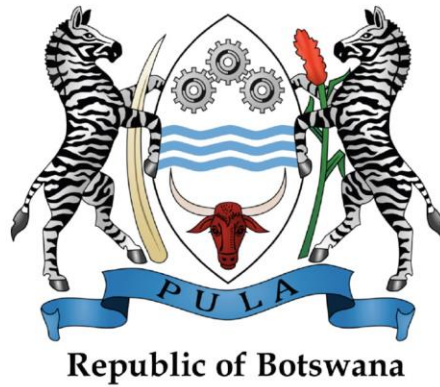**Republic of Botswana**

GBV SURVIVOR

Botswana's Gender-Based Violence Referral System Project
Operations Research End Line Report

Republic of Botswana

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Operations Research
End Line Report

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ACKNOWLEDGMENTS

CONTENTS

FIGURES

TABLES

ABBREVIATIONS

BPS	Botswana Police Service
CDC	United States Centers for Disease Control and Prevention
CSOB	Central Statistics Office Botswana
DSP	Department of Social Protection
FGD	focus group discussion
GBV	gender-based violence
GBVRSP	Gender-Based Violence Referral System Project
GeAD	Gender Affairs Department
HIV	human immunodeficiency virus
IPV	intimate partner violence
KII	key informant interview
M&E	monitoring and evaluation
MOESD	Ministry of Education and Skills Development
MOH	Ministry of Health
MoLHA	Ministry of Labour and Home Affairs
NGO	nongovernmental organization
OR	operations research
PEPFAR	President's Emergency Plan for AIDS Relief
RIS	referral information system
RS	referral system
SADC	Southern African Development Community
S&CD	social and community development
SDP	service delivery point
SMS	short message service
SOP	standard operating procedure
SPI	service provider interview
SSI	Stepping Stones International
TA	technical assistance
USAID	U.S. Agency for International Development
WAR	WoMen Against Rape
WHO	World Health Organization

EXECUTIVE SUMMARY

The Government of Botswana has committed to addressing gender-based violence (GBV) by advocating for national policies and laws and supporting programmatic efforts targeting both prevention and response. As part of these efforts, the Gender Affairs Department (GeAD) of the Ministry of Nationality, Immigration and Gender Affairs has been working over the past decade to improve access to comprehensive, quality services for GBV survivors, enhance case reporting, and strengthen stakeholder collaboration.

In this context, stakeholders identified a need to improve how referrals were made between GBV providers, such as police, social workers, health facilities, and domestic violence shelters. The GeAD acted to address this need by planning a formal referral system for care and support of GBV survivors in 2011 In 2013, the GeAD engaged the U. S. Agency for International Development (USAID)-funded MEASURE Evaluation to collaboratively develop and pilot a multifaceted project, the Gender-based Violence Referral System Project (GBVRSP), to increase community awareness of GBV, improve care and support to survivors, and launch a new mobile-based referral information system in four pilot sites. The GBVRSP began in 2015 with community mobilization, the development of standard operating procedures (SOPs) for handling GBV cases among providers within their own service delivery points (SDPs), and training on GBV for providers. The mobile-based referral information system was implemented in August 2016.

MEASURE Evaluation was also commissioned to design operations research (OR) to better understand the process and results of the GBVRSP. The aims of the OR were to evaluate the short-term results of the pilot, inform potential scale-up, document successes and challenges, and facilitate system corrections. The OR used a quasi-experimental design, including quantitative referral data and qualitative data from service provider interviews (SPIs), key informant interviews (KIIs), and community focus group discussions (FGDs). Two rounds of data collection took place in the four pilot sites and four comparison sites in August 2016 and August 2017.

MEASURE Evaluation contracted a local nongovernmental organization (NGO)—WoMen Against Rape (WAR)—to hire and direct a research team to conduct qualitative data collection. This report is based on both initial and end line data collection. The first round of data collection took place about one year after the start of the GBVRSP but just before the implementation of the mobile-based referral information system (RIS). The purpose of this report is to compare changes within and across comparison and intervention communities and their service providers on themes pertaining to understanding of GBV, service utilization, and referrals to demonstrate the effects of implementing the RIS and to inform potential scale-up or future GBV programming.

Background

The prevalence of HIV in Botswana is one of the highest in the world, with 18.5 percent of the population living with HIV (Republic of Botswana National AIDS Coordinating Agency, 2015). Gender-based violence has been identified as a significant driver of HIV and a cross-cutting priority for the government, international agencies, and funders (PEPFAR, 2013; Kharsany & Karim, 2016). Worldwide, more than one-third of women report experiencing GBV in their lifetime, but in Botswana that figure is doubled (Machisa & van Dorp, 2012; Garcia-Moreno, et al., 2013). Although almost 70 percent of women in Botswana have experienced some form of GBV in their lifetime, with almost 30 percent experiencing GBV in the past 12 months, only 1.2 percent of women reported GBV incidents to the police (Machisa & van Dorp, 2012).

The Government of Botswana has made reducing GBV a priority by increasing access to services and improving the quality of services for survivors of GBV (National Policy on Gender and Development, 2015). Through its attention to GBV, the GeAD identified the need to develop a formal referral system. In 2013, GeAD, USAID/Botswana, and MEASURE Evaluation began working to develop the GBVRSP. The GBVRSP is designed to link service providers across sectors, improve access to comprehensive and good-quality care for survivors, enhance reporting, and strengthen stakeholder collaboration. The GBVRSP was piloted in four sites: Maun and Shorobe in Ngamiland District, and Artesia and Mochudi in Kgatleng District. These pilot areas represent the north and south and urban and rural locations.

The GBVSRP encompasses the following:

1. Facilitating collaboration among GBV service providers in the pilot areas by identifying all GBV providers in each pilot site and creating a service directory[1] that includes these providers.

2. Creating an RIS to track GBV cases at SDPs offering care and support to GBV survivors, including referrals made and completed. The RIS relies on the use of simple mobile technology to capture and disseminate information to GBV service providers, enabling efficient, timely, and accurate referrals for GBV survivors.

3. Conducting community mobilization activities, implemented by Stepping Stones International (SSI) in Artesia and Mochudi and WAR in Maun and Shorobe, to raise awareness of GBV and encourage survivors of GBV to access services.

4. Developing, disseminating, and training providers on draft SOPs[2] to ensure consistent and high-quality processes of care for survivors of GBV.

Community mobilization efforts began in 2015. The pilot of the mobile referral information system took place from August 2016 to August 2017.

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[1] Service directories originally created by FHI 360
[2] Standard operating procedures created by Management Services for Health (MSH) and trainings conducted by MEASURE Evaluation

Operations Research Purpose and Questions

The OR process documented the strengths and weaknesses of the GBVRSP, informed potential scale-up, and evaluated the short-term effects of the GBVRSP. The evaluation component assessed changes in community awareness and perceptions of GBV and GBV services, as well as changes in GBV service providers' awareness and self-efficacy in providing GBV services over time and between pilot and comparison sites. OR monitoring data also documented successes, challenges and how they were addressed, RIS usage, and referral initiation and completion trends over time.

The primary research questions were:

1. What are the patterns and trends of referrals provided to GBV clients who need services that are not available at the initiating agency when they present?

2. What are the patterns and trends of initiating agencies over time?

3. What are the patterns and trends of receiving agencies over time?

4. What are the patterns of uncompleted referrals, and what explains these patterns?

5. How have community awareness and perceptions of GBV and GBV services changed over time?

6. How have GBV service provider awareness and self-efficacy around GBV and provision of GBV services changed over time?

7. How was the overall experience of the GBVRSP and of using the RIS among GBV service providers?

Operations Research Design, Methods, and Limitations

The OR employed a quasi-experimental design, with data collection in four pilot sites (Maun and Shorobe in Ngamiland District, and Artesia and Mochudi in Kgatleng District) and four matched comparison sites (Gumare and Tsau in the north, and Kanye and Ranaka in the south). Comparison sites were selected to match cultural context, available services (e.g., police, healthcare facilities, NGOs addressing GBV, social workers) and the rural and urban locations of the pilot sites.

In August 2016, researchers conducted 58 interviews with service providers (approximately four to five interviews in each rural site and nine to 10 in each urban site); they also carried out 32 FGDs (four per site) with community members in pilot and comparison sites. Service provider interviews in intervention sites were conducted with service providers from the healthcare, police and justice, education, and NGO sectors that had just completed training on GBV and the GBV referral system. In comparison sites, equivalent service providers from those sectors were interviewed (these providers had not received any trainings related to this project). FGDs were conducted with groups of participants ages 18–25 and over age 25, with separate groups for men and women. This data collection process was repeated in August 2017; 59 service provider interviews and 33 community FGDs were conducted. In addition, at end line, seven key informant interviews were conducted with people who had a direct hand in organizing, implementing, and leading the GBVRSP.

Service provider interviews and FGDs were conducted in local languages, digitally recorded, and then simultaneously translated and transcribed into English. Transcripts were coded in Dedoose qualitative

analysis software. Code reports were generated and synthesized using matrices that allowed for comparisons across time and among all sites, genders, provider types, and comparison or intervention sites.

Key informant interviews were analyzed using a rapid memo process that summarizes each transcript into a template to elucidate themes across interviews. At least two members of the research team reviewed transcript summaries for clarification or follow-up, if necessary. Transcript summaries were then reviewed and analyzed to identify themes.

Aggregated quantitative data from the referral system were analyzed to identify trends in system utilization and referral patterns. Site summary reports documenting monthly subcontractor activities and mobilization efforts, challenges, and successes were also analyzed to illuminate the challenges and successes of system uptake. All four types of data were then triangulated and analyzed to identify any contradictory or complementary findings.

Findings and Conclusions

The following summarizes key findings of the analysis:

Community Perceptions and Acceptance of GBV

There was substantial variation in understanding and acceptance of GBV among community focus group discussion (FGD) participants. Overall, modest improvements were demonstrated between intervention and comparison sites at end line, whereas no differences were exhibited at initial data collection.

- More FGD participants thought GBV was unacceptable at end line than at initial data collection, but many participants, particularly in male focus groups, were still quick to condone violence when women did something "wrong" or to say that men often react in violent ways as a result of strong emotions, which was viewed as justifiable.

- Males in intervention sites more commonly condemned violence between partners, as compared to males at comparison sites. The majority of focus groups whose participants fully condemned GBV were located in rural areas (6/8).

- Understanding of GBV among FGD participants in either intervention or comparison sites exhibited little change between initial data collection and end line. Participants demonstrated an overall lack of clarity around defining GBV, often speaking of it as general abuse or mistreatment. There was also confusion around children disrespecting elders, homosexuality, and broader crime as types of GBV. There was also an exhibited belief that improved rights for women and children has contributed to an increase in GBV, particularly abuse towards men.

- Almost universally, male participants of focus groups at end line mentioned that male victims of GBV are not taken seriously by the community or by service providers, specifically indicating that justice providers often "laugh at" male victims reporting GBV. Many of the examples mentioned would not be generally considered GBV—e.g., characterizing a wife refusing to cook

food for her husband as a form of abuse towards the man. However, this theme was exhibited more strongly at end line than at initial data collection.

- As in initial data collection, most focus group participants indicated that GBV cases should first be resolved within the family, if possible, then the next line of reporting would be to the police or tribal authority. However, female FGDs in both intervention and comparison sites felt that survivors of GBV were not supported by families or their communities.

- Focus group participants were not recruited based on their experience with GBV or accessing GBV services, but all participants were asked to share their perceptions on the quality of care in their community. Focus group participants were mixed on their perceptions of the quality of GBV services provided in their community; however, in contrast to initial data collection, intervention sites more frequently reported that services were confidential and comparison sites more frequently reported that services were not confidential. At end line, across all groups participants were critical of police handling of GBV cases in terms of sensitivity towards clients, timeliness in processing cases, and maintaining client confidentiality.

- Focus groups in intervention sites more frequently reported improvements over the last year regarding GBV within their community than comparison sites. These improvements included women more frequently reporting GBV, providers being more supportive to survivors of GBV when providing care, or that there were fewer cases. Most participants in intervention sites knew of community activities around GBV taking place, whereas few comparison groups knew of any such activities.

Provider Perceptions and Handling of GBV

At both time points, intervention service providers indicated a higher level of understanding of GBV, comfort handling GBV cases, and increased trust and collaboration between providers in the referral system compared to providers in comparison sites.

- Definitions of GBV varied among all types of service providers at baseline and end line. However, intervention sites seemed to demonstrate improvement in their understanding of GBV from initial data collection to baseline, particularly among tribal leaders. Many comparison service providers were hesitant in defining GBV at both time points.

- At both time points and in intervention and comparison sites, justice service providers more frequently exhibited attitudes that victims were responsible for attracting violence or excusing those who perpetrate violence compared to other kinds of service providers.

- Providers' perceptions on client barriers to accessing care did not change over time or differ by intervention or comparison site status. These included financial dependency, shame, embarrassment, fear of retribution or violence, and a desire to protect the perpetrator. Most service providers still believed that facilitators for reporting GBV included personal attributes, such as education, empowerment, or being "fed up."

- More service providers in intervention sites were comfortable with their role handling GBV cases than in comparison sites—only two service providers in intervention sites were clearly

uncomfortable handling GBV cases compared to more than a quarter of service providers in the comparison sites. In comparison sites, comfort handling GBV cases and understanding of GBV were not always correlated, with some comparison service providers saying identifying GBV was easy while still exhibiting simplistic understanding of GBV and its causes.

- At end line, service providers in intervention sites more frequently reported confidence that clients were getting the services they needed than those in comparison sites.

- Some service providers (primarily school-based) demonstrated confusion about effectively and safely involving family and other stakeholders in GBV cases. Others, especially police, revealed a lack of sensitivity towards victims of GBV, such as excusing those who perpetrate violence or suggesting that victims were responsible for attracting violence.

