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READINESS ASSESSMENT FOR COSTING POST-GENDER-BASED VIOLENCE CARE SERVICES IN MOZAMBIQUE

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Readiness Assessment for Costing Post-Gender-Based Violence Care Services in Mozambique

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Acknowledgments

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Abbreviations

CDC	U.S. Centers for Disease Control and Prevention
GBV	gender-based violence
HIV	human immunodeficiency virus
HPP	Health Policy Project
MOH	Ministry of Health
NGO	nongovernmental organization
PEP	post-exposure prophylaxis
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
USAID	U.S. Agency for International Development

Executive Summary

The USAID-funded Health Policy Project conducted a readiness assessment in Mozambique to see if would be possible and useful to conduct a costing study of post-gender-based violence (GBV) care services. Broadly, the readiness assessment was designed to assess if there is a shared understanding about GBV and the need to scale up services. On a narrower level, the readiness assessment looked specifically at whether the data and information needed to apply the Health Policy Project's GBV cost calculator are available.[1] The calculator was initially developed and tested using the GBV management guidelines for the Ministry of Health and Social Welfare for the United Republic of Tanzania, which has invested heavily in standardized care protocols, training, and data collection.

The Mozambique assessment involved several steps:

- Assess stakeholders' understanding of GBV definitions, service, and data availability.
- Review national policies, protocols, guidelines, and standards for post-GBV care services.
- Review GBV service delivery data to assess their completeness and quality.
- Outline the steps required to conduct a costing study of GBV clinical services and identify opportunities for using the results for policy and program decision making.

The assessment highlights several important challenges and opportunities to conducting a GBV costing study in Mozambique. The challenges include a lack of agreement about what constitutes GBV, a lack of protocols on what constitutes a GBV-facility, and a deficiency in national data collection protocols. The opportunities are reflected in a policy environment that offers a range of multisectoral and health sector policy documents, and in the commitment by donors and the government of Mozambique to expand high-quality and accessible support for GBV survivors.

The GBV cost calculator is not equipped to deal with all the existing challenges; however, if the calculator was applied to a narrow set of issues, such as was done in Tanzania, the resulting data would help to inform sound programming decisions. Therefore, based on the available data, the authors of this readiness assessment recommend that a study be conducted to assess the costs per client-visit of providing care related to sexual violence. The study could draw a sample from partner facilities funded by USAID and the U.S. Centers for Disease Control and Prevention (CDC) to capture costs disaggregated by region and facility levels. Such a study would be useful to the Ministry of Health to help estimate the funds needed to scale up GBV services, and to donors as a baseline for how much key, post-GBV care services cost per client visit. Additionally, this type of costing study could support advocates in the nongovernmental (NGO), donor, and government circles to make informed, evidence-based arguments on the need for additional government funding for post-GBV care services.

Aside from the need to conduct a more in-depth costing study, the readiness assessment also highlighted several issues that are important to consider, not only in the context of a GBV costing study, but in general to support expanded services and monitoring and evaluation. These include the following:

- Coordinate among all the parties that provide support to GBV survivors to ensure consistency across definitions and protocols and to offer training to providers in a timely, cost effective way.
- Improve the way GBV data are collected by including GBV data in the Mozambique National Health Information System.
- Harmonize the list of facilities that provide post-GBV care services by establishing standard definitions of what services are to be provided at different levels in the health system and consolidating information from the Ministry of Health- and donor-supported activities.

[1] The GBV program cost calculator is available at http://www.healthpolicyproject.com/index.cfm?id=publications&get=pubID&pubID=865.

1. Introduction

The USAID-funded Health Policy Project (HPP) conducted a readiness assessment in Mozambique to see if would be possible and useful to conduct a costing study of post-gender-based violence (GBV) care services. Broadly, the readiness assessment was designed to examine if there was a shared understanding about the definitions of GBV and GBV service protocols, and what cost components would be needed in a comprehensive costing study.

