STOCKHOLM EVALUATION UNIT

MEDECINS SANS FRONTIERES LÄKARE UTAN GRÄNSER

EVALUATION OF

COMMUNITY ENGAGEMENT IN CABO DELGADO - MOZAMBIQUE

August 2026

This publication was produced at the request of Médecins Sans Frontières (MSF) – Operational Centre Brussels (OCB) under the management of the Stockholm Evaluation Unit (SEU).

All evaluators contracted by the SEU adhere to the SEU Ethical Guidelines for Evaluations.

It was prepared independently by Neidi de Carvalho & Eva Capa

Acknowledgements

This evaluation would not have been possible without the time and openness of the communities and MSF teams in Macomia and Mocímboa da Praia, as well as in Pemba and Maputo, and the support of the SEU. The evaluation team is grateful to all participants who shared their daily experience of working with communities and with MSF, often under difficult and uncertain conditions, who made time for interviews and shared their views, and who provided access to project documentation, including several who did so after having already left their positions. Appreciation goes to the MISAU representatives and community leaders and members who agreed to speak with the evaluation team, and whose views form the foundation of this report. Thanks, are also due to colleagues at HQ whose reflections helped shape the analysis. The findings, and any errors, remain the responsibility of the evaluation team.

TABLE OF CONTENTS

ABBREVIATIONS AND ACRONYMS

APES — Agente Polivalente Elementar de Saúde (Community Health Worker, Ministry of Health)

ARO — Annual Review of Operations

CG — Consultation Group

CE — Community Engagement

CMHW — Community Mental Health Worker

FC/PC — Field Coordinator / Project Coordinator

GDPR — General Data Protection Regulation

HP — Health Promotion

HPCE — Health Promotion and Community Engagement

MISAU — Ministério da Saúde (Ministry of Health, Mozambique)

MHPSS — Mental Health and Psychosocial Support

MSF — Médecins Sans Frontières / Doctors Without Borders

OCB — Operational Centre Brussels

OCBA — Operational Centre Barcelona-Athens

PESS — Patient Experience and Satisfaction Survey

PFA — Psychological First Aid

PMC — Project Medical Coordinator

PMR — Project Medical Referent

HRMP— Rural Hospital of Mocímboa da Praia

SEU — Stockholm Evaluation Unit

SGBV — Sexual and Gender-Based Violence

SRH — Sexual and Reproductive Health

TB — Tuberculosis

TBA — Traditional Birth Attendant

EXECUTIVE SUMMARY

EVALUATION SCOPE

This evaluation, commissioned through the Médecins Sans Frontières (MSF) Stockholm Evaluation Unit (SEU), examines how community engagement (CE) has been understood, implemented, and experienced across MSF´s two projects in Cabo Delgado, Mozambique: **Macomia** and **Mocímboa da Praia** (the latter transferred from Operational Centre Barcelona-Athens (OCBA) to Operational Centre Brussels (OCB) in April 2026). The evaluation assesses how CE contributes to medical and operational priorities in this conflict-affected setting, with the intended use of informing a strengthened, context-adapted CE model for MSF in Cabo Delgado. Its objectives were to: (1) understand and document CE approaches across the two projects; (2) analyse the level of community participation; (3) assess the contribution of CE to medical and operational priorities; and (4) identify practical recommendations for a strengthened CE approach. Consistent with the SEU approach, the evaluation was designed as a learning and reflection process for MSF´s operational teams, not an assessment of individual or team performance, and covers the period from the design of current CE approaches through subsequent suspensions and adaptations up to June 2026.

METHODOLOGY

The evaluation used a mixed-methods approach, triangulating a review of over 60 key project documents (annual project and HPCE strategies, handover reports, needs assessment, sitreps, and data handover documents, CE guidelines, etc.) with quantitative data review and qualitative evidence. Ten preliminary interviews scoped the evaluation, followed by 34 semi-structured individual and group interviews conducted between April and June 2026, in person and remotely, in English, Portuguese, Spanish, and local languages. Participants ranged from MSF staff (HQ, country coordination and project) as well as representatives from the communities (community leaders, traditional birth attendants, and community-based health workers). Reflection sessions with project teams and consultations with the evaluation Consultation Group (CG) were used to scope the work, review emerging findings, and ground conclusions in operational realities. Ethical principles of informed consent, voluntary participation, confidentiality, and data protection were upheld throughout, in line with SEU ethical guidelines. Limitations included security-constrained access to project locations, staff turnover and gaps in institutional memory (particularly following the Mocímboa da Praia handover), and incomplete CE monitoring data around suspension phases. These were mitigated through triangulation across sources.

MAIN FINDINGS

The evaluation finds that in both projects CE is conceptualised on paper as participatory but practised primarily as health promotion and outreach, structurally delegated to the HPCE team rather than owned transversally across medical, operational, and coordination roles. Both projects operate mainly at the level 1 (OCB CE Framework, Annex A), informing communities, with inconsistent consultation mechanisms and no sustained involvement or collaboration; community input reaches decisions through motivated individuals rather than formal structures, and the feedback loop back to communities is rarely closed. Even so, CE demonstrably contributes to medical and operational priorities: health promotion reaches large numbers, referral systems support facility utilisation, and

trust and acceptance of MSF remain high, though dependent on direct presence. Each suspension has exposed how reliant CE remains on MSF's physical presence, underscoring the need for a suspension-resilient model.

MAIN CONCLUSIONS (FULL SET UNDER SECTION 5)

Both projects operate in a context of sustained armed conflict, mass displacement, and repeated security-driven suspensions that have interrupted activities, fragmented community relationships, and made CE both harder to sustain and more essential. The main elements needed for meaningful community engagement are present in both projects: trusted and diverse community actors, referral pathways, surveillance data, community meeting structures, and documented community feedback. What is missing are the systematic mechanisms that turn these elements into genuine participation: clear objectives, a shift in teams' mindsets, systems that transform community input into decisions and answers back to communities, shared ownership of CE beyond the HPCE team, and a CE model designed to survive operational suspensions. In a context where insecurity is not an external barrier, but the very reason MSF is present, this kind of CE is an operational need rather than an aspiration. MSF needs to adapt how it does what it already does, and the consolidation of both projects under OCB provides the opportunity to make that shift. The report's recommendations, prioritised for implementation in Q3–Q4 2026 and through 2027, set out the practical steps to do so.

PRIORITY RECOMMENDATIONS

(For implementation in Q3–Q4 2026, in alignment with the 2027 planning cycle. The full set is presented under EQ4):

- Reach internally a shared understanding of what CE means in practice in the Cabo Delgado context, distinct from health promotion, and map CE responsibilities explicitly across all roles (PC, PMC, HP Manager, coordination, and all teams with community linkages).
- Design a minimum CE model that does not depend on full MSF presence and can be maintained during suspensions or hybrid management, with scenarios agreed and tested before the next disruption.
- Set a concrete participation target for the next six months (e.g. move at least one activity per project up the participation ladder) and conduct a rapid mapping of structurally underserved groups (depending on operational priorities) with at least one targeted action per group.
- Introduce a simple feedback loop: every community request receives a response, including when the answer is 'we heard you but cannot act on it', with this responsibility explicitly assigned within team roles.
- Reinstate or sustain at least one structured needs identification mechanism per project, and act rapidly on documented feedback collected at community, health facility, and mobile clinic levels.
- Strengthen referral systems: ensure adequate referral data collection is in place in Macomia, formalise the HP-"matrona" pathway, and review the referral system design with community input, co-designing solutions with community actors.
- Communicate operational decisions and transitions (suspensions, role shifts, clinic closures) to communities before changes happen, supported by a standardised, pre-approved communication plan. Formalise what currently works CE wise, so it is not lost with staff turnover.

INTRODUCTION

CONTEXT

MSF Operational Centre Brussels (OCB) has been operating in Cabo Delgado since 2019, the most northern province of Mozambique, with two projects currently active in Macomia and Mocímboa da Praia districts, both projects covered by this evaluation. Mocímboa da Praia was transferred from MSF Operational Centre Barcelona-Athens (OCBA) to OCB[1] in April 2026. The two projects share a common humanitarian context: sustained armed conflict since 2017 by non-state armed groups that has caused mass population displacement, the destruction of health infrastructure, and a severe deterioration in access to essential health services. Cabo Delgado is home to diverse ethnic communities, mainly Macua, Makonde, and Muani, with distinct languages, cultural and religious practices, and relationships to both health systems and traditional medicine. This shapes how communities engage with health services and influences how both MSF projects design and adapt their community engagement approaches.

The conflict has affected different districts unevenly, but insecurity, population movement, and disruption to basic services are shared realities across the area. Both projects have experienced security-driven suspensions that have interrupted activities, fragmented community relationships, and created significant gaps in data and institutional continuity. This insecurity has also made community engagement (CE) itself more difficult to sustain, limiting field presence, access, and regular contact with communities. This is precisely why CE remains central to navigating this reality and dynamics: it allows MSF to understand how contexts evolve, maintain relationships through operational suspensions or changes in activities, and rebuild continuity where it has been lost. More than that, CE informs the design of interventions and enhances their relevance and efficiency, adding tangible value to what MSF does.

OPERATIONAL BACKGROUND

Macomia has experienced repeated security-driven operational suspensions. Following an attack in May 2024, the project was largely evacuated, with partial presence only resuming from July 2024. A further security deterioration in October/November 2024 forced an additional withdrawal, after which the international team operated in hybrid mode management. At the time of this evaluation, the project operates through a fixed health centre in Macomia Sede, a mobile clinic in Muagamula, and community outreach across six locations and multiple IDP camps. Key partners include the Ministry of health or Ministério da Saúde (MISAU) and its community health workers (APES), together with other community entities (mainly water point committees, and traditional birth attendants).

The Mocímboa da Praia project operates in Mocímboa district, the capital of Cabo Delgado's coastal zone, which before the conflict had a population of approximately 120,000. The city was occupied by non-state armed groups in August 2020, recaptured by Mozambican and Rwandan forces in August 2021. MSF OCBA relaunched a permanent presence in September 2022. In September 2025, all

[1] OCs are group of entities with the MSF movement that operationally provide guidance and support to the projects in the countries where MSF works.

activities were again suspended following a spike in violence and were resumed in December 2025. Unlike Macomia, the project has currently no MSF standalone medical activities: it works in support of the MISAU system, covering the Rural Hospital of Mocímboa da Praia (HRMP) and three health centres (Nanduadua, Diaca, and Quelimane), alongside community-based health promotion and mental health activities across the town's neighbourhoods and surrounding villages. The main partners are MISAU, including community health workers (APEs) and other community structures such as health and hygiene committees, traditional birth attendants, and traditional medicine practitioners. From April 2026, the project was formally transferred from MSF OCBA to OCB, consolidating both Macomia and Mocimboa projects under a single operational centre.

PURPOSE AND OBJECTIVES OF THE EVALUATION

The overall **purpose** of this evaluation is to assess how community engagement (CE) has been understood, implemented, and experienced across the projects in **Macomia** and **Mocímboa da Praia districts**, and to identify how CE contributes to **medical and operational priorities** in a conflict-affected context. The intended use of the evaluation is to inform a strengthened and context-adapted CE model for MSF in Cabo Delgado.

The **objectives** of the evaluation are:

1. **Understand and document CE approaches across the two projects**
2. **Analyse the level of community participation**
3. **Assess the contribution of CE to medical and operational priorities**
4. **Identify practical recommendations for a strengthened CE approach**

COMMUNITY ENGAGEMENT DEFINITION

There is not a unified definition of “Community” and “Engagement”, let alone, “Community Engagement” within MSF. The term is used inconsistently across MSF sections and projects. An OCB review[2] concluded that despite frequent appearance of the word ‘community’ in 42 evaluation reports, there is limited consistency to how the word “community” is used. This becomes even more apparent when we start using terms like ‘community engagement’ which risks masking the complexity of diverse communities and the nature of the engagement. This evaluation aims to help better conceptualise CE for this specific OCB's operational context.

Currently, OCB uses the following definitions: “*Community engagement is the process of developing a continuous dialogue with target populations in all their diversity in order to increase their ability to make decisions, it means MSF has to increase their space to contribute to decisions and create the conditions for them to participate into decision making processes”*[3]*. Further, “CE is the process of and commitment to: Listen to and act on feedback and needs. Affected people are at the centre of the*

[2] PAPER 2021 Enhancing Evaluation Use | Communities Stockholm Evaluation Unit. SEU Evaluation Day Communities PAPER 2021

[3] PPT Community Engagement: How to integrate CE into your Operations July 29, 2025

action. Provide information as aid. Involve community's members in MSF project design, implementation, monitoring and exit strategy"[4].

OCBA has developed alternative definitions:

"What is a community? *"Community" can be described as a group of people who recognises itself or is recognised by outsiders as sharing common cultural, religious, or other social features, backgrounds, and interests. A community forms a collective identity with shared goals. However, what externally is perceived as a community might in fact be an entity with many sub-groups or communities. It might be divided into clans or castes or by social class, language, ethnicity, race, background or religion.*

What is engagement? *Involvement of people in the activities of common interest to achieve common goals. In humanitarian situations, means involving* ***people and communities*** *in the humanitarian response in whatever way and to whatever extent possible in a given context.*

What is then Community Engagement*? Community Engagement can be defined as the process of working in an inclusive and proactive collaboration with diverse people and groups in the community to address issues affecting their quality of life and well-being."*

This evaluation draws on elements of both OCB's and OCBA's definitions, as each contributes something distinct. The OCB definition stresses what MSF must create to enable participation. In its own words, MSF has to 'increase [communities'] space to contribute to decisions and create the conditions for them to participate in decision-making processes', including involvement in project design, implementation, monitoring, and exit. The OCBA definition contributes a useful framing of CE's purpose: CE is not an end in itself (the 'what') but the way of working through which common interests (MSF's operational and medical expected outcomes) are achieved (the 'how').

AUDIENCE AND USE OF THE REPORT

This report is primarily intended for MSF OCB project and coordination teams in Mozambique, and those involved in managing the Mozambique country programme in HQ. The evaluation was steered by a Consultation Group, composed of a mix of key project and coordination and headquarters staff. It is also relevant for OCB operational and technical staff at headquarters level who support CE design and strategy in other conflict-affected contexts.

SCOPE

The geographic coverage for this evaluation is the selected districts in Cabo Delgado (Macomia and Mocímboa da Praia) where MSF is currently running operations.

The evaluation covers the period from when current CE approaches started to be implemented and then following major suspensions and changes took place and up to June 2026, allowing analysis of both earlier design and ongoing activities related to CE.

