejudicial comments, implying blame on the victims. This led many patients to feel unwelcome and to resort to unsafe abortion practices in their communities. But the mentorship program, through continuous training and supervision, reshaped these perceptions, highlighting the importance of providing safe abortion services. Healthcare professionals now understand that when a woman or girl is determined to end her pregnancy, she will proceed, regardless of legality or safety. By offering safe abortion care, we can prevent these women from risking their lives with unsafe methods. The program also enhanced the quality of care for sexual violence survivors, shifting from just offering immediate medical treatment and STI/HIV prophylaxis to a more holistic approach that includes counselling, mental health support, and follow-up care."

Mentor, KP & SRH

Overall, most mentees and mentors interviewed appreciated the mentorship program for its tailored approach to local healthcare needs and for its role in improving clinical practices within health centres. However, they emphasised the importance of ongoing mentorship, particularly to train new staff due to the high turnover of healthcare professionals in these clinics.

> "I think that a key gain of this mentorship program from MSF is the way it was organised, like thinking about the specific problems mentees were experiencing in their local healthcare clinic. It wasn't just about general training—it was tailored to their actual needs, it was somehow adapted to their doubts, the kind of patient under their care, the resources available. And by working together, I believe that we made a difference, the possible change given each clinic's reality and resources available. Until nowadays, I keep receiving calls from former mentees to discuss specific patients, to decide what would be the best treatment, or where to refer someone in need of a treatment unavailable at the local clinic. We created a bond, you know? My main concern is that, with so many staff coming and going, today we would need to train the new staff all over again. Actually, in a perfect scenario, MISAU would offer continuous mentorship to keep the improvements going and ensure new staff can also benefit from the training."
>
> Mentor, AHD

COHERENCE

MENTORSHIP COMPONENT: DESIGN AND IMPLEMENTATION

The mentorship across various healthcare disciplines was designed to integrate theoretical instruction with hands-on, practical supervision, aiming to strengthen both technical competencies and provider-patient interactions. These mentorships typically lasted a few months and were rolled out in multiple health clinics, allowing healthcare workers to immediately apply their newly acquired skills in real-world settings. According to most mentees, the combination of theory and practical guidance not only enhanced technical proficiency but also fostered more effective and compassionate patient care.

"I'll never forget seeing patients who came to us in such poor health—barely able to walk—recover and come back later, thanking us for the care that saved their lives. The mentorship program played a huge part in that transformation. It gave us a solid foundation in managing both HIV and advanced HIV. Even now, long after the official training ended, I still reach out to my mentor to discuss cases and share good news about patients A or B. The biggest shift has been how we approach patient care; now, we take the time to fully understand each patient's situation, even if they look healthy on the outside. We know that advanced HIV can hide beneath the surface, and this program has made sure we don't miss it."

Mentee, Health Centre of Inhamizua.

Capacity building and the mentorship component of AHD decentralisation

Capacity building has been a key element of the mentorship component of AHD decentralisation in Beira, aimed at strengthening the quality and sustainability of healthcare delivery. Initially, traditional classroom-based training efforts to improve healthcare workers' skills showed limited impact. To address this, the mentorship component transitioned to a decentralised, workplace-based learning model, supported by evidence of its effectiveness.

In particular, the laboratory mentorship focused on enhancing practices, introducing diagnostic tests such as point of care CD4, TB-LAM and CrAg test, and ensuring alignment with best practices in patient care. MSF developed and implemented a clinical mentorship component that integrates classroom training, mentorship, and supervision to holistically improve healthcare workers' skills, knowledge, and attitudes. Using an adult-learning, staff-centred approach, the mentorship component emphasised experiential learning within the workplace, allowing healthcare workers to apply new competencies directly to real-life situations. According to some mentees and mentors, this approach fostered both technical proficiency and improvements in patient care.

"The MSF mentorship and support have provided us with key tools like the rapid TB test, CrAg screening, rapid CD4 count test (Visitect)—all of which were previously unavailable but are now essential for addressing the specific needs of patients diagnosed with AHD. We can also offer less invasive abortions using just misoprostol pills, and PrEP is being implemented in many facilities. These developments are transforming the treatment landscape for patients with AHD, those seeking safe abortion, and key populations. We now know what to do and how to do it; we're better prepared to provide both counselling and treatment."

Mentee, Manga Loforte Health Centre

Mentorship process

The mentorship in Beira was implemented from May 2021 to September 2023 and spanned across 10 selected HCs. It offered a comprehensive training package, emphasising critical areas such as friendly services for KP, SRH, and the management of AHD. The mentorship component was designed to run for six months in each HC, progressing through five structured phases and involving both clinical staff and patient support personnel. To date, approximately 124 healthcare workers have actively participated as mentees, gaining valuable hands-on experience through an immersive, practical learning approach. Interviewed mentors were MSF and MISAU staff who had been trained on being a mentor and conducting mentorship.

Design and phases of the mentorship

The mentorship component was organised and implemented in five structured phases as following.

Pre-mentorship Phase (2-4 weeks): During this initial phase, an in-depth assessment of the needs and available resources at each healthcare centre was conducted. This allowed the mentorship component to be customized to the specific requirements of each HC, ensuring relevance and efficacy in addressing local challenges.

Classroom training Phase (3-5 days): This phase involved delivering focused training sessions on SRH, KP-friendly care, AHD management, and laboratory services. These sessions aimed to provide healthcare staff with essential knowledge and practical skills necessary to deliver effective, patient-cantered care.

Mentorship Phase (4-14 weeks): Following the training, healthcare workers received daily mentorship, which supported them in applying the newly acquired knowledge directly in their clinical practice. This hands-on guidance fostered a learning environment where mentees could gain confidence and refine their skills in real-time patient care settings.

Follow-up Phase (3-6 months): During this phase, the mentees continued to receive ongoing supervision and support. Weekly case discussions, monthly feedback sessions, and remote assistance ensured that healthcare workers could sustain and further develop their competencies. This continuous engagement was developed to reinforce the skills acquired during the mentorship period.

Replication Phase: In the final phase, promising mentees were identified and invited to participate in a 'Training of Trainers' workshop. These individuals were trained to become mentors themselves, with the objective of replicating the mentorship process in other healthcare facilities. This phase was implemented to contribute with a possible the long-term sustainability and expansion of the mentorship component of the HIV decentralisation in Beira. The underlying idea was to create a network of local mentors capable of cascading the training to other professionals.

The possibility of replicating and scaling up the mentorship was generally seen as a promising idea by most mentees and mentors. However, they expressed several concerns, as highlighted in the FGD discussion below.

> "— I think one of the big issues was that there were only a few of us mentees in each service, right?
> — Yeah, and we were kind of expected to train everyone else! Putting in extra hours with no extra pay…
> — And the ones who weren't in the mentorship thought we were getting paid for it, remember?
> — Totally. There was a lot of talk, a lot of jealousy... like we were somehow better just because we got into the MSF mentorship program.
> — And don't forget the turnover! Someone gets trained, then MISAU moves them, and they don't even get a chance to pass on what they learned. All that mentorship knowledge just goes with them.
> — Let me just say, the MSF mentorship was great, no doubt about it. It was as good as it could be.
>
> But if we really want this to last, MISAU has to take charge. MSF can only do so much—they come, they help, but then they leave. We've seen it before. Honestly, I don't know if this mentorship will keep going in our clinics, let alone be scaled up to other services…"
>
> FGD with mentees from Manga Loforte and Ponta Gêa HC

Traditional classroom-based training programs for healthcare worker, especially in the context of infectious diseases like HIV—where management practices are frequently evolving—often reveal several weaknesses:

- **One-size-fits-all approach:** Traditional mentorship often relies on standardised curricula that may not address the unique needs of every individual. This can lead to disengagement or inadequate support;
- **Limited interaction**: Classroom training typically restricts interaction to a formal setting, reducing opportunities for personal connections and informal sharing of experiences that can enhance learning;
- **Low understanding of context and lack of adaptation**: Traditional classroom trainers may lack firsthand experience with the specific challenges faced by their mentees, making their guidance less relevant and relatable;
- **Focus on theory over practice**: traditional classroom-based training programs may prioritise theoretical knowledge over practical application, leaving mentees unprepared to navigate real-life situations.

In the Beira project, some of these limitations were addressed through supervision. However, some mentees and mentors still perceived these supervisions as time-consuming, as we can see in the quotation below.

> "It was confusing to have the mentoring during our working hours, and we felt sometimes stretched to the limit, without doing either thing to the best of our ability: mentoring and patient care. The lack of financial support was a key concern and a major reason for many healthcare professionals to opt out of the mentorship. After all, you are putting hours into the training to improve your practice but also the clinic's indicators."
>
> Mentee, Nhaconjo Health Centre

A peer-to-peer mentorship model, as part of the decentralisation strategy, could improve relatability and trust between mentors and mentees. Peer mentors might offer more personalised, context-specific support by tailoring their guidance to the unique circumstances of each mentee, rather than relying on standardised assessments. Different needs may require tailored approaches, content, and schedules.

Moreover, peer mentorship can foster a sense of community and belonging, which could be particularly beneficial for individuals managing stigmatised health conditions like HIV or those caring for KP within the Beira project. This type of support has the potential to positively influence motivation, treatment adherence, contributing to improved outcomes, as suggested by this evaluation.

> "As a peer healthcare worker and a mentor, I could relate to my colleagues' struggles because I've been in their shoes. It wasn't about ticking boxes or following a script; it was about understanding their specific challenges during their daily activities and helping them find practical solutions that fit the context of this specific health clinic. This approach made them more open to feedback, and I could see that they felt more supported, which is so important, especially when dealing with sensitive issues like HIV care and working with key populations. Many former mentees still call me to discuss something that happened on their day, or as for guidance on a more complicated case."
>
> Mentor, AHD

ALIGNMENT WITH HIV/AIDS STRATEGIC PLANS AND POLICIES

The mentorship component of AHD decentralisation in Beira aligns with national HIV policies and guidelines, enhancing local capacity to deliver quality care and treatment, though there remain areas for improvement. This approach supports the transition from centralised, hospital-based care to

community-based services, addressing key challenges outlined in documents like the ***"MSF HIV/TB Guide"*** and the ***"Clinical Mentorship Program Guide"***. By providing tailored training and support, the mentorship component contributes to advancing UNAIDS 95-95-95 targets, which focus on diagnosing, treating, and achieving viral suppression for 95% of people living with HIV.

This mentorship component fosters collaboration between the Ministry of Health and community health workers (CHWs), helping to improve service delivery and patient retention while remaining consistent with Mozambique's national HIV response framework. Integrating mentorship into decentralised care built local expertise and capacity, which ensures accessible care, especially for vulnerable and marginalised populations. This, in turn, contributes to reducing HIV-related morbidity and mortality, supporting more equitable healthcare access.

In Mozambique, CHWs, including *'mãe mentora'* (mum mentor) and *'homem campeão'* (man champion), play a key role in patient outreach, linkage, and retention in care. While these CHWs were not formally included as mentees in MSF's mentorship program, the initiative indirectly influenced and supported their work within the broader community health framework. CHWs benefited from improvements in healthcare practices fostered by the mentorship, which led to a more patient-centred approach and improved communication between healthcare facilities and the community. By fostering informal interactions and partnerships with activists, the project contributed to enhancing HIV and TB care outcomes through a collaborative and supportive network.

> "Through this mentorship, we've seen much stronger collaboration between our mentees and community health workers, like the 'mãe mentora' and 'homem campeão.' Even though they weren't formally part of the mentorship, they work closely with mentees trained in AHD and KP care. For example, if a patient misses their ARV refill, mentees often reach out to these community workers to locate the patient and remind them of their appointment. If a community worker identifies someone, like a sex worker, in need of care, they'll often accompany them to the clinic, knowing exactly who to approach—those trained in KP care who are sensitive to their specific needs. This improved communication between mentees and community workers has made follow-ups easier, ensuring patients remain in care. It's been a significant step in making sure even the most vulnerable populations are not left behind."
>
> Mentor, AHD and KP

COHERENCE WITH OTHER PROJECT DECENTRALISATION ACTIVITIES

The mentorship component of AHD decentralisation in Beira appears to be well-aligned with other decentralisation efforts led by MISAU, such as logistics support to local healthcare facilities. Through targeted training, the mentorship program complements logistics activities like drug supply management and laboratory support, enabling local facilities to enhance their HIV services. This

integrated approach is crucial as it strengthens the supply chain and could improve the availability of essential resources like diagnostic tools.

However, many mentees and mentors raised concerns about recurring supply chain issues that frequently disrupted laboratory activities and the availability of treatment for opportunistic infections. As one mentee from Chingussura HC expressed:

> "During the mentorship, MSF ensured we had all the necessary supplies for lab testing, office materials, forms for recording patient results, and tools for follow-ups. However, our current reality is challenging. While we now have the knowledge and skills to provide excellent care, we frequently face shortages in lab supplies. MISAU often sends fewer supplies than we request, and we regularly run out of essential forms to record patient information and lab results. The mentorship program was an amazing training, but we're now struggling with a difficult situation where inadequate supplies hinder our ability to fully implement the strategies and skills, we learned during the MSF mentorship."
>
> Mentee, Chingussura HC

This highlights the need for better coordination to ensure that the necessary resources are consistently available, allowing healthcare workers to apply the skills and knowledge gained from the mentorship.

Mentors and MISAU representatives viewed the mentorship component of AHD decentralisation in Beira as an opportunity to strengthen collaboration between the central MISAU government and local healthcare clinics, contributing to the broader decentralisation process. This collaboration was seen as essential in reinforcing the role of local governance in healthcare delivery and promoting sustained commitment from both local and national authorities to support decentralised service models. However, despite these positive intentions, some gaps in coordination were noted. The mentorship component had the potential to contribute to broader systemic improvements, contributing to the broader efforts from MISAU to enhance the effectiveness, sustainability, and scalability of the national HIV response.

MSF supported these efforts not only by offering the mentorship component but also by improving lab stock management and contributing to infrastructure enhancements, which complemented the mentorship initiative. However, as one MISAU representative noted, there were missed opportunities for greater collaboration and alignment between MSF's efforts and MISAU's existing programs.

"I believe that there was a significant weakness in an otherwise strong strategy, the MSF mentorship. MISAU already had a similar HIV training initiative in place, so MSF didn't need to start from scratch. If there had been a partnership from the beginning, MSF could have complemented MISAU's existing program, particularly by adding its focus on AHD, which was missing from the MISAU training. It wasn't about creating a separate, parallel program—it could have been about enhancing what was already there. Now that the MSF mentorship has ended, we've gone back to the old training system, which lacks that critical focus on AHD. If MSF and MISAU had collaborated earlier, we could have had a fully integrated, ready-to-go package by now."

MISAU Representative

COHERENCE WITH OTHER INTERVENTIONS IN MOZAMBIQUE

Although the evaluators were unable to interview other NGOs and stakeholders involved in the decentralisation of AHD services in Beira, valuable information regarding complementary interventions was obtained through a literature review and interviews with members of health centres. Mozambique benefits from funding for HIV response, which includes resources for testing, laboratory capacity building, and the procurement of medications. In the ten health centres that received mentorship from Médecins Sans Frontières (MSF) as part of the decentralisation initiative, medications are supplied by the Global Fund. This arrangement necessitates that health centre staff possess the requisite skills and competencies for effective drug management, encompassing everything from prescription practices to pharmacy and supply chain management. The mentorship component aimed to enhance staff capacity, which is believed to contribute to improved drug and pharmacy management. Prior to the implementation of the mentorship component, identified gaps indicated a pressing need for enhanced capacity to manage advanced HIV disease at the health centre level, particularly in light of the introduction of new and diverse medications provided by external partners, notably the Global Fund in the context of Beira. This observation underscores the coherence between the mentorship component of the decentralisation effort implemented by MSF and other interventions led by different organisations, such as HIV testing and drug supply initiatives. A limitation of this evaluation, however, is its inability to thoroughly explore the activities undertaken by other NGOs or funding entities, such as PEPFAR, the Global Fund, and the World Bank, which are primary contributors to the HIV response in Mozambique.

EFFECTIVENESS

ROLES AND RESPONSIBILITIES OF MENTORS

In-depth interviews with mentors shed light on their roles and responsibilities within the mentorship. These mentors, chosen for their expertise in critical areas like laboratory services, SRH, KP, and AHD, were experienced MSF staff tasked with providing guidance and support to their colleagues to improve healthcare delivery in local clinics. Most mentors received specialised training aligned with their focus areas, preparing them to effectively share knowledge and offer practical support. However, a few mentors mentioned starting their mentorship roles without adequate training, as reflected in the quote below.

"Before the mentorship project began, I was already working with MSF, visiting healthcare clinics to offer informal supervision and guidance in sexual and reproductive health. When the mentorship project started, I was asked to become a mentor without any formal training, as MSF assumed my prior experience would be enough for the role. However, the beginning felt rushed, and the lack of structured training left me feeling overwhelmed and insecure. I had to rely heavily on weekly meetings with other mentors to share challenges and find solutions, and I often turned to the mentorship supervisor for guidance. Although I had experience providing informal training, I wasn't familiar with the structured approach, guidelines, and reporting requirements of the mentorship project, which I had to figure out on my own. Over time, I grew more comfortable in my role, but I believe having proper training beforehand would have been incredibly helpful."

Mentor

Mentors with a background in laboratory work played a critical role in enhancing lab practices and improving diagnostic accuracy. Those with experience in mobile clinics and SRH focused on providing education around vital topics, including SGBVs and SACs. Mentors specialising in advanced HIV care and KP services worked closely with healthcare professionals to manage complex HIV cases and address the specific needs of vulnerable populations, ensuring that comprehensive and inclusive care was available.

Despite some initial challenges—such as assuming their roles without formal training—mentors quickly adapted, relying on their prior experience and frequent collaboration with MSF colleagues to navigate uncertainties. This flexibility enabled them to successfully fulfil their mentorship duties, even in complex and evolving healthcare environments.

"I worked with MSF as a focal point in the field of advanced HIV care, and due to my prior experience, I was selected to join the mentorship program as a mentor. However, I started the role without any formal training and only received mentorship training from MSF after I had already begun mentoring. Despite this, I adapted quickly because I was already well-versed in managing AHD, which allowed me to effectively guide my mentees. Even now, some mentees still reach out to me for advice on specific cases, such as adjusting ARV regimens or dealing with particular opportunistic infections. I'm always happy to help and provide guidance when needed."

Mentor, AHD

Overall, most interviewed mentors reported feeling well-trained and supported by MSF, which allowed them to excel in their responsibilities. They regarded their involvement in local clinics as essential not only in skill transfer but also in improving service delivery and contributing to the success

of the decentralisation initiative. Their diverse expertise, combined with a structured mentorship approach, played a pivotal role in building the capabilities of local healthcare professionals and reinforcing decentralisation efforts across the region.

As one mentor, a laboratory technician, reflected:

> "Through the mentorship I felt empowered not just to share my expertise, but to truly transform the way healthcare was delivered in the clinics. It wasn't just about training—it was about creating lasting change by equipping my colleagues with the skills and confidence they need to provide better care, especially for those who need it most. The support from MSF gave me the tools to guide others, and seeing the impact on both the staff and the patients has been incredibly rewarding."
>
> Mentor

Diverse roles in decentralised HIV care

Focus group discussion (FGD) with 28 mentees (from a total of 124 who received MSF mentorship) highlighted the varied roles and responsibilities participants held in HIV service delivery, which appeared to contribute to the overall perception about the effectiveness of the mentorship component within the decentralisation of HIV care. These mentees, including laboratory staff and patient care providers, played a crucial role in ensuring positive outcomes. Laboratory staff were responsible for conducting tests, organising supplies, requesting reagent kits, and recording results, all of which ensured timely and accurate diagnostics to support effective patient management.

> "I The mentorship program gave me an incredible opportunity to deepen my knowledge of advanced HIV care and gain a better understanding of the specific needs of key populations. For HIV-positive patients, I've significantly improved my approach by spending more time with each individual, carefully evaluating them clinically, asking about signs and symptoms, and ensuring they're in good health before prescribing ARVs or scheduling their next appointment. When there is any uncertainty, I immediately request a CD4 test. Patients with CD4 counts below 200 cells/mm^3 are referred for additional tests, like TB and CrAg screenings, and if everything goes smoothly, they leave with the treatment they need for opportunistic infections. The same level of attention is now provided to key populations, and I feel more informed and sensitive to their needs, which allows me to offer better counselling, HIV testing, PrEP, and more. The mentorship was exactly what I needed as a healthcare professional to better serve my community."
>
> Mentee Nhaconjo HC

Patient care providers focused on counselling, promoting ARV adherence, referring patients to specialised care, and tracking patients to improve retention—critical tasks for ensuring treatment continuity and better health outcomes. Some mentees worked specifically with KP, a few in mobile health units, offering services such as HIV PrEP, counselling, and treatment for people living with HIV/AIDS in hotspot areas. This approach helped extend healthcare services to marginalised groups that often face barriers to access.

Others worked in prenatal care and maternity wards, providing HIV counselling, rapid testing, and prevention of mother-to-child transmission (PMTCT) services, working to improve early intervention and reduce HIV transmission risks. A few FGD participants were involved in providing SAC, addressing broader sexual and reproductive health needs. Collaboration with peer educators and community-based organisations, according to a few mentees, helped improving the impact of the mentorship, allowing mentees to better engage and retain KPs in care through services like PrEP, PEP, and rapid testing—essential components of HIV prevention and treatment.

> "I would go out with the mobile clinic and talk to them—sex workers, gay men, transgender people. Over time, they got to know me, liked me, and would even wait for our car at the same spot on the day and time we were scheduled, seeking tests, medications, and other services. Eventually, they began coming to the clinic specifically asking for me. I became a focal point for them. The MSF mentorship really enhanced my ability to provide better counselling and care, particularly for those key populations with advanced HIV disease. I now understand how to communicate with them more effectively and the importance of ensuring they get timely care. If someone misses an appointment, we work with community health workers like 'mãe mentoras' to bring them back to the clinic. It's a group effort, really."
>
> Mentee, Manga Mascarenhas HC

These varied roles demonstrate an integrated approach to providing HIV care at local clinics, ensuring, to the best of local resources, that services were tailored to meet the diverse needs of different patient groups and supporting the overall success of the mentorship component of HIV decentralisation in Beira.

KNOWLEDGE AND CONFIDENCE OF MENTEES

Participation in the mentorship

A total of 124 participants took part in the mentorship component of HIV decentralisation initiative across 10 health centres in Beira. Collectively, they participated in 181 training sessions. The distribution of participants by mentorship area and health centre is presented in the chart below.

