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# Healthcare Provider Perceptions of Post-Violence Clinical Care Services in Mozambique, 2023: A Qualitative Interview Study

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## Abstract

# Background

Over the past decade, the Ministry of Health (MoH) in Mozambique rapidly established and scaled up post-violence care services in coordination with HIV clinical services. This study, led by the MoH Violence Response Program, aimed to understand healthcare providers' perceptions regarding weaknesses in post-violence care.

# Methods

We conducted semi-structured, in-depth interviews with 20 healthcare providers of post-violence care services, 3 men and 17 women, purposively selected using a theoretical sampling approach from 20 health facilities that received external post-violence care quality assessments across seven provinces during March–August 2023. Transcriptions were uploaded to MaxQDA for coding and analysis in Portuguese, and data were analyzed using inductive and theoretical thematic analysis.

# Results

Three themes emerged which capture provider perceptions of post-violence care weaknesses. 1. Insufficient materials, including appropriate medications, patient registration forms and phone credit; 2. Inadequate trained human resources, including nurses, doctors and psychologists, and 3. An ineffective multisectoral response that includes participation by social welfare, police and justice sectors and ongoing support to ensure shelter (as needed) and successful resolution of cases. Providers expressed their commitment to providing the best post-violence care possible as well as their frustration that they could not further assist survivors and periodically had to return them to unsafe conditions.

# Conclusions

Provider perceptions suggest that materials and human resources for post-violence care response may be insufficient in the facilities represented in this study. They also emphasize the importance of a robust multisectoral response to successfully prevent and resolve complex issues of violence. The weaknesses identified and recommendations outlined can help guide improvements in Mozambique moving forward. The findings may also be useful and applicable for other low and middle-income countries seeking to expand and improve post-violence care.

## Introduction

Around the world, 31% of adolescent girls and women aged 15–49 years have experienced violence at some point in their lives, leading to negative health consequences, including HIV acquisition [1]. Women

experiencing intimate partner violence (IPV) are 1.5 times more likely to acquire HIV compared with women who have not experienced IPV [2]. Over the past decade, Mozambique has established and scaled up violence prevention and response services for IPV and other types of violence in coordination with HIV clinical services, growing from just 56 public health facilities providing post-violence care services in 2012 to 1,450 in 2021, representing 81% coverage of the country's 1,778 health facilities [3].

The essential post-violence care package, as defined by the Mozambique Ministry of Health (MoH), includes clinical services, rapid HIV testing with referral to care and treatment as appropriate, sexually transmitted infection testing and treatment, HIV post-exposure prophylaxis, emergency contraception, and additional counseling and referrals as needed (e.g. police, legal, psychosocial support) [3].

A comprehensive response to violence rests on three mutually reinforcing pillars: prevention, response and justice [4–5]. Mozambique has made a concerted effort to proactively address two of these pillars—prevention and response—through expansion of post-violence care services. However, despite this progress, the quality of post-violence care offered in Mozambique had not been systematically assessed. This study aimed to explore healthcare providers' perceptions of the strengths and weaknesses of post-violence care.

## Methods

# Data Collection

Semi-structured in-depth interviews were conducted with 20 healthcare providers from 20 health facilities (supported by U.S. Government funds) across seven provinces in March–August 2023. Interviews took place in private rooms within each health facility, lasted 30–45 minutes and were conducted in Portuguese by two lead investigators. The semi-structured interview guide was developed for this study by the study team (supplementary file) and covered the following domains: provider sociodemographic and professional background, including training, abilities, roles, and responsibilities; provider perspectives on the strengths and weaknesses of post-violence care; health facility violence prevention activities; and provider recommendations for promoting post-exposure prophylaxis access and adherence.

Interviews were audio-recorded and transcribed by three members of the study team. Transcriptions were uploaded to MaxQDA for coding and analysis in Portuguese. Personal identifiers, such as name and contact, were not recorded. Participants were assigned coded numbers, and any unintentional identifiers were removed during transcription.