[4] *C. Zahnd, Cited in the OCB COMMUNITY ENGAGEMENT STRATEGY 2020 - 2023*

Thematic areas explored are the different project activities that currently appear to be implemented via CE in both projects (as part of both current HPCE strategies and other community- based activities). The evaluation considered these areas to explore how CE is taking place and to what degree, including both medical but also to include other non-medical areas.

EVALUATION APPROACH

Consistent with the approach promoted by the MSF Stockholm Evaluation Unit (SEU), this evaluation is a learning and reflection process for operational teams. It is not an assessment of individual or team performance. The emphasis is on generating practical, operationally grounded insights that can support ongoing adaptation and strengthen of CE approaches in both projects going forward.

The evaluation aims to produce findings and learning that are useful for MSF teams, including identifying good practices and capitalising on operational lessons related to CE, highlighting contextual factors that influence implementation, and providing practical recommendations to inform project adaptation and future activities. Findings and recommendations are intended to be used directly in project planning, strategy revision, and the ongoing integration of CE across medical and operational priorities, including in the context of the recent handover of the Mocímboa da Praia project from OCBA to OCB.

The evaluation team worked closely with the evaluation Consultation Group, organising validation and reflection discussions to help scoping the evaluation and review preliminary findings and ensure that conclusions and recommendations are grounded in operational realities. Through this approach, the evaluation aims not only to assess current practices but also to support ongoing learning and the strengthening of CE approaches in this complex humanitarian context.

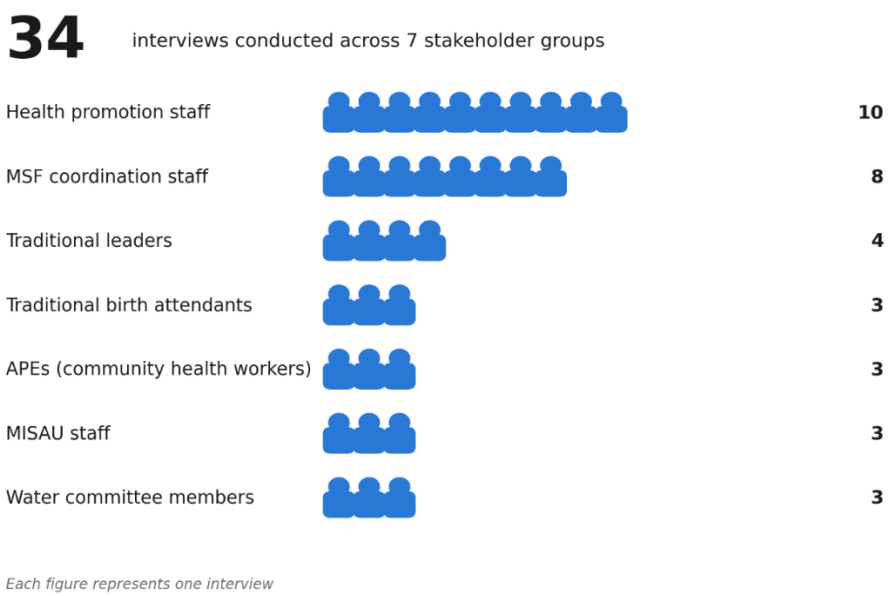
METHODOLOGY

This evaluation used a mixed-methods approach, combining documentary analysis with quantitative data review and qualitative evidence gathered through semi-structured interviews and consultations. The methodology was designed to triangulate multiple sources of information and to remain adaptable to the access and security constraints inherent in both project locations:

Document review: A review was conducted of over 60 key documents from both projects, including annual strategies, Health Promotion and Community Engagement (HPCE) strategies, handover and capitalisation reports, quarterly and monthly sitreps, data handover documents. This review allowed the evaluation team to reconstruct the evolution of CE approaches over time, understand how strategies were initially conceived and how they adapted to context, and identify both what was available and where data gaps existed. Documents were collected from the shared evaluation library and supplemented by materials provided directly by project teams.

Semi-structured interviews were conducted with MSF staff and other key informants across both projects and at country and HQ level. 10 preliminary interviews were conducted to scope the evaluation and prepare its workplan. Additionally, 34 Interviews (individual and group) were conducted between April and June 2026, combining in-person and remote modalities (phone and WhatsApp), in English, Portuguese, Spanish, and local languages. All interviews were voluntary, and inputs have been anonymised throughout this report. Participants included project coordinators, medical and project medical referents, HPCE managers, HP supervisors, outreach staff, CE/HP mentors and focal points, and community consultations with community leaders, traditional birth attendants “matronas”, community-based health workers (both MSF and MISAU), etc. Interviews explored how CE has been understood and implemented in each project, how approaches have evolved in response to contextual disruptions, and the perceived contribution of CE to medical and operational priorities.

Figure 1 Interviews conducted during the evaluation



Reflection sessions with project teams were used at key stages to design the evaluation roadmap, validate emerging findings and ensure that conclusions and recommendations were grounded in operational realities. These sessions supported a participatory approach consistent with the evaluation's learning purpose.

Throughout the evaluation, ethical principles of informed consent, voluntary participation, confidentiality, and data protection were upheld in line with MSF Stockholm Evaluation Unit (SEU) ethical guidelines. No children were interviewed. All data collected has been de-identified and stored in accordance with General Data Protection Regulation (GDPR) requirements. AI tools were used to summarise interviews transcripts, support editorial review, and produce select visuals in this report. The findings and analysis presented are entirely the evaluators´ own.

LIMITATIONS

Limitations encountered were broadly as anticipated in the evaluation roadmap. Access to both project locations remained constrained by the security situation, limiting the depth of direct community consultation and the time spent with project teams. Remote interviews ensured that key staff were interviewed. Staff turnover and record transfers, particularly in Mocímboa da Praia following the handover from OCBA to OCB, meant that some institutional memory was difficult to recover, and several key documents from earlier project phases were unavailable. The shift to hybrid management in both projects affected the quality and completeness of CE monitoring data for certain periods, particularly around suspension phases. These limitations have been mitigated through triangulation across document and sources. Some project staff finalised their contracts between the evaluation preparation and data collection phases, and the evaluation team made contact to ensure their perspectives could be included. External participants were limited to MSF counterparts (MISAU) and community members, but no other organisations were interviewed, as currently MSF is the only organisation with operational presence in both project locations. Participation was most active during one-to-one interviews, with reflection sessions also generating strong engagement, especially to validate findings and ensure shared understanding and sense making.

FINDINGS

EQ1: HOW ARE COMMUNITY ENGAGEMENT (CE) APPROACHES CURRENTLY CONCEPTUALISED, STRUCTURED, AND IMPLEMENTED ACROSS THE TWO PROJECTS (INCLUDING EVOLUTION OVER TIME)

CE ALIGNMENT WITH MSF PRIORITIES, DEFINITION AND UNDERSTANDING IN EACH PROJECT

Key finding: CE lacks a shared definition in both projects and is widely mixed up with health promotion. While CE aligns with MSF's medical and operational priorities on paper and HPCE project strategies frame CE as a participatory two-way dialogue, in practice it functions mainly as a way of building the relationships that enable access and operational presence, measured through output indicators and shaped by a sense of community dependency on MSF, leaving its participatory and transformative dimensions largely unrealised.

Alignment with MSF priorities

CE in both projects is consistent with MSF Mozambique's core priorities, and both HPCE strategies align at goal level with the projects' medical objectives, supporting priority groups through health promotion, early case detection, and community referrals in Mocímboa da Praia, and, in Macomia, extending beyond service delivery to include sanitation, participation, social cohesion, and well-being. This broader framing in Macomia creates opportunities for deeper community integration but raises the question of how these goals are resourced and operationally supported.

CE as conceptualised in strategic documents

The table below presents how CE is conceptualised in each project's strategic documents[5], the indicators those documents contain, and what was tracked and reported in practice.

Table 1: CE as conceptualised in project strategic documents

	Mocímboa da Praia	Macomia
How CE is framed	No single formal definition[6]. CE is scattered across multiple documents. Described and planned as a two-way dialogue with the local population, structured around regular participatory meetings (community leaders, religious figures, traditional birth attendants	The HPCE strategy's main objective[10] sets a broader goal (reducing morbidity and mortality in a conflict-affected population) and frames CE with participation and social

[5] Mocímboa da Praia 2025 HPCE strategy and the 2026 OCBA-to-OCB handover report

[6] The OCBA data handover document offers the clearest articulation: CE is described as "a participatory process, rather than a methodology or something we 'do'", centred on "careful listening, two-way communication, and collaboration" to enable stakeholders to work together on health issues. The 2025 HPCE strategy frames the overall goal as strengthening the HPCE component to reduce morbidity and mortality in the conflict-affected population, with CE positioned as contributing to that health outcome rather than as an end in itself. The draft 2026 OCB strategy (in Portuguese) broadly reflects the same concept.

[10]2025-26 CEHP Strategy: To contribute to improving living conditions and access to health through integrated health promotion, strengthening of health centre services, expansion of community prevention strategies, and creation of spaces for participation and social engagement.

	(TBAs), traditional medicine practitioners), systematic triangulation of community feedback with medical data[7], and active linkage between actors (MISAU, community leaders, community health workers) for coordination and shared ownership[8]. Communities positioned as contributors to the health response (vaccination campaigns, blood donation drives, surveillance), with cultural adaptation as a cross-cutting requirement. The logframe frames CE as a structured effort to build acceptance and collaboration by bringing local influencers and the population into planning and monitoring of health services[9].	engagement as goals — a step toward a deeper conception of CE. This broader framing is not developed further in the specific objectives or logframe, which focus on health promotion: lectures, home visits, referrals, HIV/TB case finding, rumour collection, and patient feedback on medication understanding.
What indicators exist	Some logframe indicators go beyond activity counts and could initiate basic measurement of community participation (e.g. % of rumours addressed, number of CE meetings with key actors).	Indicators are almost entirely output-based (number of sessions, participants, feedback collected), with no indicators on quality of participation, community influence on decisions, or level of engagement achieved. Partial exception: patient satisfaction surveys and drug comprehension questionnaires.
What was tracked	Predominantly session counts, referral numbers, and surveillance data[11]. The more participatory indicators were not systematically reported against: participatory mechanisms (e.g. Patient Experience and Satisfaction Survey (PESS), health committee strengthening) were either not fully implemented or suspended.	Output counts. Satisfaction and comprehension data introduced a degree of feedback measurement, but oriented toward service quality assessment rather than co-decision with the community, and the information was not always analysed and used for that purpose[12].

[7] Project 2025 HPCE Strategy, Activity 1.2, and OCBA to OBC CEHP Handover Report 2026

[8] Project 2025 HPCE Strategy, Activities 1.2 and 1.6; OCBA to OBC CEHP Handover Report 2026, Operational Area 1)

[9] OCBA to OBC CEHP Handover Report 2026, Logframe Status Table, Expected Result 1, Activities 1.4 and 1.6

[11] OCBA to OBC CEHP Handover Report 2026

[12] Noting that the community feedback tool remained underutilised, and the patient satisfaction survey protocol had been validated but not yet implemented at the time of handover (April 2026).

CE as understood in practice

During scoping interviews with participants for this evaluation, we encountered different perspectives on what CE means in practice, reflecting the broader challenge of finding clarity within the organisation.

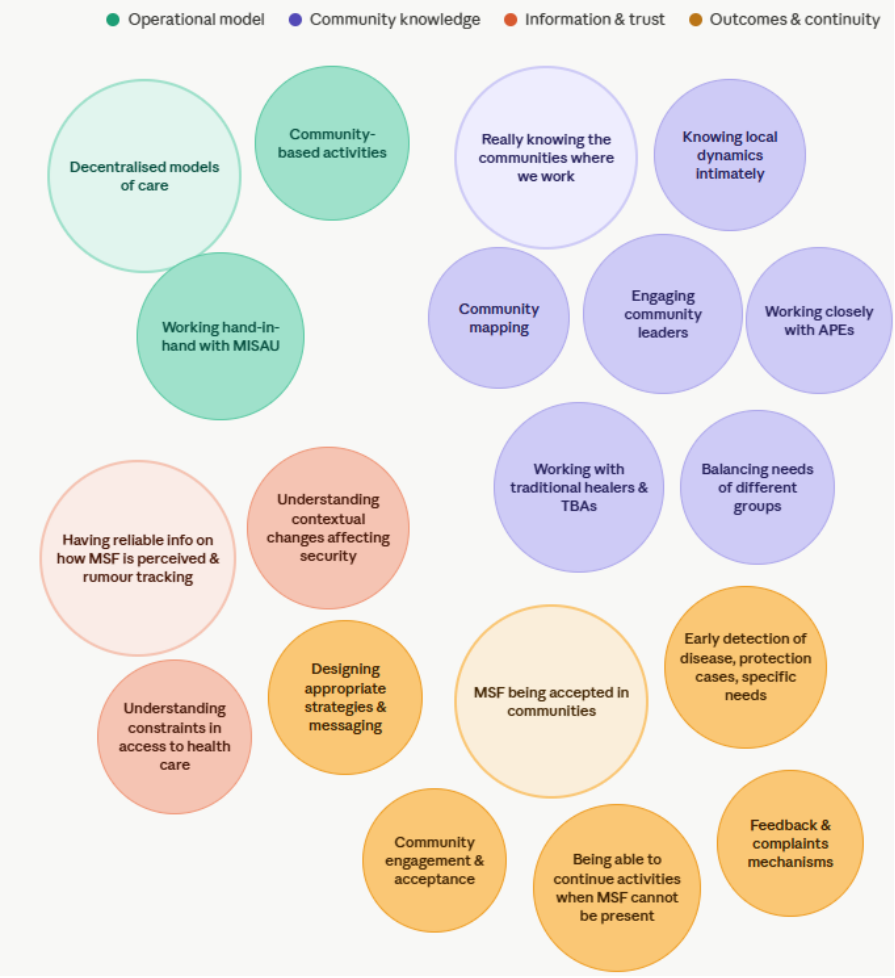
"*We call a lot of things community engagement, but I'm not sure if they actually are*."

MSF project staff

When asked evaluation participants for their understanding of CE there was not a single agreed definition, but a variety of practices, relationships, and capabilities. The following map (figure 2) showcases the different meanings shared by participants, which can be divided as:

1. **Operational model** — decentralised care, community-based activities, and close partnership with MISAU.
2. **Community knowledge** — relationships with community actors and an intimate understanding of local dynamics and needs.
3. **Information and trust** — tracking access constraints, perceptions of MSF, and rumours as active, ongoing responsibilities.
4. **Outcomes associated with CE** — appropriate messaging, early detection, acceptance, continuity during withdrawal, and feedback mechanisms.