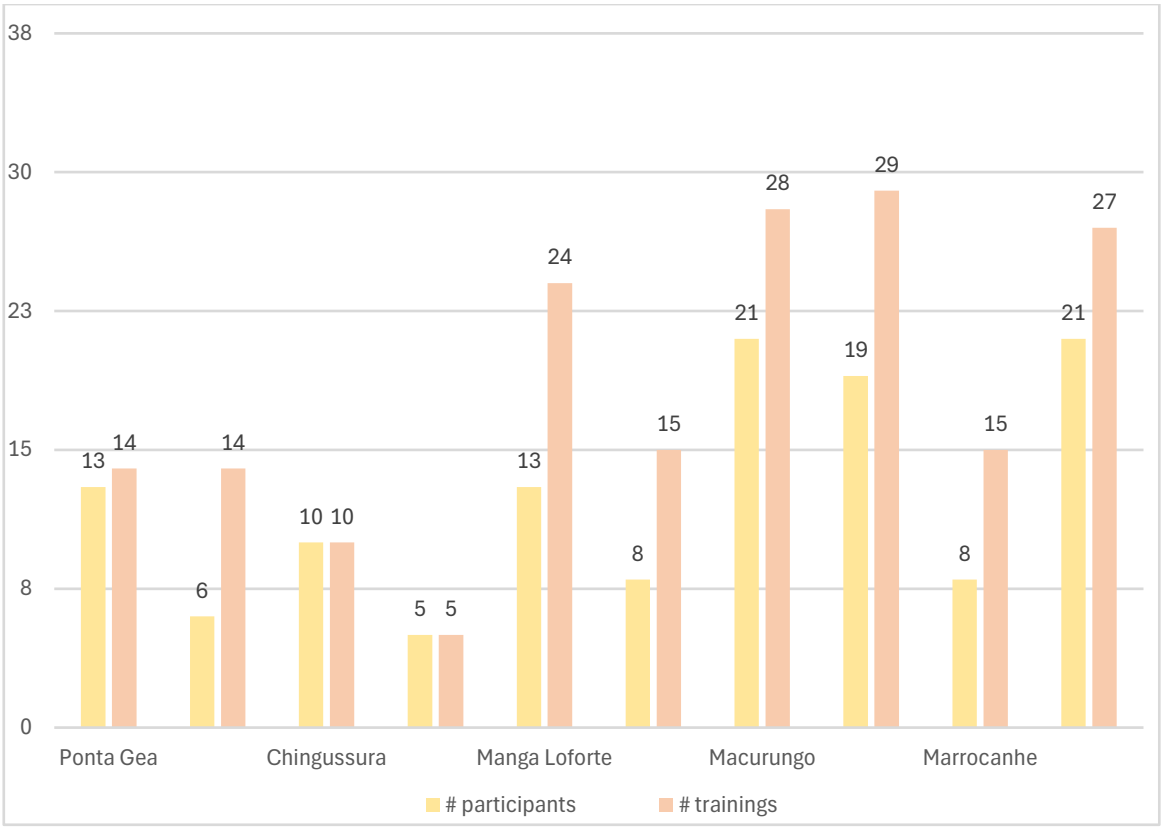

Figure 2. Number of participants, by training and health centre

The number of participants in the mentorship component varied significantly across health centres, largely due to the diverse sizes of the facilities. However, all centres received mentorship training in AHD, KP and SRH and some had laboratory and pharmacy best practices mentorship as well.

Among those who participated in the training, engagement levels—measured by the activities recorded in the logbooks— were above 85% across health centres. The charts below illustrate that participation rates exceeded 85% across all health centres and for all mentorships.

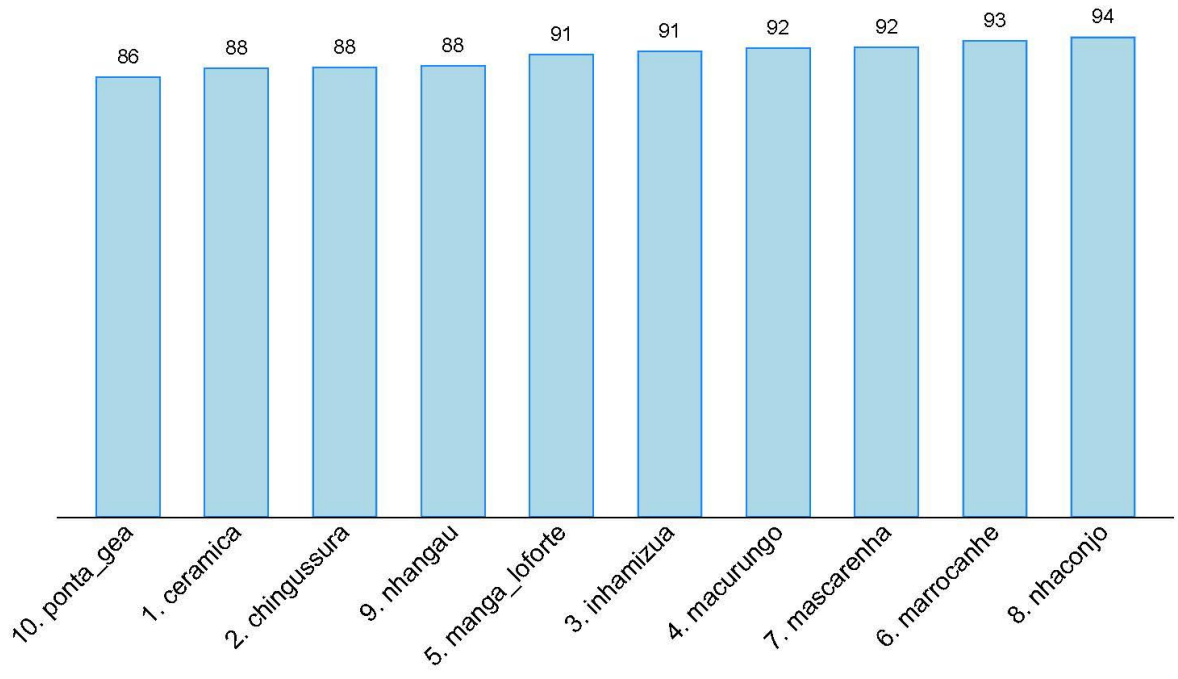

Figure 3. Mean participation by health centre

The chart below illustrates participation in the mentorship across various training modules, with coverage rates ranging from 85% for AHD and KP training to 96% for SRH. These participation figures highlight the involvement of healthcare workers from different health centres, ensuring that key areas such as HIV management, SRH, and services for KP were adequately addressed through the training.

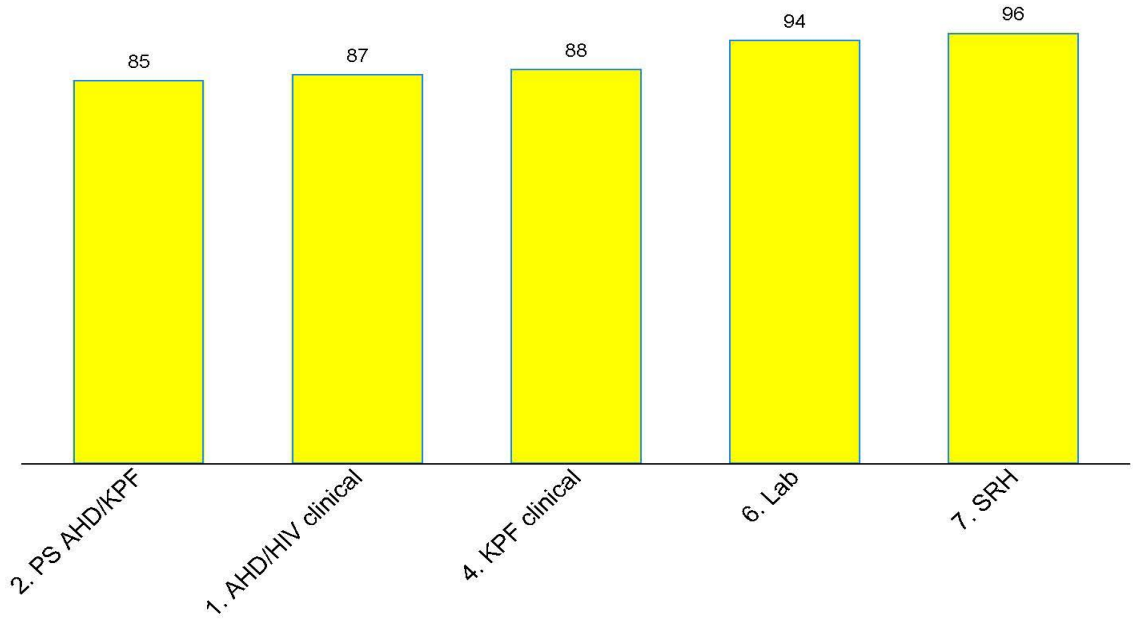

Figure 4. Mean participation (%) by mentorship

Discussions and data analysis revealed that participation in the mentorship did not necessarily equate to full engagement or the development of competencies among mentees. Although Memorandums of Understanding (MoUs) were signed with health facilities and the Ministry of Health (MISAU), and participants were selected or designated by their supervisors, this did not guarantee their motivation or investment in the mentorship. In some cases, mentees viewed learning new skills—such as managing AHD—as an additional burden to their already demanding workloads, especially in the absence of incentives or rewards for their participation.

> "It was hard balancing mentoring with patient care during our working hours—we often felt stretched, and neither task was done to the best of our ability. Another major concern was the lack of financial support. Many healthcare professionals chose not to participate in the mentorship for this reason. You're putting in extra hours to improve not only your own practice but also the clinic's performance indicators, right? Everyone in our group agrees that even a small financial incentive would make a huge difference in getting more people to commit to the training."
>
> Mentee Macurungo HC

Some specific challenges were faced by the mentorship regarding the participation and engagement of mentees and mentors. The mentors encountered several key challenges during their work in the mentorship component of AHD decentralisation:

1. **Resistance from healthcare workers:** Many healthcare professionals were initially reluctant to participate in the mentorship. Some felt confident in their existing practices and saw no need for further training, particularly in sensitive areas like abortion and sexual and reproductive health. Cultural and religious beliefs around abortion further heightened resistance, as some workers believed the mentorship on SRH promoted *"baby killing"*. In some cases, stigma against sex workers and other KP groups continued to hinder the provision of care, despite the mentorship efforts to address these issues. The following quotations summarises frequent perceptions from mentors:

> "At first, many healthcare workers didn't want to participate. They felt like they already knew everything, especially when it came to abortion care. Convincing them that this wasn't just about procedures but about giving patients the support they need was tough. Cultural beliefs run deep, and it took a lot of time and patience to break through that resistance."
>
> Mentor

"In the beginning, it was overwhelming! Many of the lab technicians were resistant to change—they didn't want to let go of their old practices or learn new procedures. The labs were disorganised, with no SOPs [Standard Operating Procedures] or proper supply management. We frequently ran out of essential materials because there was no system in place to track inventory or place timely orders. Worse, they didn't keep any patient lab records; once results were given to the patient, that was it. If the patient lost them, or if a doctor needed to check their history, there was no information on file. It took a lot of effort, but we eventually got the labs organised, set up SOPs, and trained the technicians on inventory control. Now, even if a new technician comes in, they know exactly what to do. The mentorship really improved service quality and patient outcomes—patients don't need to travel far for tests like CD4 and viral load anymore, they can get everything at their local clinic."

Mentor

Figure 5. Flowcharts and testing algorithms at the Ceramica Health Centre

As shown in the above image, flowcharts and testing algorithms are readily available in the clinics to guide the proper management of patients, following the guidelines provided during the MSF mentorship.

2. **Lack of formal training for mentors:** Several mentors started their roles without formal preparation. This left them feeling overwhelmed and unprepared, especially when facing structured mentorship processes, guidelines, and reporting requirements. They often relied on peer support and supervisor guidance to navigate their new responsibilities. Formal training before the start of the mentorship would have significantly improved their readiness. The following quotation captures a common sentiment expressed by mentors who began their roles without prior training.

> "When I started as a mentor, I thought my experience would be enough, but I quickly realised I wasn't prepared for the structured mentorship. There were so many guidelines and reporting requirements that I had to learn on the job. It was overwhelming at first, and I really wish we had formal training before we were thrown into the role."
>
> Mentor

3. **Overworked and understaffed clinics:** Mentors often found healthcare workers overwhelmed by their existing workloads, making them hesitant to engage fully in the mentorship. Many viewed the training as an additional burden without financial compensation, which contributed to a lack of motivation and commitment to putting into practice-acquired competencies. The quote below reflects a common perception regarding resistance to changing routines among mentees.

> "The lab technicians were already stretched thin and asking them to learn new procedures felt like adding fuel to the fire. They were set in their routines and convincing them that change was necessary was one of the hardest parts. I had to show them, step by step, that these changes would actually make their jobs easier in the long run."
>
> Mentor

4. **Disorganisation in Clinics:** Many clinics lacked Standard Operating Procedures (SOPs), proper inventory management, and systematic approaches to care. Mentors, especially those focusing on laboratory services, faced the daunting task of improving operational efficiency in disorganised settings. The absence of proper record-keeping and supply management further complicated their efforts, as illustrated by the following quotation:

> "The labs were a mess—no proper inventory, no records of patient results, and constant shortages of supplies. It felt like I was fighting an uphill battle just to get the basics in place. But I knew if we didn't fix these things, the quality of care would never improve..."
>
> Mentor

5. **High Turnover of Mentees:** Frequent staff transfers disrupted the continuity of the mentorship. Mentees were often relocated to different clinics before completing their training, hindering the mentorship long-term effectiveness and continuity of care in certain areas. Many mentors expressed frustration over the impact of high staff turnover at healthcare clinics, as indicated in the quote below.

> "It was frustrating to start mentoring a group of healthcare workers, only to have them transferred to another clinic halfway through the training. It disrupted everything and made it hard to maintain the continuity needed for real progress. We needed better coordination to make sure mentees can complete the mentorship without interruptions."
>
> Mentor

6. **Mental Health Toll:** Dealing with traumatic cases, such as the rising instances of child rape, left some mentors emotionally overwhelmed. Many mentors recognised the need for mental health support to help healthcare professionals process their experiences, as the emotional burden of their work affected both their personal lives and their ability to provide care, as illustrated by the following quote:

> "The hardest days were when I worked with survivors of sexual violence, especially young girls. After seeing so many traumatic cases, I'd go home feeling numb, and it started affecting my family life. There's only so much one person can handle before it starts taking a toll, and mentors like me need more mental health support to deal with these experiences."
>
> Mentor

7. **Medication diversion and black-market issues:** In the SRH mentorship, in a few healthcare clinics, mentors faced issues with the diversion of essential medications like mifepristone and misoprostol, which were sometimes sold on the black market. This compromised the availability of safe abortion options and created additional challenges in ensuring patients received proper care, as demonstrated in the following quote:

> "One of the biggest challenges we faced was the disappearance of essential medications like mifepristone and misoprostol. We later found out they were being sold on the black market, which made it even harder to provide safe abortion care. When the drugs were not available, patients were left without the options they needed, and it really compromised the quality of care we were trying to offer."
>
> Mentor

8. **Inadequate Collaboration and Communication:** Poor communication between MSF and clinic directors sometimes disrupted mentorship sessions, with mentees being pulled away for other tasks. A lack of coordination between the organisations also led to mentees missing critical training sessions due to prior commitments or scheduling conflicts, as illustrated by the quote below:

> "There were times when poor communication really messed things up. We'd be in the middle of a mentorship session, and mentees would get pulled away for other tasks because the clinic directors weren't on the same page. Plus, a lot of mentees missed key training sessions because of scheduling conflicts that could've been avoided with better coordination."
>
> Mentor

These challenges collectively highlight the complexities of implementing a mentorship in resource-limited, culturally diverse healthcare settings.

Specific improvements brought to mentees by mentorship

Despite the challenges presented above, there is definitive evidence of improvement in mentee competencies and knowledge as the charts below attest. Figure 4 shows the percentage increase in post-test scores for all health centres except Manga Loforte; while Figure 5 shows a similar increase in all subject areas.

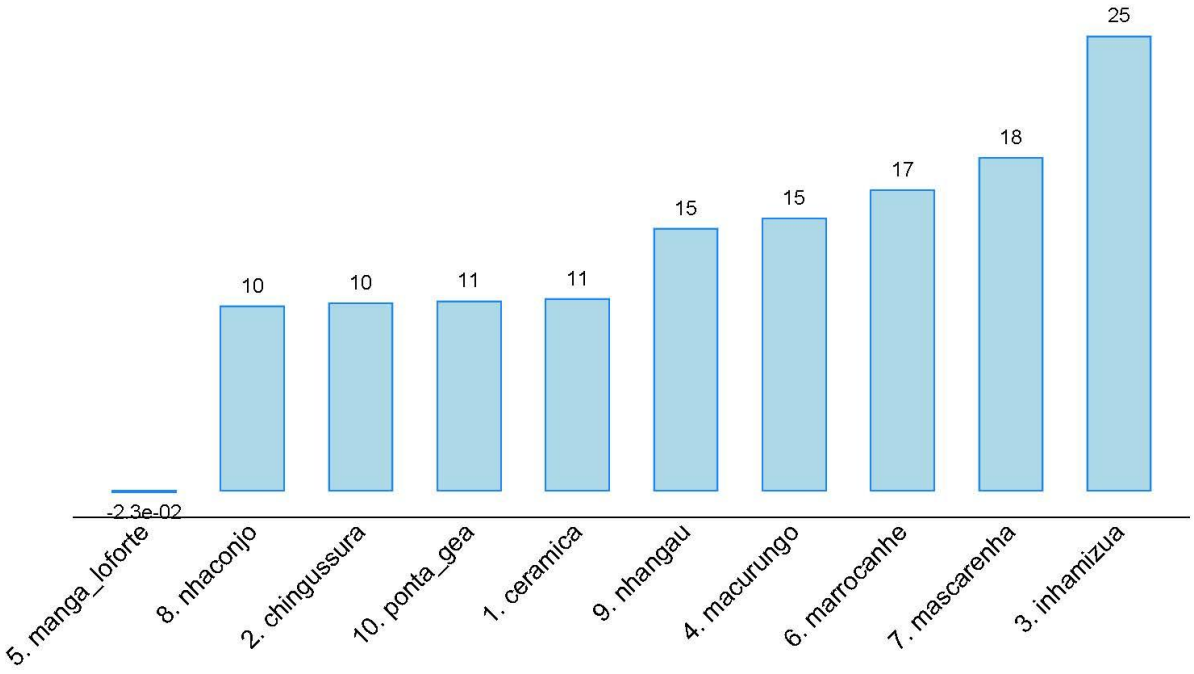

Figure 6. Percent improvement in test scores, by health centre

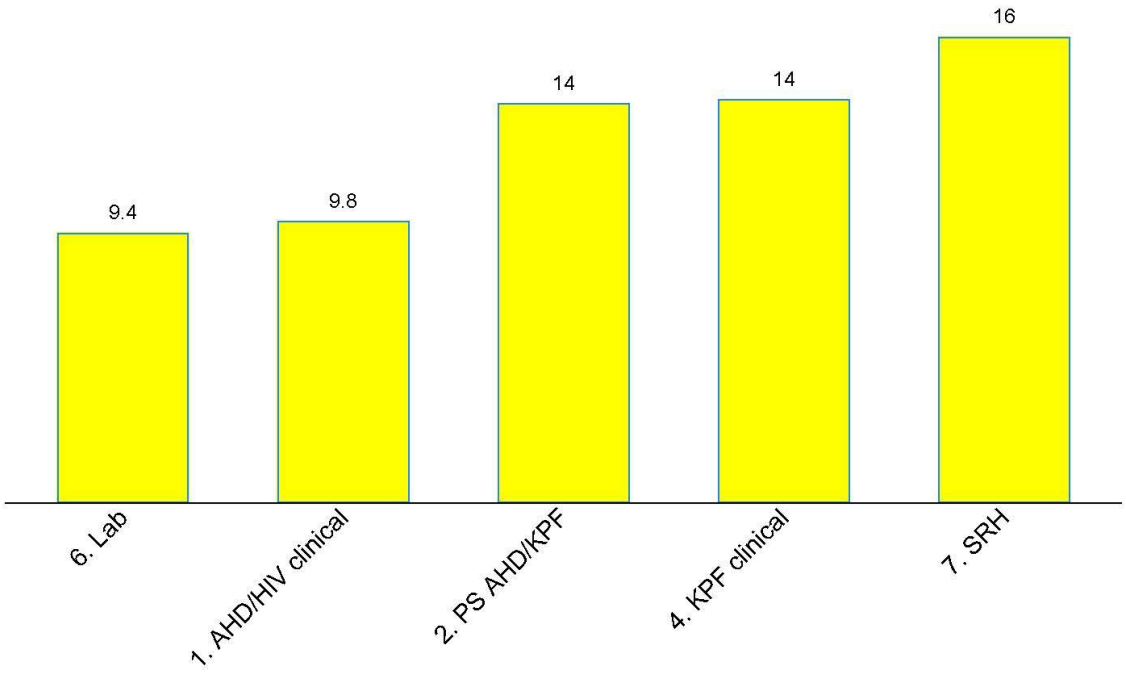

Figure 7. Percent improvement in test scores, by mentorship training package

Findings are similar in the global impact scores (as assessed by the mentor) **Figures 8** & **Figure 9** show a remarkable increase in these scores across all centres and for all the mentorships.

