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Functioning of Primary Health Care Services for Women Victims of Gender-Based Violence in Beira City, Mozambique: A Qualitative Case Study

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Abstract

Background

Gender-based violence (GBV) constitutes an important public health and human rights problem. In Mozambique, despite the existence of a normative response framework, challenges persist in service implementation. Primary health care (PHC) services are often the first point of contact between women victims of GBV and the formal health system, but evidence on the functioning of these services in Mozambican urban contexts remains limited. This study analyzed the functioning of PHC services for women victims of GBV in Beira City, Mozambique, from the perspectives of women receiving care, health professionals, and managers.

Methods

An exploratory qualitative study with a case study design was conducted in two primary health care facilities in Beira City. Individual semi-structured interviews were conducted with women victims of GBV, program managers, and clinical directors, two focus group discussions with health professionals. Data were thematically analyzed, guided by an intersectional feminist perspective.

Results

Health services constituted an important entry point for care for women victims of GBV, providing reception, listening, and initial support. Although protocols, care pathways, and some clinical resources were available, their implementation was variable and strongly dependent on the availability of human resources and the individual actions of professionals. Limitations were identified in training, intersectoral coordination, particularly with the police and social action services, and continuity of care, including nighttime care and referral to specialized mental health services. Fear, economic dependence, family influence, and experiences of institutional revictimization constituted additional barriers to access and continuity of care.

Conclusions

PHC services play a strategic role in the response to GBV, but institutional weaknesses persist that limit continuity and integration of care. Strengthening the response requires consistent implementation of existing mechanisms, with regular supervision, continuous training, formalized intersectoral coordination, and improvement of referral and continuity-of-care systems.

INTRODUCTION

Gender-based violence (GBV), particularly against women and girls, constitutes an important public health, gender equality, and human rights issue. It includes physical, sexual, and psychological harm, coercion, control, and other forms of deprivation of autonomy, disproportionately affecting women in contexts marked by gender inequalities and power relations (1). The most recent global estimates indicate that approximately 30.4% of women aged 15 years or older, corresponding to about 840 million women, have experienced physical and/or sexual violence by an intimate partner or sexual violence by a non-partner at least once in their lifetime (2). Progress in reducing intimate partner violence remains slow, compromising achievement of Sustainable Development Goal target 5.2 by 2030 (3). Violence is also associated with important physical, sexual, reproductive, and mental consequences, including injuries, unintended pregnancy, sexually transmitted infections, depression, anxiety, post-traumatic stress disorder, and suicidal behavior (1, 2).

In Sub-Saharan Africa, intimate partner violence remains among the most prevalent globally, influenced by social and economic inequalities, gender norms, and institutional limitations in prevention and response (2). In Mozambique, data from the 2022–2023 Demographic and Health Survey show that 32.65% of women reported some form of emotional, physical, or sexual violence perpetrated by their current or most recent intimate partner, while 23.61% reported physical and/or sexual violence by an intimate partner (4). The country has legal and institutional instruments, including Law No. 29/2009 and the Multisectoral Mechanism for Integrated Assistance to Women Victims of Violence, which seeks to coordinate the health, social action, interior, and justice sectors (5). However, national studies identify a persistent gap between the normative framework and its operationalization in services, including weaknesses in care organization and intersectoral coordination (6).

Primary health care (PHC) occupies a strategic position in the response to GBV because it is often one of the first points of contact between women and the formal health system. It can provide identification and first-line support, assessment of safety needs, sexual and reproductive health care, psychosocial support, and referral. WHO recommends trained professionals, safe and confidential environments, and coordination with protection sectors and other relevant services (1, 7). However, the existence of protocols does not guarantee their consistent implementation, with barriers related to insufficient training, professional workload, limited resources, stigma, difficulties in case identification, and weak referral mechanisms being described (8). Recent literature also reinforces the importance of rapport, active listening, humanized care, referral, and intersectoral coordination, as well as institutional mechanisms capable of transforming individual practices into systematic and sustainable responses (8, 9).

Despite existing evidence on violence and response policies in Mozambique, qualitative research on how PHC services function in practice remains limited, particularly when the perspectives of women receiving care, health professionals, and managers are integrated. This gap is relevant in urban contexts such as Beira City, where understanding service functioning requires consideration not only of protocols and resources, but also of power relations, socioeconomic inequalities, and institutional conditions that influence access, continuity, and quality of care (4, 10).

The research was guided by an intersectional feminist perspective, which informed the analysis of how gendered power relations intersect with other dimensions of social inequality to shape women's experiences of violence and their access to and experiences within health services (11, 12). The interpretation of determinants of violence also engaged with the ecological model proposed by Heise (13), used complementarily to organize the analysis of factors operating at individual, relational, community, and sociocultural levels that may influence both experiences of violence and the response provided by health services.