## Sampling

We used purposive sampling with a theoretical sampling approach- seeking cases "from which one can learn a great deal about issues of central importance to the purpose of the research" [6]. A manager or

healthcare provider of post-violence care, sometimes the same person served both roles, was interviewed at each of the twenty health facilities where external quality assessments were also conducted. The external quality assessments were simultaneously implemented at fifty health facilities that met 80% of the quality assessment criteria according to an evidence-based quality assurance tool created to assess post-violence care [7]. Study team availability and geographic representation were considered when selecting facilities. Eligible providers met the following criteria: providing post-violence care for over 6 months and having attended at least one violence-related training. Providers were excluded if they did not provide post-violence care, had done so for less than 6 months, or had not attended any relevant training.

Interviews were conducted until saturation was reached, that is, until interviews yielded no new themes. Saturation was achieved after twenty interviews, and no additional interviews were conducted during the external quality assessments.

Over half of the interviews were conducted in the south, predominantly at primary and urban health facilities. Most facilities received between 100–300 cases and the majority provided HIV care and treatment to between 5,000–10,000 clients (Table 1). In order to ensure the inclusion of information-rich cases, we interviewed providers from a wide range of professional categories, years of experience and a mix of classroom and on-the-job training. [6] (Table 2).

Table 1
Characteristics of healthcare facilities included in the qualitative study of post-exposure prophylaxis access and adherence in Mozambique, 2023

| Healthcare Facility Characteristics | | Number of Facilities |
|---|---|---|
| Region | South | 13 |
| | Center | 4 |
| | North | 3 |
| Center for Integrated Attendance | | 3 |
| Level of Healthcare Facility | Primary | 16 |
| | Secondary | 4 |
| | Tertiary | 0 |
| Urban or Rural | Urban | 13 |
| | Rural | 7 |
| Cases of Violence: 2022 | 0-100 | 9 |
| | 101–300 | 8 |
| | 301+ | 3 |
| Patients on HIV Treatment: 2022 | 0–3,000 | 4 |
| | 3,001–5,000 | 6 |
| | 5,001–10,000 | 7 |
| | 10,001–16,000 | 3 |

Table 2
Characteristics of healthcare providers interviewed in the qualitative study of post-exposure prophylaxis access and adherence in Mozambique, 2023

| **Healthcare Provider Characteristics** | | **Number of Providers** |
|---|---|---|
| Professional category | Doctor | 2 |
| | Nurse- Superior level | 4 |
| | Nurse- Mid level | 4 |
| | Psychologist | 3 |
| | Superior technician | 3 |
| | Medical technician | 3 |
| Sex | Male | 3 |
| | Female | 17 |
| Years in category | 1 to 4 | 9 |
| | 5 to 9 | 8 |
| | 10+ | 3 |
| Years worked in health facility | 1 to 4 | 12 |
| | 5 to 9 | 7 |
| | 10+ | 1 |
| Number of classroom trainings | 1 to 4 | 13 |
| | 5 to 9 | 4 |
| | 10+ | 3 |
| Number of on-the job trainings | 0 to 4 | 9 |
| | 5 to 9 | 8 |
| | 10+ | 3 |
| Post-violence care role: service provision/management/both | Both | 15 |
| | Service provision only | 5 |
| Number of post-violence care clients per month (avg) | 4 to 9 | 6 |
| | 10 to 15 | 6 |
| | 16 to 30 | 6 |

| Healthcare Provider Characteristics | | Number of Providers |
|---|---|---|
| | 30+ | 4 |
| Number of providers trained to offer post-violence care | 4 to 9 | 8 |
| | 10 to 14 | 7 |
| | 15 to 30 | 5 |
| Year health facility began to offer post-violence care | 2010–2015 | 8 |
| | 2015–2020 | 10 |
| | N/A | 2 |

## Data Management

All electronic data were stored on a password-protected network and backed up weekly. Signed informed consent forms were stored in a locked cabinet. Access to all information was restricted to study staff.

# Data Analysis

We analyzed the data using inductive and theoretical thematic analysis [8]. Following an initial round of data collection (roughly ten interviews), the three-member study team collectively coded two interviews to identify emerging themes and develop a codebook through a standard iterative process. Initial codes included: strengths, weaknesses, provider role, provider responsibilities, violence prevention activities, positive provider abilities, post-exposure prophylaxis access and adherence recommendations. Emerging themes informed probes used in subsequent interviews.