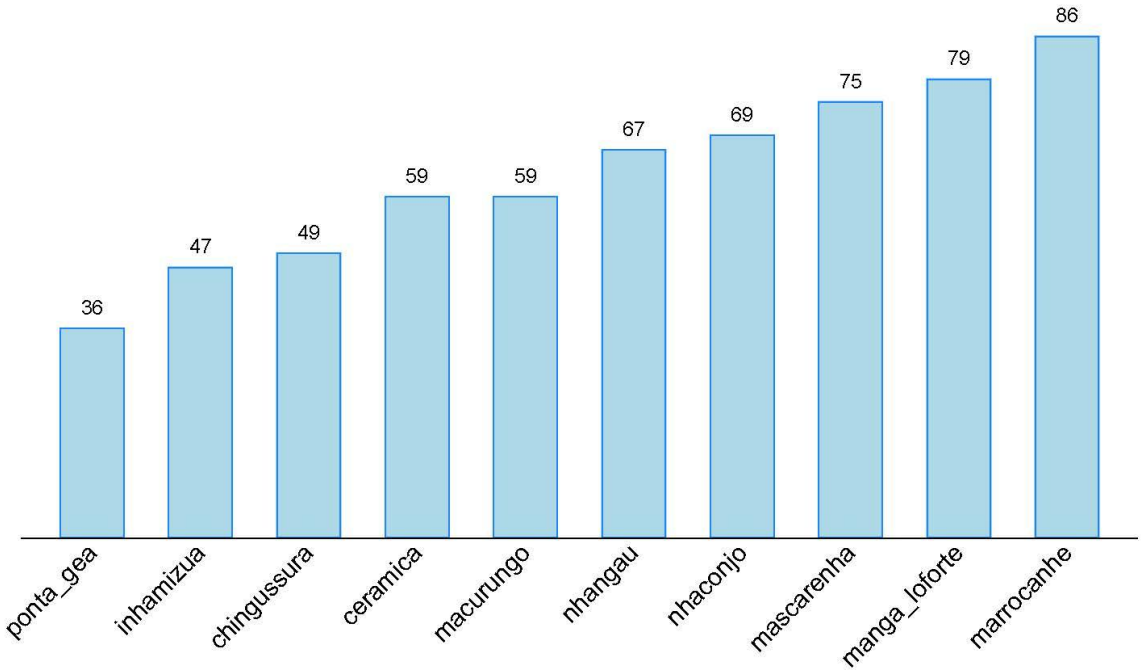

Figure 8. Percent improvement in global impact scores, by health centre

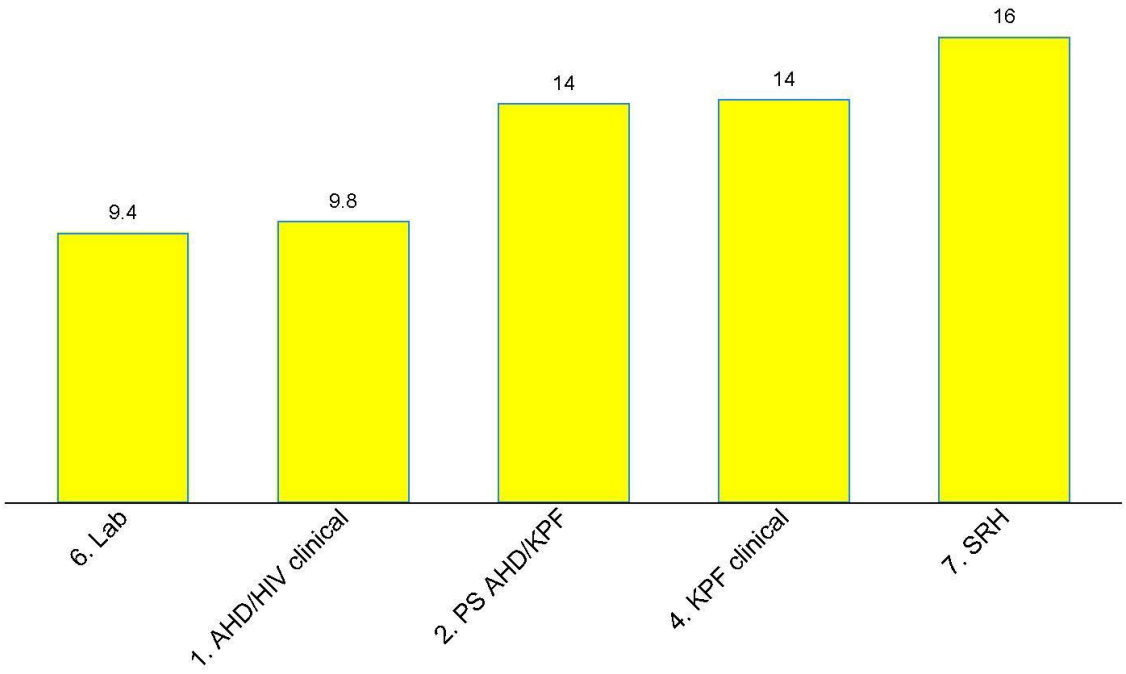

Figure 9. Percent improvement in global impact scores, by mentorship training package

DECENTRALISATION OUTPUTS AND OUTCOMES IN HC

Advanced HIV disease outcomes

In **advanced HIV care**, the mentorship component lasted 12 weeks and focused on the early diagnosis and management of opportunistic infections, patient retention, ARV adherence, and increased testing for TB and cryptococcal antigen. The mentorship component aimed to reduce early morbidity and mortality by improving healthcare professionals' ability to manage complex HIV cases and coordinate care with central hospitals when necessary.

> "I used to see a patient walk into the consultation room and think, 'Good, they seem fine.' But now I know that being able to walk doesn't mean much. They could be walking in and suddenly collapse, dying right in front of me. HIV is a tricky disease, and you can't tell who's really well just by looking at them. There's no way to judge someone's health just by their appearance. I didn't know that before MSF mentorship. For patients with advanced HIV, I know the protocol of testing and treatments to follow now."
>
> Mentee, Health Centre of Manga Loforte

The mentorship contributed to better service integration, allowing patients to access multiple services—such as blood tests, medication refills, and clinical consultations—during a single visit. This reduced the burden of multiple clinic appointments, making care more efficient. Mentors noted that healthcare workers gained a deeper understanding of comprehensive HIV management and became more adept at identifying advanced HIV cases early. Additionally, the mentorship fostered a culture of support, with mentees continuing to seek guidance from mentors even after the formal training period ended, illustrating the ongoing value of the program.

> "I have seen that the mentorship program has led to great improvements in the flow of care for people living with HIV/AIDS. In many clinics, patients can now access multiple services in a single visit, such as blood work, prescription refills, and clinical appointments, all on the same day. This changed, before the mentorship it was not like that. For clinics that do not yet offer this "one-stop-shop" model, efforts are being made to schedule all necessary appointments on the same day to reduce the burden of multiple trips to the health clinic for patients."
>
> Mentor

According to most mentors interviewed, the general perception is that the mentorship program has improved healthcare professionals' understanding of advanced HIV care, enabling them to recognise complex cases earlier and provide appropriate, timely treatment. This proactive approach seems to be enhancing patient retention and outcomes by ensuring that patients receive comprehensive care—including tests, medication, and consultations—all in one visit. According to the majority of mentors, this streamlined process has reduced the chances of patients being overlooked, contributing to better overall management of advanced HIV and improved health outcomes in the community. These quotes highlight the transformative impact of mentorship component on healthcare services, patient care, and the professional development of healthcare workers.

> "One of the most rewarding parts of the mentorship has been seeing healthcare professionals really understand the complexities of advanced HIV. Now, they're able to catch it early, provide the right care, and ensure that patients don't fall through the cracks. We have even set up systems where patients can get everything, they need in one visit, from tests to medication. It's made a huge difference in patient outcomes."
>
> Mentor

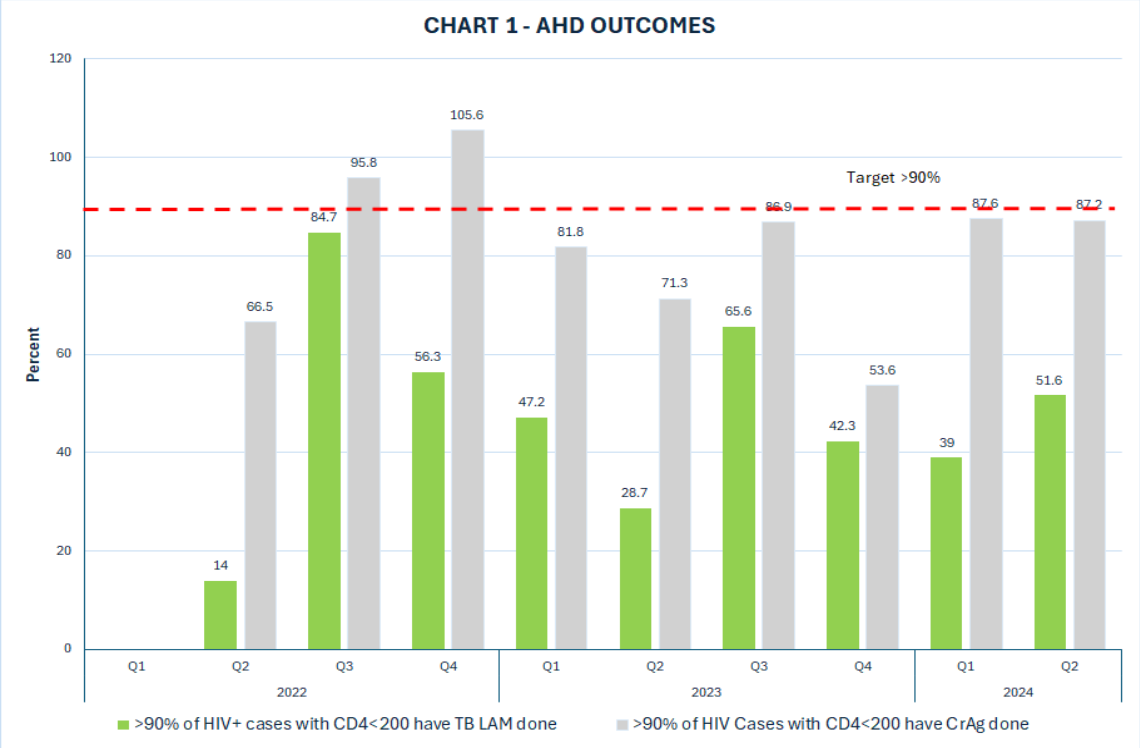

Figure 10. Advanced HIV disease outcome of the decentralisation at the PHC

Challenges:

According to many participants, before the mentorship component, healthcare workers often referred critically ill patients to Beira Central Hospital, where many arrived in poor condition and passed away shortly after admission.

> "Before MSF mentorship, many HIV patients were arriving at Beira's major hospital, Hospital Central da Beira (HCB), in very advanced stages of the disease, with a huge percentage of them succumbing to the illness just days after hospital admission. And this high mortality rate was a big worry for MISAU, and, of course, healthcare professionals in general."
>
> MISAU representative

The mentorship initiative helped local staff better recognise early signs of immunosuppression, particularly in patients with advanced HIV, leading to more timely referrals and lab investigations, which improved patient outcomes by enabling earlier interventions. However, sustaining this level of care has become increasingly challenging without MSF's ongoing support. Although the mentorship project introduced valuable skills and protocols, many healthcare facilities now face difficulties in maintaining proactive care due to limited resources, including diagnostic tools, medications, and lab supplies, as this mentee summarises:

> "We have experienced three distinct phases: before the MSF mentorship, during the mentorship with ongoing supervision, and now, after the mentorship has concluded. Before the MSF mentorship, we were providing the best care we knew how, but in hindsight, we were likely sending home many patients with advanced HIV that we failed to detect. Mortality rates were high, and many patients abandoned their treatment. During the mentorship, it felt like we were in an ideal situation. We were learning and practicing under MSF supervision, growing more confident each day. MSF ensured we had all the necessary supplies for lab testing, office materials, forms for recording patient results, and tools for follow-ups. However, our current reality is challenging. While we now have the knowledge and skills to provide excellent care, we frequently face shortages in lab supplies. MISAU often sends fewer supplies than we request, and we regularly run out of essential forms to record patient information and lab results. The mentorship program equipped us well, but we're now grappling with a difficult situation where inadequate supplies hinder our ability to fully implement the strategies and skills, we learned during the MSF mentorship."
>
> Mentee Chingussura HC

According to some mentees, although the MSF mentorship equipped healthcare professionals with the skills to diagnose and manage advanced HIV, the lack of essential resources, such as point-of-care testing tools like Visitec, has severely hindered their ability to apply this knowledge. Especially in health centres that lack full laboratory infrastructure, patients must now travel long distances to access CD4 testing, leading to missed diagnoses and delayed treatment for opportunistic infections. According to mentees, many patients, due to financial or personal constraints, are unable to make these trips, leaving them without the necessary care. This gap in resources undermines the progress made during the mentorship and leaves healthcare workers feeling frustrated and powerless to deliver the care they know is needed:

> "How can we call it decentralised if patients have to travel long distances to specialised services just to get their CD4 counts? With MSF we had Visitec, which could tell us in minutes if the patient had less than 200 CD4 counts—letting us test for other opportunistic infections and treat them right away. But now we need to refer them… What happens if they don't have the time or money to travel? What if they have no one to look after their kids? Many patients simply don't go, don't get diagnosed with advanced HIV, and don't get the tests and treatment they need. We know what we should do, but we're unable to apply what we learned during the MSF mentorship because we don't have the resources to do so. And that gets me really frustrated, angry even…"
>
> Mentee, Health Centre of Manga Loforte

The net result of these challenges is reflected in Figure 9, which shows the quarterly variation in two measures of AHD outcomes tracked by the project – the percentage of HIV+ cases with CD4<200 who have TB LAM and CrAg done. The project set a target of 90% for these measures, which was met/nearly met in some quarters for CrAg, but never for TB LAM.

Sexual and reproductive health outcomes

a. General comment on SRH outcomes

The **Sexual and Reproductive Health (SRH)** mentorship program spanned three months and included comprehensive training on various topics, such as sexual and gender-based violence, safe abortion care, and a range of SRH services, including contraception, STI prevention and treatment, and maternal health care. Since maternal health care encompasses SRH services like contraception and STI treatment, the training provided a holistic approach to SRH, though it could benefit from clearer distinctions among these services. Beyond clinical skills, mentors also worked to raise community awareness through innovative methods, including collaborations with radio stations and organising drama performances in waiting rooms to dispel common misconceptions about SRH services.

> "To enhance community awareness and encourage the utilisation of SRH services, I collaborated with local radio stations to spread the word. Additionally, we also organised a drama club that performed brief sketches for patients while they were in the waiting room, addressing common misconceptions—such as the belief that SRH services were costly or abortion unavailable—and emphasising that these services were free and accessible."
>
> Mentor

According to both mentors and mentees, the SRH mentorship has transformed how mentees now provide care for individuals seeking safe abortion and survivors of sexual and gender-based violence, with many adopting a more holistic and compassionate approach. This includes offering psychological support, counselling, and legal referrals. Mentors highlighted the significant shift in healthcare professionals' attitudes, who now prioritise long-term psychological care in safe environments, addressing the profound trauma these children experience.

> "The SRH mentorship was about more than just teaching clinical skills—it was about changing perspectives on how we care for vulnerable patients. We focused on sensitive issues like safe abortion and sexual violence, but we also worked to ensure that healthcare professionals understood the importance of providing emotional support and follow-up care. The challenge was helping them see beyond the medical procedures, to really connect with patients on a deeper level. And while many were hesitant due to the lack of financial compensation, those who stayed saw the real impact this kind of care can have on a person's life."
>
> Mentor

> "The biggest change I've seen is in the way we handle survivors of sexual violence. We've moved from just treating their physical wounds to offering real, ongoing support. These patients are no longer just numbers—we've created safe spaces where they can get psychological help, legal support, and follow-up care. It's about treating the whole person, not just their immediate needs."
>
> Mentor

Additionally, the mentorship helped to challenge and gradually change deeply rooted stigma surrounding abortion, leading to expanded access to safe abortion services. This progress has been especially impactful for marginalised groups like sex workers and adolescents, who previously faced considerable barriers to care. Mentors emphasised that healthcare professionals now recognise the critical importance of providing safe, legal abortion services to prevent dangerous alternatives.

> "One of the biggest challenges we had with the SRH mentorship was getting healthcare professionals to participate in training about abortion. Here in Mozambique, abortion is tied up with a lot of cultural and religious beliefs—people think that if you're involved in providing abortion services, you'll be cursed, won't be able to have kids, or even you're going to hell. These beliefs made it really hard to get people to come to the training sessions. But I kept at it, talking to them about how important it is to offer safe abortion care in the clinics. I explained that women who want to end an unintended pregnancy are going to do it no matter what, and if it's not safe or legal, they're risking their lives. Slowly, they started to see that abortion is a necessary part of reproductive healthcare. They even began using these conversations to talk about family planning, HIV prevention, and STI services too."
>
> Mentor

> "At first, many healthcare workers didn't want to talk about abortion. But over time, we've shifted their mindset. They've come to realise that women will seek abortions no matter what, and it's our responsibility to make sure they do it safely. Now, we're seeing more women coming to clinics for safe services instead of risking their lives with unsafe methods."
>
> Mentor

b. Safe abortion care

The mentorship component ensured access to comprehensive SRH care, particularly for those looking for safe abortion care. This is reflected in Figure 11, which shows that the target indicator for SAC

(>90% of SAC requests <12 weeks of pregnancy are done at the PHC) was easily exceeded for all quarters.

Figure 11. SAC outcomes of the decentralisation at the PHC

The mentorship trained healthcare workers on providing safe abortions, but the lack of misoprostol and other essential medications has forced services to send patients to other clinics, and some patients end up seeking unsafe alternatives. This has led to cases of patients returning to the clinic with infections or even sepsis after attempting clandestine abortions, according to some mentees interviewed during fieldwork. Many mentees expressed frustration that despite being equipped with the knowledge and skills to provide life-saving services, the inconsistency in pharmacy stock refills is jeopardising patient safety and care quality.

> "Preventable deaths from unsafe abortions (…) are still happening. It's less common now, but it's still happening. Even after all the effort and amazing mentorship from MSF. The worst part? We're stuck dealing with MISAU's inefficiency—empty stocks, missing tests, poor lab conditions, no misoprostol. We know we could do better, and that's what makes it so heart-breaking."
>
> Mentee, Health Centre of Manga Loforte

> "Without misoprostol, we would have to resort to aspiration abortions—a more invasive method with a higher risk of complications. While it's still better than clandestine abortions, it's far less ideal than simply administering misoprostol pills."
>
> Mentee, Health Centre of Ponta Gêa

The SRH mentorship provided by MSF enabled healthcare workers to offer safe abortion services using misoprostol. However, according to a few participants, this created tensions with other partners, such as UNICEF, who expressed concerns that the focus was shifting too much towards abortions rather than family planning and prenatal care. This reflects a clash of priorities between different organisations, leaving healthcare providers caught in the middle of competing agendas.

> "We received MSF safe abortion mentorship and had access to misoprostol, so whenever a patient sought a safe abortion, we provided it using the pills. But after a while, some partners, like those from UNICEF, started complaining, saying, 'You're making too many abortions! You need to focus more on family planning and prenatal care.' It's a clash of different agendas, you know? And here we are, caught in the middle between these big partners—UNICEF and MSF."
>
> Mentee, Health Centre of Ponta Gêa

c. Post abortion care

Persistent challenges were also identified for the post-abortion care (PAC) by many mentees. For healthcare professionals working in hard-to-reach clinics located in rural areas, inaccessibility to PAC was due to poor roads, lack of transport and long distance from the community to the clinic, as we can see in the quote below:

> "I had this patient who took some herbs to end her pregnancy and started bleeding after a day, and she thought the bleeding would stop. But her bleeding went on for almost one week. When she arrived here, she was really frail and in need of specialised care that we were not able to provide. She was referred to Beira Central Hospital. She came back a few months later and told us that when she arrived at Beira Central, she was given another date to come back and never returned. I'm glad she is alive, but she was not able to receive any post-abortion care…"
>
> Mentee, Ceramica Health Centre

Another persistent issue, according to mentees, is the stigmatisation faced by women seeking post-abortion care, particularly sex workers and adolescents. Despite some healthcare providers participating in the SRH mentorship, many others responsible for SRH services at local clinics did not participate in the mentorship. Some mentees shared instances where women were labelled as "baby killers" or "sinners" by healthcare staff.

> "I remember one day, I was working in another sector and saw a very young woman who was clearly in pain. She told the receptionist she was there for post-abortion care, and I could immediately see the look of disapproval on his face. When I entered the office, I overheard him telling her she needed to go to another window because he wasn't going to deal with 'easy women who were baby killers.' My heart sank when I heard that. I went over to speak with her right away and made sure she got the care she needed. She was devastated. And this is just one example of many. Here in Mozambique, people are very conservative, and abortion and post-abortion care are still huge taboos."
>
> Mentee, Manga Loforte Health Centre

> "When I sought safe abortion services, the nurse recognised me from her community. She knew I was a sex worker, and it was clear she wasn't happy to see me there. She made a point of asking me painful, probing questions about my life, making sure I understood the unspoken message that she believed I was murdering a child, that I was ending a life, and doing the devil's work twice—first by selling my body and then by ending my pregnancy. I had the abortion, but I will never forget the way she looked at me with those sharp, judgmental eyes. I cried almost every night for a long time, feeling like I was nothing but trash."
>
> Activist

Inconsistent support for post-abortion services is reflected in Figure 11 where the target (100% of women who seek post-abortion care have access to services) was met only occasionally.

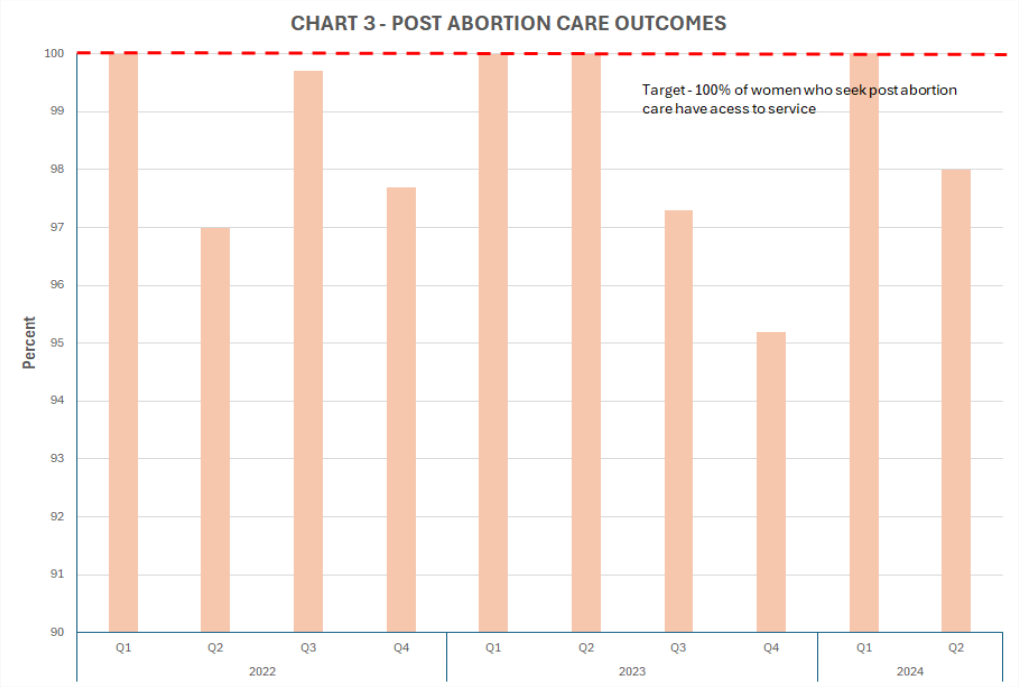

Figure 12. Post abortion care outcomes of the decentralisation at the PHC

d. SGBV survivors care

According to some mentees, they have been observing improvements in how health workers engage with and support survivors of sexual and gender-based violence (SGBV) following the MSF mentorship program. Before the SRH mentorship, survivors often faced judgment, blame, and indifference from healthcare workers, creating barriers to accessing critical support. Many survivors felt stigmatised or dismissed, which led to low levels of trust in the healthcare system.