In this context, this study aimed to analyze the functioning of primary health care services for women victims of GBV in Beira City, Mozambique, integrating the perspectives of women receiving care, health professionals, and managers. By jointly examining care experiences, professional practices, and organizational conditions, the study seeks to contribute to an understanding of the factors that facilitate or limit the implementation of an integrated, continuous, and woman-centered response at the primary care level.

METHODS

Study design

An exploratory qualitative study using an embedded case study design (14), was conducted between August and October 2025. The case was defined as the primary health care response to women experiencing GBV in Beira City, with the two selected health facilities constituting embedded units of analysis. The qualitative approach allowed exploration of participants' experiences, perceptions, and practices, as well as organizational and institutional factors influencing the provision and continuity of care. The use of individual interviews and focus group discussions allowed for triangulation of information and identification of convergences and divergences in participants' reported experiences and perspectives. Reporting of the study was prepared in accordance with the recommendations of the Consolidated Criteria for Reporting Qualitative Research (COREQ) (15) (Supplement file 1).

Study setting

The study was conducted in Beira City, the capital of Sofala Province, located in central Mozambique, on the Indian Ocean coast. According to data from the National Institute of Statistics, the city had an estimated population of 767,787 inhabitants in 2024 (16). The city's public health network comprises 15 primary-level health facilities and one central hospital. The city was severely affected by Cyclone Idai in 2019, which exacerbated pre-existing vulnerabilities in health infrastructure and service provision (17).

Two primary health care facilities were purposively selected based on four criteria: (i) availability of a psychology service; (ii) high volume of general consultations; (iii) provision of integrated care for women who had experienced GBV; and (iv) physical accessibility and availability of urban public transportation. Additionally, the number of women victims of GBV attended in 2023 was taken into account, according

to administrative data from the Health Information System for Monitoring and Evaluation (SISMA) (18), provided by the Ministry of Health for research purposes. During this period, the two selected health facilities recorded 321 and 49 women receiving care for gender-based violence (GBV), respectively. The selection of these facilities sought to incorporate variation in the city's socio-spatial context, including one facility located in a densely populated area and another situated in a consolidated urban area. This strategy made it possible to explore different contextual conditions in the organization and functioning of the primary health care response to women victims of GBV.

Participants and sampling

The target population included GBV program managers (municipal and provincial levels), clinical directors of the selected health facilities, health professionals involved in providing care to women victims of GBV, and women victims of GBV who received care at these facilities. Non-probability purposive sampling was used, with the aim of maximizing the diversity of perspectives and professional profiles, prioritizing analytical depth over statistical representativeness.

Inclusion criteria: health professionals with experience providing direct or indirect care to victims of GBV, from different categories (physicians, nurses, general medicine technicians, psychologists, social workers), with a minimum of 12 months of work at the health facility or in the GBV program; women aged 18 years or older who had received care at the selected facilities as a result of GBV and who were in adequate physical and emotional condition to participate at the time of the interview. In all cases, voluntary consent and signature of the Informed Consent Form were required. Exclusion criteria: professionals on extended leave (medical, maternity, or study leave) during the data collection period; women who had sought the service only once, with no possibility of reporting aspects of the care due to absence of follow-up.

The final sample consisted of 40 participants: 20 women victims of GBV, 16 health professionals directly involved in care, 2 clinical directors, and 2 GBV program managers (city and provincial). Recruitment of professionals was preceded by internal mapping of the teams in coordination with the management of each facility. Women were identified by the health team exclusively after clinical care, to avoid any interference with the care provided; following an initial phase of low adherence, attributed to the sensitivity of the topic, brief awareness sessions conducted in a non-coercive manner by professionals were introduced, with referral to the research team only upon spontaneous expression of interest. Refusal to participate occurred exclusively among invited women: 21 women refused to participate, and 7 women who had initially agreed withdrew before the interview because they considered that there was no immediate direct benefit from their participation. No refusals or withdrawals were recorded among health professionals, clinical directors, or managers. Each participant was interviewed once, and no follow-up interviews were conducted.

Recruitment of women continued until data saturation was reached, defined as the point at which additional interviews yielded no substantively new information relevant to the study objectives. Health

professionals were purposively selected to capture diverse professional perspectives across the two facilities, while clinical directors and GBV program managers were included based on their key institutional roles (19).

Data collection

Data collection involved two complementary techniques - individual semi-structured interviews and focus group discussions (FGDs) - allowing for methodological triangulation and a more comprehensive understanding of the phenomenon under investigation.

Twenty-four individual interviews were conducted, 20 with women victims of GBV, 2 with managers (city and provincial), and 2 with clinical directors, as well as 2 focus group discussions with health professionals (one per health facility, with up to 8 participants each), totaling 16 professionals. Individual interviews lasted 50 minutes, and FGDs lasted 120 minutes. All interviews and FGDs were conducted in Portuguese, the official and predominant language in the National Health Service, an English version is provided as Supplementary File 2.