RIS Uptake

Uptake of the system varied by location and provider type. Most cases were entered, referred, and completed in Maun; among providers, NGOs entered the most cases, and healthcare providers and police referred the largest percentage of their clients.

- Between August 2016 and August 2017, 401 GBV cases were entered in the system. Of the referrals logged into the system, over 33 percent (n=134) were provided with a referral, and approximately 30 percent (n=41) of received referrals were completed.

- Most GBV cases entered (307/401), referrals initiated (97/134), and referrals completed (29/41) were in Maun. Although fewer cases were entered in Mochudi (78/401), almost 40 percent of them were referred to another provider. Only 16 percent of those referrals in Mochudi were marked as completed. Uptake of the system was low in rural sites, with only seven cases entered in Artesia and nine cases entered in Shorobe. However, all received referrals were completed in Shorobe (5/5); one referral was completed in Artesia.

- Use of the system varied by provider type, as documented in Table 1. NGOs entered the majority of GBV cases; healthcare providers and those in the legal/justice field (e.g., police)

Table 1. Cases entered, referrals made, and referrals completed, by provider type

	Cases Entered		Referrals Made		Referrals Received		Referrals Completed	
	#	%	#	%	#	%	#	%
Education	3	1	3	2	0	0	0	0
Health	63	16	30	22	25	19	3	8
Legal/justice	90	22	48	36	40	30	13	33
NGOs	205	51	50	37	37	27	21	53
Social welfare	40	10	3	2	33	24	3	8
Total	401	100	134	100	135	100	40	100

- referred the highest *percentage* of their entered cases. Approximately 57 percent of referrals made to NGOs were marked as completed; a third of referrals made to legal/justice providers were marked as complete. Only 9 and 12 percent of referrals were marked as complete by social workers and healthcare providers, respectively.

- Implementing partners and key informants reported that the main reasons for not completing referrals were (1) clients not arriving to referred service provider; (2) referred clients arriving to the SDP but not identifying as a referred client, so data were not entered into the RIS as a completed referrals; and (3) challenges with phone uptake among providers (e.g., not remembering to use phone; trained provider not available; deactivated sim cards), so data were not entered into the RIS as completed referrals. This research did not include data directly from clients of the referral system, which precludes additional conclusions regarding reasons for lack of referral completion.

Referral System Feedback

At initial data collection, just following GBVRSP training, providers in intervention sites were enthusiastic about the potential for project success. At end line, most providers were positive about the GBVRSP, particularly due to the increased interaction and collaboration among providers. However, there were some challenges with use of the RIS, including heavy workloads, difficulties with the technology, and lack of consistent access to the phone system.

- Service providers in intervention sites frequently mentioned the benefits and increased collaboration that resulted from the GBVRSP trainings, monthly meetings, and service directory.

- Providers in both intervention and comparison sites were interested in additional GBV training. Intervention site providers frequently asked for their colleagues to be trained on GBV and the RIS to allow collaboration on GBV cases within their offices.

- Intervention site service providers expressed frustration with the lack of feedback from the RIS and expressed a desire for notifications from the system to update them on the status of a GBV client.

- Comparison site providers did not mention any changes to GBV service provision processes or referral protocols over the previous year.

- Over half of providers trained on the RIS in intervention sites reported using it. Among those who had not used the phones, reasons included not encountering a GBV case (n=4), phone was misplaced or had technical difficulties (n=2), no cases to be referred (i.e., all could be handled on-site) (n=2), was on leave (n=1), was not trained in use of RIS (n=1), and unknown (n=2).

- Providers often referenced challenges using the RIS. Service providers often had heavy workloads, and this made it difficult to spend time typing case notes into the mobile system, something many providers indicated was time-consuming. Additionally, providers often did not have ready access to the phone or had network difficulties that prevented them from completing referrals.

Key Informant Interviews

Key informant interviews (KIIs) provided valuable perspectives on the design, coordination, and operations of the GBVRSP.

- Key informants (KIs) echoed service providers in reporting that collaboration among providers was one of the largest successes and strengths of the GBVRSP. Several KIs mentioned that they believed providers would continue to refer clients to each other, even without the phones, because they are now familiar with the other's services and have mutual trust.

- KIs discussed the need for dedicated government personnel to focus specifically on coordinating the GBVRSP, both on the ground and between points of contact at each ministry.

- KIs felt that challenges around establishing buy-in and accountability with service providers and their supervisors could be addressed by ensuring top-down prioritization of the GBVRSP by each relevant ministry.

- KIs expressed mixed opinions regarding the use of the older model phones currently being used versus smartphones. Suggested potential improvements included designing an application for use on individually-owned smartphones.

- Most KIs felt that the GBVRSP needed to be improved or adjusted before scale-up, specifically noting that additional justification was needed to establish that the RIS was used enough to warrant scale-up. Most suggested a second pilot phase was necessary, with GeAD implementing and incorporating lessons learned before expanding the system.

- KIs also highlighted community mobilization as a critical part of the GBVRSP, advocating for more intense and frequent activities to sensitize the community.

Program Implementation Findings

The desk review of implementing partners' final reports documented the number of community mobilization activities conducted and service providers trained. **Implementation challenges included ensuring that the correct staff were trained, engaging with all sectors, finding ways to encourage uptake of the system, logistical challenges with the mobile phones, and some cross-sector collaboration difficulties.**

- As reported by implementing partners' year-end reports documenting their activities between August 2016 and August 2017, more than 10,000 contacts with community members were made through gender and GBV awareness activities in the Ngamiland intervention sites, and more than 5,000 contacts made with activities in Kgatleng intervention sites.

- Seventy-eight service providers were trained on GBV and the referral system, 100 service providers were sensitized on GBV, and 32 RIS monitoring and support visits were conducted in Ngamiland. In Kgatleng, 141 service providers were trained or sensitized on GBV, and 96 RIS monitoring and support visits were conducted.

- Making sure each agency had a sufficient number of people trained and the correct people trained on the system was a challenge in both northern and southern service provider points.

Some sectors, such as social and community development (S&CD), had only a few providers who were granted permission to be trained on the RIS. This created a gap in the referral system for GBV clients.

- In general, implementing partners reported that service providers were not universally held accountable or provided support by sector management to use the RIS and that this decreased uptake of the system.

- While implementing partners felt that the GBVRSP resulted in improvements in service provider collaboration in general, implementing partners in the south observed some reluctance by providers to refer clients to other agencies because of skepticism in the quality of the care provided. This was not reported in service provider interviews in intervention sites.

- Maintaining monthly meetings with all providers seemed successful in the north but was reported as a challenge in the south. By the end of the pilot, eight monthly meetings with a total of 232 service providers were held in the north; in the south three meetings were held with a total of 42 providers.

- Site summary reports suggest that service providers experienced challenges with logistics, such as network or server problems, phone deactivation, sharing phones, and keeping phones charged.

Table 2 summarizes the main results by research question by time point; it also highlights differences in themes among sites (i.e., intervention versus comparison, north versus south, and rural versus urban) within the summary for each research question. As noted previously, initial data collection was conducted after community mobilization activities had commenced and with intervention providers recently trained on GBV and the GBV referral system. As such, this will influence comparisons between initial and end line data.

Table 2. Results summary and site differences by research question

Research Question	End line Results
Community understanding of GBV	There were no differences demonstrated between time points regarding community understanding of GBV. **Variation in definitions and causes of GBV was observed across all sites, and there were no discernable differences between intervention and comparison sites**.
Community awareness of GBV	**As at initial data collection, most focus group participants disagreed about if and when violence was acceptable; however, some moderate gains were seen in the data at end line**. At initial data collection, 6/32 focus groups thought GBV was acceptable, whereas only one focus group at end line fully endorsed GBV. Half of the male focus groups in interventions sites were unanimous in condemning violence between partners, whereas male focus groups in comparison sites were almost all conflicted, except for one in which all participants seemed to agree that there were instances where GBV was acceptable. Interestingly, the majority of focus groups that fully condemned GBV were in rural areas (6/8). There were no differences between north and south.
Community perceptions of availability and quality of services	**Resources reported at end line mirrored those reported by participants at initial data collection**, which included family, the kgotla (traditional community council), police, social workers, health facilities, NGOs, and educators. While there was substantial variation in participants' perceptions of service quality, **participants in intervention sites at both initial and end line data collection more frequently reported that service providers maintained confidentiality than did participants in comparison sites**. Women at end line more frequently reported mixed feelings about the quality of the services as opposed to high or low quality (8/15), while men more frequently reported that services were low quality (7/15).
Provider understanding of GBV	As was demonstrated at initial data collection, **providers in intervention sites provided more complex and thorough definitions and understanding of GBV than providers in comparison sites**. Similar to initial data collection, providers in comparison sites more frequently demonstrated attitudes which justified violence on the basis of victim behaviors (e.g., dressing inappropriately), and these attitudes were most commonly demonstrated by justice service providers. Traditional leaders seemed to demonstrate improvement in their understanding of GBV from initial data collection to end line. Facilitators and barriers to victims reporting cases of GBV did not differ between initial data collection and end line, though **at end line service, providers in intervention sites more frequently reported that provider confidentiality and trust can be a facilitator to reporting.**
Provider comfort in delivering GBV services	**At end line, fewer service providers in the intervention sites were clearly uncomfortable handling GBV cases than in comparison sites**. In comparison sites, there was also a demonstrated disconnect between understanding of GBV and comfort handling cases, with some providers saying identifying GBV was easy, but giving simplistic definitions of GBV and its causes. School service providers, particularly in intervention sites, demonstrated inconsistencies in their processes for involving external stakeholders in GBV cases. **At end line, SOPs were more readily acknowledged and available in**

	intervention sites than at initial data collection. As at initial data collection, comparison sites were not familiar with SOPs at end line.
Provider collaboration and trust	**Trust and collaboration between providers in intervention sites remained high between initial data collection and end line, while no changes were seen among comparison providers**. Intervention providers mostly attribute improved working relationships with other sections as the result of collaboration at monthly support meetings. Service providers in intervention sites more frequently reported confidence that clients received the care that they needed than comparison sites.
GBVRSP/RIS feedback	Similar to initial data collection, **service providers expressed positive views towards the GBVRSP at end line, particularly related to increased collaboration among providers due to trainings and meetings**. In service provider interviews, more than half of NGO and healthcare providers reported using the system. School-based providers were least likely to say that they had used the system. While only a small number of social workers were available for end line data collection, all three had reported using the GBVRSP. RIS data show that NGO providers had the highest number of cases entered into the system at end line, as well as the largest percentage of completed referrals. Northern sites still demonstrated the highest proportion of cases and referrals in comparison to southern sites.

Conclusions

Overall, providers in intervention sites were enthusiastic about the GBVRSP. According to service providers and key informants, the GBVRSP resulted in increased collaboration, trust, and knowledge of GBV services among providers in the intervention sites. RIS uptake varied by site and provider type. Thirty percent of referrals were marked as completed. Service providers and community members listed barriers to seeking services in general, and it is possible that such barriers affected referral completion; further barriers to using the RIS system among providers could have resulted in completed referrals remaining undocumented. As the RIS did not collect data on why referrals were not completed, and it is unclear whether referrals were uncompleted due to provider or client-related factors. As this is the first formal system in Botswana to collect data on number of GBV cases reported, referred, and referrals completed, there are no data to compare whether these results are an improvement upon previous rates.

Implementing partners conducted community mobilization activities using the SASA! Model, which has been proven effective in significantly reducing intimate partner violence (IPV), IPV acceptability and increasing access to resources in other settings (Abramsky, et al., 2012). In this pilot, modest improvements were seen in community perspectives on acceptability of GBV in intervention sites at end line. The difference between these results and previous SASA! evaluations are likely due to both length of intervention and research design. SASA! was previously evaluated after a four-year intervention, using a pair-match cluster randomized controlled trial surveying over 1,500 community members at baseline and 2,500 community members at end line.

Key informant interviews and a desk review of final reports from implementing partners found that implementation of the GBVRSP required substantial staff time to coordinate trainings and monthly meetings, provider technical support for the RIS system, and to encourage uptake of the system. Key informants and implementing partners expressed that increased coordination, support, and accountability from the central government and ministry leads would help increase the success of the GBVRSP.

Several themes, including characteristics of male victims of GBV, training for SPs in resource-constrained settings, acceptability of any kind of violence, and barriers to referral completion, were identified during analysis as topics for future research.

Recommendations

The purpose of conducting this operations research was to facilitate system corrections and to provide feedback for potential scale-up and future GBV interventions. As such, the following recommendations are based on the OR findings:

1. **Implement a second year of the GBVRSP Pilot under GeAD's leadership.**

   1.1 Taking into account both the success of the pilot in intervention sites, as well as operational challenges, MEASURE Evaluation recommends a continuation of the pilot of the GBVRSP as the project transitions to independent implementation by GeAD. During this second pilot, we recommend **incorporating improvements into the GBVRSP** (see recommendations below). **We also recommend undertaking basic monitoring and evaluation of this second year of the pilot** to ascertain whether providers are using the RIS, referrals are being completed, monthly meetings are occurring, and adequate support is being provided from government and civil society partners.