Once data collection was complete, the remaining transcripts were divided among team members. After individual coding, the team reviewed and discussed coding approaches and refined the codebook as needed. The first author generated multiple analytic memos to process the data and explore emerging themes related to provider-identified weaknesses [9]. Data was re-coded as necessary. For example, redundant codes capturing the same concepts were consolidated. Analytic memos were discussed among lead authors to build consensus on emerging themes and to promote dialogue about thematic consistency across participants [10]. Representative quotations were selected to illustrate the themes identified through the analysis.

## Results

Three overarching themes emerged from the data, capturing healthcare providers' perceptions of post-violence care weaknesses: (1) insufficient materials; (2) inadequately trained providers; and (3) an

ineffective multisectoral response.

# Theme 1: Insufficient Materials

Providers identified insufficient materials as a primary barrier to delivering quality post-violence care. These materials spanned a wide range—from medication to registration forms and information, education, communication materials, computers and phone credit needed to follow up with patients, coordinate meetings and liaise with police or social welfare. Although providers noted increased availability of certain medications, such as HIV prophylaxis, they expressed frustration that many other medications are not consistently stocked, and that shortages, particularly of emergency contraception or pain medication, are common. Providers readily identified which tests and supplies were most frequently in short supply, including pregnancy tests and patient registers.

One provider captured the breadth of material needs:

We have a shortage of paper for printing the legal medical reports... so, I don't have a computer, I don't have sheets of paper, I don't have toner for printing the reports, I don't have a phone for emergencies. For post-violence care we use the phone they use to track HIV patients and that is the phone that we sometimes use but at a certain time of night it is no longer possible. And we also do not have some tests that are part of the protocol such as for example the pregnancy test, hepatitis, the vaccine itself and etc.

The lack of phone credit was a particular concern to many providers, who expressed a strong desire to maintain closer contact with patients and recognized that periodic check-in calls could meaningfully improve medication adherence as well as multisectoral coordination of patient cases.

One provider astutely described the importance of check-in calls:

*These are strategies that the health facility implements that after 7 days you have to call, after so many days you have to call- they are only reminder calls for the person to adhere. We had people returning because many times these people... then they feel more welcome.*

Another provider concisely described the impact of the lack of phone credit for coordination:

We have a problem with phone credit for communication. Our program always requires having phone credit so that we can communicate, both with the peripheries, as well as with the community, with the leaders…in these instances, the NGOs are the ones that help us. As we know, post-violence care is multisectoral. So, sometimes at some point we run out of phone credit to communicate as it should be. And sometimes the message arrives late, the person may not respond at that time.

## Theme 2: Inadequate Trained Human Resources

Providers identified the shortage of adequately trained providers dedicated specifically to post-violence care as another primary barrier to quality care. Most providers hold multiple roles within their health facilities, and post-violence care is one of many competing responsibilities. Despite this, interviewed providers recognized the importance of the violence program and expressed a desire to devote more time and attention to post-violence care.

One provider described this tension clearly:

*“It's a little complicated because if we had one professional to attend to the victims only, I*

*think we would have improved service, but for example I am here to attend children and the nurse there is to attend other consultations- it is very complicated to work only on post-violence care and for us to have quality services, we aren’t able to offer quality services because of that- before you all arrived I was there attending a case of violence... it took me a long time to bring the case to the psychologist because I have a huge line out here.”*

Another provider echoed this sentiment, describing her desire to screen more patients for violence but her practical inability to do so:

I think this package is very important. I'm a maternal child health nurse. Within the health facility I have other activities. I'm not just implementing this package. I should screen more. In a day in a health facility, we can receive a thousand patients, at all entry points, but I do not have the... sometimes I have to make a schedule each week and stay at ANC, and it is there where I'm going to screen. Colleagues are working, but as focal point I would like to go out to those other sectors in order to do this work. So, I think because it's an important package, we're all trying to do better. The person who is doing violence should do violence. And not have other functions.