Data collection instruments consisted of semi-structured guides, differentiated by participant group: a first section with sociodemographic data (age, residence, marital status, occupation, education) and a second thematic section focused on service functioning. Interviews with women explored experiences of access to and use of services, perceptions of reception, and barriers encountered; interviews with managers and clinical directors addressed policies, protocols, intersectoral coordination, resources, and monitoring mechanisms; focus groups collectively explored care practices, training, institutional barriers, and suggestions for improvement.

Individual interviews were conducted in private offices within the health facilities; FGDs took place at the Beira Operational Research Center (CIOB), in an environment that ensured confidentiality. No individuals other than the participants and the research team were present during the individual interviews or focus group discussions. During data collection visits, the research team checked whether signage indicating the GBV care pathway was displayed in the triage and waiting areas. Specific ethical risk mitigation measures were adopted, including the possibility of interrupting the interview at any time without prejudice to care, continuous assessment of signs of emotional distress, availability of immediate referral for psychosocial support when necessary, and strict anonymization of data. Individual interviews were conducted by FC and MC, both holding bachelor's degrees in Clinical Psychology, and JQ, who holds a bachelor's degree in Sociology. Focus group discussions were moderated by SLM, who holds a bachelor's degree in Nutrition, with FC, MC, and JQ assisting through note-taking. FC and SLM were female, while MC and JQ were male. All received prior specific training on interviewing in sensitive contexts, conducting focus groups, managing emotional reactions, and ethical principles of human subjects research. No member of the data collection team had a prior professional or personal relationship with the topic of GBV or with the participants that could have influenced data interpretation: women were referred by the clinical team of the health facilities, and not by the research team, while

professionals and managers were contacted for the first time as part of this study. At the beginning of each interview and focus group discussion, participants were informed about the purpose of the study, as well as the guarantees of confidentiality and anonymity, before informed consent was obtained. All interviews and FGDs were audio-recorded, with consent, and subsequently transcribed in full.

Data analysis

Interview and focus group transcripts were produced in Microsoft Word and organized in Microsoft Excel for coding. The data underwent thematic analysis, following the approach proposed by Braun and Clarke (20, 21) which involved: familiarization with the data; generation of initial codes; grouping of codes into themes and subthemes; review and refinement of themes; and interpretation of findings. The analysis sought to identify patterns of meaning related to women's experiences, the practices of professionals and managers, and organizational conditions influencing the primary health care response to GBV. Coding and interpretation were performed by the first and third authors (CTR and SLM). Both conducted repeated readings of the transcripts, identified initial codes, and jointly developed a coding framework. The framework was iteratively reviewed as new patterns of meaning emerged, with previously analyzed transcripts recoded when necessary. Disagreements in coding and interpretation were discussed between the two researchers until consensus was reached.

Data interpretation was guided by an intersectional feminist perspective (11, 12), considering how gender and other dimensions of social inequality may interact in producing vulnerabilities and in experiences of access to and use of services. The analysis also engaged with Heise's ecological model of violence (13), considering the interaction between individual, relational, community, and sociocultural factors. This approach allowed the findings to be interpreted beyond individual experiences, incorporating power relations, structural inequalities, and institutional conditions influencing the response to GBV.

Triangulation was performed across individual interviews and focus group discussions, incorporating accounts from health professionals and managers and the experiences of women receiving care. Triangulation allowed comparison of different perspectives and identification of convergences and divergences between reported practices and users' experiences. To preserve confidentiality, health professionals were identified by the abbreviation "HP," followed by their professional category; managers were identified as "Manager," followed by a number; and women participants were identified by pseudonyms. Any potentially identifying information was excluded from excerpts.

Although the analysis integrated perspectives from women receiving care, health professionals, and managers, the findings were organized thematically rather than by participant group. This approach was adopted to emphasize cross-cutting dimensions of service functioning and to avoid treating each participant group as an analytically isolated source. Within each theme, perspectives from different groups were compared where relevant to identify convergences and divergences. However, because

some themes were more strongly represented by particular participant groups, the distribution of perspectives across themes was not entirely symmetrical.

Thematic analysis resulted in four main themes, which synthesize the experiences, perceptions, and practices of participants: (1) knowledge, experiences, and practices of health professionals in the response to GBV; (2) availability and quality of services from the perspective of women receiving care; (3) organization of the institutional response, including policies, resources, and monitoring; and (4) barriers and facilitators to access and continuity of care.

Ethical considerations

The study protocol was approved by the National Bioethics Committee for Health of Mozambique (CNBS) IRB00002657, under number 45/CNBS/25, in accordance with the principles of the Declaration of Helsinki, and registered on the National Health Research Registration Platform (REGISA) under number 971F/1/12/2024. All participants signed the Informed Consent Form and were informed of the voluntary nature of participation and the possibility of refusing or withdrawing without any prejudice to the care received. The data collection team received prior training in research ethics, confidentiality, and informed consent.