Figure 2. Mapping what CE meant for evaluation participants (Source: Scoping interviews with evaluation participants)



It also became clear during interviews, that the term “community” had more than one definition, which has consequences in the understanding of CE, describing very different relationships and levels of participation. For instance, both MSF HPs and MISAU APES are considered to be community members, working in the same place they live and with deep local roots. But once affiliated with MSF or MISAU they are mostly treated as intermediaries, a dual identity that is neither formally recognised nor consistently managed, creating risks around accountability (blurry interests) and dependency (relationship with the person itself and not the institution they represent).

The gap between how CE appears to be designed on paper (previous section) and how it is understood in practice (as evidence collected during the evaluation) reflects the broader ambiguity within the organisation (section 2.5) and the risk that "community engagement" becomes a label applied to a wide range of activities taking place in the community but without clarity about the aims of it and what level of participation is actually intended or achieved, if any. The absence of specific indicators that can properly measure community participation and decision making makes it harder to assess whether CE as it was designed in strategies were translated into practice.

Across both evaluation interviews and the desk review, a mix-up between CE and health promotion activities (education sessions, home visits, referrals, epidemiological surveillance) was evident and appears to have further compromised the conceptual space available for the more transformative dimensions of CE. This blur reduces CE to a medicalised view of how MSF engages with communities: the community is primarily a recipient of health services and information, and where the measure of engagement is largely the reach and coverage of those activities, mostly based in numbers of sessions, people reached, etc. It also leaves underexplored both the medical dimension (embedding community perspectives in how care itself is designed, delivered, and experienced) and the non-medical realities of conflict-affected communities (insecurity, protection needs, how trust is built and lost, and care-seeking beyond health facilities). These dimensions are considered in the proposed model under EQ4.

CE is understood inconsistently, and while it is occasionally practised at higher participation levels without being recognised, this is largely implicit and constrained by an underlying dynamic of structural dependency. In practise, CE is often perceived not as a two- way dialogue but rather as a mechanism through which communities communicate needs and requests to MSF. This dynamic reflects and reinforces a broader relationship of dependency on MSF's resources and services. Some project staff described it as a *"banking system"*: communities have learned that MSF provides, so they request.

CE ROLES AND RESPONSIBILITIES

Key finding: In both projects, CE is delegated to the HPCE teams rather than functioning as a shared responsibility across project coordination and teams (transversality). CE’s influence on actual operational and medical decisions remains informal, undocumented, and dependent on individuals, making it vulnerable to staff turnover and operational disruptions.

Mocímboa da Praia: CE responsibility is formally delegated to HPCE team, instead of functioning as a transversal commitment and responsibility across different team and positions. Activities in the community in Mocímboa da Praia, including those around the community of patients, are built mostly around the MSF HPCE team, with some cross-cutting activities from other teams (Mental Health and

Psychosocial Support (MHPSS) and Sexual and Gender-Based Violence (SGBV), currently covering a catchment area of approximately 72,000 inhabitants across 16 neighbourhoods and 26 villages, operating through four health structures (Rural Hospital (district level secondary care and three primary health centres in Nanduadua, Diaca and Quelimane[13]). The HPCE team was composed by a HPCE Manager (position nationalised and locally based since May 2025) that provides overall strategic and technical oversight and reported to the FC (under OCBA), and now reports to the PMC. Additionally, an HP Supervisor coordinating field activities and data quality; three CHE Managers (referred to in the strategy as Head Community Health Workers (HCHWs)) that serve as the supervisory link between the manager and field staff; and 42 Health Promoters deployed across neighbourhoods and rural villages to carry out day-to-day community-level work. By January 2026, following the September 2025 suspension, this team had been partially reconstituted with 25 staff reactivated. The number of HPs was reduced to 33 staff at the time of handover (April 2026), mainly due to budget considerations. HPCE team meetings are currently set as monthly. Additionally, Community Mental Health Workers (CMHW)[14] serve as focal points for MHPSS educational-related activities and rely on the HPCE team for access to the communities, however activities in the community are carried out separately. An outreach manager (NAM Outreach position nationalised in December 2025) holds a cross-cutting coordination role linking the community referral system, MISAU, and the HPCE team. An MSF social worker coordinates referrals[15] (via HP team, at the health facility or through MHPSS team). A dedicated SGBV focal point at community level was identified as a pending priority at the time of handover in April 2026.

In Mocímboa da Praia, weekly meetings (Project Coordinator (PC), PMR and HP Manager) were planned to triangulate qualitative and quantitative information from patients and communities to identify trends and define priorities[16]. These meetings were reported to be operational in Q1–Q3 2025 but interrupted in Q4 and remain a pending issue in April 2026. The project logframe (expected result 1, activity 1.5) states that the FC and PMR were to be involved in adapting activities based on participatory findings. Currently, it seems that the main interaction in this respect is based in security assessment and context understanding (information gathered via community leaders).

The Mocímboa da Praia project relies on two categories of community-based actors: APES[17] and TBAs (traditional birth attendants), both of whom pre-existed MSF's presence in the communities and are engaged through regular meetings, training, and referral collaboration. Community health committees and health and hygiene committees are also cited in the strategy as key partners in community surveillance and engagement. Meetings with community actors (community leaders, TBA etc) are reported to be held every 1- 3 months.

[13] At the time of the handover, main hospital and Diaca MSF activities had been reactivated, while Nanduadua and Quelimane were only receiving limited support and visits by MSF.

[14] Community mental health workers (CMHW) to provide psychoeducation, psychosocial support, Psychological First Aid (PFA), child-friendly spaces, and counselling linked to the PS referral system. However, at the time of the handover the reestablishing of regular mental health group sessions and psychoeducation in all neighbourhoods was pending.

[15] An MSF social worker manages referrals and protection cases for vulnerable patients in Mocímboa da Praia (including unaccompanied children, orphans with HIV/TB, elderly people, and women-headed households) connecting them to MSF medical services and external protection actors (foster care, documentation, NFIs) while navigating significant gaps left by a shrinking partner network in the province.

[16] The 2025 HPCE strategy (activity A.4.3) explicitly mandates monthly meetings between the CEHP team, PMR, and FC

[17] Multipurpose health agents employed and supervised by MISAU but supported by the project through training and material kits

Macomia: The Macomia HPCE team is structured around an HPCE Manager (international, hybrid role, depending on security status), and a local team formed by a HP Supervisor, two HPCE Officers (a role introduced in late 2025 and the first of its kind in the project's history), and 16 Community Health Educators (CHEs) deployed across six community zones: Nanga A, Nanga B, Napulubo, Changane, Xinavane, and Muagamula, as well as at the Macomia Health Centre and one mobile clinic in Muagamula. The two HPCE Officers have different roles: one oversees health facility-based activities and mobile clinic support, while the other is responsible for community peer-based activities. The team was deliberately oversized relative to available activities following the October 2025 security withdrawal. However, the absence of sufficient MSF vehicles initially prevented the HPCE team to work full days, limited geographic coverage, and delayed the working hours alignment between HP and Mental Health teams. In Macomia there is no specific CE responsibilities tasked to either PC or (Project Medical Coordinator) PMC roles as part of the broader project coordination structure, appearing to be more of an ad hoc interaction depending on people and activities. The HP manager reports to the PMC and the HPCE is part of the medical team.

Beyond the MSF team, the project engages a network of 28 APEs through monthly training sessions, positioning them as an extended community health workforce. Traditional birth attendants ("matronas") are engaged through a Mother-to-Mother Groups initiative, with approximately 30 "matronas" mapped and regularly met with the team throughout 2025, and 23 re-engaged in March 2026. Traditional healers are identified as a priority group for similar structured engagement in 2026. Water Committees established in 2025 and revitalised in 2026 by the HPCE team across all neighbourhoods and now numbering 14, represent a distinct community governance structure, with their purpose being WASH-related (maintenance of water points, personal hygiene education, dissemination of hygiene disease prevention methods).

The most outstanding structural element is the community-based care programme, which was initially designed as Sexual Violence Focal Points (community members trained to identify and support SGBV survivors) and youth peer facilitators based at the Xinavane Integrated Centre for Culture and Community Care, a physical community space launched back in 2025 by MSF OCB and opened in early 2026. These focal points represent the closest Macomia comes to formally designated community representatives. However, in practise this community centre was not designed with the involvement of the community and has now a different use.

For both projects, there is no clear description or evidence on who is responsible for CE to take place and how CE is to be integrated across departments (medical, operations, environmental health/WATSAN). In practice, the FC/PC and PMC appear primarily as recipients of information (through triangulation meetings or rumour-sharing) rather than as active owners of CE as a transversal way of working. The HP team's role in CE is almost entirely in terms of information flow back to the medical team: disease surveillance, patient experience monitoring, latrine and water point monitoring. Although an important function, it positions CE primarily as a reporting mechanism for the medical team rather than as a space for community voice.

The question of whether community evidence gathered through CE influenced operational or medical decisions and whether that influence passed through the FC/PMR, is not well documented (linked to EQ.3). CE was at best partial and informal in both projects, dependent on individual relationships and changing with the frequent turnover of staff without any formal mechanism for coordination and monitoring.

EVOLUTION AND ADAPTATION

Key Finding: CE in both projects has adapted continuously to context, but reactively rather than by design. The dependence on MSF's physical presence, exposed by the suspensions in both projects, reveals that community ownership and resilience have not yet been built into MSF's operational model.

Mocímboa da Praia: MSF first established a presence in Mocímboa da Praia in 2019–2020 but was evacuated in March 2020 when violence escalated sharply and the MSF office was partially burned down. Following the recapture of the town by Mozambican and Rwandan forces in August 2021, the project was relaunched in September 2022, initially centred on community health promotion, mental health, and mobile clinics. From this foundation the model expanded progressively: hospital support at the Rural Hospital of Mocímboa da Praia (HRMP) began in April 2023, adult inpatient support followed in January 2024, and health centre support at Diaca, Quelimane, and Nanduadua came on stream between May and June 2024.

Mozambique has been part of the OCBA initiative towards decentralised models of care (DMC)[18] since 2023. MSF has a unique partnership with MISAU: rather than building parallel structures, MSF adapted its approach to work alongside existing community systems, pairing MSF health promoters (prevention and education) with MISAU APES (curative care) to create a complementary community-based referral pathway. In practise, this partnership has been difficult to operationalise[19]. MSF mobile clinics represented the project's most geographically decentralised CE mechanism: covering hard to reach communities and strengthening the links with communities. Mobile clinics also afford MSF some perceived independence from MISAU, which increased trust, acceptance and proximity with the communities. Mobile clinics were closed in May 2024 in favour of a shift toward fixed health structures, marking a contraction in the reach of community-based activities even as the project was otherwise expanding.

The evolution of CE in Mocímboa da Praia illustrates how a participatory design can shift during implementation. The 2025 strategy described an ambitious participatory model: weekly community meetings, systematic feedback-medical data triangulation, participatory assessments, and tools like the PESS survey. In Q1 to Q3 of 2025, much of this was broadly functional[20]. Engagement with APEs, TBAs, and community health committees was ongoing, and community-based surveillance tracked deaths, births, and nutrition across the catchment area. However, even during this active operational period, the more participatory elements had not materialised in practice: the PESS protocol was validated but not implemented; home visit data had not been integrated into HMIS since 2024; and

[18] Decentralized models of care (DMC) is an operational model where health services are implemented outside medical facilities and delivered closer to patients in the community, in order to make curative and preventive medical activities more accessible. DMC integrates CE with healthcare delivery and ties community participation to concrete service packages and medical priorities. Currently, over 20 projects in OCBA are following this approach.

[19] For example, MSF ambulance and bike drivers could not be hired because MISAU did not accept them as part of their roster, and having them as volunteer positions was unworkable, so vehicles needed to be donated to be used (around 2023-24). There were issues to reach locations where MSF identified needs but were not covered by the MISAU APES. Also, excessive referrals from MSF health promoters resulted in protocol and training adjustments.

[20] Regular weekly community meetings were held, 125,589 health promotion sessions were delivered reaching over 463,000 participants, the referral system performed well with 3,095 referrals and a 94% concordance rate, and weekly triangulation meetings between the HPCE team, field coordinator, and medical referent were maintained and interrupted in Q4 2025 with the project suspension.

the HIV/TB community follow-up strategy, identified as a priority, was not completed. CE was functioning as outreach and information-sharing but had not yet developed the systematic feedback and adaptive mechanisms that would allow a more participatory engagement.

The September 2025 suspension (seen as a near-total break) collapsed implementation abruptly: health promotion activities fell by 96%, community referrals dropped 77%, mental health group sessions reduced by 95%, and weekly triangulation meetings were interrupted. Community deaths rose 66% in Q4[21] and home births increased by 43%[22], underscoring how dependent the CE model was on direct physical presence and how little structural resilience had been built into it for periods when MSF could not be present[23]. The shift to hybrid management has effectively eroded the time previously invested in direct field supervision and community contact. What was previously weekly field visits (the main quality-assurance and relationship-building mechanism for CE) has been replaced by phone calls and monthly in-person meetings. According to interviews, communities felt de-prioritised and the suspension was experienced as an abandonment for those who had had some contact.

At the time of handover in April 2026, the project was mid-way through a second reconstruction process, partially reactivated (at least in two health facilities). But full community coverage across the 16 neighbourhoods and 26 villages had not been restored, community feedback and triangulation mechanisms had not been formally reactivated, and engagement with key stakeholders in outlying villages remained pending.

The operational model had strengths in outreach, surveillance, and actor linkage, but one that had not yet translated into community structures feeding into decision making or being able to function independently or with little support during MSF's fluctuating operational presence.

According to interviews, OCBA overall experience is that a community referral system (part of DMC) will not be able to be sustained once MSF stops operating, unless there is a strong community ownership. The original idea was to develop a referral system within the community itself that was community-founded, embedded, and accepted, to have a higher probability of surviving in the future than anything imposed from outside. The current picture is one of a CE approach that has adapted repeatedly to context, but reactively rather than by design, with the latest disruption exposing underlying fragilities and gaps.

Macomia: The 2025-2026 project HPCE strategy was developed following the project's return and represented an attempt to consolidate a CE approach that had previously been primarily distribution-focused (hygiene kits, Certeza water purification tablets, condom distribution) into something more comprehensive. The strategy introduced a broader goal: integrating health promotion with community-based care, psychosocial support, and spaces for participation and social engagement. The most visible expression being the planned Xinavane Integrated Centre for Culture and Community Care in 2025, eventually opening in early 2026. The introduction of HPCE Officers, a new position between the supervisor and field CHEs in the 2026 staffing plan reflects a further structural

[21] OCBA to OCB Handover report 2026, indicator ER1. Q4 2025 against Q3 2025. Community deaths: 63 vs 38, i.e. +66%; the 2025 series is 46/44/38/63, so Q3 was the lowest quarter, against the Q1–Q3 average the increase is 48%. These are counts of recorded deaths, not rates. No population denominator was available. The handover report notes Q4 community death data are partially unreliable owing to reduced staffing.

