AN EVALUATION OF
Community Engagement in Cabo Delgado - Mozambique

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BACKGROUND

MSF Operational Centre Brussels (OCB) has been operating in Cabo Delgado since 2019, with two projects currently active in Macomia and Mocímboa da Praia (the latter transferred from OCBA to OCB in April 2026). Both projects share a common humanitarian context marked by sustained armed conflict, insecurity, population movement, and disruption to basic services. Cabo Delgado is also home to diverse ethnic communities, which shape how communities engage with health services and influence MSF's community engagement (CE) approaches.

The overall purpose of this evaluation was to assess how CE was understood, implemented, and experienced across the two projects, and to identify how CE contributes to medical and operational priorities in a conflict-affected context. The evaluation was intended to inform a strengthened, context-adapted CE model for MSF in Cabo Delgado.

METHODOLOGY

- Desk review
- Mixed-methods approach
- 10 preliminary scoping interviews
- 34 semi-structured interviews with MSF staff and representatives from the communities

PRIORITY RECOMMENDATIONS

- **Reach a shared understanding internally 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.

MAIN FINDINGS AND CONCLUSION

FINDINGS

In both projects, **CE is conceptualised on paper as participatory but practised primarily as health promotion and outreach**, structurally delegated to the Health Promotion and Community Engagement (HPCE) team rather than owned transversally across medical, operational, and coordination roles.

Both projects operate mainly at level 1 of the OCB CE Framework (Inform), informing communities, with inconsistent consultation mechanisms and no sustained involvement or collaboration. 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.

CONCLUSION

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.