Many providers also noted that violence services were often perceived as the sole responsibility of the designated focal point rather than a shared responsibility across team members. As stated by a provider:

The program is looked at as being the focal point. The integration of the other technicians is a bit lacking... the violence program at this moment, is looked at as being the person who is the focal point. So, you have to undo that, the program should not be the focal point’s program, it has to be for all of the health professionals who are in this health facility and in this district. From the top to the bottom. Yes.

## Theme 3: Ineffective Multisectoral Response

Providers devoted considerable time to describing the absences of police, justice and social welfare personnel as a critical and deeply worrisome constraint that prevented them from effectively delivering a complete post-violence care response. Providers explained that they are limited in what they can

personally provide, and that survivors frequently do not successfully connect to police, justice, or social welfare services after being referred.

One provider described the consequences of fragmented referral:

*If there was someone from the police so we could respond to that case together, so we wouldn't have to refer it. Because when we refer, some cases do not arrive, they deviate because she is afraid. For example, when it comes to a case that is one of those that she depends on that person, then she will leave, she will not get there because she is afraid to complain about her husband. She thinks that every case that gets there equals jail. So, we've also missed this opportunity to be able to hold accountable the actual who? Aggressor. That's why the same victims at some point come to health facility with the same complaint. Because the rapist was not held accountable. So, it would be very good, it would be very good indeed. Yes."*

A second provider echoes this:

We are losing many victims because of referring to the police. We give the guide- you go to the police. At some point you don't arrive. So, if we had all sectors: police, social welfare in the same place, I believe that those ladies would not get lost.

Regarding social welfare services particularly, a third provider noted:

When they find themselves in the position of victim, support has to be immediate and within the reach of the victim. If it's to make a referral for example, in terms of bringing a clinician from here in the health facility to observe, that's not a problem. But to refer, to social welfare that is not close to the health facility, nor is it close to the victim's home, it is difficult for the victim to follow up. We're saying that... it inhibits the victim from having all the care that could be offered. Although the person can make the reference, we are not sure that the victim is receiving the care she needs for the violence situation.

The absence of integrated one-stop centers and temporary shelters for survivors was repeatedly mentioned as a critical gap.

On the lack of integrated one-stop centers, one provider stated:

*What should really be improved is the one-stop center, because we are losing many victims because of referring…we call, we have a case X and we send the victim, the survivor there. At some point on the way the family starts to say- 'haa you, you're taking this case to the police, they will arrest you,' then that person ends up getting lost. So, I believe that if we had a one-stop center where all services are there it would be very good. Yes*.

Providers emphasized that health, police and social welfare services need to be available in the same space—so that survivors who need these services can access them immediately, before they are overwhelmed by outside pressures and disengage.

On the lack of temporary shelter, one provider articulated the immense challenge it poses for supporting survivors in pursuing justice:

Well, one of the things that's been a challenge for us, is the subject of…we call it temporary accommodation, right? Because honestly, we have received many victims, and they are dependent on the aggressor. So, due to lack of this temporary accommodation, at some point they are forced to go live with the same rapist, because the victim can only stay one day or two days in the house of a relative. Because of provision issues she already... she feels forced to go back there. And we have also had several cases that the victims are over 18 years old, she comes, we begin the follow-up, we open the process, and then before we forward to the police, send the report, the victim comes to ask us to cancel the sending of the report, because she has already annulled the case. Because... she says because the rapist has already apologized. But we feel it's because she's depending on the same person. So that's been a very big challenge at our level.

Another provider described her frustration at not being able to do more:

That part at some point I try, I try, I try. That lady says that 'If I report, who will give me food? Who will take care of my children? He's going to be arrested, and then I can't do it. Please doctor, don't open a lawsuit, don't say anything, this matter has to stop here.' Yah, that part there. It's the really weak part, and I feel like I'm already limited here.