RESULTS

The findings reflect the experiences of women who received care for GBV and the perspectives of health professionals and managers involved in the institutional response. They are organised according to the themes identified through the analysis.

Characteristics of participants

Among the women interviewed (n = 20), the majority were aged 25–34 years (55%), had secondary education (70%), lived in an urban area (60%), and were single (55%); the most frequent occupations were domestic worker (50%) and vendor/trader (30%) (Table 1).

Table 1
Sociodemographic characteristics of the interviewed women (N = 20)

Characteristic	Category	n (%)
Age group, years	18–24	5 (25.0)
	25–34	11 (55.0)
	35–49	4 (20.0)
Education level	Primary	5 (25.0)
	Secondary	14 (70.0)
	Higher education	1 (5.0)
Occupation	Domestic worker	10 (50.0)
	Vendor/trader	6 (30.0)
	Nurse	2 (10.0)
	Cargo handler	1 (5.0)
	Student	1 (5.0)
Place of residence	Urban	12 (60.0)
	Peri-urban	8 (40.0)
Marital status	Single	11 (55.0)
	Married	8 (40.0)
	Separated	1 (5.0)

Among the professionals (n = 20), females predominated (85%), with a relatively balanced age distribution between 30–39 years (30%) and ≥ 40 years (35%); half had secondary-level education and half higher education. Nurses (35%) and general medical technicians (20%) were the most represented professional groups; 70% lived in urban areas and 65% had between 1 and 2 years of experience in the GBV program (Table 2).

Table 2
Sociodemographic and professional characteristics of healthcare professionals (N = 20)

Characteristic	Category	n (%)
Sex	Female	17 (85.0)
	Male	3 (15.0)
Age group, years	20–29	7 (35.0)
	30–39	6 (30.0)
	40–49	7 (35.0)
Education level	Secondary	10 (50.0)
	Higher education	10 (50.0)
Profession	Nurses	7 (35.0)
	General medical technicians	4 (20.0)
	General nurses	3 (15.0)
	Clinical psychologists	3 (15.0)
	Physicians	3 (15.0)
Place of residence	Urban	14 (70.0)
	Peri-urban	6 (30.0)
Time working in the GBV programme	1–2 years	13 (65.0)
	≥ 3 years	7 (35.0)

Knowledge, experiences, and practices of health professionals

Health professionals consistently recognized the role of the health facility as the first space of emotional safety after violence, often described in affective rather than merely technical terms:

"When the first reception takes place (…) they are welcomed and have received good care" (Psychologist).

This reception included, in some cases, management of immediate risk of self-harm, depending primarily on the psychologist's occasional availability at the facility. Regarding the guidelines underlying practice, professionals reported a combination of clinical algorithms, informally known multisectoral pathways, and active listening, but without evidence of institutional systematization:

"*We had a little training to support how to receive and how to treat this patient (…) we also have some algorithms"* (Psychologist).

GBV training was described as irregular, fragmented, and predominantly transmitted among peers, without a formal structure, defined workload, or learning assessment:

"We did not have any training on gender violence (…) it was really training from colleague to colleague" (Nurse).

The professionals themselves identified content gaps, highlighting psychological violence as a poorly explored and highly underestimated dimension in training, as well as the absence of formal protection strategies for women returning to the home where the perpetrator resides.

Regarding care organization, reports described a functional flow from case identification, clinical screening, medication (including prophylaxis for sexually transmitted infections and HIV in cases of sexual violence), and registration, but strongly dependent on improvisation of physical space. No visible signage indicating the GBV care pathway was displayed in the triage and waiting areas of the two health facilities. Reception strategies prioritized privacy and confidentiality, although they depended more on individual initiative than on structural guarantees:

"Ensuring the principle of confidentiality (…) makes her more comfortable (…) she will trust (…) and encourage other victims" (Nurse).

The existence of protocols was widely recognized, but their use varied among professionals and facilities, in some cases as a reference consulted on one's own initiative, and in others as a standard followed "step by step," although in practice conditioned by infrastructure and human resource limitations.

Availability and quality of services from the perspective of women receiving care

For the women interviewed, the first contact with the health service repeatedly represented a positive break with a previous context of silence, fear, and devaluation:

"I came here, they attended to me, listened to my story, helped me with some advice" (Paula, 32 years).

The challenges reported were predominantly before or outside contact with the health facility, aggravated physical suffering (including pregnancy), fear of judgment, and family isolation as barriers to seeking help early:

"I was afraid (…) I took a long time to come, but with encouragement from my neighbor it was easy for me to come here" (Ana Maria, 36 years).

Limitations in night-time care were identified as a concrete weakness in continuity of care:

“When I got there it was 10 p.m. and they recommended that I come tomorrow morning (…) so let's say the challenge was the hours” (Cátia, 25 years).