2. **Undertake significant and targeted efforts to ensure that the system is owned and managed by the stakeholder ministries and its use is enforced within ministries at all levels.**

   2.1 Given overwhelming recognition of the importance of stakeholder ownership and accountability at all levels, we recommend the following:

   - Targeted consultations with high-level government officials, including permanent secretaries, ministers, and heads of departments, to share the results of the GBVRSP pilot and gain support for ongoing implementation through an adapted model of ministry ownership and implementation.
   - Support and maintain the National Reference Group, through quarterly meetings and regular communication, to act as champions of the GBVRSP and continue raising awareness and buy-in.
   - Engage ministers in each sector to support the GBVRSP through advocacy and formalize agreements to institutionalize use of the referral system within each relevant sector. Support ministry leadership to identify ways to encourage uptake of the RIS among their service providers. This should also include regular review of the RIS usage, using the data for decision making, and internal ministry communication on the importance of the RIS and GBV prevention.
   - Allocate financial resources nationally and within ministries to support the implementation and coordination of the GBVRSP.
   - Create, fund, and staff one to two **dedicated** positions at the Gender Affairs Department to oversee, manage, and facilitate the GBVRSP.

3. **Rededicate sustained and significant efforts to improve understanding of GBV, shift norms around acceptability of violence, and increase knowledge of available resources in the community.**

   3.1 Given the varied understanding of GBV, its causes, and the at times contradictory messages about acceptability of violence expressed by community members, MEASURE Evaluation recommends:

   - Data from community members showed some modest effects in changing norms around GBV, but there remains a clear need to **continue and intensify activities that define GBV and its causes, and address issues related to acceptability of violence.** While conducting these activities, we recommend preparing mobilizers and trainers with messaging to help counteract distorted definitions of GBV that are rooted in traditional gender norms (e.g., identifying the refusal of sex as a form of abuse).
     o **Target community mobilization and awareness raising for community members and families to be more empathetic and supportive of victims.**
     o Work **with men and women to challenge traditional gender norms that perpetuate violence against women.** *It is paramount that the staff who deliver this programming be extremely well trained in gender equality to avoid perpetuating harmful gender norms.*

- While it is important to work with both men and women, **specifically targeting men for more intensive support and engagement around GBV is critical.**
- **Support families and parents in adopting nonviolent conflict resolution strategies.**
- **Undertake national awareness raising and GBV prevention efforts to complement local GBV activities.** This could include initiating and supporting education campaigns through mass media, radio, and print.

4. **Provide on-going training and support to service providers to improve GBV understanding, identification, quality of service provision, and referrals between providers.**

4.1 Given the overwhelmingly positive findings around increased collaboration and trust among providers in intervention sites due to monthly meetings, service directories, and regular interaction, we recommend the following:

- **Continue monthly meetings of service providers** in the same area to maintain connections and trust between institutions and providers. This was one of the biggest successes of the pilot, and maintaining this collaboration is a key part of preserving progress made during the pilot.
- **Update service directories annually** to maintain an accurate account of local providers that work on GBV and what services they offer.
- **Support a local implementing partner, district gender committees, or local gender officer in each area** to facilitate monthly meetings, update service directories, keep track of staff turnover, manage stakeholders from local implementing parties, and manage the WhatsApp group for service providers.

4.2 Given the continued variation in providers' understanding of GBV, appropriate services, and referral processes between baseline and end line, as well as expressed need from both comparison and intervention sites for more GBV training, we recommend:

- **Expand GBV training and referral system trainings for all providers in target areas** using a train-the-trainer model to ensure sustainability and cost effectiveness. Expand the current training to include in-depth skill-building, sensitivity, and case management for addressing GBV appropriately.
- **Given the importance of service quality, sectors should tailor trainings to different service provider types**, such as justice and healthcare providers. The process for handling GBV differs by sector and service; thus, trainings should be customized for provider types.

4.3 Given that providing services to victims of GBV is challenging and at times painful or overwhelming for service providers, we recommend:

- **Initiating provider support groups and debriefing opportunities for service providers.**

4.4 Given the importance of consistent and high-quality care provided to GBV survivors:

- **Ensure that all sectors and service delivery points have SOPs for handling GBV cases, providers are trained on the SOPs, providers are monitored and given feedback on their performance related to the SOPs,** and that the SOPS are posted at multiple locations throughout a service delivery point.
- **Update SOPs regularly, ensuring that they follow international protocols for providing care to victims of GBV.**
- **Ensure newly hired or transferred staff are oriented in the GBV SOPs.** Frequent staff turnover requires ongoing training of incoming staff to ensure that all personnel are capable of identifying and referring GBV cases they may encounter.

5. **Address identified gaps and barriers in the mobile phone and referral information system.**

5.1 Given the challenges with turnover, providers forgetting how to use the system, and lack of routine system use, we recommend:

- **Continue routine service provider trainings on the RIS.** This will take into account high staff turnover and ensure that clients encounter trained providers who can identify, support, and refer GBV clients.
- **Identify and support a local GBVRSP officer from the government to continue one-to-one visits with providers**, addressing any logistical challenges and encouraging habitual use of the new system to help increase uptake.
- **Ensure that implementation of SMS reminders** is rolled out and being received by providers. This will serve as "cues to action" to use the phone referral system, as well as allow providers to more easily obtain follow-up information on whether and when referred clients reach their next provider.

5.2 Given the low rates of referral completion, we recommend the following:

- **Improve feedback loops to service providers**, thus increasing their trust and engagement in the larger system. This includes ensuring the SMS reminders are working, sharing data at monthly meetings on numbers of referrals made and completed in the system, and highlighting de-identified success stories.
- **Increase institutionalization of the RIS** by engaging department heads and ministers in each sector to identify ways to **monitor and increase RIS uptake among service providers.** (This is related to recommendation 2.1.)
- **Encourage use of the web-based portal, when possible.** As many service providers expressed challenges around using the small phones, we recommend local implementers promote use of the web-based portal for providers with access to computers. Other possible longer-term solutions include **exploring creation of a secure, zero-rated smartphone application for providers to use on their personal smartphones.**
- **Consider functionality adjustments to the RIS for clarity and ease of use by providers.** Specific improvements that were suggested in the results:
  - Add functionality to refer to multiple providers at one time.
  - Add capability for service providers to select more than one service provided.

- o Add functionality to allow a spectrum of "completion" so providers can track when clients arrive, are receiving services, and have completed care.
- **Explore why referrals are not being completed both from a provider and a client perspective.**
- **Explore approaches to help clients get from one service provider to the next.**

PROJECT BACKGROUND

With a population of just over 2 million, Botswana is one of the least densely populated countries in the world. It has a young and growing population, with 53 percent of people under age 24 (Central Statistics Office Botswana [CSOB], 2014). Although it has made significant progress in many development indicators and is considered by the World Bank to be an upper-middle-income country, recent estimates show that approximately 18.5 percent of adults are HIV positive (World Bank, n.d.; Republic of Botswana National AIDS Coordinating Agency, 2015). USAID/Botswana works with the Ministry of Health and key stakeholders to improve health services to provide comprehensive HIV/AIDS prevention, care, and treatment (Joint United Nations Programme on HIV/AIDS [UNAIDS], 2015).

Gender inequality and GBV are critical enablers of the HIV epidemic and have been associated with HIV incidence (Dunkle, et al., 2004; Andersson, Cockcroft, & Shea, 2008; Jewkes, Dunkle, Nduna, & Shai, 2010; Jewkes & Morrell, 2010). Women survivors of GBV are at increased risk of contracting HIV, are less likely to know their HIV status, and are often unable (or unwilling) to access health services (United Nations Development System, 2016). Male perpetrators of GBV are more likely to have multiple partners and to be HIV-positive (Botswana AIDS Impact Survey, 2013).

Nearly 70 percent of women in Botswana have experienced GBV at some point during their lifetime—30 percent during the past year (Machisa & van Dorp, 2012). However, only 1.2 percent of women report their experiences of GBV to the police and less than 1 percent of perpetrators in reported cases are prosecuted (Machisa & van Dorp, 2012). The magnitude of GBV in Botswana could affect country progress towards the UNAIDS 90-90-90 targets and to ending the HIV epidemic by 2020 (UNAIDS, n.d.). With such high rates of HIV and GBV, PEPFAR/Botswana has identified GBV as the most important crosscutting issue in its portfolio; furthermore, the U.S. Agency for International Development (USAID)/Botswana, working with the Government of Botswana, has identified GBV as a priority.

The Gender Affairs Department (GeAD) in the Ministry of Nationality, Immigration and Gender Affairs, Government of Botswana, has committed to addressing GBV by advocating for national policies and laws and supporting programmatic efforts targeting both prevention and response. The Government of Botswana recently made a commitment to preventing and responding to GBV by signing on to the revised Southern African Development Community (SADC) Protocol on Gender and Development (SADC, 2017). The protocol requires countries to empower women, eliminate discrimination, and promote gender equality through legislation, policies, programs, and projects.

Botswana's efforts on GBV have been underway for more than a decade. In 2007, Botswana developed a National Strategy for Ending Gender-Based Violence in response to a call from Kofi Anan, the United Nations Secretary General at the time, for all countries to develop national strategic multisector plans to address GBV. One of the challenges identified by the plan was the lack of coordination among the many efforts directed toward addressing GBV in the country. The plan identified objectives across sectors, including legal, services, education and awareness, social/cultural/economic, and integrated areas that included monitoring and evaluation. The monitoring and evaluation objective was to develop a database for gathering statistics using a standardized format (Draft Botswana 365 Day National Action Plan to End Gender Violence, 2007). The plan was revised in 2010.

In response to identifying this need and the lack of a formal referral system for GBV services, the GeAD planned to pilot a referral system for provision of post-GBV survivor care support services. In collaboration with the GeAD, MEASURE Evaluation assessed the existing informal referral network and worked with stakeholders at the national and community levels. To respond to these needs and challenges, MEASURE Evaluation and GeAD worked together to design the Botswana GBV Referral System Project (GBVRSP). This system is in line with PEPFAR's strategy, as outlined in the country operational plan, to strengthen the GBV referral system (PEPFAR, 2016).

Gender-Based Violence Referral System Project

The Botswana GBVRSP piloted an innovative way of connecting GBV survivors with comprehensive services. At the core of the GBVRSP is a mobile-based referral information system (RIS) to enable providers to make and receive referrals and to capture information on services for GBV survivors. The RIS captures all GBV cases reported to any provider in any sector; tracks all referrals made, received, and completed; identifies "incomplete" referrals; allows providers to follow up with clients easily; integrates follow-up reminders for providers making and receiving referrals; allows real-time data access; reduces data entry burden; and improves data quality. Furthermore, an electronic record system reduces the burden on the client, by ensuring that all relevant data pertaining to the case are shared among providers, decreasing the need for clients to retell their stories or keep track of paper referrals. The RIS is implemented with service delivery points and providers from these sectors: police, social workers, health facilities, tribal authorities, educators, and nongovernmental organizations (NGOs) (see Figure 1).

Figure 1. Gender-based violence service providers

Around this RIS core were activities to support implementation of the RIS and use of GBV services. These included training for service providers on GBV issues and on RIS use and community awareness activities at national and community levels. Draft standard operating procedures (SOPs) for treating and providing care to GBV survivors and simple flowcharts describing how to incorporate the RIS into GBV care were also developed. Figure 2 documents the components of the GBVRSP.

Figure 2. Gender-Based Violence Referral System Project
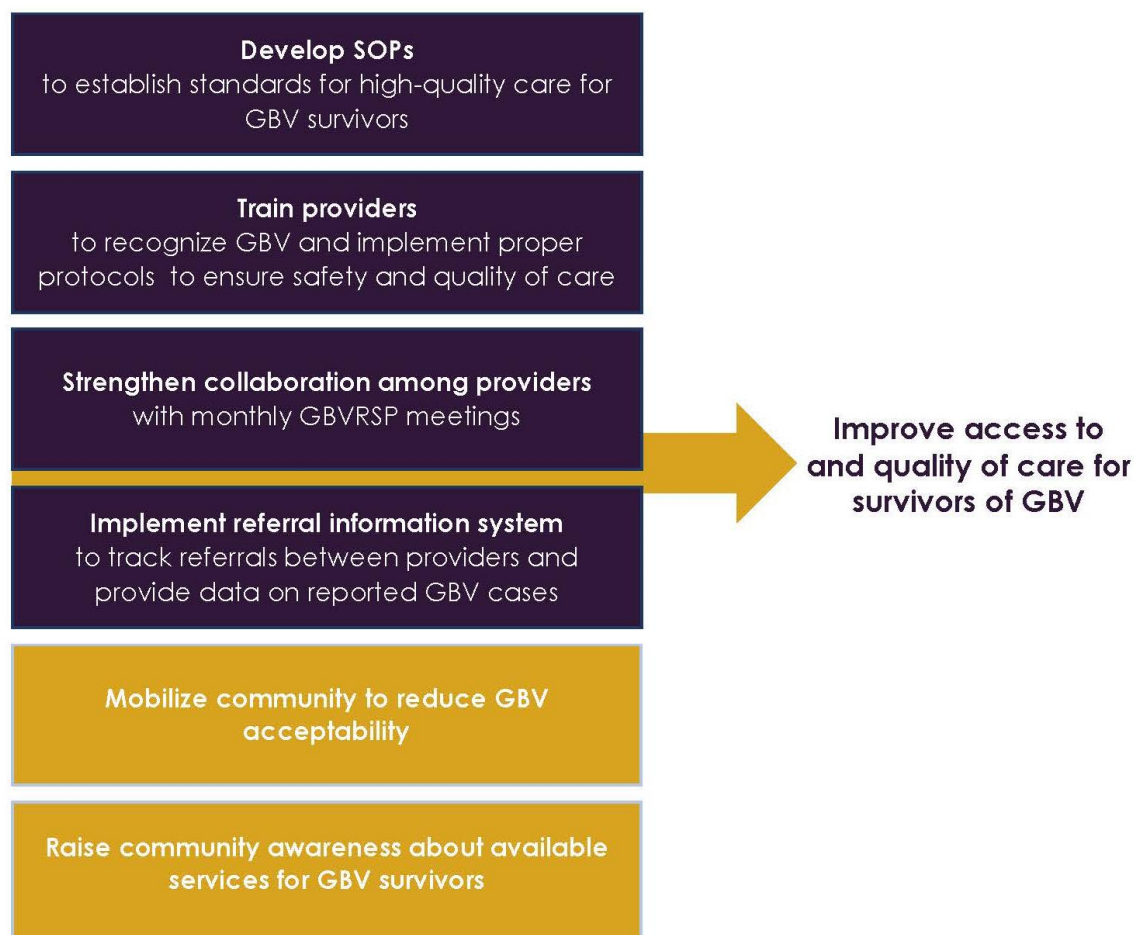
Beginning in August 2016, the new RIS began tracking all GBV survivors who seek care at any service delivery point (SDP)—whether delivered by governmental or nongovernmental agencies—within the catchment areas of the pilot communities, inclusive of all sectors and services. The RIS was designed to facilitate referrals both across and within sectors by tracking all referrals made by a provider at an initiating SDP, alerting the receiving SDP provider about the client who has been referred, and attaching a brief case history with the record of each client referred. The GBVRSP was piloted in four communities in Botswana over the course of 12 months: the urban village of Mochudi and the village of Artesia in Kgatleng in the south, and the urban village of Maun and the village of Shorobe in Ngamiland in the north. The RIS uses simple mobile technology that is available in 95 percent of the country.