On a narrower level, the readiness assessment looked specifically at whether the data and information needed to apply HPP's GBV cost calculator were available. The calculator was initially developed and tested using the GBV management guidelines for the Ministry of Health and Social Welfare for the United Republic of Tanzania. Those guidelines cover a comprehensive package that includes seven clinical services: examination/screening, forensic exam, counseling, treatment for injuries, tests administered (pregnancy, sexually transmitted infections, and HIV), and referrals given. To estimate the per unit (or per client visit) cost of these services, three types of data were collected in Tanzania:

1. Service delivery statistics on the number of GBV client encounters. To accurately reflect the extent of services provided at a facility, these data can be in the form of a register, monthly summaries, or an electronic form.
2. Facility resources used to deliver post-GBV care services. These include information from the facility on the number and cadre of staff who provide GBV clinical services (physicians, nurses, clinical officers, social welfare officers, etc.); the amount of time these staff spend in delivering each GBV service component; and the equipment, medical supplies, and drugs used for GBV clients (i.e., type and quantity).
3. Financial data. These include information on the salaries of staff providing post-GBV care services and staff supporting and/or managing GBV service delivery (clinic managers, accountants, clerks, etc.); the annual cost of facility operations (utilities, fuel, maintenance of buildings and vehicles, cost of renting clinical space); value of equipment, buildings, and vehicles used for GBV clinical services; and the cost of drugs and medical supplies used for GBV service delivery.

Clearly, the GBV cost calculator requires a significant amount of data to produce accurate results. HPP wanted to assess whether the calculator could be fruitfully applied in other settings, such as Mozambique. Mozambique, along with Tanzania and The Democratic Republic of Congo, receive specific support from PEPFAR to develop multisectoral initiatives to strengthen prevention and responses, especially in the HIV context. The Mozambique assessment involved several steps:

1. Assess stakeholders' understanding of GBV definitions, services, and data availability to support a costing study.
2. Review national policies, protocols, guidelines, and standards for delivery of post-GBV care services within healthcare settings.
3. Review GBV service delivery data to assess their completeness and quality.
4. Outline the steps required to conduct a costing study of GBV clinical services using HPP's GBV cost calculator, and identifying opportunities for using the costing study data for policy and program decision making.

The ultimate purpose of this assessment, beyond supporting the PEPFAR initiative in Mozambique, was to determine what information is needed in order to apply the GBV cost calculator, using Mozambique as a test case, to better engage with stakeholders around the need for GVB costing data to inform policy decision making.

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[1] The GBV program cost calculator is available at http://www.healthpolicyproject.com/index.cfm?id=publications&get=pubID&pubID=865.

[2] A report on the use of the GBV cost calculator in Tanzania will soon be available at www.healthpolicyproject.com.

2. Methodology

The assessment used the following approaches to gather data:

- A review of national policies, protocols, and guidelines for delivery of post-GBV care services. Most of these documents were not available online; copies were provided by key informants from the Ministry of Women and Social Action (renamed in 2015 as the Ministry of Gender, Children, and Social Action) and the Ministry of Health (MOH). All documents are only available in Portuguese.
- Eleven key informant interviews with GBV clinical partners from a list provided by USAID; almost all PEPFAR implementing partners for GBV clinical services; and the GBV focal points at MOH (see Annex A). The objective of the interviews, conducted in April 2015, was to learn about the types of data (and their quality) collected at the facility level (such as recurrent costs, capital costs, and service statistics), based on the checklist of cost data for health facilities elaborated by HPP (see Annex B). Additionally, the interviews solicited the opinions of key informants about the utility of a GBV costing study in Mozambique and its potential use to influence decisionmakers.

3. Findings from Policy Analysis

The policy analysis portion of the readiness assessment found that there was quite a strong policy environment to address GBV in Mozambique, both in terms of multisectoral support and MOH guidelines. Nonetheless, at the time of the assessment, several key documents were under revision and the MOH and the cooperating partners were still developing a GBV strategy.