[22] OCBA to OCB Handover report 2026

adaptation, driven by the growing complexity of the community-based care programme and the expansion of mobile clinic activities.

The Mother-to-Mother Groups initiative with the “matronas”, the Water Committees network which grew to 14 committees by Q1 2026, and the planned community peer facilitators and SGBV focal points all represent evolution of its operations. Engagement with “matronas” also shows the project´s adaptation: rather than treating community deliveries as a problem to be eliminated, the HP team's approach has shifted toward understanding *why* communities turn to “matronas” (distance, timing, fear of facility-based complications, and a perceived risk of discharge penalties), a reflective and less purely directive form of engagement than earlier distribution-focused approaches. This understanding served a practical purpose: since community deliveries will continue given limited access to most areas, MSF trained “matronas” on safe delivery care and provided emergency birth kits to ensure minimum safety standards, while maintaining incentives for facility-based deliveries.

The HIV/TB defaulter tracking activity, which grew from a low-volume task into an 8,000-case backlog after a joint MISAU-MSF data-cleaning effort in early 2026, illustrates both the evolution of MISAU partnership and its dependence on the quality of MISAU's underlying data.

However, these developments occurred against the persistent structural constraint of hybrid/ remote management: throughout 2025 and into 2026, the HP Manager could only visit Macomia intermittently due to security conditions, with some months limited to two visits, which affected supervision, team cohesion, and the pace of implementation. The CE model in Macomia has undergone adaptation but still in the early stages of translating those ambitions into a continuous and sustained practice that is in line with the CE approach.

ENABLERS AND CHALLENGES

The following tables describe some of the main enabling and challenging factors encountered in both projects when designing, implementing and monitoring CE approaches.

Table 2: Enablers and challenges

Enabling factors		
Project	**Factor**	**Details**
Both	Experienced staff with contextual depth	Some international Staff with prior MSF Mozambique experience at field and HQ level retain institutional knowledge across disruptions and project cycles.
Both	National HP manager & NAM outreach roles (Mdp), and local HP teams (both projects)	Structural advantage over international staff turnover: preserves institutional memory and community relationships when supported with adequate training, coaching and coordination.
Both	Sustained community presence	Consistent deployment of health promoters has preserved relationships with community leaders and sector chiefs, even during operational suspensions.

Both	Internal coordination	The strategies in both projects foresees collaboration between HPCE, mental health, outreach, social work, and medical teams (Mocímboa da Praia) and joint activities between HP, Mental Health, and WatSan that are relatively concrete (Macomia). Building on these and reinforcing them during implementation when operational conditions allow will mean an important enabler.
Both	Comprehensive handover documentation	OCBA–OCB transfer produced detailed handover documents preserving operational and community knowledge to support continuity.
Macomia	HPCE team composition, remote tools and vehicles	Two CHEs per community, GPS-linked individualised Kobo reporting, geographic dashboard, and near-doubled HPCE budget signal deliberate investment in HP and community activities despite access constraints. Arrival of new vehicles was an operational turning point.
Macomia	MISAU-aligned framing	HP activities explicitly framed as supporting MISAU systems rather than replacing them, reducing duplication and anchoring CE in existing local structures, even if this requires negotiations with MISAU
Mocímboa da Praia	Voucher-based referral system	~3,100 referrals completed in 2025 (Q1–Q3). Covers transport and consultation costs. Generates trust and families associate MSF positively after emergency support.
Mocímboa da Praia	Diverse engaging	Variety of community sources with a broad range of community actors, even if current implementation is uneven in practice.

Constraints and challenges		
Project	**Factor**	**Details**
Both	Remote/hybrid management erodes oversight quality	Direct observation, contacts with community representatives, and support and follow up of the MSFteam, and informal triangulation replaced by phone calls for most project staff. Quality assurance structurally compromised. Conduct issues and data irregularities go undetected.
Both	Feedback loops incomplete or underused	PESS validated but not implemented in either project. Data collected but not systematically analysed. Monitoring

		captures activity volume, not CE quality, community perceptions, or outcomes of feedback loops.
Both	No MOU with MISAU	APES salary delays, resource shortages, and fee-charging behaviour undermine community trust. No joint data validation process. MISAU–MSF relationship tensions risk weakening community perception of MSF.
Both	CE siloed within HP department	Strategies require transversal ownership across all departments; in practice responsibility is concentrated on HP team alone. Inter-departmental collaboration is personality-dependent rather than structural.
Macomia	Security and access limitations	Repeated security cycles since 2024: Full team withdrawals, flash visits, HP Manager confined to compound and health centre for much of Q1 2026. Entire southern communities unvisited for months. Any progress risks reset at next deterioration.
Mocímboa da Praia	Security and access limitations	September 2025 full operational suspension: HP activities −96%, referrals −77%, MH sessions −95%. Community deaths +66% (see footnote 21), home births +43%. Erased rebuilt trust; project effectively restarted CE from scratch, compounded by simultaneous OCBA–OCB handover.
Mocímboa da Praia	Unknown and shifting population base	Many villages partially or fully deserted. Geographic maps outdated and not updated to reflect post-suspension movements. Coverage figures uninterpretable; targeted CE planning structurally unreliable.
Mocímboa da Praia	Dual disruption: suspension and handover combined	Loss of experienced staff, community mappings, and project documentation. Only 25 of planned HPCE staff reactivated at transfer. Project enters OCB management with reduced capacity and incomplete institutional memory.
Mocímboa da Praia	Minimal coordination with other humanitarian actors	UIC, Save the Children, ICRC, and AAH present in the area but activities poorly mapped and coordination minimal. No active partnerships to extend CE reach or fill gaps created by access constraints.

EQ2. HOW DO CURRENT CE APPROACHES ENABLE MEANINGFUL COMMUNITY PARTICIPATION (INFORMATION-SHARING -> CONSULTATION-> INVOLVEMENT -> COLLABORATION - OCB CE FRAMEWORK)

LEVEL OF PARTICIPATION

In this section, the OCB CE framework (Annexe B) has been applied to both projects as an exercise to showcase where both projects stand in terms of community participation. The following non-exhaustive examples are used to illustrate this categorization. This exercise has not involved project teams´ input, noting that the grading might vary and examples have been used only for illustration purposes. Also, in the absence of specific indicators to measure participation, what is being reported is session counts, referral numbers, and surveillance data. That is an achievement given the conflict-affected context and project suspensions, but it falls short of the participatory level set in project strategies and opens the opportunity for both projects to invest more deliberately in CE approaches that move communities from being known and accepted toward being genuinely engaged in shaping the response.

MACOMIA

Key finding: Activities in Macomia project can be categorised mostly as at Level 1 (Inform), with some degree of consultation mechanisms (Level 2) that are inconsistently applied and rarely influence decisions. Level 3 (Involve) examples are limited and potentially unplanned. The identified examples seemed to occur mostly on an ad-hoc basis, suggesting that community participation exists but is not yet systematically enabled by project design or is part of implementation decision making. Level 4 (Collaborate) is absent.

Level	Examples (desk review and Interviews)
① **INFORM** One-way information delivery. Decision made by MSF **Grading: Dominant**	**HP sessions in the community** ● **Daily CHE sessions in 6 locations: D**oor-to-door sessions in Nanga A/B, Changane, Napulubo, Xinavane, Muagamula throughout 2025–26, with up to 1,029 sessions / 9,035 participants by July 2025)[24]. ● **Health facility sessions:** 2 CHEs at Macomia Health Centre and 2 at Muagamula Mobile Clinic[25]. ● **IDP camp sessions:** Regular education sessions in Serração, Aclin, Natamane, Nanua, combined with hygiene kit distributions throughout 2025[26].

[24] Project SITREPS 2025

[25] Project HP Report 2026

[26] Project SITREPS 2025

Level	Examples (desk review and Interviews)
	• **Community radio broadcasts:** Health promotion spots in 4 languages (Macua, Makonde, Kimuani, Portuguese) in 2025. Paused during insecurity. [27] **Trainings community actors** • **28 APES trained in 2025 (3 times) and 2026 on health issues (** Respiratory infections, vaccination, malaria, PFA in January 2026, malaria with MH/Nurse Supervisors (Feb 2026)[28] • **"matrona" sensitisation:** Monthly throughout 2025 until Oct suspension; re-established Mar 2026 with 23 "matronas". 12-month meeting schedule covering maternal health themes[29]. • **Suicide prevention sensitisation sessions:** 253 young people across 3 locations (Feb 2026), led by MH team with HP support[30] • **SGBV identification training:** MH Supervisor trained full HP team (Jan 2026)[31]. • **HIV/TB defaulter tracking:** HP team trained (Mar 2026) to launch tracking of 8,000 defaulters identified jointly with MISAU[32]. • **School health activities:** Partnerships with 5 schools for adolescent Sexual and Reproductive Health (SRH)/MH sessions (pending)[33]
② **CONSULT** Occasionally gathering opinion for decision -making while MSF leads Grading: **Sporadic. Some mechanisms**	**Examples that worked:** • **Community leader meetings:** Mostly regular in 2025 (avg 6/month at peak). Used to explain MSF strategy, collect and act on rumours (depending on criteria), discuss service requests. Leaders in Gingone IDP camp consulted before HP activities launched (Apr 2026).[34] • **Water committee meetings:** 14 committees re-engaged Q1 2026. Committees share borehole problems with HP who relay to WatSan[35]. • **"matrona" meetings:** "matronas" raised their own concerns (STIs, safe delivery, safe abortion) and frequent meetings are organised. "matronas" also reported poor experience at maternity ward[36].

[27] Project SITREPS 2025 and 2025-26 CEHP Strategy

[28] Project SITREPS 2025 and Q1 HP Report 2026

[29] Project Q1 HP Report 2026

[30] Idem

[31] Idem

[32] Idem

[33] Interview

[34] Project SITREPS 2025 and Q1 HP Report 2026

[35] Q1 HP Report 2026

[36] Q1 HP Report 2026 and Interviews

Level	Examples (desk review and Interviews)
exist but weak feedback loops	• **Patient food quality feedback:** community stakeholders concern about food theft prompted 3 polls (Jan–Mar 2026). Results confirmed issue decreased and findings shared with MACOMIA team and acted on, which showcases a clear feedback loop[37]. **Examples partially successful** •**Peer facilitators / SGBV focal points (Xinavane Integrated Centre for Culture and Community Care):** the 2025 strategy planned to train community leaders as youth peer facilitators and sexual violence focal points, with a dedicated HPCE Officer post budgeted for 2026 to accompany them. Selection and training remained pending at the 2025 end-of-mission handover, and in Q1 2026 the SGBV strand was put on hold in favour of youth suicide-prevention work. The initiative was MSF-conceived rather than community-initiated (the Q1 2026 report describes the Centre as an idea that never came from the community. Coded Level 2 in practice as Level 3 remains an unrealised design intention. •**Rumour collection very low volume** 15 collected in July 2025 (peak), 6 requiring attention, only 1 addressed. Community requests recorded (water purifier, dentist, mobile brigade hours) but no systematic follow-up[38]. •**Patient satisfaction surveys not compiled: two** surveys in Q1 2026. Compilation/comparison promised before QMM but pending as of report date. Same pattern in 2025[39]. •**Medication understanding forms not analysed:** Bad form design meant data was unusable; CHEs collected for months without output. Form redesign planned for Q2 2026[40]. •**Traditional healer engagement not yet achieved (2025 or 26):** Potential commercial interests as barrier[41].
③ INVOLVE Working with communities in some aspects (in all their diversity).	**Positive examples** • **Southern expansion proposed by CHE team:** Songueia and Mashuova sites identified and proposed by community stakeholders and validated by MSF field staff. CHEs identified sick patients unable to reach HC within 2

[37] Q1 HP Report 2026

[38] Project SITREPS 2025

[39] Idem

[40] Idem

[41] Interviews and field staff end of mission handover report

Level	Examples (desk review and Interviews)
Community shapes activities or decisions **Grading: Rare, unstructured, not replicated**	weeks. Influenced possibility of southern mobile clinic (under consideration)[42]. ● **Youth theatre at Xinavane Centre:** Young people began rehearsing voluntarily on suicide/GBV themes without incentives (Mar 2026). MSF adapted inauguration plan to preserve this momentum[43]. ● **"matrona"-shaped meeting agenda:** Aside from the meetings (level 2) "matronas "raised their own concerns during re-engagement (Mar 2026), shaping the 12-month thematic calendar (owning the agenda). Topics proposed by "matronas" rather than MSF[44]. ● **Water committee joint problem-solving:** Aside from the meetings (level 2), Committees flag infrastructure issues to HP, who relay to WatSan for joint action. Embondeiro flooding is a concrete example: The committees were expanded from 11 to 14 in Q1 2026 in response to community demand from Nanga A and Embondeiro IDP camp. However, committees also became channels for dependency requests (demanding MSF pay for sand transport)[45]. **Unsuccessful attempts:** ● **Xinavane Centre:** 'the idea of this Center never came from the community: it's a CE mistake". Community initially resisted (wanted mobile clinic back). Engagement only recovered via unexpected youth self-organisation[46]. ● **Moto-taxi scheme: Three** ambulance bikes donated by MSF but one used for private commercial purposes, two broken; communities demand MSF repair them. Initiative conceived by MSF, not communities[47].
④ COLLABORATE Work with communities in each aspect of the project. Shared decision-	● **No community involvement in project design:** HPCE strategy 2025–26 developed by HPCE team, with no documented community consultation in design phase. ● **No community role in monitoring:** Data collection by MSF staff only, no community-led monitoring or shared indicator framework.

[42] Interviews
[43] Project Q1 HP Report 2026 and interviews
[44] Project Q1 HP Report 2026
[45] Project Q1 HP Report 2026 and interviews
[46] Project Q1 HP Report 2026
[47] Interviews and CEHP Strategy

Level	Examples (desk review and Interviews)
making on design, monitoring, exit **Grading: Absent**	● **No exit or handover planning with communities:** Water committees designed for graduated handover in theory (EH toolkit model) but graduation not yet formalised. Moto-taxi handover failed. No documented exit strategy with communities.

MOCÍMBOA DA PRAIA

Key finding: Mocímboa da Praia operates primarily at Level 1 (Inform), with more structured but still inconsistent Level 2 (Consult) mechanisms than Macomia, and very rare examples of Level 3 (Involve). Unlike Macomia, Mocímboa da Praia has a longer institutional history of participatory assessments and formal feedback tools (PESS, Feedback Tracker) but the September 2025 suspension reset most of these, and Level 4 (Collaborate) remains absent.