The RIS serves to (1) enable providers to make referrals for GBV clients who need services that are not available at the initiating agency at the time they present, (2) document what services are needed and then

provided at the initiating agency, (3) document what services were provided at the receiving agency, and (4) provide a case history base that is available to all providers within the referral system, to ensure that survivors have to present the details of their case only once. The system is designed to allow only one referral for the client at a time. For example, if the client needs health and social services, the referring provider will triage to choose which is more important at the time. Once clients provide informed consent, their data are entered in the system.

The identification of referral sites, consultations on development of standard protocols for supporting GBV survivors within SDPs, and initial drafting of standard protocols for some sectors were foundational to the success of the RIS launch and the GBVRSP overall. Service directories for all GBV providers in the target areas were developed and shared with all providers. Draft SOPs were developed for the Ministry of Education and Skills Development, Department of Social Protection, and Botswana Police Services by Management Sciences for Health (MSH). Trainings highlighted when to interact with the new RIS when handling a GBV case. SOPs were not drafted for the Ministry of Health or tribal authorities by MEASURE Evaluation.[3] Flow charts (see Figure 3) that highlighted how to incorporate the RIS into existing case management practices were developed for all sectors.

Figure 3. Example flow chart documenting RIS role in case management practices

Implementation Guidelines for GBV Referral System
Botswana Police Service

- **Client presents to Botswana Police Service (BPS) in person** (999, direct telephone call, walk-in)
- Assessment made and case determined to be GBV case
- Case referred to GBV referral system focal person
- **Entry points for GBV referral system**
- **Client referral received through RIS** (hospital, clinic, social protection, school, civil society organization
- **GBV focal person inputs/updates client information into referral system database**
- **Client assessments done and further care needs determined**
- **No need for further referrals**
- **Referral(s) made to necessary departments** (social worker, medical, safe haven, courts)
- **Client information uploaded to database**
- **Follow-up with necessary departments**
- End
- End

The referral system will run parallel to the current system of BPS case management and will not replace regular reporting systems.

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[3] The Ministry of Health already had an SOP, and MEASURE Evaluation was not asked to develop one for the tribal authorities.

Before the RIS launch, staff in all SDPs included in the pilot participated in several trainings over several months, which were led by MEASURE Evaluation, GeAD, WoMen Against Rape (WAR), and Stepping Stones International (SSI). Trainings consisted of an overview of GBV, identifying GBV cases, explaining the SOPs, awareness and sensitivity training, and information on ensuring the physical and emotional safety of clients. Trainings were also conducted on the service directories and the role of other providers, and how to use the RIS mobile phone system. The Ministry of Health also held trainings for their staff on Ministry of Health SOPs for client care and management.

Finally, awareness-raising activities about GBV and available local service provision are ongoing within each of the four target communities. WAR and SSI are conducting community mobilization activities to raise awareness and reduce acceptability of GBV based on the SASA! model. Raising Voices, a nonprofit organization in Uganda, created the SASA! model to target the gender power norms that drive both HIV and violence against women.[4] Research shows that communities where SASA! has been implemented report reductions in GBV (Abramsky, et al., 2014; Kyegombe, et al., 2014; Starmann, et al., 2017). WAR and SSI train and provide stipends to community members to hold community meetings, produce edutainment in high-traffic areas, and facilitate conversations with community leaders, youth, religious leaders, and other community stakeholders. Community mobilization activities began in 2015. Both WAR and SSI are well known in their respective communities and have been providing services to their respective communities beyond the scope of the GBVRSP and prior to the start of the project. WAR provides GBV services in Maun and surrounding areas in the north, as well as providing a place of safety for GBV survivors from all parts of the country. SSI focuses on youth empowerment, family enrichment, strengthening services, and advocacy in Mochudi and surrounding areas in the south. Both organizations have a history of using community mobilization to advance their respective missions.

The aim of the components of the GBVRSP—GBV awareness and educational campaigns in communities, GBV training for providers (increasing the likelihood of word-of-mouth recommendations within the community), and the RIS—is to increase care-seeking behavior in target communities. The project also aims to increase GBV self-efficacy among service providers when they handle GBV cases. The RIS aims to increase completed referrals, meaning that survivors will get the help they need. If the project is successful in achieving these aims, it should make an important contribution to the decline in GBV in these areas of Botswana.

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[4] For more information from Raising Voices and content from SASA!, please see http://raisingvoices.org/sasa/.

OPERATIONS RESEARCH PURPOSE AND QUESTIONS

This report presents the results of the operations research study of the Botswana National Gender-Based Violence Referral System Project (GBVRSP). The purpose of this study was to explore and evaluate the short-term effects of the GBVRSP across comparison and interventions sites over time to facilitate system corrections, and to provide feedback for potential scale-up and future GBV interventions. It presents changes over time and any differences between pilot and comparison sites 12 months after the launch of the referral system.

The results of the operations research (OR) provide information to the GeAD and other stakeholders for programmatic decision making around care provision and referrals for GBV survivors. Results indicate areas of success attained by the GBVRSP in the target areas and compare information gathered from comparison sites. Findings also describe challenges encountered and how they were resolved, as well as the potential for continued implementation of the system. The OR employed a mix of quantitative and qualitative methods to address the research questions that evaluate the objectives of the GBVRSP.

The following OR research questions were developed in collaboration with the GeAD:

1. How has community awareness and perception of GBV and GBV services changed over time?

2. How has GBV service provider awareness and self-efficacy around GBV and provision of GBV services changed over time?

3. How easy is the referral system and referral information system to use among GBV service providers?

4. What are the patterns and trends of referrals provided to GBV clients who need services that are not available at the initiating agency when they present?

5. What are the patterns and trends of initiating agencies over time?

6. What are the patterns and trends of receiving agencies over time?

7. What are the patterns of uncompleted referrals, and what explains these patterns?

The research provides information for programmatic and policy decision making around GBV in Botswana. Improvements in referral pathways and processes in GBVRSP areas, an increase in community awareness around GBV and GBV service provision and increased self-efficacy among service providers in identifying and managing GBV cases was expected as a result of the GBVRSP. This would result in better overall service provision and care for survivors in pilot sites than in control areas.

OPERATIONS RESEARCH DESIGN, METHODS, AND LIMITATIONS

Study Design

This OR used a quasi-experimental design that allows for comparing change over time between intervention and comparison sites. At both initial data collection and at end line, data were collected in the four pilot sites and in four comparison sites matched to ensure a similar culture and GBV service provision environment (e.g., similar number of local NGOs, police stations, and clinics). The first round of data collection was carried out in August 2016, just after rollout of the RIS and the RIS user training. A second round of data collection was conducted in the same sites, but not with the same participants, in August 2017, one year after rollout (see Figure 4).

At each of the eight sites, four community-member FGDs and five to 10 service provider interviews (SPIs) were conducted at both initial data collection and at end line. The SPIs were conducted with providers from various sectors of GBV service provision, such as healthcare, education, police, social work, and NGOs. FGDs were conducted with young men, young women, adult men, and adult women.

Figure 4. Study design for qualitative data collection

GBVRSP Kgatleng (South)				GBVRSP Ngamiland (North)			
Urban		Rural		Urban		Rural	
Intervention	Comparison	Intervention	Comparison	Intervention	Comparison	Intervention	Comparison
Mochudi	Kanye	Artesia	Ranaka	Maun	Gumare	Shorobe	Tsau
Time 1 10 SPIs 4 FGDs	10 SPIs 4 FGDs	5 SPIs 4 FGDs	5 SPIs 4 FGDs	10 SPIs 4 FGDs	10 SPIs 4 FGDs	5 SPIs 4 FGDs	5 SPIs 4 FGDs
Time 2 10 SPIs 4 FGDs	10 SPIs 4 FGDs	5 SPIs 4 FGDs	5 SPIs 4 FGDs	10 SPIs 4 FGDs	10 SPIs 4 FGDs	5 SPIs 4 FGDs	5SPIs 4 FGDs

At end line, key informant interviews were also conducted with stakeholders from GeAD, MEASURE Evaluation, USAID/Botswana, WAR, and SSI. This was an addition to the initial OR design.

This OR also used program monitoring data, including system usage data and summary reports from implementing partners. System usage data are based on monthly reports generated from the referral system to look at number of cases entered, number of cases referred, and number of referrals complete by sector, location, age, and gender. Site summary reports are a synopsis of (1) regular SDP site visits conducted by SSI, WAR, and GeAD partners to document successes, challenges, and proposed solutions; (2) reports based on monthly user support meetings that include discussion of challenges and potential solutions, technical assistance, and other relevant topics related to the referral system; and (3) monthly documentation of community mobilization activities conducted by WAR and SSI.

Data Collection and Analysis

Data collection for both the initial OR report and at end line was conducted by two teams comprised of five women and three men; one team operated in Kgatleng and one in Ngamiland. Each team consisted of four field workers, all of whom were fluent in English and Setswana. The two teams were trained together in Maun in late July and early August 2017. Training content included research aims, description of the referral system, ethics and informed consent, including special concerns related to collecting data on GBV, interview and facilitation techniques, and mock interviews and focus groups. Trainers included two staff with gender expertise. Data were collected over a two-week period—one week in the north and one in the south, with additional days for follow-up as needed.

Participant Recruitment

Focus group participants were recruited from the community. After receiving permission from the community Kgosi, the study team recruited convenience samples from people around the local kgotla (the tribal authority). The study team recruited approximately five men and five women for each group. There were four FGDs in each site: one with men and one with women ages 18–25 years, and one with men and one with women older than 25 years. Facilitators assigned to each FGD were sex-matched (male facilitators with male FGDs and female facilitators with female FGDs). Tea and snacks were provided to focus group participants during the discussion.

A purposive sample was created for interviews with SPIs, with the goal of including the widest variety of GBV service providers as possible. In the intervention areas, the team used lists of providers who were part of the RIS to draw the sample. These providers were listed by sector; if multiple providers were identified per sector, participants were chosen by random number. If a provider was not available for an interview, the next person on the list was contacted. In comparison sites, potential providers were found by the community mobilizer in each region (north or south). Providers were contacted by a member of the research team, who explained the purpose of the OR and asked if they would participate. No incentives were offered to SPI participants. Interviews were conducted at the respective service delivery points.

Data Collection Tools

The consent form was read aloud to each focus group or provider. Focus groups were conducted in Setswana; provider interviews were conducted in either English or Setswana based on participant preference. The FGDs were conducted with two research team members. One research team member was in charge of taking notes and recording, while the other facilitated the FGD. FGDs were held outside in a space that offered privacy from other individuals and where the group could sit down. Focus groups lasted approximately 60 minutes, on average. Most service providers were interviewed in their offices; some were conducted at partner organization sites (WAR or SSI). SP interviews were, on average, 45 minutes long and KIIs were one to one-and-a-half hours long, on average.

Semi-structured guides were used to ensure consistency of questions between data collectors and data collection sites. Semi-structured service provider interview and focus group guides included questions on participant understanding of GBV, why it occurred, and why they thought survivors of GBV may or may not access services. SPIs also included questions about procedures that take place when survivors of GBV seek care with their organization and their experience and thoughts on the new referral system. Key informant interviews with people involved in GBVRSP's leadership included successes and challenges of the GBVRSP, recommendations for improvements, and their thoughts on the potential for scale-up.

Qualitative Data Analysis

All service provider interviews and focus groups were recorded and transcribed verbatim. Interviews in Setswana were simultaneously translated into English and transcribed. An initial quality check of transcripts was conducted at the beginning of the transcription process. Word files were labeled with a coding system to denote location and type of interview; no names or other identifying information were used. Recordings were destroyed after the transcription and verification process.

Transcripts were systematically coded in Dedoose by three study team members. Coding was a rigorous and systematic process that enabled the study team to identify major themes and patterns in the data. A codebook was developed using a combination of deductive and inductive codes. Deductive codes were based on pre-identified themes derived from the interview/focus group guides. Inductive codes were based on themes that emerged while analyzing data; codes for this analysis were derived from memos on themes from a subset of transcripts. Working together, the team coded the transcript of one FGD and one SPI; thereafter, each team member coded transcripts individually. Any questions or clarifications were flagged and discussed as a group. After coding, the team created matrices to identify any trends by gender, service provider type, rural/urban sites, or intervention/comparison communities. Memos, matrices, and code reports were analyzed to identify major findings, themes, and recommendations. This process was repeated with end line data, utilizing the same codebook developed for analysis of data for the initial report, and data were compared to identify changes that occurred over the time of the pilot.