The perception of the reception received was largely positive, associated with non-judgmental listening, respect for the victim's psychological timing, and emotional validation, even when the woman initially did not disclose the violence:

“Even after I had lied that it was not violence (…) the professionals talked to me so that I could feel at ease” (Maria, 25 years).

Regarding perceived problem-solving capacity, women reported both physical and emotional improvement, including one report of interruption of suicidal ideation attributed to verbal support received, without, however, evidence of formal referral to specialized mental health services:

“When I was thinking those things, I even thought that I could kill myself (…) but with what they told me (…) those thoughts ended up passing” (Dirce, 20 years).

Perceived social support was generally limited to the health facility, without consistent reference to external referrals, shelters, or additional protection measures after discharge.

Institutional response: policies, resources, and monitoring (managers' perspective)

Managers described national policies and Ministry of Health protocols as clear guides for the institutional response, including defined critical time frames (72 hours):

“The victim comes within 72 hours, finds the entire protocol that the ministry has planned” (Manager 1).

Despite the formal availability of these mechanisms, their effective implementation was described as uneven and dependent on local organizational capacity, team stability, and individual professional practices. This revealed a recurring gap between the formal organization of the GBV response and its implementation in routine practice. No direct regulatory barriers were identified, but rather indirect barriers related to the population's lack of knowledge about services and social stigma.

Regarding resources and organizational support, reports revealed a dual pattern: clinical supplies (sexual violence kits, HIV and syphilis tests, post-exposure prophylaxis) were described as stable and without stockouts, contrasting with the absence of social workers and the workload of the GBV focal point:

“Unfortunately, we do not have a social worker (…) we do not have this resource here at the health facility” (Manager 2).

Professional training was based on in-service training, ad hoc supervision, and informal induction, without a standardized curriculum or refresher schedule. Intersectoral coordination (health, police, social

action, justice) was recognized as a structuring principle, but there was no evidence of regular joint meetings or formal mechanisms for continuous communication between sectors.

Case registration was described as systematic and integrated into SISMA (Health Information System), although dependent on a single focal point and manual processes before digitization. Quarterly monitoring formally existed, but revealed heterogeneous ownership among managers, with some describing indicators accurately, while another admitted difficulty identifying them:

"It is a very difficult question for me (…) I don't know if it is difficulty, but I cannot answer it to this day" (Manager 1).

Use of monitoring results focused on reactive correction of specific gaps, without evidence of structured continuous improvement cycles with defined targets and deadlines.

Barriers and facilitators to access and continuity of care

Barriers to access and continuity of care were organized analytically across three interconnected levels: pre-institutional, intra-institutional, and interinstitutional:

"Many are afraid of losing their homes (…) because the husband is the provider" (Psychologist).

At the interinstitutional level, referral from health services to other sectors emerged as an important point of vulnerability in the continuity of care. Although intersectoral referral was formally recognized as part of the response to GBV, women's accounts indicated that the transition to police and other services could involve administrative barriers, questioning, blaming, or other interactions perceived as revictimizing. One woman reported:

"The police were saying that you have to have a referral (…) they criticized me as if I were to blame" (Berta, 40 years).

These experiences suggest that the existence of a referral pathway did not necessarily ensure continuity of care or protection. Rather, the quality of the interaction at the receiving service could determine whether referral functioned as a bridge to additional support or became a point of discontinuity and potential revictimization.

At the internal institutional level, lack of privacy due to a shortage of offices dedicated to women's care was identified as the most recurrent structural limitation, compromising confidentiality and the therapeutic relationship. A dissonance was also noted between professionals who recognized these limitations and others who minimized them, stating that there were no barriers.

As facilitating factors, professionals highlighted occasional technical support from district and provincial management (monitoring, supervision, on-the-job training) and the availability of clinical kits and specific GBV offices in some facilities. However, this support remained concentrated in occasional and reactive actions, without a structured plan for continuous training or formal psychosocial support for

the teams themselves. Confidentiality was identified as the main perceived good practice, although professionals acknowledged uncertainty regarding the standardization of these practices across health facilities:

"We do not know whether what we do is good practice for other facilities (…) but for us they are good practices" (Nurse).

These findings are consistent with the intersectional and ecological perspectives adopted in this study. Women's access to and continuity of care were shaped not by gender alone, but by the interaction of economic dependence, family relationships, social stigma, and institutional conditions. From an ecological perspective, these factors operated across interconnected levels, from individual and relational circumstances to health-service organization and intersectoral structures. This helps explain why the availability of health services alone did not guarantee timely access, continuity, or protection.