Level	Examples (desk review and interviews)
① **INFORM** **One-way information delivery.** *Decision made by MSF* **Grading: Dominant**	**HP sessions: community and health facilities** ● **HP sessions in 16 neighbourhoods and 26 villages:** Daily group sessions, door-to-door and in-facility HP covering 7 key health areas: emergencies/outbreaks, child health <5yrs, SRH, vaccination, sexual violence, MHPSS, HIV/TB, WASH. Strong performance before suspension (125,589 sessions, 463,924 participants Q1–Q3 2025).[48] ● **Health facility sessions:** HP teams present at HRMP and 3 health centres (Diaca, Quelimane, Nanduadua) for patient orientation, information and support[49]. ● **Home visits:** Systematic visits covering epidemiological surveillance (deaths, births, nutrition), clinical detection, and health education. Key community surveillance mechanism Q1–Q3 2025. Suspended Q4. Community births increased 43% during suspension[50]. ● **Drama / theatre and radio spots:** Drama groups active before suspension on malaria, RSV, and other diseases. Radio spots planned (local radio station). Cultural communication tools differentiated by location and language (Mwani, Makua)[51]. ● **Community Mental Health sessions:** Community MH workers providing psychoeducation, PFA, child-friendly spaces, group sessions in neighbourhoods. 2,475 group sessions / 22,809 participants in 2025 (before suspension drop of 95%)[52].

[48] OCBA to OCB CEHP Handover Report 2026

[49] Mapping activities 2026

[50] OCBA to OCB CEHP Handover Report 2026

[51] HPCE strategy 2025 and OCBA to OCB CEHP Handover Report 2026

[52] OCBA to OCB CEHP Handover Report 2026

Level	Examples (desk review and interviews)
	Trainings: community actors • **APES and TBA engagement:** Regular collaboration with APES and TBAs and training on health protocols. APES provided with phone credit and transport for monthly meetings. APES and health committees considered community members by MSF teams[53]. • **Health and hygiene committee trainings:** 15 committees planned to receive kits and training on PSEC, water management, referral system, hygiene, MH, SRH, GBV, WASH. Active Q1–Q3 2025; interrupted during suspension[54]. • **Pregnant women mapping:** Systematic community-level mapping of pregnant women with follow-up for those in 3rd trimester. Active Q1–Q3 2025[55].
② CONSULT **Occasionally gathering opinion for decision-making** *while MSF leads* **Grading: Sporadic with loops disrupted by suspension**	**Examples that worked** • **Weekly participatory meetings with community leaders:** Weekly meetings held with leaders and key stakeholders in 16 neighbourhoods and 26 villages throughout Q1–Q3 2025. Two-way dialogue on health issues, MSF services, and referral system. Maintained minimally via Mueda-based visits during Q4 suspension[56]. • **Weekly triangulation meetings (HPCE + FC + PMR):** Functional Q1–Q3 2025: qualitative and quantitative information from communities triangulated to identify trends and define priorities. Used to adapt activities (e.g. IDP camp response in Nanili and Cooperativa in Q4). Interrupted Q4, needs re-establishment[57]. • **Feedback Tracker operational:** Community feedback tracking tool operational throughout 2025. Good community acceptance reported. Used to collect and monitor community perceptions and complaints about MSF services[58]. • **Participatory needs assessments (historical):** Mocímboa da Praia overview (2020), Knowledge Bank (2023), Health-Seeking Behaviour assessment completed. Qualitative and quantitative methodologies including FGDs, RQAs, surveys, simulations. Findings shaped programme design. 2024 assessments still pending update into strategy[59].

[53] HPCE strategy 2025 and Interviews

[54] HPCE strategy 2025 and OCBA to OCB CEHP Handover Report 2026

[55] HPCE strategy 2025

[56] OCBA to OCB CEHP Handover Report 2026

[57] Idem. The handover documents record that activities were adapted during Q4 to respond to the IDP camp situation in Nanili and Cooperativa, based on participatory findings channelled through these meetings withHP manager, FC and PMR. The meetings were interrupted in Q4 2025 with the suspension and had not been re-established as routine at handover (April 2026).

[58] Idem

[59] HPCE strategy 2025 and OCBA to OCB CEHP Handover Report 2026

Level	Examples (desk review and interviews)
	• **Hospital patient surveys on medicines and care:** Surveys currently being implemented at hospital to collect perceptions on medicines and care. Results planned to be used as advocacy tool to influence MISAU for better care once available[60]. •**Community surveillance as community-driven input:** Mocímboa da Praia HPs record community deaths (cause), births, nutrition (MUAC), and population movements through home visits: a structured community-level surveillance mechanism that feeds into project decision-making[61]. This goes further than consult as community actors (APES, TBAs) co-produce surveillance data. But because APEs and TBAs collect data on MSF's terms and for MSF's use with no say in what is monitored or how findings are used, this relationship is categorised as level 2. • **IDP camp response in Q4 adapted to community findings:** During Q4 suspension, triangulation meetings adapted project activities to emerging IDP camp response needs in Nanili and Cooperativa, based on community-level data.[62] Although this is evidence of community-informed operational adaptation, the decision loop remained internal to MSF •**Community psychosocial groups:** Level-one psychosocial support groups being planned at hospital and in neighbourhoods to identify cases of sexual violence and other MH issues, with community members trained to facilitate. L2 by design but not yet operational[63]. **Examples partially successful** • **PESS protocol validated but not implemented:** Patient Experience and Satisfaction Survey (PESS) protocol validated but not yet implemented requires a dedicated data collector and epidemiologist.[64]. • **Community feedback loop not closed:** Feedback collected (Feedback Tracker, community meetings) but no systematic evidence that community input altered project decisions. Community leaders consulted, but decision-making remained largely with MSF. Example: community request for return of mobile clinics not implemented[65]. • **Traditional healer engagement limited:** Strategy mentions engagement of traditional healers as a key activity but no documented structured engagement achieved in 2025 or 2026[66].
③ INVOLVE	**Positive examples** • **Health committee co-management (intention):** Strategy plans for health and hygiene committees to co-manage water points, referral monitoring,

[60] Interviews

[61] OCBA to OCB CEHP Handover Report 2026 and Mapping activities

[62] OCBA to OCB CEHP Handover Report 2026

[63] Interviews

[64] OCBA to OCB CEHP Handover Report 2026 and interviews

[65] Interviews

[66] HPCE strategy 2025 and interviews

Level	Examples (desk review and interviews)
Working with communities in some aspects. *Community shapes activities or decisions* **Grading: Rare, unstructured, not replicated**	and hygiene activities. A Level 3 model in design, but in practice, committees were interrupted during suspension and re-engagement is pending[67]. **Unsuccessful attempts** ● **Referral system dominated by MSF, not community-managed:** Originally conceived under DMC (see 4.1.3) a community-based system that could potentially be implemented without full MSF's presence (an L3 ambition), the referral system in practice remained fully MSF-managed: MSF set and changed criteria and provided resources. .[68] ● **Community consultation not translating to changed decisions:** Community meetings were intended as forums through which community views would shape project decisions, consistent with involvement (level 3). Community meetings function as 'polite listening sessions' rather than forums for real influence. Community fragmented into many small groups with different leaders and agendas requiring an specific representation approach that has not been developed.[69] Without both a decision-influence mechanism and a representation strategy, the consultative infrastructure exists but not the involvement. ● **No documented examples of community input changing project design:** No evidence identified in documents or interviews of a community-initiated request that led to a change in project design or strategy at Mocímboa da Praia. Even with mobile clinic reactivation, a consistent community request, has not been implemented when requested[70].
④ COLLABORATE **Work with communities in each aspect.** *Shared decision-making on design, monitoring, exit* **Grading: Absent**	**Gaps** ● **No community involvement in project design:** HPCE strategy 2025–26 developed by HPCE team and MSF management. Participatory assessments (2020, 2023) informed background analysis but no documented co-design process with communities for current strategy[71]. ● **No community role in monitoring:** All monitoring and data collection performed by MSF and MISAU staff. No community-led monitoring framework. Indicators focus on outputs (sessions, participants, referrals) not participation quality[72]. ● **No exit or handover planning with communities:** OCBA-to-OCB handover focused on institutional transition but changes made not consulted with communities. No documented community-level handover or exit strategy. Blood donor groups, health committees, WASH and school activities all

[67] OCBA to OCB CEHP Handover Report 2026 and interviews

[68] Interviews

[69] Idem

[70] Idem

[71] HPCE strategy 2025 and OCBA to OCB CEHP Handover Report 2026

[72] OCBA to OCB CEHP Handover Report 2026

Level	Examples (desk review and interviews)
	paused since September 2025 with no community-led continuity mechanisms[73]. • **No MOU with MISAU: A**bsence of a memorandum of understanding with MISAU hinders alignment of objectives and sustainability. Relationship based on MSF as provider rather than strategic partnership. This affects ability to reach communities through APES and health committees[74]. • **Structural dependency acknowledged:** need to 'deconstruct the mindset in both the community and with MISAU: paternalism and assistance-based relationship, not partnership.' Frequent manager changes, project suspensions, and MSF's dominant role have built dependency over time[75].

INCLUSION AND REPRESENTATION

Key finding: CE engages some community groups with relative consistency, but leaves others structurally underserved due to operational, social, and access factors. Suspensions have further eroded engagement quality: relationships that were established have become transactional, and key links such as traditional healers remain broken.

CE in both Mocimboa da Praia and Macomia reaches a defined set of community groups with relative consistency, while several populations remain structurally underserved. The following mapping draws on interviews with community representatives across the two sites to distinguish between groups engaged through regular, structured activities, where meaningful relationships and two-way interaction are more evident, and those whose contact with MSF, mostly via the Health Promotion teams, is limited, ad hoc, or absent. The gaps identified are not incidental: they reflect operational constraints (mobile brigade reduction, staffing ratios), social barriers (stigma, gender norms, partner dynamics), and programming choices (priority populations, activity design) that a strengthened CE approach would need to explicitly address.

Groups with Relatively Stronger Engagement

- Community leaders and neighbourhood chiefs: formally introduced to HP teams; involved in beneficiary list drafting; consulted before operational changes; positive relationships consistently reported.
- Water committee members in Macomia: trained, equipped, and regularly visited by HPs; active in borehole maintenance and hygiene campaigns; monthly meetings with HP team.
- “matrona”s (TBA): monthly meetings with HP team; integrated into referral system valued as community anchors for maternal health.
- CHAs/APES (Macomia): longstanding collaboration since 2012; participate in MSF refreshers; propose community expansion areas.

[73] Idem

[74] Interview

[75] Interview

- Youth (Xinavane Center, Macomia): recently engaged through theater group on mental health and suicide; four groups of up to 15 members; rehearsals four times weekly.
- IDP centre residents: covered by HP activities in Macomia (hygiene kit distribution, sensitisation).

Groups with Limited or Insufficient Engagement

- Girls and young women have low participation in theater group in Macomia due to shame and social stigma and not systematically reached.
- Adolescents in schools: outreach only recently initiated; school-based activities planned but not yet implemented at time of interviews.
- Pregnant women and mothers required more engagement for antenatal and postnatal care
- Remote/peripheral community members: mobile brigade reduction increased access gaps; underserved communities in southern zones of Macomia.
- Hospitalised patients and companions: limited HP team presence to provide humanised care guidance as MSF facilitating mainly patient flow support; companions not included in meal provisions; communication gaps between health professionals and patients noted.
- Patients with chronic conditions: lack of confidentiality in some procedures creates discomfort; suboptimal follow-up when cases are reported.
- Men and partners: noted barrier in antenatal context (partner presence required at first consultation); not specifically targeted by HP activities.
- Traditional healers in Macomia were a referral entry point before the suspension. Their disengagement breaks a critical first-line referral entry point.

The following table illustrates how engagement with some key community groups has shifted across both project sites following the 2024 and 2025 respective suspensions, highlighting where relationships have been maintained, weakened, or not yet restored.

Table 3: Community group engagement before and after operational suspensions

Community group	Before suspension	Currently
Community leader meetings (both projects)	Regular; focused on project activities, information sharing regarding project activities changes, rumour management	Ongoing but less consistent; content and purpose less clearly defined and tend to have a focus on security (Mocimboa)
"Matrona" engagement (both projects)	Regular structured meetings; highly engaging	Continuing mainly as training sessions; less community dialogue
Traditional healer engagement	Active; focused on disease referral criteria; very effective	**NOT RESTARTED — acknowledged as urgent gap**
Water committee engagement (Macomia)	Active	Less engaged than before, mainly due to activities still picking up pace after suspension

Although some evidence of gender-related barriers emerged, including limited participation of adolescent girls, gender norms affecting ANC attendance, and barriers for GBV survivors, the projects currently lack a systematic approach for assessing how different groups experience participation and access differently. Future CE monitoring should disaggregate participation and feedback by sex, age and other relevant vulnerability criteria.

PERCEPTIONS OF MEANINGFULNESS

Key finding: Communities feel heard, but there is no feedback loop: apart from rumour tracking, input receives no systematic follow-up, and engagement consists mainly of MSF informing communities rather than communities shaping activities: a gap that risks jeopardising trust rather than building it.

Within both project sites, community members stated that they felt heard by MSF when reporting on any issues affecting them. However, this did not lead necessarily to feedback being provided to the communities regarding actions taken.

The clearest example of communities being listened to is rumour tracking, embedded in community leader meetings, in both project sites. These meetings were structured partly to discuss and address false beliefs that can have a major impact to MSF (e.g., that MSF was bringing diarrhoea to the community). This represents a documented needs identification and barrier-removal mechanism: community leaders serve as both information channels and rumour capture points.

Beyond rumour tracking, community members reported raising concerns without receiving any follow-up. An example of this is with regards to the lack of food availability at the health centres for those accompanying patients in Mocimboa da Praia. This was reported to MSF, however there was no feedback if this was followed up on with MISAU. There is no evidence of a systemic feedback mechanism through which the communities are informed of actions taken in response to their input.

Interviews from both sites indicate that the dominant mode of engagement has been MSF informing communities of planned activities, rather than communities shaping what those activities are.

There was an overall limitation in gathering information of meaningful perceptions from the communities, regarding information provided to MSF. While there are operational and institutional reasons behind not responding to all community requests, communities received limited explanation, which risks eroding trust rather than building it.

EQ3: HOW DOES CE CONTRIBUTE TO THE ACHIEVEMENT OF MEDICAL AND OPERATIONAL PRIORITIES?

'We are sacrificing quality as we are trying to do too many things without clear objectives. Collecting data that we don't always use.'