Key informant interviews were analyzed using a rapid memoing process that summarized each transcript into a template to elucidate themes across interviews. At least two members of the research team reviewed transcript summaries for clarification or follow-up, if necessary. Transcript summaries were then reviewed and analyzed for commonalties and insights.

Site summary reports were also examined to identify convergent or divergent themes from the interview and focus group data and to explain trends in RIS usage. A desk review of reports from each implementing partner was conducted. Major themes on challenges and successes in both regions of implementation (Ngamiland and Kgatleng) and differences in experiences between the two areas were assessed. Number of activities reported by implementing partners, including trainings, support visits for RIS implementation, and communication mobilization activities were presented.

Quantitative Data Analysis

RIS usage data were analyzed descriptively. RIS data were examined to identify trends in use (e.g., number of cases entered and referred) and referral completion over time, by site, by provider type, and by client type. Data was then assessed to identify any observed differences in cases entered, referred, or completed by each of these subcategories, although these differences were not tested statistically.

Ethical Approval

The study was approved by the Republic of Botswana's Ministry of Health Internal Review Board (Ref: HPDME 13/18/1 X [601]) and the Gender Affairs Department in June 2016; this approval was renewed in June 2017. The study was given a determination of "nonresearch" by the Institutional Review Board at the University of North Carolina at Chapel Hill, USA.

Study Sites

Data were collected in eight sites—four in the north of Botswana and four in the south (see Table 3).

As noted earlier, intervention and comparison sites were matched by district and size (urban or rural) so that sites with a similar culture and GBV service provision environment (e.g., similar number of local NGOs, police stations, and clinics) were being compared. However, the population in Botswana is very mobile. All villages with a population of over 100 are connected to the main transport grid. The population of large villages fluctuates seasonally as people move out to satellite homesteads and cattle posts to plant, harvest, and herd their animals. Also, people move over weekends to do shopping in towns, where products are cheaper and more varied. Further, rural areas have limited GBV, health, policing, and social services, and complicated cases have to be referred to larger towns. This means that there could have been "spillover" or "contamination" of intervention activities from intervention to comparison sites.

Figure 5. Map of data collection sites

Table 3. Data collection sites and characteristics

Region	Urban/ Rural	Site*	Intervention/ Comparison	Description
South	Urban	**Mochudi**	Intervention	• Mochudi is an urban village and the capital of the Kgatleng District of Botswana. • Mochudi had a population of 44,815 in 2011 and is the tenth largest village in Botswana. • In 2008, agriculture was the primary industry in the district, followed by wholesale and retail trade and education (CSOB, 2008). • The village had 11 primary schools, 5 junior secondary schools, and 1 senior secondary school; a magistrate court and a police station; and 10 health facilities, including 1 hospital, 5 clinics, and 3 health posts. • Mochudi has 9 social and community development (S&CD) offices and 5 civil society organizations. It also has the Mochudi Main Kgotla and Village Development Committee.
		Kanye	Comparison	• Kanye had a population of 47,007 in 2011, making it the eighth largest village in the country. • It had 1 senior secondary school, 6 junior secondary schools, and 24 primary schools; 1 Gender Affairs office; and 18 health facilities, including 1 hospital, 7 clinics, and 10 health posts. • There were two police stations, one or more S&CD offices, and the Kanye Main Kgotla and Village Development Committee.
	Rural	**Artesia**	Intervention	• Artesia, also known as Mosomane or Artisia, is a rural village of approximately 2,365 as of 2011 (CSOB, 2014). • Artesia is also located in the Kgatleng District. • Local facilities and services include 1 primary school and 1 junior secondary school, 1 police post, a clinic, 1 S&CD office, the Main Kgotla, and the Village Development Committee.
		Ranaka	Comparison	• Ranaka is a small village in the Southern District of Botswana, proximate to Kanye. • Principal livelihoods are cattle farming and production of maize and sorghum. • The population is 2,409 as of 2011 and it has 1 clinic, 1 primary and 1 junior secondary school, a police post, an S&CD office, the Main Kgotla, and the Village Development Committee.
North	Urban	**Maun**	Intervention	• Maun is a town of 60,273, making it the fifth largest village in Botswana (CSOB, 2011). • Maun is the administrative center of the Ngamiland District in northern Botswana and is

				considered the tourism capital of Botswana due to the nearby Okavango Delta.
				• Local facilities and services include: 1 Regional Education Office, 20 primary schools, 5 junior secondary schools, 1 senior secondary school, 8 postbasic educational institutions, 1 police station, and 3 police posts, 9 S&CD offices, 1 Gender Affairs office, and 14 health facilities including 2 hospitals, 7 clinics, 4 posts, and a rehabilitation center, the Main Kgotla, and the Village Development Committee.
				• The directorate of public prosecution, Legal Aid Botswana, and the Magistrate Court are located in Maun.
				• Seven civil society organizations are listed in the GBVRSP service directory.
		Gumare	Comparison	• Gumare (population 4,556 as of 2011) is a rural village located in the North-West District of Botswana near the panhandle of Okavango Delta.
				• The major economic activities include tourism, subsistence fishing, rearing livestock, handicrafts, and small-scale industries.
				• Facilities and services include 4 primary schools, 1 junior secondary school, 1 hospital, 1 clinic, 1 police station, 2 civil society organizations, S&CD, and the Kgotla.
	Rural	**Shorobe**	Intervention	• Shorobe is a very small village in the North-West District of Botswana.
				• The population was 1,031 at the 2011 census (CSOB, 2014).
				• Local facilities and services include 1 primary school, 1 police post, a clinic, 1 S&CD office, the Main Kgotla, and the Village Development Committee.
		Tsau	Comparison	• Tsau is a small rural village (population 2,000 as of 2011) with 1 primary school and 1 junior secondary school, 1 health post, 1 police post, 1 S&CD office, and 1 civil society organization.
				• Like all villages and towns, Tsau has a Kgotla and a Village Development Committee.

* Bolded sites are intervention sites; all others are comparison sites.

Limitations

This research has some limitations. Initial data collection occurred after the system rollout and community awareness and trainings had begun. WAR and SSI have been implementing GBV community mobilization activities in their respective communities since 2015, and the Gender Affairs Department has been engaging stakeholders and GBV providers in a long series of conversations about how to improve quality of care to survivors of GBV for many years. As such, initial data collection does not reflect a true pre-intervention baseline for the intervention areas, which may explain initial differences

between intervention and comparison sites. Comparison sites, however, did not receive any of the referral system or GBV trainings, thus remaining a comparison group.

The research design intentionally did not include sampling survivors of GBV to explore their experiences accessing services and completing referrals due to ethical and safety protocols. This does, however, limit the conclusions that can be drawn regarding quality of care received and reasons why clients may not complete referrals. While survivors of GBV were not intentionally sampled, they were not excluded from participating in focus group discussions. There were no questions about personal GBV experiences in the FGD guide. Recruitment for the FGDs was also a limitation in that participants were selected via snowball sampling among individuals who were available and near the Kgotla community at the time of data collection. This was not a random sample of community members, and it is possible this method was more or less likely to include individuals that participated in local community mobilization efforts.

Social desirability may play a role in FGDs if participants do not voice their opinions or beliefs when they feel their views are less popular or in contradiction with more popular views of gender norms or understanding of GBV. This may be a limitation of provider interviews as well; providers may have been more likely to report positive responses about the referral system due to social desirability bias.

While recruitment of service providers for interviews aimed to include the widest range of GBV service providers, it is possible that potential participants could have been systematically excluded, for example, if there was a systematic difference in service providers who were unavailable to be interviewed or trained. However, in rural sites almost all relevant service providers were interviewed, and most providers in the intervention sites agreed to participate in interviews; as such, it is unlikely that these results are biased by this potential limitation.

Finally, the time period of one year between initial and end line data collection is a limitation as well. Changes in attitudes, norms, and behaviors often take substantial time to shift. A similar study of a SASA program, for example, was of a four-year intervention (Abramsky, et al., 2014). One year of implementation of community mobilization efforts may not be enough to affect sustained and noticeable change in GBV among community members. Change among service providers regarding collaboration and RIS usage would be more likely to reflect differences over the period of a year.

The triangulation of data from community members, providers who were trained and not trained, referral system usage, and monthly site summary reports from intervention staff strengthen this study. Both consistencies and conflicts among data sources provide a richer demonstration of the referral system's strengths and areas for improvement.

FINDINGS AND CONCLUSIONS

At initial data collection, 59 in-depth interviews and 32 focus groups were conducted in four intervention sites and four comparison sites matched on urbanicity (rural/urban) and location (north/south). Service provider interviewees were predominately female (n=39); 20 men were interviewed. At end line, 59 in-depth interviews and 33 focus groups were conducted. Service provider interviewees were predominately female (n=43); 16 men were interviewed. Seven key informant interviews were also conducted at end line. Table 4 documents the number of SPIs by type for each site at each time point.

Program monitoring data show that, between August 2016 and July 2017, more than 10,000 contacts have been made through gender and GBV awareness activities in the northern intervention sites and more than 5,000 in southern intervention sites. Since May 2016, 178 service providers in the north and 141 in the south from all sectors were trained on GBV awareness, the GBV referral system, or provided with a general GBV sensitization training. Between August 2016 and July 2017, 401 GBV cases were logged into the system, 33 percent (n=134) were provided with a referral, and 30 percent (n=40) of referrals were completed.

Below are detailed results of the primary research questions for this pilot: (1) differences in community awareness and perception of GBV and GBV services between intervention and control sites; (2) differences in provider awareness of GBV issues and self-efficacy regarding GBV service provision between intervention and control sites; (3) provider feedback to improve functionality of the referral system; and (4) patterns of data on referral system usage and completion between sites and provider types. Table 5 summarizes differences between sites and over time for each research question; more detailed results are documented in subsequent sections.

Table 4. Number of interviews and focus groups by site at data collection time point (initial or end line)

Site Information			Focus Groups		Service Provider Interviews														
Region	Urban/ Rural	Site*	**Total FGs**		Health Sector		Police/ Justice		NGO		School		Social Worker		Tribal Authority		**Total SPIs**	
			i	e	i	e	i	e	i	e	i	e	i	e	i	e	i	e
South	Urban	**Mochudi**	**4**	**4**	**2**	**2**	**1**	**2**	**1**	**2**	**2**	**2**	**2**	**1**	**1**	**1**	**9**	**10**
		Kanye	4	4	2	2	2	2	3	2	2	1	0	2	1	1	10	10
	Rural	**Artesia**	**4**	**4**	**1**	**1**	**1**	**1**	**0**	**0**	**1**	**1**	**1**	**0**	**1**	**1**	**5**	**4**
		Ranaka	4	4	1	1	1	1	0	0	2	1	0	1	1	1	5	5
North	Urban	**Maun**	**4**	**5**	**1**	**4**	**2**	**2**	**3**	**1**	**2**	**1**	**1**	**1**	**1**	**1**	**10**	**10**
		Gumare	4	4	1	2	2	2	3	1	3	2	1	2	1	1	11	10
	Rural	**Shorobe**	**4**	**4**	**1**	**2**	**2**	**1**	**0**	**0**	**0**	**0**	**1**	**1**	**0**	**1**	**4**	**5**
		Tsau	4	4	1	1	1	1	0	0	1	1	1	1	1	1	5	5
Total			32	33	10	15	12	12	13	6	13	9	7	8	7	8	59	59

*Shaded rows with bolded font indicate intervention sites; i = initial data collection; e = end line data collection

Table 5. Summary of results and site differences, by research question

Research Question	End Line Results
Community understanding of GBV	There were no differences demonstrated between time points regarding community understanding of GBV. **Variation in definitions and causes of GBV was observed across all sites, and there were no discernable differences between intervention and comparison sites.**
Community awareness of GBV	**As at initial data collection, most focus groups had disagreement among participants about if and when violence was acceptable; however, some moderate gains were seen in the data at end line.** At initial data collection, participants in 6/32 focus groups thought GBV was acceptable, whereas only one set of focus group participants at end line fully endorsed GBV. Participants in half of the male focus groups in interventions sites were unanimous in condemning violence between partners, whereas participants of male focus groups in comparison sites were almost all conflicted, except for one in which all participants seemed to agree that there were instances where GBV was acceptable. Interestingly, the majority of focus groups that fully condemned GBV were in rural areas (6/8). There were no differences between north and south.
Community perceptions on availability and quality of services	**Resources reported at end line mirrored those reported by participants at initial data collection**, which included family, the Kgotla, police, social workers, health facilities, NGOs, and educators. While there was substantial variation in participant's perceptions of service quality, **participants in intervention sites at both initial collection and end line more frequently reported that service providers maintained confidentiality than participants in comparison sites**. Women at end line more frequently reported mixed feelings about the quality of the services as opposed to high or low quality (8/15), while men more frequently reported that services were low quality (7/15).
Provider understanding of GBV	As was demonstrated at initial data collection, **providers in intervention sites provided more complex and thorough definitions and understanding of GBV than providers in comparison sites**. Similar to initial data collection, providers in comparison sites more frequently demonstrated attitudes that justified violence on the basis of victim behaviors (e.g., dressing inappropriately), and these attitudes were most commonly demonstrated by justice service providers. Traditional leaders in particular seemed to demonstrate improvement in their understanding of GBV from initial data collection to end line. Facilitators and barriers to victims reporting cases of GBV did not differ between initial data collection and end line, though **at end line, providers in intervention sites more frequently reported that provider confidentiality and trust can be a facilitator to reporting.**
Provider comfort in delivering GBV services	**At end line, fewer service providers in the intervention sites were clearly uncomfortable handling GBV cases than in comparison sites.** In comparison sites there was also a demonstrated disconnect between understanding of GBV and comfort handling cases, with some providers saying identifying GBV was easy, but giving simplistic definitions of GBV and its causes. School service providers, particularly in intervention sites, demonstrated inconsistencies in their processes for involving external stakeholders in GBV cases. **At end line, SOPs were more readily acknowledged and available in intervention sites than at initial data collection.** As at initial data collection, comparison sites were not familiar with SOPs at end line.