A particularly distressing example was shared by another provider, who described a six-year-old child who was sexually abused, provided post-exposure prophylaxis, and returned home, only to come back two weeks later with new injuries. Despite efforts to engage the police and social welfare, no appropriate accommodation could be arranged:

I called the police- 'Look: we have a situation in site X.' I called social welfare, there is no transportation. I spoke to the head doctor. The head doctor provided an ambulance. And the ambulance went to get the child for the police, to see if they could talk to the child. The child didn't say anything. I had this sadness that the child had to go back there because she doesn't have a place to stay. So, if the first time we gave prophylaxis, she returned, she was raped for the second time, now the third time we are returning her, what will happen? So, I even said- 'Look, isn't our job to help this child until the end? Our objective is to help that child leave the situation they find themselves in.' But we couldn't. The child had to return, and in the end I don't even know how that situation is... I asked the colleague from social welfare- 'How did that situation end?' And I didn't know anything else, because the police were here, then the ambulance had to return them there. Are you imagining a child? And we said- 'The rapist is there.'

# Discussion

Through in-depth interviews with twenty healthcare providers in Mozambique, we obtained important insights into the weaknesses of post-violence care established and scaled up in coordination with HIV services. Findings indicate that additional resources could improve quality of post-violence care

services, and providers repeatedly expressed frustration at lacking what they needed to do their jobs well. These findings align with broader global literature, which demonstrates that violence against women should be a higher priority in budget allocations, particular in lower- and middle- income countries that are chronically underfunded and understaffed [11]. A recent study highlighted that less than 1% of aid spending targets violence, despite the fact that intimate partner violence and sexual violence against children rank among the top contributors to the global disease burden — representing the fourth and fifth leading risk factors for Disability-Adjusted Life Years among females aged 15–24 in 2023 [12]. Given this gap, the authors called for sustained investments in intimate partner violence and sexual violence against children prevention and response.

Although some of the necessary materials require substantial investment (such as computers and equipment), others—including essential medication, phone credit, or transportation—could be addressed with national and donor budgets. Yet, without sustained investments, it will be a continuous challenge to ensure that providers at all levels have the materials they need to provide high-quality post-violence care.

Findings also suggest a shortage in the number of trained violence providers dedicated to post-violence care. Inadequate staffing is a well-documented challenge in public health facilities in low and middle-income countries (LMICs) [11, 13–14] and was identified as a primary concern by partners in the Population Council study on violence services in LMICs [16]. As demand creation activities expand and more survivors seek services, the need for dedicated post-violence care will only grow. Mozambique has already seen a steady increase in reported cases — from 38,045 in 2019 to 72,315 in 2022 (MoH data) — mirroring a 156% increase in clinical care services for sexual violence across sub-Saharan Africa between 2017 and 2021 [16–17]. This trend is likely to continue or accelerate.

In the interim, integrating post-violence care content into the mandatory pre-service health professional curricula would ensure that all providers receive the foundational training in violence recognition and response from the onset of their careers. This need is broadly recognized: studies have found that 50% or fewer nursing students in countries, such as Saudi Arabia and Australia, have received any violence-related content in their degree programs [18–19], and medical students fare similarly, with most universities offering minimal violence education [18, 20]. As a result, most post-qualifying health professionals feel unprepared and lack the confidence to support survivors of violence [18, 20–25].

In 2019, WHO recommended the immediate integration of violence training into pre- and post-qualifying health provider curriculum [18; 26] and updated a dedicated healthcare provider curriculum in 2021 [27]. Telehealth-based training is another solution particularly given reduced budgets and increasing integration of health portfolios. Providers can access various training modules via the online telehealth platform, with recent evidence demonstrating its effectiveness in training providers and delivering scalable, integrated primary health care services worldwide [28].

Lastly, findings affirm that an effective multi-sectoral response is necessary to ensure quality post-violence care. Providers consistently voiced their frustration at being unable to fully support survivors due to the absence of police, justice, and social welfare personnel within health facilities. Co-locating

trained health, police, and social welfare staff within a single facility could facilitate timely, comprehensive support for survivors and improve case resolution when survivors choose to pursue justice. While aligning multiple sectors is inherently challenging, it is necessary to ensure that survivors receive not only the health care they need but the full package of services they may want — services that are often available, provided survivors are linked to them promptly.