DISCUSSION

The findings reveal a central tension in the primary health care (PHC) response to gender-based violence (GBV) in Beira City. While women frequently described the initial encounter with health services as supportive, respectful, and emotionally reassuring, the continuity and comprehensiveness of care appeared to rely substantially on individual professional commitment rather than on consistently institutionalized mechanisms. Training, psychosocial support, referral pathways, intersectoral coordination, and monitoring were unevenly structured, suggesting a gap between the existence of policies and protocols and their translation into routine practice. This gap is particularly important from an implementation perspective because it indicates that the main challenge may not be the absence of formal guidance, but the organizational capacity to translate existing standards into consistent practice across professionals, shifts, and facilities. Similar policy-to-practice gaps have been documented in Mozambique and in other settings, where the existence of formal policies and service structures has not necessarily resulted in standardized implementation at facility level (6, 22, 23).

This distinction between the relational quality of care and its institutional sustainability is important. Professionals recognized listening, confidentiality, and supportive care as essential components of the response to GBV, and these practices were also positively valued by women. However, they were often sustained through individual initiative in a context of irregular training, informal peer-to-peer learning, limited supervision, and uneven use of protocols. Previous studies have similarly shown that isolated training initiatives, without opportunities for supervised practice and periodic reinforcement, have limited capacity to produce sustained changes in professional practice (24–28). The findings from Beira therefore suggest that professional commitment can partially compensate for organizational weaknesses but cannot substitute for institutional mechanisms capable of ensuring consistent standards of care across professionals, shifts, and health facilities. This distinction also suggests that improvements based predominantly on individual professional motivation may be difficult to sustain over

time, particularly in settings characterized by staff turnover, competing demands, and limited supervisory capacity.

The limited availability of psychologists and social workers further illustrates this tension. Rather than indicating only a shortage of specialized professionals, the findings raise questions about how responsibility for responding to the psychosocial dimensions of GBV is distributed within PHC teams. First-line support should not depend exclusively on specialized professionals; appropriately trained PHC workers can provide supportive listening, assess immediate needs, and facilitate access to additional care when required. In this context, the dependence on the occasional availability of psychologists may reflect not only workforce constraints but also insufficient incorporation of GBV response competencies into routine team practice. Similar challenges have been reported in resource-constrained settings, particularly where clear operational procedures and supportive supervision are lacking (29, 30). The implication is therefore broader than increasing the number of specialized professionals: psychosocial competencies need to be incorporated into routine PHC practice, while clear mechanisms should define when and how specialized services are engaged.

For many of the women interviewed, contact with the health service contrasted with previous experiences of fear, silence, isolation, or devaluation. Listening without judgment, respect for the woman's pace of disclosure, and confidentiality were central to positive experiences of care. These findings reinforce the potential of PHC as an important point of support for women experiencing violence (31, 32). At the same time, they reveal the limits of equating a positive initial encounter with a comprehensive response. Restricted nighttime care, inconsistent access to psychosocial support, and limited evidence of structured referral beyond the health facility indicate that the transition from first-line support to continuity of care remains a critical point of vulnerability. This was particularly evident in the account of suicidal thoughts, in which emotional support at the facility was perceived as beneficial, but no structured pathway to specialized mental health care was identified. Such findings suggest that the capacity to receive and support women at the first encounter may be stronger than the institutional capacity to sustain care over time. Thus, the quality of the first encounter should not be considered a sufficient indicator of service quality; rather, the ability to maintain care across subsequent needs and points of referral is an important component of a comprehensive GBV response (22, 23).

A second tension concerns the relationship between the formal organization of the response and its implementation in everyday practice. Managers described a relatively well-defined normative framework, including Ministry of Health protocols, specific clinical procedures, and the critical 72-hour period for responding to sexual violence. However, professionals reported variable familiarity with these instruments and uneven application across settings. This discrepancy suggests that the existence of protocols does not necessarily translate into standardized practice. Earlier research in Mozambique identified similar gaps between legislative and policy commitments and their operationalization in services (6). The present findings indicate that this policy-to-practice gap remains relevant in the PHC settings examined in Beira and appears to be shaped by workforce stability, supervision, infrastructure, and local organizational capacity. From a health-system perspective, this pattern can be understood as a

problem of implementation readiness: protocols require organizational conditions, resources, leadership, and monitoring mechanisms that enable their routine use rather than their merely formal availability (22).

Recent investments in provider training and digital case-management systems in Mozambique indicate increasing recognition of some of these implementation challenges at policy level (33). Evidence from Zambézia Province also suggests that structured training combined with active follow-up mechanisms can improve adherence to post-exposure prophylaxis and HIV retesting among GBV survivors (34). Considered alongside the findings from Beira, these experiences suggest that strengthening the response requires more than disseminating guidelines: it requires organizational arrangements that support their routine use, monitor their implementation, and maintain professional competencies over time. The Mozambican experience therefore suggests that implementation support should accompany policy dissemination, with attention to supervision, feedback, accountability, and the organizational conditions necessary for sustained adherence to recommended practices (33–35).