Provider collaboration and trust	**Trust and collaboration among providers in intervention sites remained high between initial data collection and end line, while no changes were seen among comparison providers**. Intervention providers mostly attribute improved working relationships with other sections as the result of collaboration at monthly support meetings. Service providers in intervention sites more frequently reported confidence that clients received the care they needed than comparison sites.
GBVRSP/RIS feedback	Similar to initial data collection, **service providers expressed positive views towards the GBVRSP at end line, particularly related to increased collaboration among providers due to trainings and meetings**. In service provider interviews, more than half of NGO and healthcare providers reported using the system. School-based providers were least likely to say that they had used the system. While only a small number of social workers were available for end line data collection, all three reported using the RIS. RIS data show that NGO providers had the highest number of cases entered into the system at end line, as well as the largest percentage of completed referrals. Northern sites still demonstrated the highest proportion of cases and referrals in comparison to southern sites.

Awareness and Perception of GBV and GBV Services among Community Members

At initial data collection, there was a wide range of GBV definitions and opinions regarding the acceptability of violence among both men and women in the community. At end line, participants in both intervention and comparison sites still ascribed a wide range of action as GBV but saw some modest improvements in acceptability of GBV. At both time points, participants were fairly uniform in describing the community's response to GBV. While participants of most focus groups felt that GBV remained a problem, focus groups in intervention sites more frequently reported improvements over the last year than comparison sites. Finally, small differences in service quality perceptions by gender were noted at initial data collection. At end line, intervention sites more frequently perceived services as being confidential than comparison sites, and some differences by gender remained.

Defining GBV and Identifying Causes

In general, there was **a lack of clarity around defining GBV**. The types of violence most frequently identified were physical, sexual, and emotional violence. Participants most often spoke of GBV as mistreatment or abuse that takes place in the context of an intimate relationship or within families. Participants often included violence against children, or children disrespecting adults or not taking care of elderly parents as forms of GBV. A few participants additionally confused GBV with homosexuality.

At end line, more commonly in the comparison sites and in the male FGDs in intervention sites, participants described refusing to have sex or to cook as a type of abuse women inflict upon men. This was less common in female FGDs conducted in intervention sites. Some participants in the male FGDs stated that women were actually the primary perpetrators of GBV, and men more often victims, but the more common perception was that men are the usual perpetrators.

Here some male participants from an FGD in an urban intervention site discuss forced sex in a relationship as not constituting GBV:

> Respondent: *Are you taking about raping a partner or just a stranger being raped? Because in a relationship, that's not rape because the woman is being difficult.*
>
> Respondent: **giggles**
>
> Interviewer*: If your partner doesn't want to have sex and you force her to, that's rape.*
>
> Respondent*: If we are in love it's not rape.*

While FGDs conducted at initial data collection were generally consistent with identifying the causes of GBV—most commonly citing economic context of high rates of unemployment and female dependence on men—end line FGDs were less consistent. Economic dependency was frequently cited, as was alcohol use but a wide range of other causes were also named. A number of female groups mentioned that cultural expectations related to men being the head of the family contributed to violence, specifically by reinforcing the idea that women are expected to obey their husbands and that abuse can be a form of discipline when they disobey.

A strong theme that emerged from male FGDs were frustrations with what men perceived as women's gaining of rights at men's expense. Several participants felt that women's expression of their rights caused

GBV, as exemplified by a young man's perspective from a focus group conducted in an urban intervention site:

> Respondent: *As a young person, I've noticed that the high incidences* [of GBV] *are caused by rights.*
>
> Interviewer: *Human rights?*
>
> Respondent: *Yes. The promotion of human rights has encouraged GBV. There should be a difference between a woman and man. Everyone should know what their roles are. We should go back and define our individual roles because people feel they can perpetuate violence because they have rights. Women say they have rights just like us. We men also* [have] *rights like women.*

Like a number of the service providers interviewed at end line, some focus group participants, particularly men, expressed attitudes justifying violence towards women on the basis of behaviors that may have "attracted" the violence, such as wearing revealing clothes or drinking alcohol.

This concern regarding an increase in human rights causing GBV also extended to children's rights; many participants felt frustrated by the perceived lack of respect from youth to adults and adults' limitations in physically disciplining them. Below are two examples, the first from a group of older men in a rural intervention site and the latter from a group of older men in an urban intervention site.

> Older men, rural intervention site:
>
> Respondent 1: *According to my own understanding, gender-based violence occurs because the youth don't listen to us. I could also say that mothers don't listen to us. When we try to reprimand children, mothers get angry, therefore children aren't disciplined. This causes households to get dysfunctional, as everyone does what they want. The man is the head* [of] *household…maybe each family should be told this. Maybe that's how we can fight gender-based violence.*
>
> Interviewer: *Anyone else?...*
>
> Respondent 2: *These days there's no respect and dignity in relationships. Women undermine men, but we grew up knowing that men are to be respected. Men also undermine women and do anything they want to them because women are physically defenseless. Women violate men knowing that the law will protect her.*
>
> Older men, urban intervention site:
>
> Respondent 1: *I do believe that things have changed, because back in our days, the law was stricter. The introduction of rights changed things.*
>
> Respondent 2: *Even young children who can't feed themselves or who don't own anything have rights. We should be allowed to beat children when they misbehave but the introduction of rights prevent us from doing this.*
>
> Respondent 3: *People are going against Setswana culture by introducing rights.*

GBV Acceptability

As was seen in initial focus groups, community members displayed tension around knowing that GBV was against the law and identifying instances in which it did or should happen. Some moderate gains were seen in the data over the previous year: at initial data collection, participants of six of 32 focus groups

thought GBV against women was acceptable, whereas only one set of focus group participants at end line fully endorsed GBV. There were no female groups that fully endorsed GBV at end line, whereas participants of two female focus groups at baseline endorsed GBV.

As was seen at initial data collection, some participants at end line did not think GBV against women was acceptable in any circumstance. Here, a participant from a focus group conducted with older males in a rural intervention site fully condemns GBV:

> *The country as a whole should know that physical violence against women is unacceptable. A man that beats a woman is not a real man. This matter makes me unhappy. Nowadays we beat each other to the extent of murder. There's no reason whatsoever for a man to beat a woman. We don't condone such, violence doesn't solve anything.*

Participants in half of the male focus groups in interventions sites were unanimous in condemning violence between partners, whereas male focus groups in comparison sites were almost all conflicted, with some participants endorsing GBV and others not, except for one in which all participants seemed to agree that there were instances where GBV was acceptable. Most female focus groups conducted in the intervention sites were conflicted, with only one fully condemning GBV. In female comparison site focus groups, five of eight were conflicted and three of eight fully condemned GBV. Interestingly, the majority of focus groups that fully condemned GBV were in rural areas (6/8). There were no differences between north and south.

The majority of focus groups had at least some participants identifying violence as unacceptable, with some participants identifying violence as acceptable (23/33). Here a group of young males from a rural intervention site disagree about when it is and is not acceptable to use violence in a relationship.

> Interviewer*: Do you believe there is any reason or situation where it is acceptable for a man to beat his partner?*
>
> Respondent*: No. I don't believe there is any reason, I don't have the right to beat anyone, it could be my partner, sister or friend… or a stranger.*
>
> Respondent*: Circumstances differ. A man could lose his temper if pushed by his partner. This is what causes him to beat her.*
>
> Interviewer*: So you think that the men beat their partners due to their temper?*
>
> Respondent*: Yes.*
>
> Respondent*: I disagree with that. We know that women are people who can't stop talking. Men should solve this by leaving the house for some time to cool down their emotions.*
>
> Respondent*: I agree and would like to add onto what he said. When couples fight and disagree, one of them should go to their parent's house for some time. The two can later solve their problems after time away from each other…*
>
> Interviewer*: How about if she sleeps with another man?*
>
> Respondent*: I personally feel that if a woman cheats on me, she's not satisfied with me. In that case, we should break up.*
>
> Respondent*: I would beat my partner.*

The theme expressed by the above group regarding men's emotional unpredictability was echoed by other focus group participants. They indicated that although violence may be unacceptable, men can have strong emotional reactions that cause them to lash out at their partners and result in violence or abuse. Most commonly, this was referenced as a potential reaction to a female partner sleeping with another man.

Female participants also agreed that there were instances when men were justified in beating their partners, as exemplified by this exchange of young women in an urban intervention area.

> Interviewer: *What if she doesn't respect him?* [Can it be a valid reason for a man to beat her?]
>
> Respondent: *If she doesn't respect him, when a woman does not respect a man he should report her to the relatives.*
>
> Respondent: *By doing that she is abusing the man.*
>
> Respondent: *Yes.*
>
> Respondent: *He should report her to the relatives so that they can question why she is not respecting her father, because the husband is her father… Yes, that's how things are in my family. My husband is my "father." Yes, I respect him more than anyone in the world.*
>
> Interviewer: *What if she has sex with another man? Can it be a valid reason for a man to beat her?*
>
> Respondent: *He can beat her.*

When asked if it was acceptable for women to be violent towards male partners, substantially more focus groups unanimously condemned the use of violence against men (14/26). Again, participants in rural areas more frequently did not endorse GBV against male partners compared to urban areas, which provided more mixed responses. Below, a female focus group collectively agrees that female perpetration of violence toward a male partner is unacceptable.

> Interviewer: *Do you believe there is any reason or situation where it is acceptable for a woman to beat her partner?*
>
> **laughter**
>
> Respondent: *No.*
>
> **laughter**
>
> Respondent: *There aren't any.*
>
> Interviewer: *Why?*
>
> Respondent: *The man is the household head.*
>
> Respondent: *According to Setswana culture, a woman is not allowed to lay a hand on her partner. She is supposed to obey and respect him.*
>
> Interviewer: *Do you all agree?*
>
> Respondent: *Yes.*

There were a substantial number of groups that reported mixed feelings on women using violence against male partners. Here, women in a rural comparison site share an exchange echoed by participants in other focus groups about women using violence when their partners are violent with them:

> Interviewer*: Do you believe there is any reason or situation where it is acceptable for a woman to beat her partner?*
>
> Respondent*: No.*
>
> Respondent*: No.*
>
> Respondent*: If a man beats me, I'd beat him back.*
>
> Respondent*: No, but that's not right.*
>
> Respondent*: Why not? I'd beat him.*
>
> Interviewer*: Please elaborate.*
>
> Respondent*: I have to beat him back. I want him to feel the violence too!*
>
> Respondent*: Do you think that's the right thing to do?*
>
> Respondent*: Did he think it's right for him to beat me?!*

Only one male focus group in a comparison site fully endorsed GBV against either a man or a woman.

Availability and Quality of GBV Services

At initial data collection, participants almost universally named family and the kgotla as appropriate places for victims of GBV to seek initial help. This was also true at end line, although many focus groups, especially female groups, identified that families often discouraged women from reporting GBV to avoid ruining the family reputation or because of economic dependence on the perpetrator. At end line, participants of female focus groups in both intervention and comparison sites felt that survivors of GBV were not supported by families or the communities and that perpetrators were not held accountable.

In addition to the family and kgotla, participants in almost all focus groups named police, healthcare providers, and social workers as potential resources for victims of GBV. Intervention site focus groups often named SSI or WAR, the community mobilization implementing partners, as a resource as well. The first OR report reported that the lack of clarity about how to define GBV led to confusion about when it was appropriate to use those services. For example, one participant relayed an instance of calling police when his wife burned the food. At end line, many male participants—including those who felt refusing sex was a form of GBV against men, that women were obligated to have sex with their husbands, and who blamed women for inciting violence—felt that service providers did not take male victims of GBV seriously. It was unclear what prompted the seeking of services; for example, here a man from a focus group conducted in a rural intervention site bemoans the police's lack of sensitivity towards GBV against men but then provides examples of "violations" that do not fall within the traditional definition of GBV:

> Respondent*: Yes. GBV is a major problem. I'd like to say that even men get violated, it happens a lot. The problem is that men fear to report it because the police make fun of us for being violated by women. When a man has problems with his partner, he fears going to seek help from people such as the Kgosi, he feels ashamed. Men*

keep such issues to themselves, but at the end, when they can't take it anymore, they end up murdering their partners….

Interviewer*: You mentioned that men get violated. Please give me two examples of this.*

Respondent*: Men are violated through many ways. For example, when a man has money, he is expected to give his partner money and he has a little left for himself. Women also refuse to sleep with us, this is sexual abuse. Men fear talking about such issues. Men really suffer if they don't have jobs as women put pressure on them to make money.*

At both time points, participants listed barriers for women to access services, including shame, economic dependency, love, and self-blame. Participants reported that women would not be believed by their families, would be blamed for experiencing the violence, or would be discouraged from breaking up their families. Closely tied to shame, a fear of lack of confidentiality among service providers was seen as a major barrier, with some indicating that especially small communities increased the likelihood of confidentiality breaches. At initial data collection this was reported by women in both intervention and control sites and men in comparisons sites, but not men in intervention sites. At end line, intervention sites more frequently reported that services were confidential (9/14) than not confidential (5/14); comparison sites more frequently reported services were not confidential (8/14) than were confidential (6/14).   At both time points, many participants said that often women could not leave abusive relationships because of being financially dependent on their partner. Survivors would not seek services or were discouraged by their families from doing so to avoid breadwinners being arrested and losing their livelihoods.