MSF project staff

IDENTIFYING NEEDS, PRIORITIES, AND BARRIERS

Key finding: Formal mechanisms to identify community needs were designed but were not always in place. Where they were in place, they did not necessarily inform decisions. The gap was filled by informal channels and individual relationships. An effective engagement infrastructure appeared to be proximity to the communities through MSF mobile clinics.

Across both projects, the strategies mention some mechanisms to collect information from the community: rumour and feedback tracking systems, PESS, home visits as community surveillance tools, participatory needs assessments, and triangulation meetings between HP, project coordinators, and medical teams. In practice, however, few of these have functioned consistently or generated insights that demonstrably shaped operational or medical decisions. As set out in sections 4.1.3 and 4.2, the PESS protocols were validated or partially conducted but did not produced usable results, triangulation meetings were discontinued in Q4 2025, and home visit data (key community surveillance mechanism) was not integrated into HMIS, leaving the richest source of community-level data unavailable for decision-making. Post-lecture conversations at the health centres, surveys in health centres and brigades, and meetings held with community leaders take place but are not always properly documented. The main constraint is that no systematic feedback mechanism from community input to programme documentation and response is in place. There was therefore a set of tools that were intended to collect information, partially activated, and then interrupted, with the gap filled by informal channels and individual relationships.

One of the key mechanisms for identifying community needs in both projects was the mobile clinics, even if the primary use was to provide outreach services. When security allowed it, village visits gave MSF staff direct and regular contact with community representatives and chiefs, APES, and households, enabling real-time identification of health needs, barriers to access, and shifts in community priorities. In Mocimboa da Praia, even if mobile clinics stopped in 2024, this proximity generated the trust and MSF brand recognition that communities still reference today. The consequences of losing this proximity are operational as well as reputational. In Macomia, when the mobile clinic patient transport subsidy was discontinued, moto ambulances (based on a model piloted in MSF project in Palma) were procured and communities were informed only after the purchase. Without the consultation channel that regular mobile clinic visits would have provided, 2 out of 3 communities refused the moto ambulances, citing inability to manage them independently and unsuitability for local terrain. The mobile clinic was not simply a delivery mechanism: it was the infrastructure of community engagement itself.

ACCESS AND UPTAKE OF HEALTH SERVICES

Key finding: CE drives access and uptake even at low participation levels. But these results are presence-dependent and measured only in volume. Deeper engagement would make them more relevant and effective by adapting services to communities' actual care-seeking behaviour.

Across both projects, even with level 1 and 2 community participation levels, CE drives access and uptake through a combination of health promotion, structured referral mechanisms, peer and community outreach, and direct support at the point of care. In this section, we go through some of these mechanisms not to evaluate them, but to demonstrate how they do increase access and uptake of services, which can be further improved with increased and more participatory CE (becoming more relevant and efficient). The current model increases access by bringing people to services. A more participatory model would additionally increase access by also adapting how MSF delivers services to accommodate to people needs and behaviour. Available data measures the volume of these mechanisms, not their contribution to access, as no baseline or outcome indicators exist. Some findings are based on interviews and observation rather than data.

Health promotion. In Mocímboa da Praia, health promotion was the highest-volume activity, reaching 463,924 participants across 125,589 sessions in 2025 (Q1–Q3)[76], covering seven thematic areas: emergencies and outbreaks, child health under 5, SRH, vaccination, sexual violence, MHPSS, HIV/TB, and WASH. Sessions used group education, home visits, drama/theatre, megaphones, and visual tools (serial albums), and were adapted by location and demographics. In Macomia, the HP team delivers door-to-door sessions and facility-based education across 15 locations including IDP camps, health centres, and via the Muagamula mobile clinic. Topics include malaria, HIV/STIs, TB, SGBV, family planning, prenatal care, safe abortion, malnutrition, and vaccination. Uptake grew steadily through 2026: from 10,653 participants in January to a record 19,046 in March[77]. The HP team also responds to emerging needs in real time (e.g. training provided to community health workers ahead of the malaria season in 2026).

Community Referral Systems. In Mocímboa da Praia, between Q1 and Q3 2025, 2,845 referrals were recorded with a 94% diagnostic concordance rate, demonstrating quality alongside volume. The system targets 5,500 referrals per year and covers children under 5, pregnant and lactating women, mental health cases, and emergency presentations. During the Q4 2025 suspension, referrals fell 77% while home births and community deaths rose (see 4.1.3), suggesting that CE was contributing to facility utilisation[78]. In Macomia, three motorcycle ambulances were donated to strengthened referral, but two of these were rejected. No compiled data on referral response times or health outcomes is currently available, limiting the ability to assess its actual contribution to access or uptake of services[79].

[76] Mocimboa 2026 handover reports

[77] Macomia 2026 Q1 report and 2025-26 Sitreps

[78] Mocimboa 2026 handover report

[79] HP referrals are not being counted in Macomia and were not counted in 2025 either. Macomia 2026 Q1 report.

Peer and Community Outreach. In Macomia, active search for HIV and TB treatment defaulters is carried out by the HP team in coordination with MISAU[80]: tracking patients who have dropped out of care and supporting their return to treatment. Community health educators conduct door-to-door outreach across six communities and six IDP camps. Outreach with "matronas" has been identified as a priority mechanism to address community deliveries, with the HP team working with the midwifery supervisor to improve referral pathways and community trust. In Mocímboa da Praia, pregnant women are systematically mapped at community level, with follow-up control at antenatal care and risk behaviour assessment to support safe delivery, reducing neonatal and maternal mortality.

Facility-Level Support. In both projects, HP staff are present at health facilities not only for health education but as active intermediaries: supporting patient flow, translation, queue management, weighing, registration, and in Macomia, medicine dispensing. In Mocímboa da Praia, community mental health workers are embedded in the clinical referral pathway, providing psychoeducation, PFA, and child-friendly spaces linked directly to facility care. At the hospital and health centres, patient accompaniment throughout the care pathway is documented as a structured activity, including informed consent support and SGBV detection at triage. In Macomia, HP staff assist with first assessment, triage support, patient navigation, and health card updating, helping reduce drop-off at the point of entry.

ACCEPTANCE AND TRUST

Key finding: Community acceptance of MSF is high and largely attributable to CE, but it largely depends on MSF´s direct presence. As MSF is increasingly seen as part of the MISAU health service provision system and as flagged concerns by the community go unresolved, acceptance might be eroding faster than it is being rebuilt.

Community acceptance[81] of MSF is high across both sites and is one of the most consistently reported outcomes of CE across all data sources. This acceptance is not passive: according to interviews, communities actively request more MSF activities, clinics, and mobile clinics, and express distress when activities are suspended or reduced. In both Macomia and Mocímboa da Praia, CE practices have been central to building and maintaining this acceptance, through the use of resident local health promoters who ensure linguistic and cultural fluency, through MSF's consistent practice of formally introducing itself to government and then to community leadership before commencing any activity, and through a visible record of responsiveness during emergencies. Emergency transport to Pemba for high-risk pregnancies and MSF's uninterrupted presence during the 2020 district isolation in Macomia due to increased attacks are mentioned by community members in interviews as foundational trust events that still shape MSF's image in the community today.

[80] When MISAU data was updated in early 2026, the backlog of defaulters in Macomia district reached approximately 8,000, prompting a major joint tracking effort.

[81] Acceptance appears in a 2023 CEHP strategy in Mocimboa defined as "a community-based approach with aim to reduce security threats and increasing access to vulnerable populations". Acceptance, for this evaluation, can be understood as a security and access strategy where MSF builds trust and consent within local communities in conflict zones.

"MSF always comes to ask us first. They don't just arrive and do things. That is why we trust them."
(community leader, Mocímboa da Praia)

However, this acceptance is based on a changing relationship: it was built during a period of direct, regular community presence. As interviews stated, communities previously experienced MSF as an independent and trustworthy actor because of that direct presence. As MSF is the only organisation with direct presence in the communities and both projects have shifted towards a strategy closely supporting MISAU facilities and APES, but with less sole presence in the periphery, MSF is now increasingly seen as a part of a government health system that generates its own perceptions: medication shortages, additional charges, poor treatment of patients. There are documented examples where community feedback did not lead to visible change (e.g. the closure of mobile clinics in Macomia proceeded despite widespread community opposition; 200 meticais (approx 3 EUR) charged for vaccination cards in Mocímboa da Praia, Mocímboa hospital refusals for night cases persist. These issues, despite being repeatedly flagged by community leaders remain unresolved, which risk jeopardising trust over time. Communities acknowledge that MSF sometimes communicates decisions, but communication without responding to expressed concerns is not the same as accountability.

Community-level acceptance of MSF is stronger than at the institutional (health facility) level. Health centre staff attitudes draw criticism, particularly the dismissal of "matronas" as mere companions rather than skilled professionals, and the turning away of patients without resources. This can be seen as a risk: if MSF scales back before the health system improves, the community trust built will have nowhere to go.

OPERATIONAL DECISION-MAKING AND RESPONSIVENESS

Key finding: CE has assisted to undertake operational adaptations driven by proximity and individual initiative but there is no systematic link between community input and decisions. Major operational decisions (suspensions, closures, strategic shifts) are made by MSF without community input.

"The majority of the decisions are made by MSF"
MSF project staff

CE has generated some operational adaptations in both projects, but these have been uneven, informal, and dependent on individual staff initiative rather than any systematic process linking community requests or data to decision-making. Where adaptation has occurred, it has been driven mainly by observations or data collected ad hoc. Key decisions (suspensions, activity closures or adaptations, strategic changes) have been made at coordination level without community input.

Some examples of bottom-up requests or findings driving change:

In Macomia, feedback collected by APES and MSF HP team generated a formal team proposal to expand to two new southern sites Mashuova and Sengeia. These communities that had gone without a mobile clinic visit for one to two months. Within two weeks of deployment, the team identified

patients unable to reach health facilities, including chronic cases. This prompted the case for a second mobile clinic in the south, still under consideration.

Also, in Macomia, community proximity surfaced a hidden crisis: 30 suicide attempts among young people in three neighbourhoods between September and December 2025. MSF HP and MH teams rapidly launched a session with 89 young people and supporting a community youth theatre group developing drama on the social drivers of suicide, without financial incentives, which was itself a signal of genuine community investment. School-based programming in five secondary schools followed, covering SRH and mental health.

Cultural and communication barriers are also identified through proximity: the resistance to the term 'cholera' in Mocímboa (replaced with 'diarrhoea' by MSF staff) is a concrete example of CE generating insights that improves health communications. Similarly, the belief in some communities that external organisations bring disease requires proactive communication strategies. Other documented examples informing design include: weekly HP topic prioritisation responsive to observed needs, though this is decided internally by MSF staff rather than through community consultation; adolescent programming, where identification of high GBV and early-pregnancy prevalence through community presence led to school-based activity planning; simplification of reporting forms following staff and community feedback on administrative burden; and the youth theatre group itself, established after community proximity revealed high suicide prevalence among refugee and IDP youth.

Beyond these examples, there is little evidence of systematic operational change in direct response to community requests. The most common reason currently mentioned is insecurity, which limits the geographic scope of MSF interventions.

CE AND REFERRAL SYSTEMS

Key finding: The referral system is implemented through community actors but not yet built with communities: design decisions are made at MSF level, referring community structures do not learn patients' outcomes. Establishing a feedback loop would let the system learn from the communities.

The referral system in both projects relies heavily on both MSF health promoters (local residents) and community actors, such as APES and "matronas", as the primary interface between communities and health services. HPs and APES identify cases through home visits and community sessions, accompany patients, and facilitate access to MSF and government health facilities. In Mocímboa da Praia, a structured voucher-based referral system (covering transportation and consultation costs by MSF) is the main mechanism connecting community-identified cases. MSF HP teams identify severe cases (trauma, severe cases, complicated deliveries) for referral hospital, in accordance with MSF criteria and protocols. In Macomia "matronas" coordinate with HPs for maternal referrals, while the rest of patients are identified by APES, in coordination with MSF HP and MHPSS teams. MSF in Mocímboa da Praia has a broader geographic coverage in comparison to Macomia.

Community trust means that community health workers (MSF or MISAU) are frequently the first point of contact for health emergencies, which gives MSF a genuine gatekeeping function in access to care and emergency response. In this sense, CE is structurally embedded in how patients reach services.

The more significant gap is at the feedback end of the referral loop. There is no systematic mechanism through which communities are informed of referral outcomes, and no channel through which community experience of the referral system feeds back into how the system is designed or adjusted. e. g. APES and “matronas” make referrals without knowing what happens next:

"We refer the patient and then we don't know what happened. Did they arrive? Were they seen? We have no way to follow up."

(APES, Macomia)

However, the referral system has been designed and adapted in both projects largely without community participation. Key decisions (which transport modalities to use, how to manage the transition when MSF-supported referrals were discontinued in Macomia, and how to respond to structural gaps such as night transport unavailability) have been made at MSF operational or coordination level. The moto-ambulance case in Macomia is the most documented example. As explained in section 4.3.1, refusal from the community came after no consultation. At the same time, there are examples where community actors have shaped how referrals function in practice, even if informally. In Macomia, “matronas” coordinating directly with HPs for maternal referrals, and the community-managed moto-ambulance (however imperfect), reflect a degree of community ownership of the referral pathway at the operational level. In Mocímboa da Praia, the reliance on community trust in HP officers as the entry point for emergency referrals is itself a positive outcome (one built over years of consistent presence rather than by design). Other gaps (e.g. transport costs, night coverage for emergencies, medication shortages, etc) are also unsolved. The community referral system does not currently refer protection cases to MSF social worker.

This absence means communities bear the costs and consequences of referral system failures (transport costs of up to 400 meticais per trip (approx. 6 EUR), hospital refusals at night, medication shortages on arrival) without any structured mechanism to surface those experiences and influence how the system responds. The referral system is implemented through community actors, but it has not been built with communities, and it does not yet learn from them.

CE AND COORDINATION

Key finding: Community activities engage a range of actors beyond MSF, but coordination is largely informal, uneven across actor types, and not systematically facilitated through CE mechanisms.

MISAU / Government Health System represent the primary coordination relationship in both sites. APES, trained originally by MISAU and supplemented by MSF refresher training, sit at the front line of both projects. This relationship carries structural tensions that community actors manage daily but cannot resolve. An increased level of coordination between MSF and MISAU, to address the challenges being faced by community members, as they are reported to MSF, would assist MSF in providing adequate feedback to communities, when they raise these concerns.