The findings also point to an important imbalance in the comprehensiveness of the response. Services appeared to be more clearly organized around forms and consequences of violence that can be translated into immediate clinical procedures, particularly sexual violence requiring HIV and sexually transmitted infection prophylaxis, testing, medication, and time-sensitive interventions. In contrast, psychological violence, social vulnerability, economic dependence, and longer-term protection needs were less consistently incorporated into routine care. Professionals themselves described psychological violence as insufficiently addressed in training, while women rarely reported structured social or protection support beyond the health facility.

This pattern suggests a possible biomedical orientation in the institutional response to GBV, in which needs that correspond to established clinical procedures are more readily recognized and managed than those requiring sustained psychosocial, social, and intersectoral responses. This interpretation should not be taken to mean that clinical management is inappropriate or insufficient in itself, but rather that the organization of care may privilege needs that can be addressed through standardized biomedical procedures while providing less consistent mechanisms for needs requiring longer-term and multisectoral engagement (23, 35–37). From an intersectional feminist perspective, this distinction is particularly relevant because violence cannot be separated from the gendered social and economic conditions that shape women's possibilities of seeking help, remaining in care, and acting on the support received. An effective response therefore requires not only management of the immediate physical consequences of violence but also recognition of the psychological, economic, relational, and protection dimensions that influence women's trajectories.

Economic dependence illustrates this relationship particularly clearly. Fear of losing housing or financial support from a male partner was described as constraining women's ability to seek or sustain help. Such barriers should not be understood simply as individual reluctance to access services. Rather, they reflect how gendered power relations interact with material conditions and family relationships to restrict women's available choices. Evidence from Sub-Saharan Africa similarly demonstrates that

socioeconomic position, place of residence, education, and other dimensions of inequality shape both vulnerability to violence and possibilities of accessing support (38). Although the present study does not permit direct comparison across these social positions, the accounts from Beira show that service availability alone does not determine access: women's capacity to use services is embedded in broader relations of economic dependence, stigma, family influence, and gender inequality. In this sense, access should be understood as relational and context-dependent rather than as a simple consequence of geographical or formal service availability.

Intersectoral referral emerged as a critical transition point in women's trajectories through the GBV response system, rather than merely an organizational barrier. Although collaboration between health, police, social action, and justice services was formally recognized, referral processes were not consistently supported by stable communication and coordination mechanisms. Women's accounts of being questioned or blamed by police services suggest that referral may become a point of discontinuity and potential revictimization when principles of respectful treatment, confidentiality, safety, and non-revictimization are not maintained across sectors. This means that referral should be understood as part of the care experience itself, rather than as an administrative step occurring after clinical care. The quality of interaction at each point in the service network may determine whether referral extends protection or instead reproduces experiences of disbelief, blame, or insecurity. Strengthening referral therefore requires not only formal pathways, but also clearly defined responsibilities, effective communication, and shared standards of care across institutions. Although multisectoral collaboration was recognized by managers as a core principle of the national response, coordination between health, police, social protection, and justice appeared largely reactive and dependent on interpersonal contacts rather than stable institutional arrangements. Regular joint meetings and shared communication mechanisms were not identified. This finding is consistent with previous evidence that intersectoral coordination remains one of the most difficult dimensions of GBV service organization (7, 35–37, 39).

The intersectoral dimension also reinforces the ecological interpretation adopted in this study. Women's trajectories through GBV services were shaped by interconnected factors operating at individual and interpersonal levels, such as fear, economic dependence, and family influence, as well as by organizational conditions within health facilities and relationships between institutions. Weaknesses at one level may therefore constrain the effectiveness of responses at another level, helping explain why supportive care at the facility may not necessarily translate into continuity or protection beyond it (13). From this perspective, strengthening the response requires attention not only to individual provider competencies but also to the relationships and structures connecting health services with police, social protection, justice, and community systems.

These findings also help explain an apparent contradiction in participants' assessments of service quality. Women frequently valued the care received, whereas professionals and managers identified substantial organizational limitations. Positive experiences of interpersonal care can coexist with weaknesses in the broader system. Indeed, the capacity of individual professionals to provide empathetic and respectful care may partly conceal institutional fragilities by allowing services to

function despite inadequate infrastructure, limited specialized staff, inconsistent training, and weak referral arrangements. Reliance on professional commitment is therefore simultaneously a strength and a vulnerability: it enables care under constrained conditions but produces variability because quality depends on who is available, at what time, and under what organizational circumstances. The convergence of women's positive assessments of interpersonal care with professionals' and managers' recognition of organizational limitations should therefore not be interpreted as contradictory evidence. Rather, these perspectives illuminate different dimensions of the same service system: women primarily described the experience of care, whereas professionals and managers more directly described the conditions under which that care was delivered.