After the SRH mentorship, mentees have shown a shift towards a more compassionate and patient-centred approach. They now treat survivors with greater dignity and empathy, taking their experiences seriously. This change has helped create a safer, more supportive environment for survivors, making it easier for them to access services like contraception and safe abortion with less stigma or judgment.

> "Since the MSF training, you can tell things have changed a bit. The nurses who went through the mentorship actually listen now, without all the judgment. It's like they finally get that we [sex workers] have unique needs too. Now, it's not such a hassle to get contraception or even safe abortion pills if you need them. They're not looking down on us or turning us away as much, which is a huge relief."
>
> Activist

"I used to feel really uncomfortable treating sex workers, and honestly, I had my own biases and judgments. There was a lot of stigma, even from me. But after going through the mentorship, I realised that it doesn't matter what someone's lifestyle is—when they come to the clinic, they're here for care, and that's what I need to focus on. Now, I'm able to give proper counselling, prescribe PrEP and PEP when needed, and make sure they get the support they deserve, especially after experiencing sexual violence. The mentorship didn't just make me a better healthcare provider, it opened my eyes as a person too."

Mentee, Ponta Gêa Health Centre

Despite these positive developments, certain challenges remain, particularly around the follow-up care for SGBV survivors. The mentorship component set an ambitious target for at least 50% of SGBV survivors to complete their follow-up calendar within six months, but this goal was not met (**Figure 13**). In fact, in most quarterly reports, the indicator remained below 10%, highlighting a critical gap in the continuity of care for survivors. This shortfall underscores the need for more robust systems to track and engage survivors after their initial contact, ensuring they receive ongoing support and follow-up services.

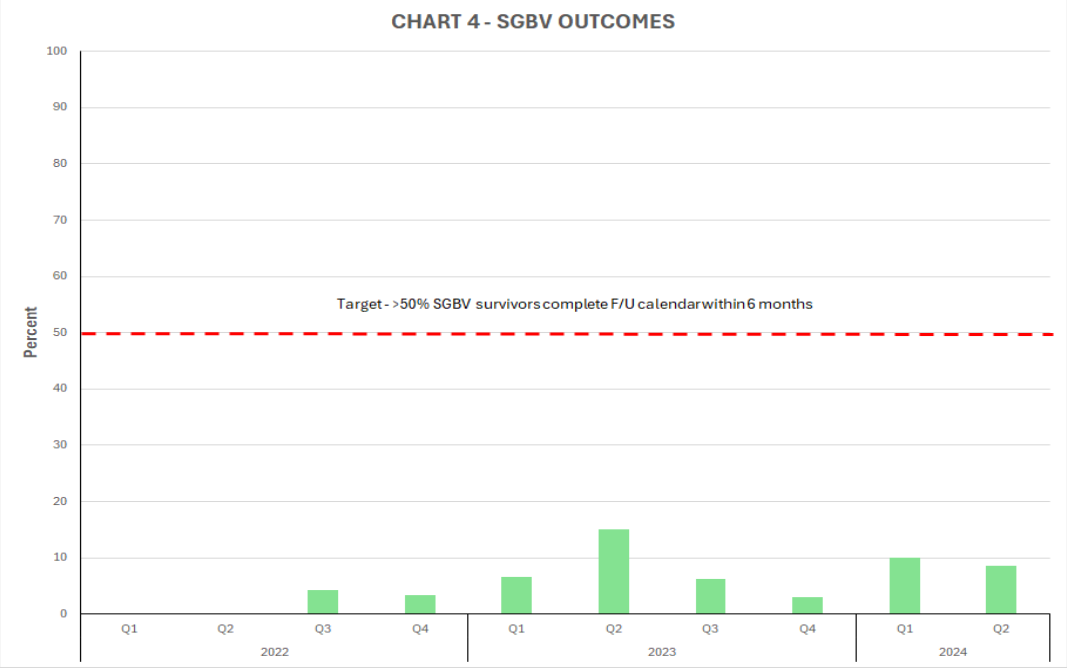

Figure 13. SGBV outcomes of the decentralisation at the PHC

Barriers to accessing SGBV care remain significant for key populations, particularly sex workers. Despite the improvements brought about by the mentorship component, many sex workers continue to face stigmatisation, discrimination, and unequal treatment when seeking healthcare. These barriers often result in delayed care, inadequate support, and feelings of exclusion from the healthcare system.

Sex workers, in particular, report feeling judged for their lifestyle choices, leading to diminished access to essential services such as PrEP, PEP, and safe abortion. The following quotes from activists highlight these persistent challenges and the emotional toll of navigating a healthcare system that often fails to treat them with the dignity and respect they deserve:

> "We, sex workers, we are often treated like we asked for the violence we face. After visiting one of the clinics, we leave feeling like we don't deserve to be there, like we don't belong. It's clear we'll never get the same level of care or attention that non-sex workers receive. We sit for hours, only to be denied PrEP, PEP, and even rapid tests. Safe abortion might be available, but dealing with the nurses is painful—they seem to take pleasure in making us feel like our lifestyle is turning us into monsters, into baby killers…"
>
> Activist

Another participant shared similar concerns about the unequal treatment of women, especially those who identify as sex workers:

> "There's no standard care that treats all women equally, no matter what they do for a living. If you identify as a sex worker, it's obvious you will face longer wait times, get less care (if any), and leave feeling mistreated. It's heart-breaking to see all the hard work we did with MSF being left behind, especially when there's still so much more to be done. Please tell them that we need more time, we need more support. We are dying and nobody cares…"
>
> Activist

Some mentors and mentees reported a significant rise in child rape cases in Beira, often perpetrated by family members. This grim scenario overwhelmed many who had participated in the SRH mentorship component. Healthcare professionals expressed feeling unprepared for the volume and severity of these cases, and the emotional toll was immense. One mentor described the deep emotional strain caused by seeing young children in distressing conditions, which affected both her personal life and increased anxiety about her own family's safety. This quote highlights the strong need for mental health support for healthcare workers themselves, as they continue to grapple with the emotional weight of dealing with such traumatic cases.

> "I wasn't ready for this. It's one thing to do the SRH mentorship and talk about safe abortion and best practices. But mentoring my colleagues who were dealing with case after case of children being raped by their step-parents, uncles... that's a whole other level. No one's prepared for that. After a day working on those cases, trying to support my mentees the best I could, I was completely drained. The images of those kids in such awful conditions stuck with me. It started to affect my personal life too—I didn't want my husband to even bathe our kids. I was anxious all the time, worried about their safety. And I wasn't the only one—my mentees were feeling the same way. I really believe that healthcare workers need mental health support to cope with the trauma of handling these cases."
>
> Mentor

These cases involve particularly vulnerable minors, including infants and very young children, who require not only immediate medical intervention but also long-term psychological support to heal from the trauma. Mentees have made efforts to provide comprehensive care for these patients, and some clinics have established child-friendly spaces to create a more comforting environment for these young survivors. For example, the Health Centre of Chingussura has set up a specially designed room for children who have experienced sexual violence. Outfitted with toys, colourful walls, and a carpeted floor, the room aims to provide comfort and security, reflecting a growing awareness of the importance of trauma-informed care. This initiative acknowledges the significant emotional toll on child survivors and represents an effort to offer compassionate, safe environments for those affected by sexual violence. It is important to note, however, that these safe spaces were developed after the mentorship program concluded and were part of a separate initiative, not directly linked to the mentorship. Despite these efforts, follow-up of those cases was difficult:

> "For children who survived sexual violence, two clinics set up safe spaces with toys and child-friendly decorations to create a welcoming atmosphere where they could feel more at ease talking with healthcare professionals and getting the care they needed. The trauma these children endure calls for more than just immediate medical attention—it demands long-term psychological support to help them heal and rebuild their lives. Providing a safe, nurturing environment for these young survivors is crucial but also incredibly challenging. Healthcare professionals, now trained through the SRH mentorship, are doing everything they can to offer comprehensive care and support, focusing on both the children and their legal guardians, with the utmost priority on their safety and well-being at every step. Case follow-up is very delicate and difficult, though - especially if the child is living with the perpetrator…"
>
> Mentor

The findings highlight several challenges and improvements in how healthcare workers address SGBV following the SRH mentorship. A large number of mentees and mentors perceived a shift towards

more compassionate, patient-centred care, especially for survivors of violence and key populations such as sex workers. Despite these improvements, many barriers persist, particularly regarding stigmatisation and unequal treatment of sex workers. Survivors often face judgment and discrimination, resulting in delayed or inadequate care. Additionally, the rising cases of child rape in Beira overwhelmed many healthcare workers, who felt unprepared for the emotional toll of handling such cases. Although efforts were made to create child-friendly environments and provide psychological support, follow-up care remains challenging, particularly for children still living with their abusers. Mentors emphasised the need for ongoing mental health support for healthcare workers themselves to manage the trauma they encounter in these cases.

Specific services for KP

Clinic directors across various health centres have observed that following the MSF mentorship the mentees had improved sensitivity and competencies/skills to engage with and support KP. Some clinics, such as the Macurungo Health Centre, have introduced dedicated areas specifically designed to cater to the needs of KP. These spaces offer services like PrEP, PEP, and comprehensive counselling, which includes not only health education and risk reduction strategies, but also emotional and psychological support tailored to the unique challenges faced by KP. This holistic approach fosters a more inclusive and supportive healthcare environment, aiming to make healthcare settings more welcoming and responsive to the needs of vulnerable groups.

Our field observations identified that after the MSF mentorship for KP, many health centres have partnered with KP led community-based organisations, local activists who are themselves sex workers, MSM or Transgender, and often capacity built and employed as community health workers to reach, engage, and maintain KP in care. A few health centres started utilising mobile units to offer treatment and care inside the communities, improving their reach. At the Ponta Gêa Health Centre, for example, community members welcome patients twice a week, guiding them through the facility to ensure they receive necessary services and are treated with respect and dignity. This partnership with members of Takaezana organisation, has helped foster a more inclusive and supportive environment for KP.

Similarly, the Manga Loforte Health Centre has collaborated with community KP sector activists to ensure KP feel comfortable and respected when accessing care. According to mentees, MSF's mentorship on working with KP has significantly enhanced the clinic's ability to identify and support these groups, offering specialised counselling, newly introduced PrEP, rapid HIV tests, and ARV treatment for those who test positive. Both a nurse and a psychologist from Manga Loforte Health Centre have participated on the KP mentorship, and now provide tailored care to KP, further improving service delivery.

At the Manga Mascarenhas Health Centre, the clinic actively engages with the community by employing targeted outreach strategies, such as using the 'male champion' (*homem campeão*) for men and the 'mum mentor' (*mãe mentora*) for women, ensuring a broader reach to various populations. These partnerships and strategies have strengthened the clinic's capacity to provide

comprehensive and respectful care for KP. Those positive impacts can be illustrated by the following quotes:

> "I know I can trust Nurse S. She doesn't look at me with disgust or just hand me condoms while telling me to think about my clients' wives and kids. She's better than that. She'll sit with me, listen to what my life is really like, and work out a plan to help me take my ARVs on time, even though I'm working late and sleeping with many men to feed my own kids. That's new, and it is thanks to MSF mentorship that now we have people like Nurse S. as our allies."
>
> Member of KP population

> "MSF changed everything! Before they came, there were no mobile units, and it all started when MSF began reaching out directly to the communities. We never felt like we belonged at the clinics—people would stare at us, thinking things like, 'A man in a capulana? [colorful sarong worn mostly by women in Mozambique] That's against God.' Even the women and nurses looked at us like we were destroying the community, saying things like, 'Those prostitutes are breaking up families and spreading disease.' But at the mobile units, for the first time, we felt truly seen—not just as patients, but as humans with pain, suffering, needs, and problems like anyone else. When we found out that the nurses from the mobile units also worked at a specific clinic, we started asking when they'd be there and going to that clinic just to be treated with respect."
>
> Member of KP population

Despite these advancements, significant challenges remain:

> "MSF really changed it all. It's easier now to go to a clinic and get the treatment we need, we know who to look for, who will know our names and treat us with respect. It's not perfect, especially when those persons who received MSF mentorship are not at the clinic. That's when we feel like trash again… It would be good if everyone, everyone in the clinic was trained to respect us all. We are all human beings, and inside a clinic we are all patients. No matter what we do outside the clinic, if we're there, we are a patient in need of care… But it's definitely better."
>
> Member of KP population

Field observations and interviews with KP and local activists revealed that stigma and discrimination continue to be significant issues for this population. While the KP mentorship made strides in fostering more inclusive care, not all healthcare providers have fully embraced its principles. Many still struggle

to offer non-judgmental, comprehensive services. Some staff members missed out on the mentorship training due to transfers or being overwhelmed by their existing workloads, which limited their ability to train colleagues and ensure consistent care across clinics. This has led to varying levels of service quality, where patients often face barriers such as dismissive attitudes or, in some cases, outright refusal of care.

These inconsistencies highlight gaps in the mentorship's implementation, underscoring the need for broader and more sustained training across all levels of healthcare staff, advocacy strategies and inclusion of representatives of KP on the development and improvement of strategies. Without a complete commitment to understanding and addressing the unique needs of KP, the potential impact of the KP mentorship remains underutilised. Reports from patients about being denied rapid HIV testing or receiving inadequate counselling reflect a failure to fully adhere to inclusive, patient-centred care principles, which further exacerbate health disparities and reinforces feelings of marginalisation among these vulnerable groups.

The persistence of these barriers not only hinders the progress made by the mentorship project but also perpetuates the marginalisation of KP within the healthcare system. For lasting change to take hold, a sustained commitment to ongoing training and support is essential, along with fostering a healthcare culture that consistently prioritises the dignity, rights, and well-being of all patients. Only with such dedication can the healthcare system fully embrace an equitable, respectful, and patient-centred model of care, ensuring that no one is left behind in accessing essential services.

> "The law changed, it legalised sex work, but healthcare professionals did not change their mindset. For them, we are not workers, we are careless vectors of diseases. And we don't deserve the same care as a woman with a family or a pregnant woman. Our life is less valuable."
>
> Member of KP population

> "The stigma is still really tough... A lot of times, healthcare providers treat us with disrespect, and it's hard not to feel judged or unwelcome. Just getting an appointment is a struggle, and even if you do, the wait times are longer for us. Sometimes, you leave without even getting the medicine you need. Lab tests, like for syphilis or HIV, are often unavailable or saved for others, like pregnant women, which makes us feel like our health doesn't really matter."
>
> Member of KP population

LOGISTIC SUPPORT FOR EFFECTIVE DECENTRALISATION

Importance of logistic support to decentralisation

Without exception, participants agreed that while mentorship component has been essential in improving mentees' ability to provide better HIV and SRH services, they also unanimously reinforced

that the mentorship is not sufficient on its own without reliable logistics and supply chain support. They emphasised that a stable and consistent supply of laboratory materials, medications, and other essential resources is crucial for healthcare workers to effectively apply the skills and knowledge gained during the mentorship. Unfortunately, frequent supply chain disruptions often result in shortages, forcing healthcare workers to turn patients away, thereby compromising the overall quality of care.

> "The mentorship was really helpful, but what's the point of learning all these new skills if we don't have the supplies to actually use them? It's so frustrating to know how to provide the best care but not have the tools you need. People are still having unsafe abortions, patients with HIV and TB are being under diagnosed, and those with advanced HIV aren't getting CD4 results as quickly as we need. Lab staff are spending hours on the phone, begging friends for a few tests, and when they finally get them, they have to choose who gets tested because there's never enough to go around. I believe that if we really want to decentralise HIV care, it has to be a government-led effort. We can't keep depending on outside donors forever."
>
> Mentee

Many participants stressed that the impact of the mentorship also depends on broader support from higher levels of the healthcare system, including the MISAU, provincial leaders, and health centre directors. Without strong political commitment, adequate infrastructure, and proper resource allocation, the full benefits of the mentorship program cannot be realised. Comprehensive logistical backing is vital, including constructing additional clinic rooms, properly equipping laboratories, and ensuring the availability of diagnostic tests and treatments. These elements are critical for turning the gained skills from the mentorship into practical, sustained improvements in decentralised HIV healthcare settings.

> "How can we call it decentralised if patients have to travel long distances to specialised services just to get their CD4 counts? With MSF we had Visitec, which could tell us in minutes if the patient had less than 200 CD4 counts—letting us test for other opportunistic infections and treat them right away. But now we need to refer them… What happens if they don't have the time or money to travel? What if they have no one to look after their kids? Many patients simply don't go, don't get diagnosed with advanced HIV, and don't get the tests and treatment they need. We know what we should do, but we're unable to apply what we learned during the MSF mentorship because we don't have the resources to do so. And that gets me really frustrated, angry even…"
>
> Mentee, Marrocanhe HC

> "For the mentorship program to really survive in Beira and beyond, we need more than just good intentions. We need strong financial support, and honestly, I don't think MISAU can provide that consistently, especially with the supply shortages we're seeing everywhere. We also need to assess each region's specific needs before launching the program elsewhere and work closely with local organisations. Without that, I don't see how the program can be sustained or expanded, especially with the health system already stretched so thin."
>
> Mentor

Field visits revealed that rural and hard-to-reach health centres, such as Marrocanhe and Ceramica Health Centres, face significant challenges due to a lack of dedicated laboratory space. These centres rely on a limited stock of rapid tests for HIV, malaria, and syphilis, as well as a small supply of Visitect tests to assess CD4 levels below 200 cells/µL. Even health centres with laboratory capacity frequently struggle to maintain a stable supply of essential lab reagents and materials, including office supplies and patient forms. Supplies provided by MISAU are often delayed and insufficient, hindering the clinic's ability to deliver consistent care. It is common for health centres to experience shortages of laboratory supplies, forcing them to halt testing services mid-week. Despite clinic managers' efforts to secure materials by reaching out to other clinics, calling in favours, or contacting MISAU, the supplies that eventually arrive are often inadequate to meet the centres' demand.

Laboratory services

According to many mentors and mentees, the mentorship component of AHD decentralisation improved laboratory technicians' knowledge and skills. Many are now equipped to perform critical tests, such as CD4, CrAg and TB LAM, directly at local clinics. This advancement has significantly reduced the need for patients to travel to distant, specialised centres, thus improving access to timely care. The introduction of Standard Operating Procedures (SOPs) across the labs further enhanced efficiency, ensuring consistent quality of services and sustainability, even when new staff members join the team. Mentors observed a marked improvement in laboratory management, inventory control, and patient record-keeping, making labs more organised and effective.

a. Supply

During the mentorship, lab technicians received thorough training, enabling them to offer additional tests such as Visitec (rapid CD4 qualitative test), TB LAM and CrAg at the clinic level, which played a crucial role in decentralising the diagnosis of AHD and diagnosis/treatment of opportunistic infections. This training was supported by a consistent supply of lab materials, ensuring that these tests could be conducted without interruption. However, after the mentorship ended, clinics began experiencing frequent shortages of lab supplies and essential forms for recording patient information. MISAU's inconsistent and insufficient supply deliveries have become a major hurdle, making it difficult to fully implement the strategies and skills learned during the mentorship. The inability to maintain a steady

supply chain has put a strain on healthcare providers, who are now often left calling colleagues weekly in search of essential tests and reagents.

> "The ARV supply is always consistent, but when it comes to the lab, the MSF mentorship really improved our ability to perform tests by giving us both the training and all the supplies we needed. Sadly, after MSF left, the materials started to run low. Now, if we want to run CD4 tests or anything else, we have to submit multiple requests to MISAU, call in favours, and rely on personal connections. We have the skills, and we know how crucial it is for each patient. We want to prevent them from progressing to advanced HIV, but without the right supplies for TB tests, CrAg screenings, or CD4 counts, our hands are tied. It's frustrating—the system just feels broken, you know?"
>
> Mentee, Nhaconjo Health Centre

b. Infrastructures

Laboratory capabilities across the health centres showed significant variation, highlighting a critical infrastructure gap in the healthcare system. Clinics like Ponta Gêa stood out for their advanced biomolecular labs, which were capable of conducting a wide range of diagnostic tests, serving as referral hubs for smaller and less-equipped facilities. This comprehensive lab infrastructure allowed Ponta Gêa to provide timely and accurate diagnoses, contributing to improved patient care and outcomes. However, such well-resourced facilities were the exception rather than the rule.

In stark contrast, rural clinics like Ceramica and Marrocanhe were limited to providing only basic rapid tests due to a lack of infrastructure, equipment, and trained personnel. These clinics lacked essential laboratory services, such as CD4 counts, viral load testing, and hemograms, which are crucial for monitoring and managing HIV and other chronic conditions. Without these advanced diagnostics, healthcare providers at these clinics faced significant challenges in delivering comprehensive care, often resulting in patients being referred to larger facilities. Unfortunately, this referral system was far from effective. Many patients did not return with their test results, either due to the distances involved, transportation costs, or a lack of understanding of the importance of follow-up, thus disrupting the continuity of care and undermining the effectiveness of treatment.

Even clinics that had more adequate laboratory infrastructure, such as the Health Centre of Nhaconjo, struggled to provide uninterrupted testing services. Despite being coordinated by the Catholic Church and receiving substantial support from donors like PEPFAR, USAID, and Italian government agencies, Nhaconjo faced frequent supply shortages that impeded its ability to offer comprehensive diagnostics. During on field visit, the lab manager reported that they had to cease testing earlier in the day due to a lack of necessary supplies. Despite the manager's efforts to obtain materials by reaching out to other health clinics and calling in favours, as well as contacting MISAU, the shortage persisted. This meant that the lab was unable to meet patient needs for the remainder of the week, causing delays in diagnosis and treatment.

These incidents underscore a broader systemic issue: the inconsistency in laboratory services across different health centres leads to significant disparities in patient care. Clinics with well-established lab facilities can provide a higher standard of care, while those without such resources leave patients at a disadvantage. The inability to perform crucial tests like viral load measurements and CD4 counts not only hampers effective patient monitoring but also contributes to the risk of treatment failure and the spread of opportunistic infections.

The situation highlights an urgent need for investment in laboratory infrastructure and supply chain management to ensure comprehensive care is available at the point of service. Strengthening lab capabilities in rural and underserved areas is essential for improving healthcare outcomes and ensuring that all patients, regardless of their location, have access to the necessary diagnostic tools and timely interventions. Ensuring a consistent and adequate supply of lab materials, along with the maintenance of essential equipment, should be a priority to bridge the gap in care and prevent further disruptions in service delivery.