The Ministry of Gender, Children, and Social Action is charged with coordinating the multisectoral approach. At the time of this assessment, the principal, national GBV policy documents guiding the ministry are as follows:

- *The National Plan to Prevent and Combat Violence against Women, 2008-2012* is a five-year implementation plan related to the government's gender policy and the international conventions ratified by Mozambique such as the Convention on Eliminating all Forms of Discrimination Against Women, the African Charter on Human Rights, and Women's Rights in Africa.
- *The Law 29/2009 on Domestic Violence against Women, 2009* defines seven types of domestic violence: physical violence, psychological violence, moral violence, non-consensual sexual intercourse (rape), sexual intercourse with transmission of disease, violence against property, and social violence. It is provides that examinations and medical care for the victims of domestic violence be free of charge.
- *The National Plan for the Advancement of Women, 2010–2014* does not address post-GBV care services in the healthcare setting directly, but it does address the following topics related to health and GBV in its strategic actions: (i) review, develop, and adapt policies related to access to healthcare; (ii) involve men in the promotion of sexual and reproductive health; (iii) reduce the risk of HIV infection in women and vertical transmission of HIV from mother to child; (iv) promote research, studies, statistics, and collection of information on the causes and consequences of violence against women and girls and promote dissemination activities.
- *The Multisectoral Mechanism for Integrated Assistance to Women Victims of Violence, 2012*, which was under revision at the time of the assessment, identifies key actors, priority areas, assistance protocols, and how ministries are meant to coordinate in order to provide assistance to GBV survivors. It covers the ministries of health; gender, children and social action; interior; and justice. Integrated actions will include:
    - Improving quality of assistance, from the definition of basic to better coordination among various entities
    - Elaborating standard protocols for all professionals and institutions involved in supporting survivors
    - Institutionalizing data collection and analysis, based on standardized forms and in accordance with the defined indicators

There are also a number of plans and strategies that guide how the MOH should provide support for GBV survivors:

- *Strategy of Inclusion of Gender Equality in the Health Sector, 2009* include strategies related to GBV, most notably to (i) create an enabling environment in clinical settings to treat survivors with empathy and confidentiality; (ii) train the workers to understand and follow regulations; (iii) register cases of violence properly so that the information can be used in the legal system; (iv) include violence cases in the Health Information System, using sex disaggregated data; (v) encourage and support women who have been raped to report violators: (vi) create local services for psychological counseling and support and refer survivors to organizations that provide counseling, legal, and social assistance. The indicators of successful implementation of the GBV components of the strategy include the following: the extent and nature of inter-ministerial coordination; proportion of women victims of GBV that are treated in the health facilities per type (physical or sexual violence); proportion of women that are treated by a psychologist; and proportion of violence cases referred to the court, police, or NGOs.

- *Ministerial Order of Ministry of Health, 2011* provides key guidance about how post-GBV care services should be provided in healthcare settings. The five priority actions include (i) improve the quality of service; (ii) provide capacity development for providers; (iii) improve the referral system; (iv) expand legal services; and (v) conduct advocacy about the GBV survivors' needs.
- *Health Ministry Strategic Plan for Prevention and Control of Trauma and Violence, 2011-2015* is a sectoral document that addresses the delivery of post-GBV care services in two of its objectives: Objective 3: Improving coverage, quality of preventive services, and healthcare for trauma and violence; and Objective 4: Strengthening and expanding the surveillance system, research, and monitoring and evaluation for trauma and violence.
- *The Guidelines for Integrated Assistance to GBV Victims, 2011* is a sectoral document, developed with technical assistance from U.S. Government partners, which addresses how to provide high-quality, post-GBV care services in healthcare settings. Its goal is to offer guidance in the organization and management of health services so that GBV survivors receive assistance on time and in a supportive, yet cost-effective way. It aims to ensure the standardization of assistance for physical and psychological trauma and the legal aspects of both. A companion document, the Manual for the Integrated Assistance to Victims of Violence, 2012, is comprised of eight modules to train staff on how to implement the Guidelines for Integrated Assistance to GBV Victims. Module five specifies the roles of health units and professionals staff in providing the integrated service package, including the protocols that are part of the 2011 ministerial order and the 2012 multisectoral mechanism mentioned above.