Women who were able to access services, according to community members, could do so because they were "empowered" and knew that abuse was not allowed; were "fed up" with the abuse; had support from their families or friends; needed medical care; or were afraid for their lives because the abuse had escalated dramatically. This was reported at both time points. Despite most participants being able to name several reasons that would prevent a woman from leaving an abusive relationship, some focus group participants displayed negative attitudes towards these women. For example, young women in a focus group conducted in an urban intervention area at end line display both sympathy towards women who are not able to report abuse as well as blame:

Interviewer*: What are some of the reasons that may force a person to not report even when they had wanted to report?*

Respondent*: Fear of being laughed at. They don't want people to gossip about them because they have reported. That's what I think.*

Interviewer*: Erh, what are the reasons that would make a person to report abuse?*

Respondent*: Extreme emotional pain. That's when one would report. Ah, let me keep quiet, I talk too much!*

Respondent*: You are not talking too much. The thing is, when I am the part of the family (it's hard for me to say out some of the things). There is nothing that you can do but get help from other people.*

Respondent*: When it has worsened.*

Respondent*: Yes.*

Interviewer*: Why are some people reporting abuse while others don't?*

> Respondent: *Some people like hiding the truth. Even when they are being abused they sill hide it. Maybe they enjoy what they are going through. When someone is abusing you, you must go to the police. When you don't report, when you choose to become a slave that* [is] *your problem.*

At initial data collection, participants also said victims of GBV were discouraged from reporting abuse because of slow, insensitive, or inadequate responses by service providers. At end line, similar barriers were reported, including victims feeling demoralized by poor quality services. Participants repeatedly mentioned that men were embarrassed, laughed at, and mocked by service providers when reporting. Participants of focus groups in intervention sites at end line were more likely to say that services were confidential overall but were just as likely as comparison groups to cite lack of police sensitivity and/or confidentiality. Social workers were also occasionally mentioned in both intervention and comparison sites as lacking confidentiality. Female focus group participants in intervention sites did not frequently name service provider quality as a barrier to accessing services at end line.

In general, participants provided mixed opinions on the quality of GBV services in their communities. Participants in eleven focus groups felt that some providers were better than others, or there was disagreement within the group about the quality of services; participants of 10 focus groups felt that service providers provided low quality services, while those of nine focus groups felt that services were high quality. Rural focus group participants more frequently reported that services were high quality, whereas urban focus group participants more frequently reported that services were explicitly low quality than rural focus group participants. Women more frequently reported mixed feelings about the quality of the services as opposed to high or low quality (8/15), while men more frequently reported that services were low quality (7/15). At end line, participants across groups were particularly critical of police handling of GBV cases in terms of sensitivity towards clients, timeliness in processing cases, and maintaining confidentiality.

A female participant from a focus group of young women from an urban comparison site reported this experience at the police:

> Respondent: *In December last year, a friend of mine got rape*[d]. *It was during the festive season. She was drunk. When we got to the police, the policemen didn't take her very seriously because she was drunk. We were shocked to find out that the rapist was a member of our community. The police men mentioned that if she doesn't stand up for herself, no action will be taken. The perpetrator has many rape cases. The policemen know him.*
>
> Interviewer: *Why did the policemen say that no action will be taken?*
>
> Respondent: *Because the rapist has many cases that still haven't been attended.*

Changes in the Previous Year

While most focus groups felt that GBV remained a substantial problem in their community, focus groups in intervention sites more frequently reported improvements over the previous year (6/16) compared to comparison sites (2/16). These improvements included women more frequently reporting GBV, providers being more supportive to survivors of GBV when providing care, or there being fewer cases. For example, participants of one focus group of young women in a rural intervention site said:

> Interviewer: *Do you think these reasons and barriers have changed over the past year? Reasons why others report while others don't. Do you think these reasons have changed over the past year? Is there a difference?*

Respondent*: There's no difference.*

Respondent*: These days I've noticed that things are different. People report cases nowadays. This shows that they have been educated about GBV. Stepping Stones is here in the village to educate and raise awareness.*

Most participants in intervention site focus groups reported knowing that GBV community activities were being held in their community and all mentioned WAR or SSI. Few comparison site focus groups reported any GBV activities, sometimes mentioning service providers, a police forum, or a youth or church group providing education. In intervention focus groups, there were mixed opinions from participants about the breadth of coverage or whether the community took these activities seriously. No male focus groups and only two female focus groups in the comparison sites reported any changes in service provision in the previous year; similarly, in intervention sites, most did not report change, but participants of one male FGD and two female groups did report positive change. A handful of male and female participants in interventions sites had heard of the GBV referral system, but most had not.

GBV Service Provider Awareness and Self-Efficacy around GBV and Provision of GBV Services

Definitions and causes of GBV referenced by service providers were varied at both time points, with some improvements noted among intervention providers at end line. Improvement was clearest among traditional leaders. At end line, fewer service providers in intervention sites were uncomfortable with their role handling GBV cases than in comparison sites.

Intervention site service providers strongly emphasized the usefulness of monthly support meetings in establishing connections with other providers and troubleshooting difficult cases. More providers in the intervention sites said they were confident that GBV clients received the services that they needed, and comparison site providers sometimes mentioned that they did not know what services other providers offered or whether they were trained.

As in initial data collection, providers in intervention sites generally expressed positive views towards the GBVRSP, and over half of providers in intervention sites reported using the mobile RIS. Overall, providers thought that the RIS was more efficient than the old system, though providers sometimes noted difficulties in using the mobile RIS. Between both comparison and intervention sites providers expressed a desire for more training on GBV.

Understanding GBV

As with the initial results, at end line, service providers varied in how they defined GBV, with responses ranging from defining GBV as any form of violence perpetrated against someone because of their gender to defining GBV more generally as abuse or ill-treatment of others. Defining GBV is particularly challenging, especially in the local language, Setswana, as the words "gender-based violence" do not have a direct translation, but rather translate to "violence between a woman and a man." As a result, some variation in defining GBV may be explained by difficulties in translation. However, intervention service providers specifically mentioned gender in their definition of GBV more frequently than providers in comparison sites at end line. This difference was not observed at initial data collection.

Many service providers highlighted that victims of GBV are primarily or exclusively women, and some mentioned the role of cultural norms and power dynamics in GBV perpetration. These concepts related to culture and power are primarily described as being linked to the roles that men and women are expected to occupy in relationships. Local implementing partners note that discussion of power dynamics is likely due to use of the SASA! method in education and mobilization, which focuses on men's individual and collective power over women. One NGO service provider in an intervention site said:

> *Belief systems are also powerful… Some may think that it doesn't really matter. For example, in marriages, men feel that they own their wives. Cultural influence and socialization also play a role and make people to believe that although GBV exists, they have the power to determine what happens in their home. Men believe they have the power to choose if they want to beat their wives, so violence goes unreported. People know it happens, but they don't term it as GBV—they call it discipline.*

Overall, service providers in the intervention sites demonstrated more complexity in their understanding of GBV than comparison sites. Many comparison service providers exhibited hesitation in defining GBV, sometimes giving short answers with little elaboration, and two comparison service providers requested not to answer the question regarding defining GBV. NGO service providers and social workers

demonstrated a more thorough understanding of GBV and its causes in both intervention and comparison sites. There was little consistency in the type of service providers who demonstrated the least thorough or complex understanding; however, responses from justice service providers in general gave less detailed descriptions of GBV or often simply described GBV as general abuse or violence. Seven service providers, mostly from justice, discussed GBV in ways that excused those who perpetrate violence or justified how victims were responsible for attracting violence, such as alcohol consumption or other behavior by victims that led to or invited violence. For example, one justice service provider in a comparison site said of their role in identifying GBV cases:

> *We have to look causes and the subcauses of the GBV incidence. We have to investigate rape cases and look at the possible causes, such as if the victim was drunk, and their dress code. Sometimes the victim was unaccompanied at night and drew attention to rape through their dress code. These are the issues we talk about in public forums. We ask victims why they walk unaccompanied late at night and why they got drunk… as these are the reasons why they faced rape. Some victims fear reporting rape cases to their family members, because family members always warn victims against gallivanting late at night and drinking alcohol. They feel ashamed for not listening.*

As was also the case at initial data collection, these attitudes justifying violence due to behaviors of the victim were less common in the intervention sites than in comparison sites.

Understanding of GBV in intervention sites seems to have improved between time points. At initial data collection there were some service providers from intervention sites who were not confident in their description of GBV and its causes, which was not demonstrated in interviews at end line. Traditional leaders in intervention sites, in particular, showed improvement at end line, describing GBV and its causes with more depth and clarity than the previous year. One traditional leader went even farther and adopted the role of gender champion in his community, saying:

> *I've taken it upon myself as a village leader to be a gender activist against my customary demands. Now people know…whether it is at funerals, weddings or kgotla meetings, I speak about GBV at any form of gathering. People now know and think about why they still practice these things. It is a matter of time because others don't understand. Some understand…they're a drop in the ocean but it'll make a difference over a period of time.*

Service providers were generally consistent in identifying the primary causes of GBV, with many referencing culture, lack of education, and poverty/financial difficulties. Alcohol and substance abuse also featured prominently as a cause of GBV in many responses across both intervention and comparison sites. This link between alcohol abuse and GBV was expressed by more northern service providers than southern service providers. As was seen at initial data collection, service providers also referenced barriers that prevent GBV victims from reporting, including shame, embarrassment, fear of retribution or violence, and a desire to protect the perpetrator. Financial dependence was a common barrier to reporting mentioned by service providers in both intervention and comparison sites, particularly among women whose partners were the family breadwinners. This barrier was echoed in focus group discussions with community members. One justice service provider described this barrier, saying:

> *Others fear that their perpetrators will go to jail, especially if it's their partner… I've once had victims tell me that their perpetrator is their provider and if they lay charges against them, what will they eat?*

Causes of GBV and reasons for not reporting GBV did not differ substantially between time points. Facilitators to reporting at end line were still primarily attributed to victims' internal attributes, such as

being educated and empowered, and most service providers in both intervention and comparison sites still indicated that victims report when they are "fed up" with abuse or when the situation becomes life threatening. At end line, a few service providers also mentioned that the referral system plays a role in GBV reporting, as provider confidentiality and trust can be a facilitator to reporting. Similar to initial data collection, this was primarily mentioned in the intervention sites.

When asked whether members of the community know about GBV, service providers primarily said that knowledge about GBV was limited. Across intervention and comparison sites, service providers indicated that culture and stigma play a role in community understanding of GBV and reporting of cases. Many providers also said that victims in their community often lack sufficient knowledge of where to report instances of GBV. However, overall, service providers seemed to express agreement that there is a need for more education within their communities, and some indicated that they already knew of awareness-raising activities that were currently ongoing. One service provider said:

> Interviewer*: Do you think people in your community know what GBV is?*
>
> Service Provider: *Some do, some don't. I'd say there's an effort in educating the community, community facilitators and educators have been working to educate the community. I wouldn't say they are clueless. Most people know but due to ignorance, they choose not to. The police and kgotla also educate people…there's always something being said.*

Comfort Handling GBV Cases That Present at Their SDP

Service providers' comfort levels in handling GBV cases varied significantly. Only two service providers in intervention sites were clearly uncomfortable handling GBV cases, compared to more than a quarter of service providers in the comparison sites. This difference in comfort handling GBV cases between intervention and comparison sites is one that was also observed at initial data collection. One healthcare service provider in an intervention site described their process for handling a GBV case in this way:

> *I welcome her in a silent room where there's enough fresh air…it has to be conducive environment. I have to be alone with her and take her history and let her explain herself. After collecting the history, I start doing physical assessments from head to toe… After this I start counseling her and after meeting her emotional needs I then give her some therapy if she needs some medication… and even refer her case to the appropriate people, like social workers or police.*

Most service providers in intervention sites demonstrated comfort describing their role and process for handling GBV cases. Many service providers in intervention sites were also comfortable describing their process; however, in comparison sites, a service provider's comfort in describing their process for handling GBV did not always correlate with their explanation and understanding of GBV. For instance, a few service providers in comparison sites said that identifying GBV cases was straightforward and easy, but then gave vague and simplistic definitions of GBV, indicating that they lacked an in-depth understanding of GBV that would facilitate identification of potential GBV cases and provision of appropriate and sensitive services.

There were also some concerns expressed in both intervention and comparison sites that in order to determine whether a case was GBV, the provider needed to do some additional investigation to get to the root of what happened. One comparison site service provider described difficulty in identifying GBV cases as follows:

Service Provider*: It's very difficult to identify them.*

Interviewer*: Why is it difficult?*

Service Provider*: Because, what I am saying is, the person will present themselves with subjective data. So, you only take the word of the person who has presented themselves, but you wouldn't know if that was gender based or it was something else.*

There were inconsistencies demonstrated between service providers at end line regarding how to involve family and other stakeholders in the process of care for a GBV victim, particularly involving the perpetrator. There were some instances of this demonstrated at initial data collection, but the theme was stronger at end line. These inconsistencies primarily appeared among school service providers in comparison sites, as well as some police and social workers. Some providers discussed calling the perpetrator to weigh in or bringing in parents or guardians without consideration for the fact that they may be the perpetrator. At times, providers indicated that they needed to hear multiple sides of the story to validate what happened and determine if it was in fact a GBV case. For instance, one service provider said:

So, as a social worker first thing what I do is… What happens is that the client will come to report to my office that I have this kind of particular situation at home. What I will do is I will hear the story first, right?... then from there from the… the… then from what I picked I will just encourage the partner to call the perpetrator. Eeeh, normally you find that they may be afraid to call the perpetrator themselves. But, that's when I will be engaged in making sure that I call the perpetrator to reach my office. Because, sometimes when you discuss an issue you have to take both sides of the story so that at the end of it, when you make a conclusion you have all the information, since during the mediation process they will be together now. During the mediation process if I realize that there is a third party I make sure I call the third party who is involved. I also make sure he/she is involved, that when we reach to the conclusion. But, if ever that the issue is beyond me because as social workers we have a limit. We have a limit… whereby let's say the other one is not complying I cannot say that I'm going to send you to jail or cells or what. That's when I can make a referral or engage other service providers to assist me on this particular issue.