OVERVIEW OF FIELD OBSERVATIONS FROM 10 HEALTH CENTRES

Overview of health centres

The field visits to 10 healthcare centres in BEIRA, Mozambique revealed significant disparities in infrastructure, resources, and service delivery. Centres managed by the Ministry of Health (MISAU) often suffered from limited resources, exemplified by outdated furniture, broken equipment, and a general lack of essential supplies (e.g. lab kits and reagents). In contrast, facilities managed or supported by international organisations such as the Community of Sant'Egidio and the Catholic Church, with funding from entities like PEPFAR, USAID, and the Italian government, exhibited better infrastructure, adequate supplies and a more organised environment. These facilities had modern amenities, well-maintained buildings, and used advanced tools like computers for patient record-keeping.

HIV/AIDS care and treatment

All centres provided HIV/AIDS care, but the quality and scope of services varied greatly. All the 10 centres participated in the MSF mentorship and showed substantial improvements in HIV care, particularly in managing advanced HIV disease (AHD). These clinics adopted a more comprehensive approach, offering a range of services such as CD4 counts, viral load testing, TB-Lam, and CrAg screening, which allowed for more precise and effective patient management. For instance, the Health Centre of Chingussura's Sant'Egidio clinic provides a wide range of services, including adolescent and young adult healthcare, paediatric care, and specialised HIV treatment in a well-equipped environment.

However, access to these advanced diagnostics was inconsistent across centres. In many cases, once the MSF mentorship ended, the advanced diagnostic capabilities, such as CD4 counts and TB-Lam, were discontinued due to a lack of infrastructure or supplies. This issue was particularly acute in rural clinics like Marrocanhe and Ceramica, where patients were limited to rapid tests (when those were available) and had to be referred to better-equipped facilities for more complex diagnostics.

Community engagement and activist involvement

Healthcare professionals and clinic directors across the visited sites emphasised the crucial role of community engagement in improving healthcare access for vulnerable populations. Many health centres have established strong partnerships with local community-based organisations (CBOs) and activists, who act as vital connectors between healthcare services and hard-to-reach groups. These collaborations have proven particularly effective in promoting treatment adherence and encouraging the use of preventive services.

Projects like "mum-mentor" (mãe mentora) for pregnant women and "male champions" (homen campeão) for men have been instrumental in ensuring continuity of care. Local activists proactively reach out to patients who miss follow-up appointments or neglect to refill their antiretroviral medications, providing support and encouragement to resume their treatment. Representatives from CBOs such as Takaezana and other activists working with KP play a key role in identifying and engaging these groups, offering guidance and support to help them access essential health services.

At the Health Centre of Inhamizua, for example, community activists have been essential in locating and re-engaging patients who have abandoned their treatment, significantly improving adherence rates for conditions like HIV and TB. Peer educators from the community are particularly effective in reaching KP, offering services including counselling, rapid testing, PrEP/PEP distribution, and referrals to specialised care. Their involvement has not only increased the uptake of healthcare services but has also helped build trust between these communities and healthcare providers, creating a more inclusive and supportive healthcare environment.

Through the collaboration between MSF and Takaezana, many vulnerable groups have gained access to HIV testing and have started receiving ARVs. Local activists are also essential in re-engaging those who have abandoned treatment, often accompanying them to appointments.

> “Without us, there’s no way they'd reach the people who need help the most—trans women, sex workers, gay men. They’re scared to go to clinics because they think they will be treated like s***, or they just don't know what they’re entitled to or how to ask for it. We're the bridge, helping them get to the clinic and making sure they feel safe enough to go back. We're not just getting them in the door; we're fighting for the care and respect they deserve.”
>
> Activist

Persistent challenges and resources gaps

Despite the advancements brought by the mentorship, several significant challenges persist. A major issue is the ongoing shortage of lab supplies and essential medications for treating opportunistic infections. Many clinics face frequent breakdowns or a complete lack of CD4 machines, severely hindering effective patient monitoring and treatment. This lack of equipment forces patients to be

referred to other facilities for advanced testing, resulting in delays and a high likelihood of patients not returning for follow-up care.

These resource gaps are particularly pronounced in rural, hard-to-reach areas. For instance, the Health Centre of Ceramica lacks a dedicated lab space and lab technicians—a situation that only improved temporarily when the MSF support was provided. Once the mentorship ended, the clinic reverted to offering only basic rapid tests (while supplies last), leaving a critical gap in comprehensive diagnostic services.

Additionally, while the mentorship program has contributed to reducing stigma against KP, discrimination and mistreatment remain issues in some areas. Reports indicate that certain healthcare providers are still dismissive or refuse to provide essential services like PrEP/PEP and rapid testing, particularly to sex workers and other marginalised groups. In some clinics, the quality of care a patient receives continues to depend heavily on the specific healthcare worker on duty. This inconsistency exacerbates the stigma, acting as a significant barrier to healthcare access for those who are most vulnerable.

Observations of negative incidents

Field visits uncovered several negative incidents that underscore persistent issues within the healthcare system, particularly regarding the treatment of KP. In some cases, healthcare providers were observed raising their voices at patients, creating an environment of discomfort and fear. For instance, in one clinic, an elderly HIV-positive patient was denied care because it was deemed "too late," despite it being only 11 a.m. and appointments being available until noon. The patient, visibly distressed, left the clinic, highlighting the rigid and sometimes arbitrary nature of healthcare access.

Another troubling incident involved a group of three sex workers, one of whom was an activist from the community-based organisation Takaezana, who arrived at a clinic seeking post-rape care and counselling for one of the women. Despite being in a highly vulnerable state, they encountered numerous barriers. They were stopped multiple times—by security personnel, the head nurse, and the nurse responsible for sexual and reproductive care. At each stop, they were forced to repeatedly explain the reason for their visit, adding to the emotional toll on the woman seeking post-rape care.

This fragmented and bureaucratic process not only delayed their access to care but also subjected them to a series of invasive questions, reinforcing the stigma they already faced. By the end of the morning, they were informed that rapid HIV and syphilis tests were reserved exclusively for pregnant women, furthering their sense of being unwelcome and undervalued. Feeling mistreated and dehumanized, they left the clinic without receiving any thorough counselling or care.

Such incidents contribute significantly to the erosion of trust in healthcare services, particularly among groups already facing substantial barriers to access. For individuals like the sex workers seeking post-rape care, these experiences serve as a stark reminder of the discrimination that still exists within the

system. They exacerbate feelings of marginalisation and can discourage these groups from seeking necessary medical attention in the future, potentially leading to worsening health outcomes.

IMPACT

TRAINING AND IMPACT ON STAFF SKILLS, ATTITUDES, AND PRACTICES

The mentorship program had clearly made a significant impact, instilling a sense of empowerment among healthcare staff. Many had gained valuable skills and knowledge to manage complex cases, particularly among KP and patients with AHD. In some clinics, those who had undergone MSF's mentorship were seen as local champions, driving improvements in patient care and implementing new protocols. This led to more thorough patient assessments, enhanced monitoring of ARV adherence, and a more compassionate, patient-centred approach, especially for vulnerable groups like sex workers, MSM, and survivors of SGBV.

According to the majority of mentors and mentees, MSF mentorship improved the quality of healthcare delivery across the visited centres. Healthcare workers who participated in the mentorship reported a transformative shift in their practice, transitioning from a routine, task-oriented style of care to a more thoughtful, empathetic, and patient-centred model.

For example, a registered nurse at the Chingussura Health Centre described how the mentorship fundamentally changed her approach to supporting survivors of sexual violence. Before receiving mentorship, she only provided the basic post-rape care required, but now she offers more personalised counselling tailored to each survivor's individual experiences and needs and emphasises the importance of follow-up visits to ensure ongoing support. Similarly, a clinical officer, shared that before the mentorship, her main goal was to move patients through the clinic as quickly as possible. Now, she takes time to gather detailed medical histories and perform thorough clinical assessments, ensuring that even seemingly healthy patients are carefully examined for signs of advanced HIV and referred for further tests and treatments when necessary.

The mentorship also helped reduce stigma and discrimination against KP. Healthcare providers who were trained became more understanding and less judgmental, leading to a more welcoming environment for KP such as sex workers, MSM, and transgender individuals. For instance, healthcare workers began offering services such as PrEP, PEP, and tailored counselling, which were previously inaccessible or difficult to obtain.

Participants across the focus group discussions were in full agreement that the mentorship was invaluable in strengthening their capacity to provide better healthcare services, particularly in advanced HIV care and working with KP. The mentorship significantly enhanced their knowledge, skills, and confidence, leading to a more comprehensive and patient-centred approach to their practice.

Before the mentorship, some participants avoided providing care to sex workers and MSM due to personal biases and discomfort. Through the mentorship, they gained a deeper understanding and became more open to offering proper counselling, prescribing PrEP and PEP, and providing comprehensive support. This shift in perspective not only improved their professional practice but also broadened their outlook as healthcare providers.

> "Before the mentorship, I used to feel awkward and would avoid working with sex workers and gay men because of my own biases. But the training really opened my eyes! I realised it's not about judging anyone—it's about being there to help. They're my patients, after all, and what they do in their personal life shouldn't matter. After the mentorship, I feel way more confident approaching them, offering proper counselling, and prescribing PrEP and PEP. The MSF mentorship really made me a better healthcare provider and showed me what real patient care is all about."
>
> Mentee, Inhamizua Health Centre

> "The mentorship really opened our eyes. We used to think if a patient was walking without help, answering our questions quickly and overall looking healthy, they were fine. Now we dig deeper, asking the right questions and looking for signs of advanced HIV. It's made a huge difference—we're catching infections early, getting patients the treatment they need, and actually saving lives."
>
> Mentee, Ceramica Health Centre

> "I used to see a patient walk into the consultation room and think, 'Good, they seem fine.' But now I know that being able to walk doesn't mean much. They could be walking in and suddenly collapse, dying right in front of me. HIV is a tricky disease, and you can't tell who's really well just by looking at them. There's no way to judge someone's health just by their appearance. I didn't know that before MSF mentorship."
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> Mentee, Nhangau Health Centre

CHANGES IN HIV SERVICES POST-MENTORSHIP

The MSF mentorship has made a significant impact on HIV services in the community, transforming them into a comprehensive package that goes beyond just the delivery of ARVs. These services now include access to PrEP and PEP, the availability of condoms, psychological support, and mobile units that reach those unable to visit clinics. Many participants have noticed significant improvements in the quality and accessibility of these services.

Mentorship played a crucial role in reducing discrimination within health clinics. Patients are now more aware of which healthcare professionals are welcoming and supportive. These professionals engage with patients empathetically, listening to their needs and struggles without judgment. This has positively changed how people perceive and engage with HIV services.

> "I know I can trust Nurse S. She doesn't look at me with disgust or just hand me condoms while telling me to think about my clients' wives and kids. She's better than that. She'll sit with me, listen to what my life is really like, and work out a plan to help me take my ARVs on time, even though I'm working late and sleeping with many men to feed my own kids. That's new, and it is thanks to MSF mentorship that now we have people like Nurse S. as our allies."
>
> Activist

However, not all healthcare professionals participated in the MSF training, and many continue to uphold discriminatory practices. Mozambique remains a conservative country with rigid gender roles, and sex workers, MSM, and transgender individuals often face severe stigmatisation. A transgender woman highlighted the ongoing homophobia and transphobia in healthcare services:

> "Honey, when I walk into the clinic, every eye is on me—and not in a good way! [laughs] I'm 1.80m tall, love my makeup, and always wear my capulana [colorful sari used in Mozambique]. So, as soon as I step in, some people start laughing, others look away, and some even call me names. It takes a lot of strength to keep my head up, sit down, and wait for my doctor to call me. I've lost count of how many times I skipped my monthly appointment because I just couldn't handle it that day. You're asking about the MSF mentorship, right? Yeah, it was interesting, and in some clinics, when I'm accompanying a gay friend, you can tell they're a bit more welcoming. But overall, I gotta say, not much has changed. We still get mistreated—sometimes by security or other patients, but sometimes by doctors and nurses too."
>
> Activist

Specific and significant changes as impact of the mentorship component of the decentralisation on some key aspects of the HIV continuum of care have been found. These include the following:

- **Enhanced advanced HIV care:** The mentorship debunked common misconceptions, such as assuming that a healthy-looking patient couldn't be severely immunocompromised or have hidden co-infections. Mentees learned to conduct thorough consultations, asking detailed questions to detect signs of advanced HIV. This proactive approach led to the timely detection and treatment of co-infections, reducing hospitalisations and saving lives. Participants felt empowered to apply these best practices with greater confidence in their daily interactions with patients. Mentees reported a fundamental shift in their understanding of what

constitutes a healthy patient. They learned to look beyond physical appearances, recognising that a patient who seems well might still be at risk for advanced HIV. This nuanced approach has led to earlier and more accurate interventions, improving overall patient outcomes.

- **Reorganisation of services:** Initially, mentees found it challenging to implement the comprehensive anamnesis required for advanced HIV assessment, leading to extended consultation times and patient frustration. In response, services were reorganised to improve patient flow. Clinics now have dedicated areas for patients with AHD, HIV-positive patients without advanced disease, paediatric HIV care, and prenatal care for pregnant women living with HIV/AIDS. This new approach allows for more targeted and effective care.

IMPACT OF MOBILE HEALTH UNITS

One of the most impactful strategies implemented through the MSF mentorship was the introduction of mobile health units. These units made HIV services more accessible to KP, offering them rapid tests, lab work, and immediate treatment in a way that was previously unattainable. The convenience of mobile units allowed people to access healthcare in familiar environments, without the fear of judgment or stigma often associated with traditional clinics. Although many participants expressed sadness over the discontinuation of the mobile units, they acknowledged that these initiatives forged strong relationships between patients and healthcare professionals. These workers have become their "safe people" within clinics—trusted individuals in an otherwise intimidating and often unwelcoming healthcare system.

> "MSF really changed it all. It's easier now to go to a clinic and get the treatment we need; we know who to look for, who will know our names and treat us with respect. It's not perfect, especially when those who received MSF mentorship aren't at the clinic… That's when we feel like trash again… It would be good if everyone in the clinic was trained to respect us. We are all human beings, and inside a clinic, we are all patients."
>
> Activist

The reliance on specific healthcare workers, however, presents challenges. Many patients have built deep trust with certain nurses or doctors, and when those trusted individuals are transferred or unavailable, patients are left feeling unsupported and vulnerable. This dependence on individual staff members exposes a gap in the system: the mentorship component has not fully transformed the broader healthcare culture, leading to inconsistency in the quality of care and respect provided.

One participant shared the emotional toll of losing their trusted healthcare provider:

> “Doc, I know nurse Y. She worked at a mobile unit, and I was used to her. She knew my history, she knew what treatments I needed, and she never made any prejudiced comments about me being a sex worker. She was good. So, I always look for her at the clinic. But one day, I found out she was transferred to another clinic far from my home… I cried when I found out because she was the only one, I really trusted, and she knew me, my problems—she was the first good nurse I’d seen in a long time… Now I feel kinda lost, you know? I go to the clinic, but I feel like they’re talking about me behind my back, like judging me for being a sex worker.”
>
> Activist

This highlights the fragility of patient trust when it hinges on individual relationships rather than systemic change. While the mentorship has led to significant improvements, there remains an urgent need for more widespread training and cultural shifts within the healthcare system. Patients should not have to rely on finding their "safe person" in clinics but instead should be able to trust that all healthcare workers will treat them with the dignity and respect they deserve. Until this is achieved, vulnerable populations, such as sex workers and other KP will continue to face disparities in care, feeling alienated when their trusted providers are no longer available.

The success of the mobile health units and the mentorship demonstrates the potential for creating a more inclusive healthcare system, but sustaining these gains requires deeper, systemic changes. Healthcare workers across all levels need to be trained to provide non-judgmental, patient-centred care, ensuring that every person who enters a clinic feels safe and respected, regardless of their background or circumstances.

IMPACT ON MORALE AND PATIENT CARE

Some participants reported that KP are still experiencing longer waiting times compared to other patients and, in some instances, are denied essential services like PEP/PrEP and rapid testing. By accompanying these individuals, activists act as peer navigators inside the health centre, helping to mitigate these challenges and ensure access to necessary services.

One participant shared an experience where she accompanied two other FSWs to a clinic for rapid HIV tests. Despite a long wait, they were eventually told that the clinic had run out of tests. This happened even after the implementation of the MSF mentorship, highlighting the persistent stigma and discrimination in some services.

The disconnect between the skills healthcare workers acquired during the mentorship and their inability to fully apply them due to resource limitations is having a significant impact on morale. Despite their enhanced understanding of life-saving interventions, many healthcare workers find themselves unable to deliver the quality of care they know is possible. Systemic barriers—such as

supply shortages, poor infrastructure, and inconsistent support—are undermining the progress made during the mentorship, casting doubt on the sustainability of decentralised AHD services.

While the mentorship component has significantly improved the quality of HIV care and equipped healthcare workers with essential skills, the lack of consistent support from MISAU, along with ongoing logistical issues, threatens to erode these gains. Supply chain disruptions, insufficient lab resources, and the absence of key medications have created an environment where preventable deaths and treatment delays persist.

One mentee expressed frustration over the ongoing challenges:

> "Preventable deaths from unsafe abortions or advanced HIV due to delayed diagnosis are still happening. It's less common now, but it's still happening. Even after all the effort and amazing mentorship from MSF. The worst part? We're stuck dealing with MISAU's inefficiency—empty stocks, missing tests, poor lab conditions, no misoprostol. We know we could do better, and that's what makes it so heartbreaking."
>
> Mentee, Macurungo Health Centre

The withdrawal of MSF's support has left many healthcare workers feeling abandoned. They believe a more gradual exit, with continued oversight to ensure the proper functioning of patient referrals, lab activities, and supply chains, would have better sustained the improvements made during the mentorship.

> "Is it MSF's fault? No. But that's our reality now. It would have been better if MSF had stayed a little longer, ensuring a gradual exit from each service, and making sure that all the flows of information, patient referrals, lab activities, and stock supplies were functioning properly. Now, without MSF's influence, we're left to fight on our own just to get the basic supplies we need. And it is not working."
>
> Mentee, Nhaconjo Health Centre

Another mentee highlighted how the absence of essential diagnostic tools, such as Visitec for CD4 count testing, has disrupted decentralised care. This lack of resources forces patients to travel long distances to specialised centres for testing, which many cannot afford, resulting in missed diagnoses and delayed treatments.

> "How can we call it decentralised if patients have to travel long distances to specialised services just to get their CD4 counts? With MSF we had Visitec, which could tell us in minutes if the patient had less than 200 CD4 counts—letting us test for other opportunistic infections and treat them right away. But now we need to refer them… What happens if they don't have the time or money to travel? What if they have no one to look after their kids? Many patients simply don't go, don't get diagnosed with advanced HIV, and don't get the tests and treatment they need. We know what we should do, but we're unable to apply what we learned during the MSF mentorship because we don't have the resources to do so. And that gets me really frustrated, angry even…"
>
> Mentee, Marrocanhe Health Centre

> "At first, the detailed assessments took forever, and patients were getting frustrated with the long waits. So, we had to switch things up. Now, we've got separate rooms for AHD, regular HIV care, HIV-positive kids, and HIV-positive pregnant women. It's made everything run smoother and lets us give more focused care to each patient."
>
> Mentee, Nhaconjo Health Centre

This ongoing struggle highlights the importance of sustained logistical support, not just a mentorship component, for the long-term success of decentralised healthcare services. Without the necessary resources and infrastructure, healthcare workers are left unable to deliver the high standard of care they were trained to provide, which continues to erode both their morale and the quality of patient care.

SUSTAINABILITY OF THE IMPACT OF MENTORSHIP

While the mentorship program demonstrated its potential—reducing unsafe abortions, improving care for survivors of sexual violence, and enhancing healthcare workers' skills—mentors expressed concerns about sustainability without continued external support. MISAU's chronic funding shortages and understaffing are significant barriers to sustaining the program independently. Additionally, the lack of essential supplies in many clinics complicates efforts to maintain and build on the mentorship's outcomes without MSF or other supporting organisations.

> “For the mentorship to really survive in Beira and beyond, we need more than just good intentions. We need strong financial support, and honestly, I don’t think MISAU can provide that consistently, especially with the supply shortages we’re seeing everywhere. We also need to assess each region’s specific needs before launching mentorship elsewhere and work closely with local organisations. Without that, I don’t see how the mentorship can be sustained or expanded, especially with the health system already stretched so thin."
>
> Mentor

> “What’s amazing is that even after the formal training ended, mentees kept reaching out. They call me to discuss cases, share ideas, and ask for advice. It shows that the mentorship didn’t just teach skills—it created a culture of support and continuous learning. The changes we’ve made aren’t going away; they’re here to stay.”
>
> Mentor

The mentorship component appears to have been transformative in shaping how healthcare workers deliver services, demonstrating that hands-on knowledge transfer and support from mentors have led many mentees to develop significant competencies, including shifts in previously held attitudes and beliefs. This approach has enhanced their capacity to provide comprehensive, patient-centred care, enabling early intervention in advanced HIV cases and fostering greater empathy and understanding in their support for key populations.

Despite the overall positive atmosphere, there were also clear signs of anxiety among clinic staff regarding the future sustainability of these improvements once MSF winds down its activities. This concern was particularly acute in rural and resource-limited clinics, where the reliance on MSF's support was most evident. Many staff members voiced concerns about the potential discontinuation of critical services and supplies. They feared that without MSF's ongoing mentorship and resources, maintaining the progress in patient care, particularly in advanced HIV management, key population services, and SGBV support—would be an immense challenge.

In clinics where infrastructure and supply chains were already fragile, the dependency on MSF’s involvement was palpable. A prime example was the provision of patient documentation forms. While these may seem like a minor aspect of healthcare delivery, they were vital for keeping accurate records, tracking patient progress, and ensuring continuity of care. Without them, clinic staff feared they would struggle to maintain the meticulous record-keeping needed to provide effective, high-quality care. Such concerns highlight the importance of not only clinical skills but also logistical support in ensuring sustainable healthcare delivery.

The anxiety also extended to the continuity of activities and improvements that had been initiated or strengthened through MSF's mentorship. Staff expressed concerns that, without MSF's presence, ongoing mentorship for newly hired or relocated staff might not be a priority for MISAU or other local authorities, potentially leading to a decline in service quality. Enhanced/tailored services for key populations and trauma-informed care for SGBV survivors were seen as advancements that could easily regress without continued support, training, and oversight.