4. Findings from GBV Service Delivery Review

Key informants were asked to review HPP's checklist of service statistics and cost data for health facility-based, post-GBV care services developed for the Tanzania application of the GBV cost calculator to see if the necessary data to apply the tool would be available in Mozambique (see Annex B).

4.1 Service Statistics

List of GBV service facilities

To understand how accessible post-GBV care services are to clients and to map out the clinics from which one could draw a sample to apply the cost calculator, it is important to have an accurate list of facilities. According to informants there is such a list in Mozambique, but it is not up to date, nor is there agreement on what criteria defines a health unit that provides post-GBV care services. The Ministry of Health has a package of six post-GBV services: post-exposure prophylaxis (PEP), HIV and other STI testing and treatment, emergency contraception, psychosocial service, and referrals to legal aid, police, etc. Depending on their level, all clinics are not expected to provide all services, however, according to informants who work on CDC-funded projects, a facility must be able to provide at least (PEP, emergency contraception, HIV and STI screening and testing, and socio psychological support) in order to be count as a GBV provider. Others viewed provision of only one element as sufficient. According to the MOH there are 221 health facilities that provide post-GBV care services. This represents only 15 percent of the total health facilities in the country. While there are plans to expand the number of health facilities that provide post-GBV care services, the ultimate percentage is still under discussion. Additionally there are a total of 12 centers for integrated services supported by Ministry of Gender, Children, and Social Action, and run by municipal governments or NGOs. It will be challenging to develop a costing plan for expanding post-GBV care services without a standard definition of what each kind of facility should provide and an accurate list of facilities.

Volume of services

Mozambique lacks a national management information system for GBV-related data, but some relevant information is available. Under the current GBV data collection system, data are collected monthly by the MOH provincial gender focal point, which then sends data to the central level on a quarterly basis. Based on the interviews, each donor-funded project has relevant data for the health units that they support. Unfortunately, data collected by the partners sometimes vary from the data collected by MOH at facility level. The interviewees mentioned that project staffs invest more in data quality by triangulating the data from multiple sources. In most facilities, the MOH GBV-data are initially entered on paper-based logs, and errors may be created during data entry into electronic databases. To make matters more complicated, not all the facility units use the same kind of paper registry sheets. Some projects have adapted the standard registry sheet (the notification form) for their own needs; some health units are piloting a new registry form provided by MOH; and some provinces only use the registry sheet for sexual violence (which is the old one provided by MOH).

Data limitations

Generally, informants suggested that it is easier to collect data about the victims of sexual violence than other forms of GBV since sexual violence is included in the ministry registry form. Several key informants mentioned that CDC-supported projects collect quarterly data on the number of patients who received post-GBV care services and an indicator on distribution of PEP. These two indicators are cross-checked to give a more complete accounting of sexual violence cases. The data are not usually presented by sex and age. However, informants thought the MOH would probably have such disaggregated data. The informants also mentioned that the MOH approved a new GBV registry form, but has yet to disseminate it to all health facilities. The new form may introduce new challenges; those health units that are using it may be over-reporting incidence of GBV since the form is titled "Violence," not "Gender-based Violence" and health

facilities may be registering violence cases that are not GBV-specific. Over-reporting might also result from multiple registry entries for a case in which a person receives treatment in different facilities related to same incident.