Other NGOs and Humanitarian Actors are present in both sites but largely unknown to MSF at the operational level. In Mocímboa, Save the Children supports some MISAU health promotion activities and mobile brigades, a fact that was not known to the MSF team due to the absence of coordination mechanisms. Interviews noted that UIC, ICRC, and Action Against Hunger are also present in the area,

but that little information exists on their activities. No joint planning or formal coordination mechanism between non-governmental actors exists in either site and activity overlaps have generated friction, particularly in Mocímboa where some actors operate simultaneously. This is a missed opportunity: different actors hold different geographic coverage, and coordination could extend community reach and information without additional MSF resources but also learning from other CE approaches and practices. A strengthened coordination mechanism by NGOs actors would ensure that the communities benefit from services without the actors having to use extra resources.

Community Structures are the best-coordinated external actors in both projects, which is a positive aspect in ensuring more CE at community level**.** Water committees and "matronas" are the most effectively coordinated community actors. Regular meetings, training, and material support (tools, uniforms, hygiene kits) established a structured relationship. They are also the most fragile: water committee volunteers are sometimes assumed by communities to be remunerated, creating misunderstandings that require active management; traditional healer engagement has not succeeded in Macomia due to commercial interests; and "matrona" referrals are not systematically tracked, leaving the outcomes of this coordination channel largely invisible.

Internal coordination between MSF departments and teams related to CE has improved in Macomia, where the HP and Mental Health teams have developed joint programming around suicide prevention and adolescent health from early 2026, supported by shared vehicles and aligned deployment. This integration is recent and still developing (Xinavane Center) and would require further community participation. In Mocímboa da Praia, internal coordination between HP, the medical team and project coordination remains limited and not very systematic (with no triangulation meetings between the PMR, Field Coordinator, and HP Manager). Decisions have been driven mostly by security considerations rather than community engagement and identified needs.

EQ4: PROPOSED MODEL FOR FUTURE CE

MSF OCB considers CE to be a priority ambition, with people-centred[82] approaches and mindsets to be central to the relevance, quality, and acceptance of its work[83]. According to OCB CE guidelines, for CE to work consistently, it needs to become a standard, non-optional part of every project cycle: not something that depends on which staff happen to be in post. This means, for example, clear ownership of CE strategy, systematic use of national staff's community links, and rapid contextual assessments built into project start-up. It also means standard tools and a formal way to capture and share good practice across projects, so lessons are not lost with every handover[84]. The recommendations in the table below are intended for implementation during Q3–Q4 2026, in alignment with the new planning cycle 2027, and through to end of 2027, corresponding to the end of the next Annual review of Operations (ARO) period.

EQ1 — How CE approaches are conceptualised, structured, and implemented

Recommendation	Priority	Timing	Responsible
Reach a shared understanding of what CE means in practice, distinct from health promotion, for the Cabo Delgado context: what it looks like, who is responsible, and what it is trying to change. *Tip: For each current activity, ask: who benefits, how does it change anything for the community, and how can the community be more realistically involved? (design, implementation, monitoring)*	High	Short term	PC, PMC/PMR, HP Manager, coordination[85] team joint session to align definitions and expectations

[82] People-centred approach is broader than person-centred care, encompassing not only clinical encounters, but also including attention to the health of people in their communities and their crucial role in shaping health policy and health services. It extends beyond uniquely "care" to encompass community engagement, patient charter, community feedback mechanisms, inclusiveness and more. OCB STRATEGIC AMBITIONS 2026-2031

[83] MSF-OCB will embed meaningful community participation throughout the project cycle (assessments through to design, implementation, monitoring, and exit planning). For this, we will further strengthen our commitment to community engagement so that it becomes second nature in how we work, demystifying participation and co-design. Concretely, this means we will go beyond collecting feedback, recognizing instead the role, capacity and knowledge of communities in identifying and monitoring health needs, gaps, and solutions. All staff will understand what community engagement entails at every stage, supported by training, tools, and accountability. OCB STRATEGIC AMBITIONS 2026-2031

[84] OCB Community Engagement Strategy 2020 - 2023

[85] Coordination Management Team in Capital (Maputo/ Pemba). Exact position responsible to be defined for the full table.

Recommendation	Priority	Timing	Responsible
Map CE responsibilities explicitly across all roles: PC, PMR/PMC, HP Manager, coordination, and all teams with community linkages (MH, SGBV, WASH). Reach agreement on how each role shares responsibility for co-identifying and co-designing a response to action community needs, with clear coordination mechanisms. Alongside this shared responsibility, designate a single accountable lead at project level, answerable for whether CE happens at the agreed quality and timing, following the CEHP strategy. *Tip: Each role should be able to name at least one CE responsibility that is theirs, not the HPCE team's.*	High	Short term	PC (lead), PMC and HP Manager with mapping facilitated by coordination. Outputs validated with all teams
Increase training, coaching/mentoring, and support to HP managers to keep up with MSF CE priorities and policies and adjust to volatile context with a principled approach.	Medium	Medium term	Coordination and PC/PMC with support from OCB CE technical referent
Structured handover process that help preserve community relationships across management transitions.	Medium	Short term	PC, PMC (depending on position). Template designed by Coordination; completed by outgoing staff
Design a minimum CE model that does not depend on full MSF presence and can be maintained during suspensions or hybrid management. Define in advance what community engagement should look like under each possible scenario: (1) full MSF presence; (2) restricted MSF access with remote management from Pemba and periodic visits to project locations; (3) partial suspension, with only a few essential services or activities run by locally-based MSF staff and/or community structures; and (4) full suspension, with no MSF supported activities or services. The preparation work should be led by each project (PC/PMR together with the CEHP manager and supervisors), with the MSF staff and community structures who would carry each scenario actively consulted and supported. The resulting scenarios should be agreed, resourced, and tested before the next disruption or change of context, and kept up to date thereafter.	High	Medium term	PC, Coordination with scenario planning led jointly. Shared with PMC and HP Manager

EQ2 — How CE approaches enable meaningful community participation

Recommendation	Priority	Timing	Responsible
Set a concrete participation target for the next 6 months (e.g. move at least one activity per project from Level 1 to Level 2). Document, track, and review it.	High	Short term	PC (lead), PMC and HP Manager Target agreed with Coordination and reviewed in monthly team meetings
Agree on a minimum set of indicators that track quality of community engagement and participation (not just volume). Ensure monitoring, analysis, and a minimum reporting and action plan.	High	Short term	HP Manager, PMC, Coordination, with indicators validated against OCB CE framework
Conduct a rapid mapping of structurally underserved groups (adolescents, men, out-of-reach communities, hospitalised patients) and assign at least one targeted action per group.	High	Short term	HP Manager (lead), with MH, SGBV, and WASH etc teams. PC oversees follow-up
Restart traditional healer engagement in Macomia with a concrete, time-bound plan.	Medium	Short term	PC, HP Manager (Macomia), with plan reviewed with Coordination
Ensure out-of-reach communities understand MSF operational decisions (difficulties reaching them, changes in strategy and mobile services).	Medium	Short term	PC, HP Manager, with communication materials reviewed by Coordination
Introduce a simple feedback loop: any community concern or request received must get a response — including when the answer is 'we heard you but cannot act on it.' Assign this responsibility explicitly within MSF teams/roles.	High	Short term	HP Manager (day-to-day), PC (oversight) with mechanism formally assigned in team roles/JDs

EQ3 — How CE contributes to medical and operational priorities

Recommendation	Priority	Timing	Responsible
Reinstate or sustain at least one structured needs identification mechanism per project (e.g. monthly community feedback triangulation meetings, information collected via mobile clinic). Define who is responsible for acting on findings and track this systematically.	High	Short term	HP Manager (lead), PC defining responsible role for acting on findings and tracking systematically
Develop and communicate a clearer strategic narrative on MSF's role, added value and limitations in Cabo Delgado, including an explicit account of the respective roles and responsibilities of MSF and MISAU in supporting access to healthcare. Ensure the narrative is used consistently by all teams in exchanges with communities, authorities and partners.	High	Short term	PC (lead), Coordination (HoM/Medical), with HP Manager adapting key messages for community-level communication
Agree a structured capacity-building roadmap with MISAU (mentoring, quality improvement initiatives and joint reflection sessions), with the explicit aim of strengthening MISAU ownership and the sustainability of health services.	High	Medium term	PMC/PMR and Medical Coordination (lead), PC, agreed with MISAU district and provincial counterparts
Facilitate joint discussions and workshops with MISAU on what partnership means in practice, to build a shared understanding of roles, responsibilities, mutual accountability and longer-term collaboration.	Medium	Medium term	PC (lead), Coordination, with HP Manager and MISAU counterparts at district level. Outcomes documented and revisited annually
Act rapidly on documented feedback collected at community, health facility, and mobile clinic levels (existing surveys, formalised).	High	Short term	PC, HP Manager, with feedback review as standing agenda item in management meetings
Regular review of community feedback in team and management meetings (especially HP, PC, and PMC).	Medium	Short term	PC (leads), PMC, with HP Manager presents findings; actions documented and tracked
Ensure referral data collection is in place in Macomia	High	Short term	PMC (Macomia), HP Manager, validated by Coordination

Recommendation	Priority	Timing	Responsible
Future CE monitoring should disaggregate participation and feedback by sex, age and other relevant vulnerability criteria.	High	Short term	PC, PMC
Maternal health continuum: formalise the HP–"matrona" referral pathway; advocate with health authorities for "matrona" recognition at health centre level.	High	Medium term	PC (advocacy lead), HP Manager, in coordination with MISAU through PC/coordination
Mental health: scale the theatre model to additional communities; integrate psychosocial first aid training for HPs.	Medium	Medium term	MH team (lead), HP Manager with support from other teams and planned and budgeted with PC
Develop a community communication plan for transitions (suspensions, role shifts, clinic closures) so communities are informed before changes happen, not after.	High	Short term	PC, Coordination with template standardised and pre-approved for rapid deployment
Address MISAU friction points (fees, night-time service refusals) through structured advocacy rather than leaving them unresolved.	Medium	Medium term	PC (lead), Coordination for structured advocacy plan.
Review and strengthen the existing Memoranda of Understanding (MoUs) with MISAU so that expectations, commitments, responsibilities and accountability mechanisms are clearly defined for both parties. Use this to help address trust issues related to the community and to clarify MSF positioning and identity (mobile services or ad hoc visits when possible).	Medium	Medium term	Coordination (HoM/Medical), PC with legal review required. Linked to advocacy above
Create a simple standing mechanism (e.g. a monthly field decision-maker note) that formalises community input into operational decisions.	Medium	Short term	PC (lead), PMC, with format agreed with Coordination. Linked to OPS reporting cycle
Ensure OPS priorities are clearly communicated beyond security and context assessment. All major events (disruptions, suspensions, strategy changes) must be well communicated with communities.	High	Short term	PC, Coordination with communication checklist for each major event type

Recommendation	Priority	Timing	Responsible
Community data (referrals, community feedback, birth/death surveillance) should feed into operational decisions with sufficient nuance to identify the most vulnerable groups or locations.	Medium	Medium term	PC, PMC, HP Manager with Coordination to validate the data pipeline
Review the referral system design with community input. Identify at least one friction point and co-design a solution with community actors. Ensure clear roles within the referral system in relation to HPs. Ensure referral data collection is in place in Macomia.	High	Medium term	PC, HP Manager, with community actors co-design. PMC oversees implementation
Map other actors working in the community in project locations (every 6 months). Exchange information and coordinate CE activities.	Medium	Medium term	PC, HP Manager, shared with Coordination for inter-agency coordination (Pemba/Maputo)
Map coordination gaps across three levels (internal MSF teams, MISAU, community structures) and agree on a minimum coordination frequency for each.	Medium	Short term	PC (lead), PMC, with output reviewed with Coordination
Formalise what currently works (e.g. “matrona” integration) so it is not lost with staff turnover.	High	Short term	PC, HP Manager with documented any SOPs or similar and handover reports. Coordination validates
Systematise monthly meetings with all community actor groups, with action points on requests MSF can address and feedback to community on decisions taken.	Medium	Short term	HP Manager (lead), PC meeting minutes shared with Coordination
Identify linkages with protection partners to develop a referral pathway for protection cases with community support (with MH and SGBV teams).	Low	Long term	MH, SGBV teams (lead), PC coordinated with protection/ cluster actors (as needed). Coordination facilitates

CONCLUSIONS

MSF operates in Cabo Delgado mostly because of the ongoing conflict: insecurity should not be seen as an external barrier alone but the projects' main reason for existing. Recent events and security have further compressed the conceptual space available for the more transformative dimensions of community engagement, the kind that would position communities at the centre of what MSF does, as active participants in shaping the response rather than beneficiaries of it, and that would allow MSF to remain meaningfully present, through relationships and trusted intermediaries, even when physical access is not possible. Yet this is the kind of CE such a volatile and fragile context demands: where presence is repeatedly interrupted and CE is an operational need, not an aspiration.

The main needed elements are in place: trusted and diverse community actors, community referral pathways, surveillance data, community meeting structures, documented community feedback. What is missing is the systematic mechanisms that turns these elements into participation: clear objectives, teams 'mindset change, systems that transform input into decisions and answers back to communities, MSF sharing ownership and roles beyond the HPCE team, and CE designed to survive operational suspensions and tight security. MSF needs to adapt how it does what it already does, and the consolidation of both projects under OCB is the opportunity to make that shift.

EQ1: CE conceptualisation, roles and responsibilities, and implementation over time

In both projects, CE is conceptualised on paper as participatory but understood and practised primarily as health promotion and outreach, with communities as recipients rather than agents, and often without clear objectives (what do we want to change?). CE is structurally delegated to the HPCE team rather than owned transversally across medical, operational, and coordination roles, making it dependent on individuals and vulnerable to turnover. Both projects have adapted reactively to disruptions rather than evolving by design, with each suspension exposing how dependent CE is on direct MSF presence, including its community relationships and feedback mechanisms. Despite their different backgrounds, operational centres, and set-ups, there are currently no significant differences between the two projects in the state of their CE: both practise CE mainly as health promotion, both delegate it to the HP team, both adapt reactively. This shows that the current state of CE and the level of participation depend on mindsets and ways of working, rather than capacity and resources alone (e.g HP team size), which would need to play a secondary role to facilitate the process and depending on coverage and activities.

EQ2: Meaningful participation

Both projects operate primarily at Level 1 (Inform), with inconsistent Level 2 (Consult) mechanisms and no sustained involvement or collaboration (Levels 3–4). Community input reaches decisions through motivated individuals, instead of formal structures. The conflict is a real constraint but since it is the very reason MSF is present, it makes a suspension-resilient CE model more urgent. Even at inform/consult level, CE contributes concretely to service utilisation as the essential bridge between communities and health facilities, an indication of how much more the same system could be transformed with the appropriate changes. Both projects reach a consistent core of groups even though some have more limited contact and participation (adolescents, hospitalised patients, men,

and out-of-reach communities remain structurally underserved, and traditional healers in Macomia have not been re-engaged. Teams have the opportunity to reflect on which groups MSF should target to enhance participation, and to clarify this as part of their operational objectives. Suspensions and hybrid management resulted in more fragile relationships with more transactional and irregular contact. While communities feel heard, they rarely learn what happened next. Input flows one way, with no system to close the feedback loop. This lack of response risks eroding trust.