Taken together, the findings suggest that the central challenge for strengthening the PHC response to GBV in Beira is not primarily the absence of a normative framework, but its uneven institutionalization in everyday practice. Moving from a professional-dependent response toward a sustainable, woman-centered model requires mechanisms that make supportive care, confidentiality, psychosocial assessment, referral, and intersectoral coordination routine features of the service rather than practices dependent on individual initiative. Structured and recurrent training, supportive supervision, clearly defined referral responsibilities, strengthened psychosocial resources, regular intersectoral communication, and robust monitoring systems may contribute to this transition. Monitoring is particularly important because it can transform implementation gaps into actionable information for continuous quality improvement. Quality-assurance approaches for GBV services emphasize the value of systematic assessment, feedback, and monitoring in identifying weaknesses and supporting service improvement (37, 40).

More fundamentally, however, strengthening the response requires broadening its focus beyond the immediate biomedical consequences of violence toward the psychological, social, economic, and protection needs that shape women's possibilities of achieving safety and continuity of care. The findings therefore support a shift from a model in which good care may depend on committed individuals toward one in which good care is institutionally enabled, supervised, monitored, and consistently reproduced. This does not diminish the importance of professional commitment; rather, it suggests that health-system organization should make good professional practice easier to perform and less dependent on individual initiative.

Study limitations

This study has limitations that should be considered when interpreting the results. First, the qualitative nature of the research prioritizes depth and contextual understanding but does not allow statistical generalization of the findings. Second, data collection occurred exclusively in two urban health facilities, which may not reflect the diversity of conditions existing in other facilities in Beira City, particularly in peri-urban and rural settings, where resource availability tends to be even more limited. Third, the sensitivity of the topic may have induced underreporting by the women interviewed and social desirability bias among professionals, who tended to minimize institutional barriers. Finally, the absence

of triangulation with clinical records and operational documents limits independent validation of the flows and practices described in the interviews, which were predominantly based on self-reported accounts.

The thematic organization also resulted in an uneven representation of participant perspectives across themes, with some themes drawing more heavily on the accounts of women, health professionals, or managers. Although the analysis sought to interpret the findings across participant groups, this structure may have limited the systematic presentation of convergences and divergences between perspectives on the same dimensions of care. Future studies could organize cross-cutting themes explicitly around the perspectives of all participant groups to facilitate direct comparison while preserving the contextual depth of qualitative analysis.

CONCLUSIONS

This study showed that primary health care services for women victims of GBV in Beira City provide reception, clinical care, and initial support, but the functioning of the response remains strongly dependent on the individual commitment of professionals and on still-fragile institutional structures. Although protocols, care pathways, and resources for care exist, their implementation is variable, conditioned by limitations in specialized human resources, infrastructure, and team turnover.

Barriers to access and continuity of care are multidimensional, involving individual and family factors, difficulties in interinstitutional coordination, and internal service limitations, such as lack of privacy, shortage of specialized professionals, and irregular training. These findings reinforce that a comprehensive response to GBV requires greater institutionalization of coordination among health, social action, justice, and police.

Strengthening services should prioritize effective implementation of existing mechanisms, including regular supervision, continuous training, formalized intersectoral coordination, and registration and monitoring systems that are less dependent on specific individuals. These results may contribute to improving the response to GBV in primary care in Mozambique and guide future evaluations of the implementation and sustainability of these interventions in different urban and peri-urban contexts.

Abbreviations

GBV — Gender-Based Violence

PHC — Primary Health Care

WHO — World Health Organization
HIV — Human Immunodeficiency Virus
STI — Sexually Transmitted Infection(s)

SISMA — Health Information System for Monitoring and Evaluation
FGD — Focus Group Discussion
COREQ — Consolidated Criteria for Reporting Qualitative Research
CIOB — Beira Operational Research Center
CNBS — National Bioethics Committee for Health of Mozambique
REGISA — National Health Research Registration Platform
IRB — Institutional Review Board
HP — Health Professional
SBM-R® — Standards-Based Management and Recognition

Declarations

Ethics approval and consent to participate

The study was conducted in compliance with the Declaration of Helsinki. The study was approved by the National Bioethics Committee for Health of Mozambique (CNBS) IRB, ID: 00002657. Informed consent was obtained from all individual participants included in the study.

Consent for publication

Not applicable.

Availability of data and materials

The datasets generated and/or analyzed during the current study are available from the corresponding author upon reasonable request.

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Competing interests

The authors declare no competing interests.

Authors' contributions

CTR conceived and designed the study, supervision of data collection, conducted the data analysis and interpretation, manuscript drafting, and critical revision of the manuscript. PFS contributed to the study design, literature review, methodological review, interpretation of findings, manuscript drafting, and critically revised the manuscript. SLM contributed to the supervision of data collection, conducted the data coding and interpretation and critically revised the manuscript. JQA contributed to the

conceptualization, study design, literature review, methodological review, interpretation of findings, manuscript drafting, and critical revision of the manuscript. All authors critically reviewed the manuscript for important intellectual content and approved the final version for submission.

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