4.2 Recurrent Costs

Personnel

The cost calculator uses data on both time spent by health facility staff on post-GBV care services and average staff salaries by level. There are no estimates of the amount of time clinic staff spend on post-GBV care services; however, almost all key informants thought very little time was devoted to it. The MOH does have data about the average salary for each category of clinical, support, and supervisory staff.

Since data on the time spent providing GBV-relate services are not readily available, the information would need to be collected from facilities that offer such services and have trained staff. One challenge will be that, while the ministry does maintain a database of facility staff, it does not itemize those who have been trained on GBV, either by the ministry or partners. According to key ministry and partner organization informants, this is because, in theory, everybody should be able to provide such care. However, post-GBV care services do require specialized training, which all facility staff have not yet received, even though an increasing number are receiving GBV-related training since it is now integrated into the Tecnico de Medicina. The package for maternal and child health nurses is on treating victims of sexual violence, not GBV.

Any application of the cost calculator would have to start with a assessment of which clinics have trained staff and are providing services in order to draw a sample with rich enough data.

Drugs and Supplies

According to the MOH and partners, there are national guidelines on drugs and supplies for post-GBV care services. The list, different for adult and children, is specific for sexual violence and includes HIV testing, PEP, STI treatment, emergency contraception (for girls older than age 11), and vaccination for Hepatitis B. However, all partners said that vaccination for Hepatitis B and pregnancy tests are never available at health facilities.

Building rental and utilities costs

All the health facility buildings belong to the government, so there are not rental costs involved. The utility costs such as telephone, water, gas, and electricity can be provided by MOH.

4.3 Capital Costs

Building maintenance

According to interviews with MOH and partners staff information on the capital costs of building maintenance is not available.

Training

Key informants from partner organizations reported that their biggest expenditure on GBV is for training. Most of the partners started by offering five-day training sessions at the provincial level, using the approved MOH manuals. However, there was concern that only a few people per district (one per each health unit) were receiving the training, and that there was not sufficient dissemination of the skills to the other staff. The rapid turnover of MOH facility staff

also meant that trained staff might not be available as planned. Therefore some partners started implementing three-day, district-level trainings, using a shorter manual adapted from the longer MOH version. Others started implementing shorter in-service trainings. Data on the cost of the provincial, district, and in-service trainings, including printing, per diem, transportation, facilities, and food, are available.

Equipment and furniture

The MOH maintains a list of equipment and furniture by facility level and province. Some equipment is donated by partners who should be able to provide cost estimates. Thus, the cost of equipment specific for post-GBV care services can be estimated by province.

Vehicles

There are no vehicles used specifically for the delivery of post-GBV care services. Estimates can be derived by allocating the purchase price of vehicles used at the facility level across different kinds of services, including GBV. Some partners have provided trucks to distribute medicine and supplies from the district level to the health units. Partners also provide salaries for drivers and the cost of fuel. These costs could also be proportioned as appropriate to post-GBV care services.

5. MOH's and Partners' Opinions About the Usefulness of Conducting a GBV Costing Study for the Health System

Informants from USAID and CDC partners mentioned that a GBV costing study could be useful for MOH and donors, particularly in making the case to support the expansion of services, but that the utility of a costing study would depend, in part, on how comprehensive it is. For example, such a study should include training and integrated service costs. In addition, given the diversity of costs across provinces and different kinds of health facilities, such a study would be most useful if it focused on the facility level and data was disaggregated by province. Informants expressed some concern that there is a risk that such a study could be misused to justify the small budget allocation for post-GBV care services. Other informants mentioned that there are more important issues to study, such as such as understanding the problems GBV survivors have in accessing services.

MOH informants thought a costing study would be useful for budgeting, however, even if a budget is well-prepared with realistic numbers and based on real needs, there is no guarantee that the funds will be allocated. Informants mentioned that it is important to advocate with the Ministry of Finance, which ultimately decides how much money will be allocated to the MOH. Allocation depends mostly on the government's current policy priorities and the availability of funds. To-date, post-GBV care services have been financed by partners. It wasn't until 2015 that MOH allocated any budget for GBV; one million Meticais (US$24,300) to finance a national meeting on GBV.