This uncertainty underscored a common theme in conversations with clinic staff: the urgent need for ongoing support to preserve the progress made in patient care. Healthcare workers emphasised that continued investment in training, supplies, and infrastructure was crucial to ensuring that the improvements were not temporary but became a permanent feature of the healthcare system. They expressed hope that future partnerships, whether with MSF or other organisations, would build on the foundation established during the mentorship project. For these healthcare providers, ensuring that the gains made in patient care are not lost will require sustained collaboration, funding, and commitment from all stakeholders involved.

REPLICABILITY

Sometimes a confusion between replicability and sustainability may occurs in evaluating a project or a program. While ***sustainability***[2] refers to a program's ability to maintain its positive outcomes over the long term, even after the initial funding, resources, or external support have diminished, ***replicability***[3] refers to a program's ability to be successfully reproduced or adapted in different settings, contexts, or populations, yielding similar positive results by following established procedures or guidelines.

The replicability of the mentorship program in Mozambique depends on several critical factors, as highlighted by mentors' feedback. Scaling up the mentorship—whether for advanced HIV care, SRH services, Key Population friendly services or laboratory improvements—will require substantial external funding, strong partnerships, and support from the Ministry of Health (MISAU). Mentors emphasised the importance of conducting thorough assessments of local needs, clinic capacities, and resources before expanding or replicating the mentorship component to other regions. These evaluations would guide the scope of work and help secure the necessary funding, ensuring that the program can be effectively scaled and replicated.

Expanding the mentorship program would not only require financial resources but also political will, particularly for KP, SRH services, where stigma around abortion and sexual violence remains a significant challenge. Advocacy and well-trained mentors would be critical to overcoming these barriers and replicating the program's successes.

[2] Sustainability relies on established systems, practices, and local ownership to ensure that the benefits continue.

[3] This evaluation wished to evaluate the replicability and not the sustainability.

> "Scaling up the advanced HIV mentorship would require substantial external funding, support from MISAU, and possibly the involvement of senior clinicians with experience in treating advanced HIV. The success of such a scale-up would depend on careful planning, resource allocation, and establishing strong partnerships to ensure sustainability and replicability across other regions."
>
> Mentor

> "Expanding the SRH mentorship program to other provinces would require not just funding but a lot of political support. Topics like abortion and sexual violence are highly sensitive, and stigma is still a huge barrier. To successfully scale up, we need strong advocacy, proper planning, and substantial resources. Without overcoming these cultural and logistical challenges, sustaining or replicating it on a larger scale would be difficult."
>
> Mentor

And according to a **representative from MISAU**:

> "Mentorship is certainly a critical component of HIV decentralisation, but it is just one piece of the puzzle. Decentralisation is a broad and complex undertaking. While training, skill development, and regular updates on treatment best practices are essential, they alone are not sufficient to achieve true decentralisation in HIV care. To genuinely decentralise HIV care, you also need adequate personnel, reliable supplies, and robust infrastructure. Is mentorship important? Absolutely. But is it enough on its own? No, it's part of a much larger framework that requires comprehensive support across multiple areas. I would say that some scale-up is already underway. The advanced HIV protocol has recently been incorporated into MISAU guidelines, which is a significant development. We are optimistic about continuing this progress, particularly through the establishment of strong partnerships—perhaps with MSF again? MISAU is eager to expand this program, but the challenge remains a lack of resources to support the scale-up effectively."

In conclusion, while the mentorship program has the potential to be replicated and scaled up to improve healthcare outcomes across Mozambique, its success depends heavily on external funding, meticulous planning, and sustained support from both MISAU and international partners. The program must be integrated into a broader strategy that addresses resource gaps, infrastructure needs, and personnel shortages, ensuring that mentorship is part of a comprehensive, well-supported effort to decentralise HIV care.

CONCLUSION

The evaluation of the mentorship program in the MSF Beira HIV Project provides critical insights into its relevance, coherence, effectiveness, impact, and replicability. Each dimension reveals both the successes and the challenges faced by the initiative, highlighting areas that have been impactful and those that require further attention.

The mentorship component has been a valuable strategy in addressing Beira's healthcare needs, particularly the high HIV prevalence and mortality rates associated with advanced HIV disease (AHD). By adapting the approach to local contexts, the mentorship component has successfully tackled barriers faced by marginalised populations in accessing care. Following the mentorship component, healthcare professionals have become more proactive in requesting CD4 tests and referring patients for further screenings, resulting in earlier diagnosis and treatment of opportunistic infections. Despite these gains, persistent stigma surrounding HIV continues to deter individuals from seeking care. Continuous mentorship for staff who didn't initially join the program could help combat this stigma, while ongoing supply chain issues and inadequate laboratory resources remain obstacles to effectively managing AHD. Addressing these systemic issues is crucial for realising the mentorship component's full potential and possibly expanding it to other regions within Sofala province and across Mozambique.

A key strength of the mentorship component has been its integration within Mozambique's national health framework. By aligning with policies aimed at decentralising healthcare services and improving HIV care access, the mentorship component has fostered collaboration between MSF, local health authorities, and healthcare facilities. This alignment supports Mozambique's broader public health objectives by improving the availability and quality of care for underserved populations. However, inconsistent commitment from local stakeholders, often driven by competing priorities and resource limitations, poses challenges. Sustained political and institutional support will be essential to ensuring the mentorship's long-term success and integration into routine healthcare services.

The mentorship component's effectiveness is evident in the enhanced skills, knowledge, and confidence of healthcare workers. Participants reported significant improvements in delivering comprehensive HIV services due to the structured mentorship, which combined theoretical learning with practical training. This approach strengthened clinical competencies and improved morale among healthcare staff. Mentors played a pivotal role in advancing healthcare delivery by sharing specialised knowledge in laboratory work, SRH, KP, and AHD. Despite challenges such as resistance from some healthcare workers, lack of formal training, and overburdened clinics, mentors successfully implemented improvements in lab practices and SRH services, contributing to a more patient-centred approach to care.

However, the mentorship component faced limitations. High staff turnover and the limited number of professionals who received the full package mentorship component influenced the broader implementation of best practices across some of the selected health centres. Inconsistent access to essential lab supplies and medications continues to impede the full application of the skills gained by

mentees. Addressing these resource gaps is essential to ensure that healthcare workers can provide timely and comprehensive care, maximising the mentorship component's overall impact.

The mentorship component has also positively influenced healthcare delivery through increased patient referrals and stronger community engagement. Empowered healthcare workers have become more proactive in conducting additional screenings and initiating timely treatment for opportunistic infections in patients diagnosed with AHD. The mentorship component has also helped shift community perceptions of HIV care, fostering trust between healthcare providers and marginalised groups. However, maintaining these positive changes over time is challenging due to ongoing stigma and fluctuating community engagement. Sustaining these improvements will require continued focus on community education and advocacy to create a supportive environment for equitable healthcare access.

The mentorship component's design model shows significant potential for replicability in similar low-resource settings. Its structured approach, emphasising local ownership and continuous support, makes it adaptable to different regions. The enthusiasm among healthcare workers for applying their skills and mentoring others suggests a possible ripple effect that could strengthen healthcare systems more broadly. However, replicating the mentoring component successfully will require addressing resource variability and ensuring consistent support, particularly in securing medical supplies and developing infrastructure.

Several challenges have hindered the mentorship component's objectives, including resource constraints and high staff turnover, which disrupt continuity and impede long-term capacity building. Stigma surrounding HIV also remains a significant barrier, discouraging individuals from seeking care.

The evaluation faced limitations, such as a restricted sample size and variability in data quality, making it difficult to assess the mentorship component's long-term impact. A longer evaluation period will be needed to fully capture the sustained effects of the mentorship initiative. Participants emphasised that without continuous support from MISAU and adequate resources, the progress made during the mentorship could be at risk.

In conclusion, the mentorship program in the MSF Beira HIV Project has proven to be a transformative model for improving healthcare delivery in Mozambique. Its alignment with local needs and coherence with national health policies underscores its relevance and potential for long-term effectiveness. The mentorship component's focus on capacity building, fostering stronger relationships between healthcare providers and marginalised communities, and improving patient care has made significant progress in addressing critical gaps in HIV care.

However, challenges such as resource shortages and persistent stigma must be addressed to ensure sustainability and replicability. Ongoing community education, advocacy, and engagement with local and national stakeholders will be essential to maintaining momentum. While infrastructure primarily supports patient confidentiality, it also plays a critical role in providing a safe, private space for counselling on sensitive issues, such as ART adherence, safe abortion care, SGBV, and other personal health matters. Continuous investment in healthcare infrastructure and human resources is essential

to reinforce these best practices learned during the mentorship and to ensure the long-term sustainability of the program's positive outcomes. By learning from the insights gained in this evaluation, stakeholders can position the mentorship for broader application in similar settings, improving access to HIV care for vulnerable populations and contributing to public health goals. With sustained commitment, this model can help build more resilient and equitable healthcare systems in Mozambique and beyond.

RECOMMENDATIONS

The evaluation of the mentorship program in the MSF Beira HIV Project has led to several actionable recommendations designed to enhance both the sustainability and replicability of the initiative. These recommendations were co-created through a collaborative process involving the evaluators, the Consultation Group, and key stakeholders, including MSF and the Ministry of Health (MISAU). A working session was held to review the evaluation findings and refine the recommendations, with the SEU acting as a facilitator. This participative approach led to the recommendations enumerated below.

RECOMMENDATIONS FOR MÉDECINS SANS FRONTIÈRES (MSF)

1. Recommendations regarding the current project in Beira – Mozambique

⇒ Support advocacy led by CBO

Prior to MSF exit, ensure that CBO capacities are strengthened to continue advocacy to donors and the Government to support the integration of mentorship in routine quality improvement initiatives at the primary healthcare level. This capacity building should include training on advocacy, support in building advocacy plans, and organisation of advocacy activities / campaigns.

⇒ Trauma-informed care support

Evaluate the need to provide trauma-informed care support for healthcare workers managing highly sensitive cases, such as GBV and rape, to help them handle the emotional impact of their work.

⇒ Child rape cases in Beira

Consider conducting a new assessment to better understand the rising cases of child rape in Beira, which could help identify the scope of the issue and potential interventions.

⇒ Exit strategy for SRH supplies

In order to ensure continuity and sustainability of services post-departure, MSF should explore alternative, local-managed sources for continuing essential life-saving SRH commodities such as Misoprostol and Mifepristone, AHD services, and KP friendly services.

2. Recommendations for future projects involving mentorship in decentralisation

⇒ Recommendation 1: Enhance community engagement and education

- **Targeted outreach programs:** Collaborate with local organisations to develop community outreach initiatives that address stigma and discrimination against key populations). These programs should educate communities on HIV-related issues and promote a more inclusive, understanding environment. These efforts can reduce the stigma surrounding HIV and ensure that vulnerable groups feel supported when seeking healthcare services.

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⇒ Recommendation 2: Develop a robust mentorship follow-up system

- **Structured follow-up:** Implement a structured system for continuous mentorship, including regular check-ins, refresher training sessions, and peer-to-peer learning opportunities. This will help reinforce the skills and knowledge gained during the initial mentorship and support mentees in applying these practices in daily care.
- **Supportive networks:** Foster ongoing collaboration among mentors and mentees, creating a network for sharing challenges, solutions, and best practices, ensuring that the benefits of the mentorship component are sustained.

⇒ Recommendation 3: Institutionalise the mentorship model

- **Integration with local health systems:** Work closely with the local government agencies to embed the mentorship approach into existing healthcare training programs, ensuring long-term sustainability. This will involve aligning the mentorship framework with national policies and local health system needs, supporting institutionalisation within government-run training structures.

⇒ Recommendation 4: Implement a comprehensive monitoring and evaluation framework

- **Impact assessment:** Develop a robust monitoring and evaluation (M&E) system to track the long-term impacts of the mentorship component, including health outcomes, community engagement, and resource utilisation. Regular assessments will provide data to refine the model of the mentorship component and improve resource allocation, ensuring continuous improvement in care delivery.

RECOMMENDATIONS FOR THE MINISTRY OF HEALTH – MISAU

⇒ Recommendation 1: Increase resource allocation

- **Advocate for funding:** Advocate for increased financial support to healthcare facilities, ensuring they are equipped with adequate staff, medical supplies, and essential diagnostic tools. Improved resource allocation will allow healthcare workers to fully implement the comprehensive HIV and SRH care models promoted through the mentorship component, while also addressing the high turnover rate by enhancing staff retention.

⇒ Recommendation 2: Strengthen policy support for key populations (KPs)

- **Protect Rights and Access:** Strengthen and implement policies that protect the rights of KPs, ensuring equitable access to healthcare services without discrimination. These policies should address systemic stigma within the healthcare system, ensuring that all healthcare providers are trained to deliver non-judgmental, patient-centred care.
- **Anti-stigma campaigns:** Partner with local NGOs to develop campaigns aimed at reducing stigma against KPs, reinforcing the importance of inclusive healthcare services.

⇒ Recommendation 3: Facilitate stakeholder engagement

- **Collaboration and alignment:** Establish regular stakeholder meetings involving government, NGOs, healthcare workers, and community representatives to align priorities and enhance collaboration across the health system. These meetings will

ensure sustained commitment to the model of the mentorship component and HIV care initiatives.

- **Mentorship as an ongoing supervision strategy:** Work toward shifting from traditional, top-down supervision to a more dynamic and sustainable mentorship model. This approach will promote professional growth, accountability, and continued learning within healthcare teams.
- **Ensuring mentee growth:** Capable mentees should be provided growth opportunities, for example, transitioning to mentorship roles within their facilities or districts.

The recommendations outlined above focus on enhancing the mentorship component's long-term sustainability and replicability. By strengthening community engagement, improving mentorship follow-up, and institutionalising the model of the mentorship component, MSF and MISAU can build a more resilient and responsive healthcare system. The active involvement of local authorities and consistent policy support for KPs will be essential for sustaining these improvements, ensuring that the mentorship component continues to improve HIV and SRH care in Beira and beyond. Regular monitoring, resource allocation, and collaboration among stakeholders will be critical to ensuring that the progress made through the mentorship is not only maintained but expanded to other regions of Mozambique.

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ANNEXES

ANNEX I: TERMS OF REFERENCE

Médecins Sans Frontières (MSF) is an international medical humanitarian organisation committed to providing quality medical care to people in crisis situations around the world, when and where they need it, regardless of their religion, ethnicity, or political views. Our core principles are neutrality, impartiality, independence, medical ethics, témoignage, and accountability.

The Stockholm Evaluation Unit (SEU), based in Sweden, is one of three MSF units responsible for managing and guiding evaluations of MSF's operational projects, and works mainly with the Brussels Operational Centre. For more information, visit our website evaluation.msf.org.

Fostering a culture of evaluation is a strategic priority for accountability, continuous improvement, and organisational learning. MSF does not only evaluate because of external requirements, such as donor requirements. These terms of reference should be considered as a starting point for the evaluation process. The evaluator(s) are invited to challenge them and suggest, for example, different or additional perspectives, as they see fit during the creation phase. The evaluation process must be based on a sound methodology to achieve credible results and must also ensure that values and use are at the forefront. The evaluation must involve and include the different actors and counterparts adequately throughout the process.

EVALUATION OF THE DECENTRALISATION COMPONENT THROUGH MENTORING IN MSF-OCB'S PROJECT IN BEIRA, MOZAMBIQUE	
Start date	March 2024
Duration	Final report to be submitted by July 2024 (date TBD)
Requirements	Interested applicants should submit: 1) A technical proposal 2) A financial proposal 3) CV(s), and 4) A previous (appropriate) work sample
Deadline to apply	23:59hrs CET on March 26, 2024
Send application to	evaluations@stockholm.msf.org marked BEIDE
Special Considerations	We value quality over quantity. Providing only the requested and necessary documentation should prove your interest, capacity, and competency in the best possible manner. The evaluation will require a site visit to the project, which will be planned during the initiation phase through discussions with the project, the consultation group, and the SEU.

BACKGROUND

Mozambique's health care system was after its independence in 1975 considered by the WHO as a best-case model for other developing countries.[4] A civil war in the mid-90s slowed down its progress, and today's health

[4] Pfeiffer 2003. International NGOs and primary health care in Mozambique: the need for a new model of collaboration. Social Science and Medicine.

care service provision is experiencing severe challenges. Limited medical supply, understaffed health care facilities, poor motivation of health care workers, and a lack of adequate training reflect barriers to establish quality health services within the local health structures.[5] The COVID-19 pandemic has worsened the situation and burdened the already fragile health system.[6] The country has increased its internal funding of health expenditure. In 2019, 79% of health expenses were financed internally, the rest (21%) was funded by external sources.[7] Nevertheless, poor governance and management, resource mobilisation[8] as well as gaps in documentation of the use of health funding[9], are further influencing a low level of quality health care.

Mozambique has the second highest number of people living with HIV (PLHIV) in Sub-Saharan Africa.[10] 12.4% of the adult population (15-49 years) was living with the virus in 2022.[11] HIV is the leading cause of mortality and morbidity in the country.[12] CD4 testing was introduced in Mozambique in 2003, a Test-and-Treat approach was adopted in 2016 and the routinely identification of Advanced HIV Disease (AHD) in patients was finally established in 2022. Based on an internal assessment from the *Ministerio de Saude de Mozambique* (MISAU) in 2022, 25% of PLHIV newly initiated on Antiretroviral Therapy (ART) were AHD patients.[13] This is in line with the global estimations of people with AHD in need of specialised services, as studies have estimated that over 30% of PLHIV in low- to middle-income settings initiating Antiretroviral therapy have a CD4 cell count lower than 200 cells/mm^3.[14]

The country's HIV prevalence among Key Vulnerable Population (KVP), (Female Sex Workers (FSW), Injectable Drug Users (IDUs), Prisoners, and Men who have Sex with Men (MSM) tend to be higher compared to the general population (GP). 19% of new HIV infections occur among FSW, clients of female sex workers, and partners of sex workers[15], 5% among MSM[16].

Sofala province lies in the middle of the country and shows a HIV prevalence higher than the national level of 13.2%. Beira town is the capital of and largest city in Sofala province with an estimated population of 719,806 inhabitants in 2022 and an HIV prevalence of 13.4%.[17] 84,890 PLHIV were on ART in 2020.[18]

In terms of the KVP in Beira, MISAU estimated the HIV prevalence around 24% among FSW[19] and 9.1% among MSM[20]. From 2014 until August 2023 MSF had 7,080 KVP enrolled and followed up, with a self-assessed overall HIV prevalence of 21.4%. The HIV prevalence among FSW was 39.1%, among MSM 9%, and among transgender

[5] Giardo 2020. Health, development, and institutional factors: The Mozambique case. Health, development, and institutional factors: The Mozambique case (econstor.eu)

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[9] UNICEF 2019. Budget Brief: Health Mozambique 2019.

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[16] MISAU 2011. Inquérito Integrado Biológico e Comportamental entre Homens que Fazem Sexo com Homens, Moçambique

[17] MSF Project Identity Card. Beira Mozambique

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groups (TG) 29%.[21] HIV services for KVP remain largely inadequate and they face access barriers to health services, for MSM particularly due to stigma and discrimination.

MSF History in Beira

In 2014, MSF started working in Beira as part of "the corridor project". This project offered a contextualised and comprehensive package of care to KVP along a major transport corridor running through Mozambique, Malawi, and Zimbabwe. KVP targeted in this project included FSW, MSM and workers-in-mobility (i.e. truck drivers). In 2015, MSF started to intervene in two primary Health Centres (HC) - Munhava and Ponta Gea - supporting MISAU in the implementation of specific HIV-related activities including routine Viral Load (VL) monitoring and pharmacy management, targeting KVP. In 2017, the corridor project evolved to deliver a quality and tailored package of HIV prevention and treatment, as well as Sexual and Reproductive Health (SRH) services, to KVP. The corridor project was handed over to FHI360 due to the low feasibility to follow the target population crossing borders, and therefore attain continuity of care. However, MSF continued to work with KVP in Beira at community level.

In 2018, MSF activities were reoriented with the overall objective to reduce morbidity, mortality, and incidence of HIV among KVP in Beira (including FSW, youth at risk, MSM, and TG) as well as the general population with AHD. The intervention areas of this new project focused on AHD-, TB-, SRH-, KVP-friendly services on three levels: (1) Community, (2) Munhava and Ponta Gea HC, and (3) Beira Central Hospital (BCH).

MSF has been working alongside MISAU to ensure replicability of the activities, experience and skills sharing, intending to influence sustainability of the intervention's outcomes. MSF activities in Mozambique, specifically MSF protocols and tools have influenced the national guidelines on KVP services, sexual and reproductive health (SRH) including safe abortion care (SAC), and AHD care that were finalised in 2020.[22]

In 2021, MSF concluded that it was not viable to keep a traditional clinic-centred approach for HIV. It was decided to widen MSF support to primary health care level but apply a less hands-on approach. Under the main objective to expand and improve access to health services on primary health care level for KVP, SRH and AHD patients, the project was in 2021 again restructured into now two main components:

(1) Decentralisation component including the support to 10 HCs focusing on KVP-friendly services, SRH and AHD services, and
(2) Vertical AHD services provided at BCH and Munhava HC.

The targeted population also includes the general population, assuming increased capacity of healthcare staff impacts the general population of Beira.

In 2022, MISAU started to implement the new guidelines in BCH and Munhava HC with support from MSF and the ambition to later expand to other HC in Beira. MISAU's plan to roll out the new guidelines on primary health care level did experience difficulties and has not yet been finalised. MISAU further requested MSF to help with the reactivation and improvement of the national tutoring system.

Decentralisation Component of The Project

The decentralisation component of the project aims primarily at sharing technical experience, empowering the HC staff, and improving their awareness about the impact the services have on the patient's life. MSF does not

[21] MSF internal documentation

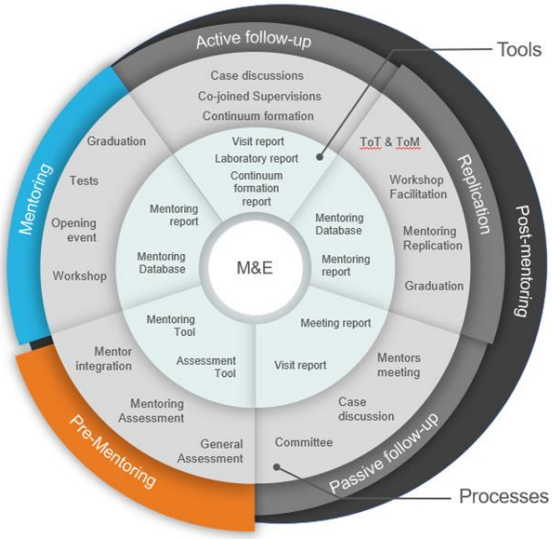
[22] MISAU 2022. Guião de manejo do paciente com doença avançada por HIV.

provide direct medical services but focuses on capacity building as well as punctual support in logistics and medical supply in 10 selected HC in Beira town (Nhaconjo, Chingussura, Inhamizua, Ponta-Gea, Macurungo, Manga Loforte, Mascarenhas, Cerâmica, Nhangau, and Marrocanhe). AHD consultation per month varied between 10 to 80 in 2023, between the different HC. From 2022 to mid-2023, a total of 6 346 women received SRH services.23 KP-specific data about service use are not available so far.