Violence programs are uniquely complex in that multiple sectors must work in coordination for the response to be effective, as reflected in the three mutually reinforcing pillars of a comprehensive response: (1) prevention—using primary and secondary prevention strategies to prevent violence and its recurrence; (2) response—identifying and supporting survivors to mitigate the health and social impact of violence; and (3) justice—promoting accessible justice processes that hold offenders accountable [29–30]. These pillars are supported across levels of the socioecological model- structural, community, interpersonal and individual [29]. When perpetrators are not held accountable, abuse continues. When survivors are not appropriately supported, vulnerability persists. The literature consistently demonstrates that an effective response requires engagement across all sectors and supports direct investment in integrated, multi-sectoral approaches [16, 31].

A review of One-Stop Centers across 20 countries, and a meta-analyses spanning more than 80 countries, found broad consensus that One-Stop Centers make a difference in the communities where they operate. When One-Stop Centers are located in hospital or medical clinic settings—as is the case in Mozambique—survivors can receive essential medical care to address injury and exposure to sexually transmitted infections and HIV. However, the review also found that One-Stop Centers are more effective in high-income settings, where relevant resources, such as material and multisectoral staff, are more readily available. Key recommendations for strengthening the impact of One-Stop Centers included increasing funding and addressing infrastructure and access [16, 31–32].

In the interim, regular multi-sectoral meetings offer a practical and low-cost mechanism for coordination. Multisectoral meetings can serve as forums for relationship-building, data sharing, case discussion, and problem-solving. One Kenyan One-Stop Center, for example, holds quarterly multisectoral meetings with health facility staff, police, and public prosecutor's office to review cases before court and address challenges in specimen collection, case preparation, and prosecution. Larger, county-wide multisectoral stakeholder meetings are held quarterly to promote community-level collaboration in preventing sexual violence [13]. This model could be replicated in other settings.

# Limitations

A key limitation of this study is that the providers interviewed were typically the most experienced and well-trained post-violence care providers at their facility, often advocates for program improvement. Therefore, their perspectives are unlikely to be representative of providers more broadly. Additionally, the potential for social-desirability bias exists due to the one-on-one interview format, though the study team

encouraged honest responses for program improvement purposes and assured participants that their responses would not be linked to any identifiable information.

## Conclusion

Healthcare provider perceptions suggest that insufficient investments in materials and human resources undermine the quality of post-violence care in Mozambique. Providers also emphasized the critical importance of a robust, integrated multisectoral response for effectively preventing and addressing the complex realities of violence. The weaknesses and recommendations identified in this study can help guide improvements in Mozambique and may offer useful lessons for other LMICs seeking to expand and strengthen post-violence care services.

## Abbreviations

CDC- Centers for Disease Control and Prevention

MoH- Ministry of Health

LMICs- Low and middle-income countries

## Declarations

*Ethics Approval and consent to participate*

This research was conducted in accordance with the ethical principles outlined in the Declaration of Helsinki. All participants provided written informed consent; no monetary reimbursements were offered. The data were covered by the Violence Umbrella Protocol (Project ID #: 0900f3eb81ac9ed9), reviewed by the Mozambique MoH Institutional Review Board and U.S. CDC. This activity deemed not research by the U.S. CDC and was conducted consistent with applicable U.S. federal law and U.S. CDC policy (45 C.F.R. part 46.102(l)(2), 21 C.F.R. part 56; 42 U.S.C. Sect. 241(d); 5 U.S.C. Sect. 552a; 44 U.S.C. Sect. 3501 et seq).

*Consent for publication*

Not applicable

*Availability of data and materials*

The dataset analyzed during the current study is available from the corresponding author on reasonable request.

*Declaration of Conflicting Interests*

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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*Authors' Contributions*

MD, AA, EX, and RP developed the study design. MD, AA, and MB led the data collection. MD, AA, MB and MA led the data analysis and interpretation. MD led the manuscript development and revisions. All authors significantly contributed to the data collection, analysis and manuscript development. The manuscript underwent review by all authors, and each one approved the final version.

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