6. Main Steps to Conduct a GBV Costing Study

In addition to providing insight into the potential challenges of using the GBV cost calculator in Mozambique, key informants also highlighted what else would be needed to produce useful results and deepen the understanding of post-GBV care services. These ranged from developing a clear agreement about what kinds of violence should be considered, to the sampling framework and other data collection procedures. (It should be noted that the Tanzania study only considered sexual violence because of data availability.)

Should it be possible in the future to conduct a GBV costing study in Mozambique, a key step would be to decide if the study would cover all gender-based physical violence or just sexual violence; and if and how to include psychological violence. There are challenging data issues because physical violence is often accompanied by psychological violence. Likewise, in sexual violence cases there are often physical and psychological violence components. Other conceptual issues included whether the study should disaggregate costs by the age of the survivors to better support policies and programs designed for children and adults. On a practical level, data availability may be the key to making these decisions.

After deciding the kinds of violence to include, the next step would be to define the sample. The goal of the cost calculator is not to specify how much money is being spent on GBV, but rather to estimate the per-unit (or per client visit) cost of an ideal set of services that can be used to estimate the amount of money needed to expand services. Thus, only health units providing GBV service should be included in the sampling frame. According to informants, partners are supporting more than 278 health units that provide GBV services. The sample could be drawn from that group to reflect the following characteristics:

- Regional and rural/urban differences (for example, Nampula or Zambezia, north provinces supported by CDC; Sofala, a center province supported by USAID; and Maputo, south province supported by CDC).
- The different kinds of facilities, such as central, provincial, general, district, and rural hospitals and health centers. In the document, The Multisectoral Mechanism for Integrated Assistance to Women Victims of Violence, 2012, there are clear distinctions among the care protocols for the central hospital; provincial, general, rural, and district hospitals; and health centers. The sample should contain at least one unit per category.
- Availability of trained staff. For example, if psychological violence is to be included, the sample would need to include health units with a psychologist and psychiatric treatment.

The Tanzania study included nine sites to reflect this kind of variation and a similar approach might work in Mozambique: a total of nine health units, three per province. If this approach is taken, the authors recommend including one central hospital, one district hospital, and one rural health center from the following provinces: Nampula in the north, Sofala in the center, and Maputo province in the south.

7. Conclusions

This readiness assessment highlights several important challenges to and opportunities for conducting a GBV costing study in Mozambique. The challenges include a lack of agreement about what constitutes GBV, a lack of clear protocols on what constitutes a GBV facility, and a lack of clear national data collection protocols. The opportunities are reflected in a policy environment that offers a range of multisectoral and health sector policy documents and in a commitment by donors and the government of Mozambique to expand the quality and accessibility of support for GBV survivors.

The GBV cost calculator is not equipped to deal with all the challenges identified by the assessment; however, if the calculator were applied to a narrow set of issues, such as was done in Tanzania, a costing study might add to the current data available and help inform sound programming decisions. Based on the assessment, the best recommendation the study team can offer is to assess the per client visit costs of providing care related to sexual violence, because there more clear definitions and data on treatment protocols. Such a study could draw a sample that would reflect costs disaggregated by region (north, center, and south), by facility level (central, district, and health center).

According to key informants, this type of study would be useful to the MOH to demonstrate the funds needed to scale up GBV services, and to provide donors with a baseline on how much key post-GBV care services cost per client visit. Additionally, such a study could support advocates in the NGO, donor, and government circles to make informed, evidence-based arguments on the need for additional government funding for the post-GBV care services.