Mentoring Program

Capacity building has been a central element in all components of the project with the aim of achieving continuity of quality services. Nevertheless, little success in influencing health worker's skills and performance has been observed before the reorientation towards decentralisation. Current evidence points strongly towards the need for teaching and learning to happen in the workplace to be effective, far more than in a classroom setting. Clinical mentoring programs are designed to this educational approach. MSF therefore decided to develop a proper mentoring program including training, mentoring, and supervision of health care workers, aiming to influence knowledge, skills, and attitude while using a staff-oriented, adult-learning approach.

The mentoring program consists of training packages on KVP-friendly, SRH, and AHD services and was implemented stepwise from May 2021 to September 2023 in all 10 HC. The program spanned over 6 months in each HC, passing five phases, and targeted mainly clinical and patient support health care staff. Since its start, about 150 health care staff were fully involved in the program, becoming so-called mentees.



The five phases include a *pre-mentoring phase* (2-4 weeks) to assess needs and resources. A *training phase* (3-5 days) then transmits specific training packages on SRH, KVP, AHD and additionally on laboratory. The *mentoring phase* (4-14 weeks) consists of a daily companionship of the mentees to support the implementation of the gained knowledge and to create a learning environment. In the *follow-up phase* (3-6 months) mentees are continuously supervised through the conduction of weekly case discussion, monthly feedback sessions and support by phone if needed. Finally, in the *replication phase* prospective mentors are selected within the mentees, to attend a training-of-trainer workshop. These mentors will then start the replication.

With the end of the mentoring program, the decentralisation component of the project will have completed its activities by mid-2024. On-demand support for the 10 HCs will continue and collaboration with community actors will be maintained. MSF will further support MISAU in the implementation of the AHD, SRH and KVP guidelines on primary health care level.

PURPOSE AND INTENDED USE

PURPOSE. The evaluation will assess the overall results of the decentralisation component with a specific focus on the mentoring program. It should further document lessons learned and elaborate recommendations for other decentralisation initiatives through mentoring in MSF contexts.

[23] MSF Beira project document 2023

INTENDED USE. The evaluation findings will be used by MSF and possibly other actors (e.g. MISAU) to inform decentralisation efforts in MSF contexts. The evaluation process and its recommendations will further provide guidance for possible adaptations of Beira project's strategy.

EVALUATION QUESTIONS

1. ***To what extent is decentralisation through mentoring relevant and appropriate?***
    a. Was the decentralisation component appropriately responding to the needs of the target population?
    b. How was the decentralisation component aligned with priorities of relevant stakeholders?
    c. Which opportunities could have improved appropriateness of the decentralisation component?
2. ***To what extent was decentralisation through mentoring effective?***
    a. What were the expected results of the decentralisation component?
    b. To what extent was improved knowledge, skills, and attitude of the targeted healthcare staff achieved? In what way were expected patient's health outcomes achieved?
    c. How could the decentralisation component have increased its effectiveness?
3. ***To what extent has decentralisation through mentoring influenced larger contributions (impact), perceived by different stakeholders?***
    a. What unforeseen positive or negative consequences did the decentralisation component influence?
    b. How could a wider positive (systemic) change have been increased?
4. ***To what extent is decentralisation through mentoring coherent within its broader context?***
    a. In what ways were synergies with local resources and interventions considered and interlinkages (internal and external) established?
    b. What could have improved coherence?
5. ***To what extent is decentralisation through mentoring replicable?***
    a. In what ways was replicability of the project's component considered in its implementation?
    b. To what extent is the decentralisation component replicable by MISAU?
    c. To what extent is the decentralisation component replicable by MSF?

EXPECTED DELIVERABLES

1. **Inception Report.** Based on conducting initial document review and preliminary interviews, the inception report should include a detailed evaluation proposal, including methodology and analysis.
2. **Development of a Theory of Change.** This is advised to be done in parallel with or before the finalisation of the inception report. It should provide a visual on the causal links and assumptions of the project's elements in relation to its main objectives.
3. **Draft Evaluation Report.** The report should answer the evaluation questions addressing the set objectives and intended use of the evaluation. It should include analysis, findings, and conclusions and, where applicable, lessons learned and recommendations.
4. **Working Session.** As part of the report writing process, the evaluator will present the findings, collect attendances´ feedback and will facilitate discussion on lessons learned with the attendance of commissioner and consultation group members in one or more working sessions.
5. **Final Evaluation Report.** The final report should consider comments and feedback received during the working session.

6. **Dissemination.** To be defined in a separate dissemination plan, can include presentations, learning sessions, sensemaking exercises, or other communication materials with partners, communities, or patients.

We expect the evaluator(s) to be flexible in considering additional deliveries that might be necessary to successfully proceed in the evaluation process. Each deliverable is reviewed by the SEU and approved by the Evaluation Commissioner.

TOOLS AND METHODOLOGY PROPOSED

In addition to the initial evaluation proposal submitted as part of the application, a detailed evaluation protocol will be prepared by the reviewers during the initial phase, following access to the documentation and initial discussions with the evaluation Consultation Group (CG). The initial report will include a detailed explanation of the proposed methods and their rationale based on validated theories. It will be reviewed and validated as part of the creation phase in coordination with the SEU.

RECOMMENDED DATA SOURCES

- Routinely collected medical data (raw and aggregated data from MSF, ECHO or MISAU).
- MSF and OCB strategic and project documents (project descriptions, logical frameworks, operational strategies, annual reports, capitalisation reports, evaluations, research and similar).
- National, regional, and global strategies, thematic documentation, and guidelines.
- External literature, research, and documentation.

PRACTICAL IMPLEMENTATION OF THE EVALUATION

Number of evaluators	TBD
Timing of the evaluation	March – July 2024

The SEU engages a Consultation Group (CG) in this assessment process with the goal of increasing understanding, buy-in, process learning, and the quality and utility of the evaluation. The CG is headed by a commissioner. They contribute to the finalisation of this ToR.

PROFILE/REQUIREMENTS FOR EVALUATOR(S)

Requirements:

- Proven evaluation competencies;
- Degree in public health, health service management, epidemiology, or related area;
- Experience in HIV patient care, service provision or similar;
- Experience in capacity building, mentoring or similar educational approaches; and
- Fluency in Portuguese, and English.

Assets:

- Experience and/or understanding of MSF.
- Experience in Southern Africa region, specifically Mozambique.
- Expertise in Advanced HIV Disease service management/provision.

- Experience working with Key Vulnerable Population (FSW, MSM, or others).
- Expertise in SRH service management/provision.
- Expertise in participatory approaches.

APPLICATION PROCESS

The application should consist of a technical proposal, a budget proposal, CV(s), and a previous work sample. The proposal should include a reflection on how adherence to ethical standards for evaluations will be considered throughout the evaluation. In addition, the evaluator(s) should consider and address the sensitivity of the topic at hand in the methodology as well as be reflected in the team set-up. Offers should include a separate quotation for the complete services, stated in Euros (EUR). The budget should present a consultancy fee according to the number of expected working days over the entire period, both in totality and as a daily fee. Travel costs, if any, do not need to be included as the SEU will arrange and cover these. Do note that MSF does *not* pay any per diem.

Applications will be evaluated based on whether the submitted proposal captures an understanding of the main deliverables as per this ToR, a methodology relevant to achieving the results foreseen, and the overall capacity of the evaluator(s) to carry out the work (i.e. inclusion of proposed evaluators' CVs, reference to previous work, certification et cetera).

Interested teams or individuals should apply to **evaluations@stockholm.msf.org** referencing **BEIDE** no later than **23:59hrs CET on March 26th, 2024**. We would appreciate the necessary documents being submitted as separate attachments (proposal, budget, CV, work sample and such). Please include your contact details in your CV. Please indicate in your email application on which platform you saw this vacancy.

MSF is committed to applying responsible data protection principles in all its activities, including assessments, respecting both humanitarian principles and the European GDPR. During the assessment process, you will potentially have access, collection, storage, analysis, and possibly disposal of MSF's and its patients' sensitive and personal data and information (SPDI). Please take particular note of the SEU's ethical guidelines when preparing your proposal, taking into account the tools and solutions you will use, how you will work to mitigate any data incidents, and how you will dispose of the data collected once the evaluation is complete.

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ANNEX II: EVALUATION MATRIX

EVALUATION CRITERIA AND CORRESPONDING EVALUATION QUESTIONS	SPECIFIC INVESTIGATION QUESTIONS	INDICATORS	DATA SOURCES
Relevance EQ 1**:** To what extent is decentralisation through mentorship relevant and appropriate?	**From ToR**: ▪ Was the decentralisation component appropriately responding to the needs of the target population? ▪ How was the decentralisation component aligned with priorities of relevant stakeholders? ▪ Which opportunities could have improved appropriateness of the decentralisation component? **Added by evaluator** (mentorship): ▪ Was the mentorship program relevant to contribute to the decentralisation? ▪ How the mentorship program aligned with needs and priorities for the decentralisation of HIV services at the PHC in Beira? ▪ As designed, does the mentorship capture attention of stakeholders as an appropriate intervention in the decentralisation?	· Alignment with national/regional HIV/AIDS strategic plans and policies; · Coherence with primary healthcare strengthening and decentralisation initiatives; · Extent to which the mentorship program addresses identified capacity gaps at the facility level; · Degree of fit between the mentorship component and the needs of health workers; · Level of engagement and ownership by local health authorities and facility managers; · Feedback and satisfaction from participating health workers (mentees); · Extent to which the mentorship program is tailored to the specific needs and realities of the participating facilities.	· Document review · Key informant interviews · Beneficiary feedback · Field observation
Coherence	**From ToR**:	· Alignment with national/regional	· Document

EVALUATION CRITERIA AND CORRESPONDING EVALUATION QUESTIONS	SPECIFIC INVESTIGATION QUESTIONS	INDICATORS	DATA SOURCES
EQ 2: To what extent is decentralisation through mentorship coherent within its broader context?	▪ In what ways were synergies with local resources and interventions considered and interlinkages (internal and external) established? ▪ What could have improved coherence? **Added by evaluator** (mentorship): ▪ Is the mentorship program designed as completing other strategies in the decentralisation of HIV services? ▪ Did the mentorship program include themes on AHD, KP, and SRH as they are the main targets for decentralisation at PHC? ▪ Is the mentorship designed as a complement or substitute to traditional training curricula or capacity strengthening of health staff in Mozambique)	strategies for primary healthcare strengthening and health system decentralisation; · Integration with existing HIV/AIDS service delivery frameworks and referral systems; · Level of coordination and complementarity with other decentralisation or HIV service delivery projects; · Extent of collaboration and information-sharing between the mentorship program and other stakeholders; · Degree of integration of the mentorship program within the existing primary healthcare structures and management systems; · Clarity of roles, responsibilities, and communication channels between the mentorship program and decentralised health facilities; · Mechanisms for promoting collaboration, knowledge-sharing, and cross-learning among the	review · Key informant interviews · Beneficiary feedback Field observation

EVALUATION CRITERIA AND CORRESPONDING EVALUATION QUESTIONS	SPECIFIC INVESTIGATION QUESTIONS	INDICATORS	DATA SOURCES
		participating health facilities; · Feedback loops and adaptations made to the mentorship program based on lessons learned.	
Effectiveness EQ 3 revised: To what extent is the mentorship program effective and contributes to the outcomes of the decentralisation?	**From ToR**: ▪ What were the expected results of the decentralisation component? ▪ To what extent was improved knowledge, skills, and attitude of the targeted healthcare staff achieved? ▪ In what way were expected patient's health outcomes achieved? ▪ How could the decentralisation component have increased its effectiveness? **Added by evaluator** (mentorship): ▪ To which level has, the mentorship program contributed to the effectiveness of the decentralisation? ▪ How was the mentorship effective in upskilling health staff and improve their practices in HIV healthcare at the PHC?	· Improved knowledge, skills, and confidence of mentees in delivering decentralised HIV services; · Changes in the competence and attitudes of mentees in providing quality, responsive care; · Increased availability, accessibility, and utilisation of HIV and sexual/reproductive health services; · Enhanced quality of service provision, including for key populations and vulnerable groups; · Improved facility-level planning, management, and coordination of service delivery; · Strengthened monitoring, reporting, and data use for decision-making; · Extent to which the mentorship program has contributed to the overall goals of the decentralisation	· Program monitoring data · Facilities assessments reports · Beneficiary feedback · Key informant interviews On-field observation

EVALUATION CRITERIA AND CORRESPONDING EVALUATION QUESTIONS	SPECIFIC INVESTIGATION QUESTIONS	INDICATORS	DATA SOURCES
		initiative; Positive changes in health outcomes and impact at the community level.	
Impact EQ 4: To what extent has decentralisation through mentorship influenced larger contributions, perceived by different stakeholders?	**From ToR**: ▪ What unforeseen positive or negative consequences did the decentralisation component influence? ▪ How could a wider positive (systemic) change have been increased? **Added by evaluator** (mentorship): ▪ How have the decentralisation been positively or negatively affected by the mentorship program in general? ▪ How mentorship has improved quality in HIV healthcare? ▪ What has been the benefit of the mentorship in improving health outcomes of PLHIV, KP, and SRH? ▪ In addition to mentorship and MSF support, what are other interventions and stakeholders contributing to the outcomes of the decentralisation?	· Perceived contribution of the mentorship program to the overall decentralisation process by different stakeholders (e.g., health authorities, facility managers, service providers, community members); · Stakeholder views on the significance and influence of the mentorship program relative to other interventions or factors; · Extent to which the mentorship program has enabled or facilitated the mobilisation of additional resources (financial, human, or material) for the decentralisation efforts; · Establishment of new partnerships or strengthening of existing collaborations as a result of the mentorship program; · Adoption or replication of the approach of mentorship by other districts, regions, or programs;	· Key informant interviews · Focus group discussions · Document review · On-field observation Beneficiary feedback

EVALUATION CRITERIA AND CORRESPONDING EVALUATION QUESTIONS	SPECIFIC INVESTIGATION QUESTIONS	INDICATORS	DATA SOURCES
		· Efforts to expand the reach and coverage of the mentorship program within the broader decentralisation initiative; · Impact of the mentorship program on shaping policies, strategies, or guidelines related to decentralisation and service delivery; · Extent to which the mentorship program has informed or influenced decision-making processes at the local, regional, or national levels; · Perceived improvements in access, utilisation, and quality of services at the decentralised health facilities, as observed by community members; Community-level changes in health outcomes and indicators (e.g., HIV testing, linkage to care, viral suppression) that can be attributed to the mentorship program's contributions.	
Replicability QE 5: To what extent is decentralisation through mentorship replicable?	**From ToR**: ▪ In what ways was replicability of the project's component considered in its implementation?	· Extent to which the mentorship program model can be adapted to different geographic, socio-cultural, and health system contexts;	· Program monitoring data · Key informant

EVALUATION CRITERIA AND CORRESPONDING EVALUATION QUESTIONS	SPECIFIC INVESTIGATION QUESTIONS	INDICATORS	DATA SOURCES
	▪ To what extent is the decentralisation component replicable by MISAU? ▪ To what extent is the decentralisation component replicable by MSF? **Added by evaluator** (mentorship): ▪ What are the success factors of the mentorship program as a decentralisation intervention component? ▪ Which specific learned lessons and experience on mentorship for decentralisation should be replicated on other projects or in other contexts?	· Identification of key program components that are flexible and can be tailored to local needs and circumstances; · Availability and accessibility of the required human, financial, and material resources for implementing the mentorship program; · Cost-effectiveness and sustainability of the mentorship approach compared to other decentralisation interventions; · Potential for the mentorship program to be scaled up within the existing decentralisation initiative or replicated in new settings; · Factors that enable or hinder the scaling up or replication of the mentorship program; · Presence of supportive policies, strategies, and guidelines that facilitate the implementation of the mentorship program; · Level of commitment and buy-in from key stakeholders (e.g., health authorities, facility managers, service	interviews · Comparative analysis (with programs implemented elsewhere like in DRC, Guinea, and Kenya) · Cost-benefit and sustainability assessments · Document review

EVALUATION CRITERIA AND CORRESPONDING EVALUATION QUESTIONS	SPECIFIC INVESTIGATION QUESTIONS	INDICATORS	DATA SOURCES
		providers) for the approach of mentorship component of decentralisation; · Availability of training, tools, and resources to support the capacity development of mentors and the replication of the mentorship program; Mechanisms for documenting and disseminating lessons learned, best practices, and success stories from the mentorship program.	

ANNEX III: INTERVIEW QUESTIONS

INTRODUCTION

Present yourself: My name is ……, and I am working as an external evaluator of the decentralisation through mentorship of the MSF Beira project.

The purpose of the evaluation is to assess the relevance, coherence, effectiveness, impact, and replicability of the decentralisation of HIV services through the mentorship project.

The purpose of my visit today is to conduct a confidential interview, which typically lasts between 30 and 45 minutes. I kindly request your consent to engage in a discussion that will help me in gaining a better understand of how mentorship is contributing to the decentralisation of HIV services in Beira. The insights gathered will support MSF in improving the intervention and potentially replicating its success elsewhere if proven effective.

You are free to participate and can stop your participation at any moment during the interview without needing to provide an explanation and any negative consequences. May we begin if I have your consent?

QUESTIONS TO THE PROJECT TEAM

Background and Context

- Can you provide an overview of the HIV service delivery landscape in Beira City prior to the decentralisation and mentorship project?
- What were the key drivers and rationale behind the decision to decentralise HIV services in the city?
- How was the mentorship project conceptualised and designed as a project to support the decentralisation process?

Relevance & Appropriateness

- How do you assess the relevance and appropriateness of the mentorship project in addressing the specific needs and challenges of decentralising HIV services in the city?
- How did you assess the specific needs and challenges of the primary healthcare facilities and health workers in the context of decentralising HIV services? How did this assessment inform the design of the mentorship project?
- Can you explain the rationale behind the selection of the key thematic areas covered by the mentorship project (e.g., clinical, M&E, procurement, sanitation and hygiene)? How were these areas prioritised based on the local context?
- What mechanisms were put in place to ensure the mentorship project was aligned with the broader health system strategies and policies related to the decentralisation of HIV services? How did you navigate any potential gaps or misalignments?
- How did you engage with the local stakeholders, including health facility managers, HIV service providers, and community representatives, to understand their perspectives on the relevance and appropriateness of the mentorship project? How were their inputs incorporated into the project design and implementation?

- What steps have you taken to ensure the mentorship project is tailored to the specific needs and capacities of the health workers at the decentralised facilities? How do you monitor and adapt the project to maintain its relevance over time?
- To what extent does the logistics component address the specific needs and challenges of decentralising HIV and SRH services in Beira, Mozambique and specifically in the MSF supported health centres?

Coherence

- How does the mentorship project align with and complement other initiatives or interventions that are part of the decentralisation of HIV services in the city? Can you explain the synergies and coordination mechanisms in place?
- What steps have you taken to ensure the mentorship project is well-integrated within the existing primary healthcare system and structures? How have you addressed any potential institutional or administrative barriers to effective integration?
- Can you describe the coordination and communication mechanisms established between the mentorship project, the decentralised HIV service delivery points, and the central/regional HIV project management units? How do these mechanisms facilitate coherence and information-sharing?
- What strategies have you implemented to foster collaboration and cross-learning between the mentors and the different primary healthcare facilities participating in the mentorship project? How do these strategies contribute to the overall coherence and effectiveness of the project?
- How well does the logistics component align with and complement the mentorship project and other components of the decentralisation process?

Implementation of the Mentorship Project

- Can you walk us through the process of rolling out the mentorship project across the 10 primary healthcare facilities?
- What were the key components of the mentorship project (e.g., training, supervision, coaching, peer-to-peer learning)?
- How were the mentors and mentees selected, and what were the criteria used for their recruitment and capacity-building?
- What mechanisms were put in place to ensure coordination and integration between the mentorship project and the wider health system?

Assessing Effectiveness and Impact

- How do you monitor and evaluate the effectiveness of the mentorship project in supporting the decentralisation of HIV services?
- Can you share any data or evidence on the key outcomes and impacts of the mentorship project, such as improvements in service quality, access, and uptake?

- What have been the most significant successes and challenges encountered in implementing the mentorship project?
- How have you engaged with local stakeholders, including health workers, community representatives, and policymakers, to understand their perspectives on the mentorship project?
- How effectively has the logistics component of the MSF Beira project contributed to the successful decentralisation of HIV (AHD) and SRH services in Beira, Mozambique?
- What measurable impact has the logistics component had on improving the accessibility, quality, and utilisation of decentralised HIV and SRH services in MSF support health centres?
- *Sustainability and replicability:*
- What strategies have been put in place to ensure the sustainability of the mentorship project beyond the current project cycle?
- What key lessons have you learned that could inform the replication and scale-up of the mentorship model in other contexts?
- What are the critical factors that you believe have contributed to the mentorship project's success in supporting the decentralisation of HIV services?
- To what extent can the logistics component and its approach be replicated in other regions or countries facing similar challenges in decentralising HIV and SRH services?

QUESTIONS TO THE MENTORS

- Can you describe your role and responsibilities as a mentor in the decentralisation project?
- How were you selected and trained to be a mentor? What were the key aspects of the mentorship training?
- What are the main thematic areas in which you provide mentorship (e.g., clinical, M&E, procurement, hygiene, and sanitation)?
- How do you assess the needs of and tailor mentorship support to the specific requirements of the mentees?
- What have been the key challenges and successes in your mentorship role?
- How do you measure the effectiveness of your mentorship in contributing to the decentralisation of HIV services?
- In your opinion, what are the most important factors for the sustainability and replicability of the mentorship project?

QUESTIONS TO MENTEES (HEALTH STAFF, HEALTH CENTRES MANAGERS, M&E STAFF)

- Can you describe your role and responsibilities in the decentralised HIV service delivery?
- What has been your experience with the mentorship project? How has it supported your work?
- As a health worker participating in the mentorship project, how has the support and guidance provided by the mentors been helpful in strengthening your capacity to deliver decentralised

HIV services? Can you provide specific examples of how the mentorship has impacted your knowledge, skills, and confidence?