EQ3: Contribution of CE to medical and operational priorities

CE demonstrably contributes to MSF's medical and operational priorities through volume, proximity, and individual initiative rather than by design. Health promotion reaches large numbers, referral systems contribute to update of services and HP presence in facilities reduces drop-off. Yet these results are visible only where data systems exist, and the mechanisms meant to systematically identify and act on community needs were partially activated, then interrupted. The same pattern repeats across trust, decision-making and coordination. Trust and acceptance of MSF are high but depend on direct presence. As MSF is increasingly linked to MISAU services and its unresolved complaints, trust is lost. In a conflict-affected environment such as Cabo Delgado, CE serves not only operational objectives but also conflict sensitivity, acceptance, access negotiation and community protection, so CE mechanisms should be judged not only on participation outcomes but on their capacity to hold trust and social cohesion through insecurity and operational disruption. Operational adaptations happen but are produced by proximity and initiative, while major operational and medical decisions are made without community consultation. The referral system runs through community actors but was not built with them. Ongoing displacement and return movements mean community mapping needs to be a continuous exercise rather than a one-off, as representation structures can become outdated quickly after population shifts. Coordination with community structures works well, but with MISAU, other NGOs, and even between MSF teams it remains informal and fragmented. In a multilingual setting, communication needs to go beyond translation to culturally adapted approaches across Makua, Makonde, Kimwani and Portuguese-speaking populations.

Annexes

Annex A: Evaluation Matrix

EQ1: How are community engagement (CE) approaches currently conceptualised, structured, and implemented across the two projects (including evolution over time)

Sub-questions	How to measure? (success indicators)	Proposed means to address question: evidence needed / possible sources of information
Conceptualisation and alignment		
1.How is community engagement defined and understood within each project? What CE structures, roles, and resources are in place in each project, and how do they function in practice?	CE definition clearly articulated and understood by staff Clear tools and processes guide CE implementation Description of CE activities and components Human/financial resources allocated to CE activities	• Strategies and other docs related to Community Engagement • CE frameworks/guidelines • Interviews with HP, medical, operational teams • Handover reports, project visit reports • Organigrams, project documents, ARO reports and presentations • Medical database extracts on community activities • • Staff interviews (CEHP managers, social workers, project coordinators/PMRs)
2.How do both CE approaches aligned with MSF OCB project medical and operational priorities in Mozambique? How is CE integrated (or not) with other components of the project (medical, outreach, operations, protection)?	Evidence of CE integration with medical/operational priorities	• Project documents, presentations and logframes • Strategies and other docs related to Community Engagement • Explos/needs assessments • Medical activity reports • Interviews with HP, medical, operational teams

Evolution and adaptation		
3.How have CE approaches adapted over time in response to contextual factors such as insecurity, displacement, or access constraints?	CE approaches demonstrate flexibility to context changes Evolution of human/financial resources allocated to CE activities	• Handover reports, project visit reports (timeline analysis) • Rapid Qualitative Assessments reports • Medical/operations activity reports and strategies • Staff and partners interviews on contextual changes
Challenges and enablers		
4.What are the main operational, contextual, and organisational factors enabling/ constraining effective CE implementation? (e.g. security, resources, staff capacity, coordination)?	Clear enabling/constraining factors identified with mitigation strategies	• Project documents and reports, handover reports (Focus on challenges/enablers) • Staff interviews, operational reporting

EQ2. How do current CE approaches enable meaningful community participation (information-sharing -> consultation-> involvement -> collaboration - OCB CE framework).

Sub-questions	How to measure? (success indicators)	Proposed way of getting this information: data collection tools and possible sources of information
5.What level of the OCB CE framework do current CE approaches operate at (inform, consult, involve, collaborate)?	CE activities demonstrate participation (As per OCB grading /CE Framework) Degree of community input documented, analysed, and fed into project decision-making Examples of CE leading to changes Difference between intention and practice	Application of CE framework (grading) considering: • Operational reports • Meeting minutes with community representatives • HP/ APES reporting, health education summaries • Community focus group discussions, staff interviews • SOPs/strategies vs. field reporting comparison • Staff interviews vs. community focus groups • Project documents vs. operational reports • Feedback mechanisms, rumour systems • Meeting minutes, field /HP /APEs reporting • HP database extracts, Kobo datasets
6.Which community groups are meaningfully engaged through CE, and which are less visible or excluded?	Diverse community groups meaningfully engaged	• Stakeholder mapping • Community focus group discussions (disaggregated)? • Patient satisfaction survey results • Community meetings (monitored by HP)
7.Do communities perceive that their views are considered in a meaningful way?	Community feedback influences operational decisions	• Feedback mechanisms documentation, Kobo datasets (if any) • Interview with community members • Patient satisfaction surveys

EQ3. How does CE contribute to the achievement of medical and operational priorities?

Sub-questions	How to measure? (success indicators)	Proposed way of getting this information: data collection tools and possible sources of information
Understanding target group's needs, priorities, and barriers		
8.How does CE contribute to identifying target population needs, priorities, and barriers to accessing care?	CE generates actionable insights on target groups' barriers/needs Strong community acceptance and trust in MSF presence Measurable improvements in service awareness/utilisation	• Explos/needs assessments, anthropological studies? • Patient satisfaction surveys, feedback mechanisms • Community focus group discussions • Rumour capture systems, feedback mechanisms
Access to and uptake of health services	Strong community acceptance and trust in MSF presence	
9.How does CE influence awareness and utilisation of health services? (examples)		• Medical activity reports, HP database extracts • Health education summaries, APES reporting • Patient surveys, community discussions
Acceptance and trust		
10.How does CE contribute to community acceptance of MSF and its activities? How do communities perceive MSF's presence and added value?	Increased community cooperation over time and reduced misconceptions about MSF. Understanding of MSF's humanitarian mandate and contribution	• Community focus groups (perception tracking over time) • Rumour capture/addressing systems (trend analysis) • Patient satisfaction surveys (trust/acceptance) • HPs/APES reporting (community feedback) • Staff interviews (observed attitude changes) • Medical activity reports (utilisation services trends)

		• Health education session feedback • Anthropological studies on community perspectives
Operational decision-making and responsiveness		
11.To what extent does CE inform project design, adaptation, and prioritisation? Provide examples		• Meeting minutes analysis, project documents • Medical/operational activity reports showing adaptations • Staff interviews • Handover reports
Coordination and referrals		
12.How does CE support identification and referral of cases to MSF services or external actors?	Effective referral systems	• Referral mapping • Data on referrals
13.To what extent does CE facilitate coordination with other actors (e.g. health services, protection actors, community structures)?	Coordination established	• Actor mapping and analysis • Examples from interviews, including partners

EQ4. What would a realistic, context-adapted CE model look like moving forward?

Sub-questions	How to measure? (Success indicators)	Proposed way of getting this information: data collection tools and possible sources of information
14.What would an appropriate and effective CE model look like for these two projects moving forward? (resources, activities, approach alignment, coherence, etc)	• Clear CE framework with defined objectives • Adequate resource allocation identified • Context-specific activity portfolio • Integration mechanisms with medical/operational components • Measurable participation outcomes • Indicators related to CE (project framework)	• Staff interviews (lessons learned, recommendations) • Handover reports (best practices identification) • Project documents analysis (resource needs assessment) • Community focus groups (preferred engagement methods) • Comparative analysis across projects • SOPs/strategies review and addressing gaps overtime
15.How can CE be better integrated into medical, operational, and protection activities?		
16.How can CE be adapted to better reflect local realities (e.g. mobility, insecurity, social dynamics)?		

Annex B : CE OCB FRAMEWORK

PROJECT CYCLE STEPS	The 4 LEVELS of COMMUNITY PARTICIPATION - ASSESSMENT GRID ☑			
WE...	1 INFORM	2 CONSULT	3 INVOLVE	MEANINGFUL COMMUNITY ENGAGEMENT 4 COLLABORATE
	PROVIDE INFORMATION Decision taken by MSF only	**COLLECT** FEEDBACKS Gather opinions to occasionally act on them MSF remains the only decision maker	**WORK WITH COMMUNITIES** (in all their diversity) to solve some issues faced **MSF shares the decision process on some aspects**	**WORK WITH COMMUNITIES** on each aspect of the project **MSF actively shares most of the strategic decisions**
NEEDS ASSESSMENT	DURING ☐ Collect **quantitative data** only ☐ **Explain** to those we talk to why we are there AFTER ☐ Share the **outcome** with communities	DURING ☐ Conduct a **social mapping** to identify influencal networks, CBOs, influencers, trusted formal and informal health providers, ... ☐ Collect **qualitative data** from community members about their expressed health needs ☐ Take proactive steps to understand specific health needs of **excluded populations** ☐ Needs asseessment reports contain **qualitative and quantitative** information AFTER ☐ Inform communities consulted about the **outcome** of the explo, even if if we will not be able to intervene there at the moment. ☐ Share with other actors any priority needs from the community that we cannot respond to	DURING ☐ Gather **expressed needs** related to health, **barriers** to accessing services, and **potential solutions** from community members in all their diversity ☐ Incorporate in the report information about expressed needs, health seeking behaviors, local resources, and suggestions from communities, so they can be included in the **project design** ☐ When suggestions cannot be integrated, we **explain why**	DURING ☐ Collaborate with community members in all their diversity about their health needs and ask them to **prioritise** them from their perspective ☐ Seek **community suggestions** for how to improve outcomes for these priority needs, guided by our medical expertise and considering our operational constraints ☐ Document what **skills and resources** that exist within communities and that we can work with to respond to priority health needs ☐ If key risks or possible **unintended negative consequences** have been identified, these should also be included in the report and any mitigation measures must be identified with community
PROJECT DESIGN strategy, elaboration & revision	☐ Write the project strategy **internally** as MSF ☐ **Share main features** of the project with local stakeholders, the MoH and/or some community members	☐ Inform the community about our plans and sometimes gather their **input**, but their feedback doesn't significantly influence our decisions ☐ Sometimes **record the feedbacks** received and share them with decision-makers at project-level. ☐ Sometimes intgrate feedbacks into the **project strategy** or design of project/activities. ☐ Try to **inform** people about whether their feedback was integrated into the project design/strategy revision or not	☐ Seek community input during planning and consider their suggestions for adjustments ☐ Involve **diverse community members** to identify solutions to key health issues and inorporate their feedback in the strategy ☐ **Proactively seek suggestions** from community about how to respond to their health needs, achieve our project objectives and overcome their barriers to access to care. We also ask their suggestions for improvement of the project ☐ **Inform** people whether their feedback was integrated into the project design/strategy revision **or not**	☐ Hold workshops with diverse community members to **reflect together** on the needs assessment findings, define priorities for action, and decide together on the necessary activities to achieve project objective ☐ **Actively collaborate** with community in planning, ensuring representation from **different groups**
PROJECT IMPLEMENTATION	☐ Do not work directly with the community and/or government structures that are mandated to support the management of health facilities or CHW networks ☐ Provide **regular information** about the ongoing project activities to certain stakeholders/community members	☐ Provide trainings to health committees, staff of health structures and CHWs based on **needs identified by MSF** ☐ Work with some **actors mandated within the health system** to implement health services, manage health structures or provide community-based services.	☐ Strengthen the capacity of the existing actors and existing local structures to implement health services, in line with their **mandates roles** and responsibilities ☐ **Create** such structures, where they do not exist, train them and involves them in the implmentation of th project ☐ Decide some training topics ourselves, but we incorporate and respond to **expressed training needs**	☐ Develop capacity building plans **alongside** those that they are for, when capacity strengthening is part of the project ☐ Add additional activities needed to achieve project objectives, based on **community suggestions**, where possible
PROJECT MONITORING, accountability, transparency, quality of care	☐ **Inform** communities about successes, advances and challenges of the project, as a result of project monitoring and evaluation activities	☐ **Record feedback** from community members, both those received pro-actively and passively ☐ Conduct **satisfaction surveys**, include the results in the monitoring of the project and shared with decision-makers within MSF ☐ Make **small adjustments based on feedback**, decide internally on actions in order to improve results of the next satisfaction survey	☐ Regularly organize **community meetings** with diverse stakeholders to discuss challenges and identify potential solutions together ☐ Regularly and **proactivly collect feedback**, through different channels defined with community to ensure inclusion. ☐ Develop a complaint and feedback mecanism with comunity, ensuring data are processed and actions ate taken. ☐ Define **action plans** to improve the quality of the project, based on feedback received on the project ☐ Inform people **whether their feedback was integrated** into the project strategy or not	☐ Regularly organize **accountability meetings** with community to share evolution, results, present indicators, identify strong aspect and improvements needed as well as activities to build skills and make space for communities to ask questions ☐ Work with diverse community members on how they would like to be **involved in monitoring** the project and how MSF could support them in doing so ☐ Build in **community-based montoring** activites into the project ☐ Community feedback drives many of our improvements, and we have a clear process to inform patients and community members about **changes** made based on their suggestions
PROJECT CLOSURE Exit strategy	☐ Inform some key stakeholders of our departure when it is **immident** ☐ Expect local stakeholders to **take over** activities after MSF's departure ☐ Have transactional relationships with the communities and CBOs, and engage them on an **ad hoc** basis, when it is beneficial to MSF	☐ Ask local actors **what they need** to sustain some of the project activities, and provide some of this support on a **one-off** basis	☐ Start developing an exit strategy **long before the end** of the project, which includes networking with other stakeholders to identify if any activities can be funded and supported by others ☐ Develop **partnerships** throughout the project that ensure equitable involvement of community and CBOs ☐ Support the community to continue activities after MSF leaves, but they are not effectively **capacitated** to continue engaging with health issues after the MSF project comes to an end. ☐ Identify **sustainable** solutions	☐ Work with **community members** and **structures** to effectively sustain certain activities ☐ **Exit gradually** to enable communities and other actors to take over some activities ☐ Integrate **advocacy initiatives** towards MoH to enable some staff supported by MSF to be integrated into the MoH or other institutional structures in a sustainable way ☐ Partner with CBOs and other stakeholders in a way that ensures that communities and CBOs can **continue to engage** with health issues even after the MSF project comes to an end ☐ Identify **sustainable** solutions and **contribute to implement** them