The readiness assessment also highlighted several issues that are important, not just for a GBV costing study, but in general to support expanded services and monitoring and evaluation. These include the following:

- Coordinate among all parties that provide support to GBV survivors to use the same definitions and protocols about what constitutes GBV, what services should be provided, and to offer training to providers in a timely, cost-effective way.
- Improve the way GBV data are collected by, for example, moving away from separate paper registers and notification forms to including GBV data in the Mozambique National Health Information System.
- Harmonize the list of facilities that provide post-GBV care services by establishing standard definitions of what services are meant to be provided at different levels in the health system and by consolidating information from the MOH and donor-supported activities.

Annex A. List of People Interviewed

ORGANIZATION	CONTACT
USAID	Mary Ellen Duke
Clinical HIV/AIDS Services Strengthening Project in the Sofala, Manica, and Tete provinces of Mozambique, Abt Associates	Joana Cunaca
Clinical HIV/AIDS Services Strengthening Project in Niassa, FHI 360	Andrieta Saeze
ICAP, Columbia University	Serena Brusamento
CCS	Brigida Mavie
Elizabeth Glaser Pediatric AIDS Foundation	Ana Monteiro
Fundacao Ariel	Catarina Mboa
Safe Hospitals, JHPIEGO	Ana Baptista and Deborah Bossemeyer
Friends in Global Health , Vanderbilt	Themos Ntasis
Health Resources and Services Administration, International Training and Education Center for Health	Florindo Mudender
MOH	Dra. Raquel and Rosa Marlene

Annex B. Completed Checklist of Cost Data for Health Facility-Based, Post-GBV Care Services

#	Data component	Available (Yes or No)											
		USAID	Abt	FHI 360	CDC	Columbia	CCS	EGPAF	Fundacao Ariel	JHPIEGO	Vanderbilt	ITECH	MOH
1	National guidelines for the delivery of GBV services within health care settings	Y	Y	Y	Y	Y	Y		Y	Y	Y		Y
2	List of facilities that offer GBV services by district and region; information on how long they have been offering GBV services	Y	Y	?	Y = Project	Y	Y		Y	Y	Y		Y
3	Routinely collected data (i.e., monthly or quarterly) on the total number of clients seen (or client visits) for all services offered at the facility -- by facility	Y = Project/ quarterly	Y	N	Y = Project/ quarterly	Y = Project	Y = with gaps		N	Y = P	Y		Partially
4	Routinely collected data (i.e., monthly or quarterly) on the number of clients who have received GBV services (or client visits) and the GBV service components they have received -- by facility	Y = Project (semi annual)	Y	N	Y = Project (semi annual)	Y = Project	Y = with gaps		Y = Project	Y = P	Y		N
5	List of clinic staff (by category i.e. doctor, nurse, counsellor etc.) who are to provide GBV-related services according to national GBV guidelines	Probably	N	N; Project = Yes	N	**Partner has the number of category trained in each province	N		Y = Project	Y = P	N		N
6	Average salary for each category of clinic staff	Probably	?	Probably	Probably	?	Y		Probably	Probably			Y
7	List of GBV support and supervisory staff by category (accountant, HR officer, clerk, etc.)	?	?	?	?	?	?			Y = P			Y
8	Average salary for each category of support and supervisory staff	Probably	Probably	Probably	Probably	Probably	?		Probably	Probably			Y
9	Estimates of the amount of time clinic staff spend on delivery of GBV services	N	N	N	N	N	N		Not yet	N	N		N
10	List of drugs and supplies for GBV services based on national GBV guidelines	Y	Y	Y	Y	Y	Y		?	?			Y
11	Price list of drugs and supplies	?	N	?	Y	N	Y		?	?			?
12	Facility building rental cost or account at facility, district or regional level	N/A	N/A	N/A	N/A	N/A	N/A		N/A	N/A			N/A