- Can you provide specific examples of how the mentorship has improved your knowledge, skills, and practices?
- What has been your experience in terms of the relevance and appropriateness of the mentorship content and approach to addressing the specific challenges you face in providing HIV services at the decentralised facility? How well has the project been tailored to your needs and the local context?
- What are the key challenges you have faced in implementing the decentralised HIV services, and how has the mentorship project helped address them?
- How do you think the mentorship project could be improved to better support the decentralisation of HIV services?
- What are your suggestions for ensuring the sustainability and scalability of the mentorship project?
- What technical capacity in terms of equipment, drugs supply, etc. Did your facility have prior to the implementation of the mentorship project?
- Do you think the mentorship only should have been sufficient to improve the availability and performance of HIV and SRH services in your health centre without any external logistics support? In other words, are there any pre-requisites that should be put in place prior to the implementation of the mentorship project or subsequently to ensure the decentralisation of HIV and SRH services is successful?

QUESTIONS FOR MISAU OFFICIALS (PROVINCIAL & DISTRICT DEPARTMENTS / HIV CONTROL PROJECT)

- Can you explain the rationale and objectives behind the decentralisation of HIV services in Beira City?
- How does the mentorship project fit into the broader strategy for decentralising HIV services?
- What policy and regulatory frameworks support the decentralisation and mentorship initiatives?
- What are the key coordination and integration mechanisms between the mentorship project and the wider health system?
- How do you assess the relevance and coherence of the mentorship project in achieving the decentralisation goals?
- What are the key factors you consider for the scalability and replicability of the mentorship project in other regions?

PLHIV - KPSKP – BENEFICIARY OF SGBV SERVICES - AND PATIENTS ASSOCIATIONS / CBO

General questions

- Have you experienced any changes in HIV service delivery since the decentralisation and mentorship component was implemented? Can you comment on those changes?

- Have you noticed any differences in the accessibility, quality, and responsiveness of the HIV services at the decentralised facilities? (Include a brief definition for 'accessibility', 'quality' and 'responsiveness')
- What are your perspectives on the engagement and participation of the community in the decentralisation process?
- How would you participate or be involved in the process to have closer access to services?
- What are the key challenges or barriers that you or your community members still face in accessing the decentralised HIV services?
- Decentralisation in HIV is making available healthcare services at the lower level of the health systems like health centres; Mentorship is all what contributes to upskilling health staff and psychosocial support assistants for taking care of patients at health centres. Do you have any suggestions for how the decentralisation and mentorship project can be improved to better meet the needs of the community and patients?

Specific questions for People Living with HIV

- As a person living with HIV/AIDS, can you tell me a little bit about your experience with the healthcare service in this clinic **before** the mentorship project started? And did anything change **after** the mentorship project? (Prompts: if not mentioned, ask about the accessibility and quality of services, how easy/difficult it is to make an appointment, receive medications, lab exams etc., and how friendly healthcare professionals are…)
- What has been your perception of the competence and responsiveness of the health workers at the decentralised facilities in providing HIV care and support? To what extent do you feel the mentorship project has contributed to improving the capacity and attitudes of the providers?

Specific questions for beneficiaries of sexual and reproductive health services (including SGBV survivors)

- Do you usually access sexual and reproductive health services at this specific clinic? Can you tell me a little bit about your experience with the SRH service in this clinic **before** the mentorship project started? And did anything change **after** the mentorship project? (Prompts: if not mentioned, ask about the accessibility and quality of services, how easy/difficult it is to make an appointment, receive medications, lab exams etc., and how friendly healthcare professionals are…)
- How accessible and accommodating have you found the sexual and reproductive health services, including services for survivors of SGBV, at the decentralised health centres? To what degree do you feel these services have become more available and responsive to the needs of the community?
- Have you observed any improvements in the way health workers at the decentralised facilities engage with and support survivors of SGBV? If so, what changes have you noticed, and how do you think the mentorship project may have contributed to these improvements?

Specific questions for Key Vulnerable Populations

Generic questions for All

- As a member of the MSM community/PWID/sex worker, can you tell me a little bit about your experience with the healthcare service in this clinic **before** the mentorship project started? And did anything change **after** the mentorship project? (Prompts: if not mentioned, ask about the accessibility and quality of services, friendly/unfriendly staff/healthcare professionals, how easy/difficult it is to make an appointment, receive medications, lab exams, etc., and how friendly healthcare professionals are…)
- What has been your perception of the competence and responsiveness of the health workers at the decentralised facilities in providing HIV care and support? To what extent do you feel the mentorship project has contributed to improving the capacity and attitudes of the providers?
- For Men who have Sex with Men (MSM):
- Since the decentralisation efforts and the mentorship project, have you noticed any changes in your ability to access HIV prevention services, such as condoms, lubricants, and HIV testing? Can you describe any improvements or challenges you have experienced?
- Have you observed any changes in the attitudes and practices of healthcare workers towards MSM individuals seeking HIV testing, treatment, or other services? How has this impacted your willingness to utilise these services?

For People Who Inject Drugs (PWID)

- How has the decentralisation of services and the mentorship project affected your access to harm reduction services, such as needle/syringe exchange, opioid substitution therapy, and overdose prevention? Have you noticed any improvements or barriers?
- Do you feel that healthcare workers are now more responsive to the unique needs and challenges of people who inject drugs when it comes to HIV testing, linkage to care, and adherence to treatment? Can you share any specific experiences or changes you have observed?
- For Sex Workers:
- Since the decentralisation efforts and the mentorship project, have you noticed any changes in your ability to access HIV testing, counselling, and prevention services, such as condoms and lubricants? Can you describe any improvements or ongoing challenges you have faced?
- Have you observed any shifts in the attitudes and practices of healthcare workers towards sex workers seeking HIV-related services? How has this impacted your comfort and willingness to utilise these services?

CONCLUSION ON THE INTERVIEW

"Is there anything else you wish to add? Is there any question I haven't asked that you think I should have asked"?

Thank you.

ANNEX IV: EXAMPLE OF MENTORSHIP EVALUATION GRIDS

MENTEE COMPETENCY GRID - HAEMATOLOGY

HAEMATOLOGY	
LEARNING CATEGORY	On successful completion of this topic you will be able to:
KNOWLEDGE	To define a practical approach a patient with anaemia.
	List the common causes of anaemia, and the useful investigations and management.
	Recognise the indications for blood transfusion.
PROCEDURE	Perform a POC Hb
ATTITUDE or BEHAVIOUR	None

Questions and concerns that need to read up or would like to raise with my mentor
New lessons learnt during a mentoring session or from my own study

MENTEE OBSERVATION GRID - MENTOR

Recommended use of this document

The grading in this document should not be completed in the presence of the mentee. Mentees should merely be caringly informed of the areas that they need to read up on, or work on, with a view to discussing the outstanding topics at a later stage.

1 – below standard 2 - satisfactory 3 – above average

DOMAIN	TOPIC and LEARNING OUTCOMES	DATE 1	DATE 2	DATE 3
Session 1	TOPIC			
KNOWLEDGE				
PROCEDURE				
ATTITUDE or BEHAVIOUR				
ADDITONAL COMMENTS				
Session 2	TOPIC			
KNOWLEDGE				
PROCEDURE				
ATTITUDE or BEHAVIOUR				
ADDITONAL COMMENTS				
Session 3	TOPIC			
KNOWLEDGE				
PROCEDURE				
ATTITUDE or BEHAVIOUR				
ADDITONAL COMMENTS				

DOMAIN	TOPIC and LEARNING OUTCOME	DATE 1	DATE 2	DATE 3

Session 4	TOPIC			
KNOWLEDGE				
PROCEDURE				
ATTITUDE or BEHAVIOUR				
ADDITONAL COMMENTS				
Session 5	TOPIC:			
KNOWLEDGE				
PROCEDURE				
ATTITUDE or BEHAVIOUR				
ADDITONAL COMMENTS				
Session 6	TOPIC:			
KNOWLEDGE				
PROCEDURE				
ATTITUDE or BEHAVIOUR				
ADDITONAL COMMENTS				

ANNEX V: MENTORSHIP PROGRAM CONTENT PER TOPIC

CLINICAL MENTORSHIP PROGRAMME FOR ADVANCED HIV

GENERAL OBJECTIVES	
1	Improve the quality of management of patients with TB / advanced HIV disease at CS level
2	Improve TB screening and detection at CS level
3	Improve management of high viral load and treatment failure at CS level
4	Reduce morbidity and mortality in patients with advanced HIV disease

Week 0 - Contract and pre-test mentoring / opening event

Week 1-2 Advanced HIV / POC test

Week 1 - Introduction to advanced HIV

- Define advanced HIV according to WHO / MSF;
- Describe the clinical characteristics of HIV disease progression according to the WHO staging system.
- List the danger signs of advanced HIV
- List the common causes of mortality in advanced HIV
- Recognise patients presenting the danger signs

Week 2 - Point-of-care testing

- Recognise the importance of determining the CD4 count
- Mention the eligibility criteria for CD4, Crag and TB LAM (according to the WHO)
- Interpret CD4, Crag and LAM TB count results
- Record the LAM TB, Crag and CD4 count results in the patient's file
- Obtain informed consent to perform POC tests in a supportive manner

Week 3 - Detecting and managing treatment failure

- Define three different types of treatment failure, according to WHO guidelines
- List criteria for diagnosing virological treatment failure (rule 123A)
- List 5 situations in which a doctor may be responsible for a high viral load
- List the necessary investigations to be carried out before switching to 2nd line
- Explain the relationship between low dosage or failure to take medication and resistance mutation
- List the common side effects of second-line drugs

- Choose the correct second-line regimen for the Hep BsAg positive patient with first-line failure
- List the second-line regimen in adults and children

Week 4 - General approach to common OIs

- Defining an opportunistic infection
- Systematically document WHO stage at clinic visits
- Demonstrate the ability to correctly stage patients during the consultation
- Perform a complete physical examination on patients with advanced HIV
- General approach to infectious skin diseases in HIV-positive patients.
- Explain the need to ask patients about specific symptoms

Week 5 - **Respiratory diseases**

- List the 'big 3' respiratory diseases (TB / PCP / Bacterial Pneumonia)
- Explain the diagnosis and treatment of the three major respiratory diseases
- Carry out a respiratory examination (including RR and chest auscultation)
- Start pre-referral (empirical) treatment for 'the big 3' when indicated and necessary

Week 6 - Neurological diseases

- List the 'big 3' CNS diseases (TB/Neurotoxoplasmosis/Cryptococcal meningitis)
- Explain the diagnosis and treatment of the three major neurological diseases
- Carry out a neurological examination on a patient with neurological symptoms
- Initiate pre-referral (empirical) treatment for 'the big 3' when indicated and necessary
- Carry out post-discharge follow-up of patients with cryptococcal meningitis/ CNS TB/ Neurotoxoplasmosis

Week 7 - Gastrointestinal System Conditions + Kaposi's disease + Ca of the uterus

- List the main causes of acute diarrhoea in HIV patients
- List the main causes of chronic diarrhoea in HIV patients
- Screening for visceral Kaposi's disease in HIV patients
- Carry out regular screening for cervical cancer and list the referral criteria

Week 8 - TB in HIV

- List 6 specific questions about TB screening
- Name at least 5 techniques for diagnosing TB

- Identify suspected TB patients
- Explain the management of positive GeneXpert results - Rif-sensitive and Rif-resistant
- List drug treatment regimens for TB S and their interactions with ART
- Switch correctly from the intensive phase to the maintenance phase
- Prescribe IPT in HIV+ patients with negative TB screening
- Systematically document the duration of IPT in the patient's master file

Week 9 - HIV in paediatrics

- Screening and diagnosis of HIV in children;
- OI screening (TB, severe bacterial infection)
- OI prophylaxis in paediatrics
- Assessment of signs of severity;
- ART in paediatrics (Build a correct ARV regimen and dosage according to weight)

Week 10- Detection and management of treatment failure in paediatrics / TB in paediatrics

- Diagnosis and treatment of TB in paediatrics;

- Identifying resistance to ART in children;

Week 11 Post-test and Graduation

LABORATORY MENTORSHIP PROGRAMME FOR ADVANCED HIV

GENERAL OBJECTIVES	
1	Improve the quality of laboratory services for advanced HIV patients
2	To improve the organisation and working environment in the laboratory.
3	Improve the safety of laboratory staff and equipment.
4	Ensure good stock management of laboratory supplies.

Week 0 - Mentoring contract and pre-test / opening event

Week 1 - HIV advanced, documents and records

- Disseminate the importance of keeping documents and records up to date in the laboratory;
- Create a master file index to keep track of common documents used in the lab.
- Updating the lab's existing documentation and creating the documents needed for the lab to function properly.

Week 2 - Work area and sample management

- Learn good laboratory practices for a safe and healthy workflow;
- Maintaining a clean, safe and functional working environment
- Observation of the main stages of laboratory sample management
- Collecting and caring for specimens appropriately (accepting and rejecting samples).

Week 3- Carrying out laboratory tests and quality assurance

- Providing accurate and validated test results on time (pre-analytical, analytical and post-analytical phases)
- Ensure accurate and reliable testing processes
- QC must be consistently carried out, monitored, analysed and considered essential. For an efficient quality control (QC) management system

Week 4 - **Inventory management and equipment maintenance**

- My lab monitors inventory
- Create a Supply List for a Test Run
- Maintain equipment to provide uninterrupted service.
- Keep equipment records and make them available to document proper maintenance of equipment and quality control (QC).

Week 5 - Post-test

MENTORING CURRICULUM: KEY POPULATION - PS

GENERAL OBJECTIVES	
1	To improve quality of psycho-social care of beneficiaries
2	To improve the psycho-social care / management of KP & AHD beneficiaries through correct use of counselling tools

Week 1 - Pretest and Mentoring agreement / Opening Event

Week 2 - Introduction of the key population

- List key and vulnerable populations
- Describe how risk behaviour is screened during counselling sessions
- Conduct risk assessment tool during all counselling sessions
- Provide KP sensitisation health education sessions at the SAAJ; utilising the session guide

Week 3 – KP Friendly Services (at the completion of this mentoring period, the mentee expected to be able to):

- Describe and understand the impact of stigma and discrimination on Key Population beneficiaries
- Conduct KP risk assessment tool during all counselling sessions – making use of the recommended tool in the KP Guideline
- Provide KP sensitisation health education sessions at the SAAJ or other patient waiting areas as decided upon by the HC management; utilising the session guide
- Visit the community sites where MSF implements KP services, to practice the counselling sessions (with special focus on KP-relevant sessions, e.g. PrEP counselling and follow-up for Key Population)

Week 4,5 & 6 – Pre-Exposure Prophylaxis (at the completion of this mentoring period, the mentee expected to be able to):

- Define PrEP (What is PrEP, how it works, Adherence) and eligibility criteria
- Describe differences between PrEP and PEP
- Conduct PrEP Initiation Counselling session using the session guide
- Assess beneficiary's comprehension about PrEP and motivation to be on PrEP

Week 7 – Mid-term mentoring evaluation

- Completion of outstanding mentoring sessions
- Mentee & Mentor - Review of portfolios of mentees
- Preparation of upcoming mentoring period

Week 8 & 9 - Advanced HIV Counselling (at the completion of this mentoring period, the mentee expected to be able to):

- Explain concepts related to Advanced HIV Disease
- List the danger signs that indicate that a beneficiary might have AHD
- Conduct Advanced HIV Counselling session using the session guide
- Conduct sensitisation health education sessions on AHD danger signs in the waiting area / SAAJ

Week 10: Catch-up

- Catch-up on sessions that might have been missed in previous weeks
- Complete mentorship dashboard

Week 11 and 12: Post-mentorship evaluation & Certification

- Completion of outstanding mentoring sessions
- Mentee & Mentor - Review of portfolios of mentees

- Presentation of mentee dashboard
- End of mentorship and certification

MENTORING PROGRAMME FOR KEY POPULATION AND VULN.

GENERAL OBJECTIVES	
1	To humanise consultations with key and vulnerable populations by promoting non-discrimination and good communication practices.
2	Improve the quality of management and screening for STI, Hep B, HIV and TB.
3	Improve management of GBV, CANCUM screening
4	Promote PrEP.

Week 0 - **Mentoring contract and pre-test / opening event**

Week 1 - **Introduction to the concept of key population**

- Define key and vulnerable populations
- Describe how to screen for risk behaviour during clinical care
- List the causes of poor PC adherence in health services
- List some of the implications for the user's health when they are identified as PC during care vs. when they are not identified
- Recognise patients who present danger signs

Week 2 - **PC-friendly services**

- Define gender and sexuality
- Describe the impact of stigma and discrimination
- List some legal and para-legal entities that protect CP rights
- List the role of the community in PC-friendly services
- Mention measures to empower users

Week 3 - **Point-of-care testing**

- Recognise the importance of prompt HIV testing and follow-up
- List criteria for HIV testing
- Carry out the HIV test properly
- Testing for syphilis and hepatitis B

Week 4 - **HIV prophylaxis**

- List the importance of PEP and PrEP
- Mention the criteria for starting PEP
- List the criteria for starting PrEP
- Describe how to follow up patients taking PrEP

Week 5 - **Integrated care packages for PC**

- PC disease screening
- STI screening and management
  - § List the components of active STI screening;
  - § Diagnose and manage STIs;
  - § Mention the risks that the PC has of contracting STIs, severe STIs and recurrent STIs;
- Screening for CANCUM
  - § Define cervical and breast cancer and means of diagnosis;
  - § List the criteria for CANCUM screening in HIV-positive and HIV-negative PC;
  - § List the advantages of screening for CANCUM in PC;
- TB screening
  - § Mention the means of TB screening in HIV-positive and negative PC;
  - § List the differences in the risks of contracting TB in PC and the general population. General (Including MDR);

Week 6 - **Integrated care packages for PC**

- GBV in PC (Sexual)
- List the differences in the risks of sexual GBV in PC vs. pop. General;
  - List possible barriers to accessing appropriate services (paralegal and health);
  - Mention the screening and prevention packages for victims of sexual violence;
  - List the possible complications of not accessing GBV services;
- HepB in PC
  - Describe the pathology;
  - List the preventive methods;
  - Mention the complications of Hepatitis B.

POST-ABORTION CARE MENTORING PROGRAMME

GENERAL OBJECTIVES	
1	Offer awareness-raising activity, health education and friendly services between the community and the health centre, the key and general population.

2	Offer quality services without discrimination in health facilities for high-risk and general population.
3	Offer a package of adapted care, contextualised in relation to family planning, post-abortion care.
4	Provide post-abortion care to the high-risk and general population.
5	Support the disuse of manual aspiration for post-abortion care and the use of Misoprostol for post-abortion care in patients requiring care with gestational age below 12 weeks.
6	Support the use of lidocaine to minimise pain during manual aspiration for patients requiring care at gestational age over 12 weeks.

Week 0 - Training and mentoring

Week 1 - Post-abortion care

- Know the importance of manual aspiration?
- Know the objectives of manual aspiration?
- Know the criteria for manual aspiration and misoprostol?
- Know the advantages and disadvantages of abortion care with Misoprostol and Aspiration?

Week 2 - Diagnosis and Differential Diagnosis

- Do you know the signs and symptoms of post-abortion care?
- Know the differential diagnosis?
- Know the signs and symptoms to differentiate the diagnosis?

Week 3 - Procedures to follow when using misoprostol for post-abortion care

- Define procedures according to diagnosis?
- How to prioritise procedures for the use of misoprostol?
- Know the route of administration, frequency and time of effectiveness of misoprostol for post-abortion care.
- Know the actions of misoprostol for post-abortion care

Week 4 - Post-abortion care by aspiration

- Learn the 10 steps for starting aspiration
- Practice

Week 5 - Continuation of the 10 steps to start an aspiration and practice

Week 6 - Post MVA care

- Post MVA procedures
- Patient follow-up
- Complications
- Contraception

Week 7 - When you go home

- What are the danger signs
- Safety of medical abortion and the steps for taking the medicine
- Effects of medication during medical abortion
- Warning signs

Week 8 - Follow-up and complications

- Follow-up care
- Confirmation of successful abortion
- Problems, complications and emergencies
- Risk of foetal malformations
- Uncommon but emerging complications

Week 9 - **Abortion and mental health**

- Patient-centred counselling
- How to validate and normalise the situation
- Identifying other support needs

Week 10 - Retained abortion

- Assessing the risks
- Treatment of abortion

Week 11 - Contraindications and debates

- Intrauterine evacuation methods

Week 12 - Post-test and graduation

SAFE ABORTION MENTORING PROGRAMME

GENERAL OBJECTIVES	
1	Offer awareness-raising activity, health education and friendly services between the community and the health centre, key and general population.
2	Offer quality services without discrimination in health facilities for high-risk and general population.
3	Offer a package of adapted care, contextualised in relation to abortion and family planning.
4	Clarification of the law on abortion.
5	Reduce the number of unsafe abortions

Week 0 - Training and framing of mentors

Week 1 - Sexual reproductive health

- Know the importance of sexual reproductive health?
- Know whose responsibility sexual reproductive health is?
- Know what men's responsibility is in relation to sexual reproductive health.
- Know sexual reproductive health rights for men and women
- Know how to reconsider women's rights during decision-making.

Week 2 - maternal mortality

- Define the context of maternal mortality
- Describe the causes of maternal mortality
- List the common devastating causes that happen to a woman that can cause her harm.
- Get to know some of the assistance that can save women's lives

Week 3-Abortion

- Define abortion and its classification
- Define the signs and symptoms of each type of abortion
- Learn why women have abortions
- Knowing the role of the health professional when dealing with a woman having an abortion
- Patient-centred counselling

Week 4 - Patient care for medical abortion

- Clinical examination before the procedure
- Know the criteria for safely administering medical abortion

- Know the steps of a simple clinical assessment for medical abortion.
- Know the contraindications for medical abortion

Week 5 - Medical history

- Evaluation of the medical history and signs and symptoms of the differential diagnosis of a pregnancy
- Precautions to take during medical abortion and their readability
- Definition of gestational age

Week 6 - Medical abortion process

- The role of medical abortion
- Safety of medical abortion and the steps for taking the medicine
- Effects of medication during medical abortion
- Warning signs

Week 7 - Follow-up and complications

- Follow-up care
- Confirmation of successful abortion
- Problems, complications and emergencies
- Risk of foetal malformations
- Uncommon but emerging complications

Week 8 - **Abortion and mental health**

- Patient-centred counselling
- How to validate and normalise the situation
- Identifying other support needs

Week 9 - Treatment of Its

- Assessing the risks of transmitting Its
- Treatment of TIs in the safe abortion process

Week 10 - Post-abortion contraception

- Family planning counselling
- When to start family planning after abortion
- What to do to prevent future pregnancies