#	Data component	Available (Yes or No)											
		USAID	Abt	FHI 360	CDC	Columbia	CCS	EGPAF	Fundacao Ariel	JHPIEGO	Vanderbilt	ITECH	MOH
13	Facility utility cost or accounts at facility, district or regional level	N	Probably	?	N	?	?		?	?			Y
14	Travel/transport costs at facility, district or regional level	N	?	?	N	?	?		?	N			N
15	Building maintenence cost at facility, district or regional level		?	?	N	?	?		?	?			N
16	Training cost at facility, district or regional level		Y = Project	?	N	Y = Project	Y			Y = Project			Y

Annex C. Interview Guide

Questionnaire for PEPFAR partners

1. What are you doing and who you are supporting in the delivery of GBV services?
2. Which are the GBV policies, standards, and guidelines that are used for the delivery of GBV services in healthcare settings? (Which one do you use and/or guide your work?)
3. Do you know what the protocols are that are implemented in the health facilities (general, provincial, district hospital and health centers)? Do the services offered at these different levels of the healthcare system vary?
4. Are there any geographical differences in terms of GBV service provided?
5. What do you know about the minimum operational package?
6. What do you know about the availability and quality of GBV data?
7. Are national reporting systems in place? If so, what is collected and to whom is it reported? Are these reported publically available? If so, where can I get these data?
8. Are data available on the numbers of gender violence clients seen at health facilities (the facilities that you support) by type of violence (i.e., physical, sexual, psychological)? Are data available on the services that were provided to the GBV client at the time of her/his visit to the facility? Who collects/records these data? Any quality check of the data? How are the data currently used?
9. Have the service providers at the facilities you support been trained on GBV? If so, what curriculum was used? How many have been trained? Are there training plans? If yes, how many people are trained per year?
10. Do you know the per capita cost of the training? Can we calculate an estimation of how much does it cost to train one health professional staff?
11. Do you know what data are collected in the CAI [Center for Integrated Services]?
12. Do you know how much does it costs the functioning of the Women and Child Support Offices? Where can we get this info?
13. Do you know about any studies or other activities that have been conducted to-date to cost GBV services or that have analyzed the GBV service delivery data?
14. Do you think it is useful to conduct a cost study of GBV services in health system? Please explain.
15. If yes, which are the decisionmakers that can be influenced by the study?
16. Which PEPFAR partners do you advise me to interview and why?
17. Can you please have a look at the check list and see if you confirm or not the availability and quality of the data mentioned below? Please answer this for the health facilities that you support.

Annex D. Documents Reviewed for Policy Analysis

Ministério da Saúde. 2011. Diploma Ministerial.Maputo: República de Moçambique.

Ministério da Saúde. 2009. Estratégia de Inclusão de Igualdade de género no Sector da Saúde. Moçambique.

Ministério de Saúde, Direcção Nacional de Assistência Médica. 2012. Guia para Atendimento Integrado às Vitimas de Violência. Maputo: República de Moçambique.

Ministério da Mulher e da Acção Social. 2010. Lei n° 29/2009 - Sobre a Violência Doméstica Praticada Contra a Mulher. Maputo: República de Moçambique.

Ministério de Saúde, Direcção Nacional de Assistência Médica. 2012. Manual para Atendimento Integrado às Vitimas de Violência. Maputo: República de Moçambique.

Ministério da Mulher e da Acção Social. 2012. Mecanismo Multissectorial de Atendimento Integrado a Mulher Vitima de Violência. Maputo: República de Moçambique.

Plano Estratégico para Prevenção e Controlo do Trauma e Violência do Ministério da Saúde 2011-2015, Ministério de Saúde, Direcção Nacional de Saúde Publica. Junho de 2012. Maputo: República de Moçambique

Ministério da Mulher e da Accão Social. 2010. Plano Nacional de Acção para o Avanço da Mulher 2010-2014. Maputo: República de Moçambique.

Ministério da Mulher e da Acção Social. 2008. Plano Nacional de Acção para Prevenção e Combate a Violência contra a Mulher 2008-2012. Maputo: República de Moçambique

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