This type of investigation, especially for service providers outside of police and justice, is often at odds with best practices of victim-centered care and support. This is especially true when there is a lack of support and training on how to involve external stakeholders while maintaining safety both for the victim and provider. However, there were also some positive changes noted between time points in the process of providing services for GBV clients. One police officer in the intervention site noted, for instance, that he had started interviewing GBV clients in private over the past year.

Availability and familiarity with SOPs in intervention sites increased between time points. At initial data collection, providers in both intervention and comparison sites did not generally use SOPs; at end line, however, over two-thirds of providers in intervention sites knew of or had seen the SOPs, with over one-third physically pointing to the location of the SOPs within their office or organization. As expected, service providers in comparison sites were less aware of SOPs and did not have them in the office, though several referred to other GBV-related material.

Service providers in intervention areas said the GBV training and referral trainings were helpful in increasing their knowledge of GBV and identifying cases, as well as in collaborating with other service providers in the referral system. Service providers mentioned that the opportunity to troubleshoot

difficult GBV cases with other providers in the context of training or support meetings deepened their understanding and allowed them to provide better services to their clients. Providers in intervention sites further expressed a desire for continued and expanded training; specifically, many requested that more of their coworkers be trained, to increase collaboration among GBV cases internally within their offices. Many also noted that since they were currently the only person trained in their office, expanding training would relieve some of their burden in handling cases. In comparison sites, providers indicated that their confidence and capacity in handling GBV cases would be increased with training. Comparison site providers mentioned the desire for more training both on how to identify cases of GBV and on service provision and referral for GBV clients.

Across sectors and locations, providers discussed the emotional toll that working with GBV survivors had on them. Providers said that dealing with GBV cases was painful, challenging, and at times caused them to fear for their own safety because of possible retribution from perpetrators. This theme was not emphasized at initial data collection; however, its emphasis at end line may be due to a change in translation of the survey, with the revised end line survey asking providers how they felt more generally about handling GBV cases as opposed to how confident they were in handling cases. Several providers noted that while it can be difficult for them, they feel confident in their ability to provide services, as explained by this service provider from an intervention site:

> *I've learnt that I shouldn't be emotional, as it is important to help the victim and perpetrator. The best thing is to make sure that both parties get assistance. I'm confident, as I've been through training and* [am] *able to apply what I've learnt to assist clients. Involving emotions wouldn't do them justice… I might not give clients the quality of service they require. Since the referral system started, I'm confident enough to assist clients to my capacity and refer clients if they're beyond me.*

Collaboration and Trust among Providers

One of the strongest results coming out of service provider interviews, as well as key informant interviews, was the improved collaboration and trust among providers in interventions sites. Service providers discussed having a better understanding of the services other providers offer, improved relationships with other providers, and increased willingness to refer GBV cases to other providers.

When asked about the monthly meetings, many service providers in intervention sites explained how they were helpful in establishing connections with other providers or troubleshooting difficult cases, as mentioned above. One service provider described the meetings as helpful below:

> *They acted as refresher meetings, platform for feedback on what is happening in our respective areas… and going forward, what can be done to improve our service delivery. They are helpful in that respect. … The interaction, that meeting involves all service providers. One can assess their individual service as a service provider. Other public services such as social workers, nurses and policemen… there's always a new face. Some may not be interested in GBV issues. Such meetings help us to regenerate our energy towards fighting GBV.*

In comparison sites, while some providers interacted and worked with other providers regularly, there was less consistency in their knowledge of other providers in their referral network and what services they offered. Some were reluctant to refer to other providers, saying that they did not know what other providers did or whether they had received training on handling GBV cases.

There was some confusion in comparison sites regarding appropriate procedures for following up with clients after referring them to other providers. Many respondents reported not following up, with several providers saying they were not sure if they were allowed to follow up with other providers about a referred case because of confidentiality issues. A small number of providers in comparison sites did report following up on referred cases. In intervention sites, many more providers reported following up by calling the provider they had referred to or checking with the provider at the next monthly meeting to see if the client had arrived at the referral point and received services. Some providers complained about not knowing what happened with the referred client, indicating a lack of follow-up to check on the status of the referral, while others expressed frustration that the phone system does not provide more internal feedback to the initiating provider. This gap was aimed to be addressed through the addition of SMS notifications to initiating and receiving providers, allowing providers to receive an SMS when a referral was pending or when a referral had been completed. However, no service providers who were interviewed reported receiving the SMS messages at the time of data collection.

There were mixed reactions on how confident service providers were that clients were having all of their needs met. Service providers in intervention sites more frequently reported confidence that clients received the care they needed than comparison sites. Comparison site service providers were mixed on whether clients had received the help they needed. Some mentioned that they did not know what other service providers did or how well they were trained, with a few providers noting examples of poor quality services. In intervention sites, there were several providers who said they could not be sure of the quality of services at other providers, but more often they felt that clients had received the help they needed, with no providers specifically noting examples of poor services or avoiding referring to specific providers. One intervention site provider described how the system has improved their work and assisted clients:

> *Wow! As for me, it has really made my work easier. Even though it hasn't reduced the number of people coming in. The output is quite good because now I have all the confidence that now my people will be assisted. If I was excluded from the system, I wouldn't be able to connect them with the necessary providers. The system has made my village a small global village with regard to communication.*

One service provider in a comparison site was concerned that women with disabilities were not getting the services they need, primarily due to the lack of disability-friendly services available. For instance, she noted that service providers were often not equipped to deal with hearing impaired clients and that she did not have the time to physically accompany clients to referral points to assist them herself. No service providers in intervention sites indicated that they avoided referring to specific providers due to lack of quality services or incompetence; however, three providers in comparison sites mentioned hesitation in referring to the police due to lack of sensitivity or feeling that clients would not receive the help they needed. Several service providers in comparison sites mentioned a lack of collaboration and awareness of what other service providers offer, with one respondent specifically noting that "the police, social worker, teachers and health workers do not work together, there is no collaboration amongst them. There should be unity between service providers. A victim could come to us to report that they have been insulted. The Headman of Record and the Headman of Arbitration have different responsibilities. Such cases are not recorded, the two people are reconciled."

Feedback on GBVRSP and RIS

As in initial data collection, many providers in intervention sites expressed positive views towards the referral system at end line. As mentioned earlier, providers frequently noted the benefits and increased collaboration that evolved from the GBVRSP trainings, monthly meetings, and service directory. The monthly meetings were regularly praised for helping providers network, follow up on referrals, troubleshoot the RIS as well as client issues, and build trust with each other. The WhatsApp group for providers was also noted as a beneficial way to stay connected with other providers or ask questions.

As expected, comparison site providers were not aware of the referral system and did not have experience with the monthly meetings. A small number of service providers in comparison sites had attended training on GBV, with one attending a WAR training.

Intervention site providers felt that they benefitted from the GBVRSP trainings, though they were still interested in more training, and they appreciated the monthly meetings. They said they had a better understanding of the referral process and had improved coordination and collaboration. Several health care providers noted they take clients more seriously now and can more easily identify cases. Providers also said they are now following up on referrals, either over the phone or in the monthly meetings; however, as mentioned earlier, some providers were concerned about the lack of feedback regarding follow-up. Several providers said they wanted notification of when a referred client reaches the next provider and when the case is closed. These notices should have been happening through the SMS notifications that were delayed due to technical issues but for which rollout began in April. However, no service providers that were interviewed had received any alerts at the time of data collection. This was also noted as a challenge in several key informant interviews.

Comparison sites did not report any changes to how GBV cases were managed over the previous year; however, several intervention providers mentioned changes over the previous year. Specific changes included the recent formation of a child protection committee, a police officer indicating that they now interviewed clients in private, another provider saying they now understood that men can be victims of violence, and one provider mentioning that police still respond slowly, albeit more quickly than before.

Figure 6. Mobile referral information system

Over half (17/29) of providers in intervention sites reported using the mobile RIS, with nine providers in the north and 8 providers in the south. All social workers interviewed (3/3), more than half of the justice (4/6), NGO (2/3) and healthcare providers (5/9), half of traditional leadership (2/4), and one quarter of school-based providers (1/4) had used the phones to record and/or refer GBV clients.

Among those who had not used the phones, reasons included not encountering a GBV case (n=4); phone was misplaced or had technical difficulties (n=2); no cases to be referred (i.e., all could be handled on-site) (n=2); was on leave (n=1); was not trained in use of RIS (n=1); and unknown (n=2).

Providers often cited competing priorities at work or a heavy workload as a barrier using the RIS and/or to them being able to attend support meetings. Some service providers with particularly large workloads indicated that they were often not able to refer clients until after they had completed their work day. For instance, one justice service provider said:

> Interviewer: *How did you feel about using the referral system after attending the trainings?*
>
> Service Provider: *It was good and was important. Sometimes there are so many clients that I don't get the chance to use the phone and refer clients using the phone.*
>
> Interviewer: *What do you do in that case?*
>
> Service Provider: *After knocking off at 14h00, I have the opportunity to refer the clients. However, messages are supposed to be sent immediately when we are with the clients, but due to our workload, we can't do this on time.*

There was also some concern that using the phone while in the presence of a client, for instance to type up case notes while listening to the client relay their experience, was bad practice. This was a concern mentioned particularly by healthcare providers, many of whom indicated that the standard practice at their facility was to not use cell phones at all in front of clients. A few providers also mentioned that clients did not want them to use the mobile RIS because of a misconception that the information sent through the RIS was not private. RIS training emphasized entering data into the system when the provider felt it was most appropriate (e.g., after the client was attended to) but did require that providers ask clients for consent to enter their information into the system.

A few providers also mentioned that typing case notes into the phone could be a time-consuming process or that the phone was not easily accessible because it was stored and/or locked in a separate office or location for security reasons. Key informant interviewees also noted challenges around the phones being turned off, preventing service providers from receiving referrals or SMS messages. Overall, a common difficulty expressed by service providers was that the phones were small and the technology was outdated, which made using the mobile RIS to make referrals less efficient. For instance, one service provider noted:

> Interviewer: *Ok. Is there anything about the referral system that you don't like?*
>
> Service Provider: *The referral system?*
>
> Interviewer: *Yah*
>
> Service Provider: *It is the tools I use, the phone particularly. It is slow and sometimes there is no network.*
>
> Interviewer: *The phone is slow?*
>
> Service Provider: *Mmh, it is slow and sometimes there is no network and it is also small.*
>
> Interviewer: *Ahah*
>
> Service Provider: *Yeah*
>
> Interviewer: *So any suggestion?*
>
> Service Provider: *Maybe they can install it in our computers, or …I don't know maybe something bigger than that small phone.*

Other difficulties mentioned by service providers included problems with the network that restricted sending referrals, stress from repeatedly having to check the phone for updates, fear of the phone being stolen, and forgetting the steps of the process of using the RIS due to infrequent cases to refer.

Key Informant Interviews

While service provider interviews and focus groups revealed program successes, challenges, and results on the ground, key informant interviews provided perspectives on the design, coordination, and operations of the GBVRSP, as well as clarification of on-the-ground issues and suggestions for future improvements.

As was reported by the service providers in intervention sites, the biggest and most commonly identified success and strength of the GBVRSP was the collaboration among providers and the informal network developed through the pilot. Both key informants and service providers observed that service providers have a better understanding of what other service providers offer and are more willing to refer clients

because they have built trust in each other. KIs discussed that service providers know and call each other, use the WhatsApp group to ask questions and provide guidance, and enjoy monthly meetings to discuss challenges and updates. This was seen as an important and significant benefit of the pilot, one that should be strengthened and expanded in the future, regardless of whether the phone-based system is scaled-up or continued. Several KIs mentioned that they believe providers will continue to refer to each other, even without the phones, if they are familiar with and trust each other. Another KI identified the biggest benefit of the GBVRSP as making the referral process easier and more manageable for seekers of services, so they receive help in the shortest possible time.

> Key Informant: *Whether the pilot has ended, they will still continue—using the phone or not— they will continue referring to stakeholders because they know each other.*

All KIs discussed the need for dedicated personnel to focus specially on the GBVRSP. GeAD staff were engaged and very supportive of the GBVRSP but had to balance oversight and engagement with many competing demands, thus were not able to offer full-time support to the pilot. This resulted in variable perceptions regarding the importance of the GBVRSP among implementing partners, sectors, and ministries involved. Civil society stakeholders discussed challenges around trying to establish buy-in and accountability with service providers and their supervisors to use the system, but they had little power or sway, saying it is important to have the government, including government officials at the highest levels fill that role. KIs expressed a strong desire for increased coordination and capacity at the central government level, with at least one to two dedicated staff for the GBVRSP.

When asked about potential reasons for the low completion rates, KIs felt the lack of completion could be due to ongoing services (e.g., a continuing investigation of a case), providers seeing clients but forgetting to log them in the system, or clients not going to the referred service. Multiple KIs reported that service providers often did not turn the phones on, have them easily accessible, and did not check them regularly. Some types of services, including counseling sessions or police investigations, can take several weeks or months, and the case may not be logged as "complete" until the conclusion of the service, potentially obscuring the fact that the client did reach the referral point. One suggested solution to this was adding one or more options to the RIS, allowing the provider to mark if the client arrived for initial contact, was receiving ongoing services, or had completed services.

Issues related to the phone itself also arose in all KI interviews. There were mixed opinions regarding the use of the current older model phones or smartphones. While everyone recognized smart phones are more expensive, most KIs wanted to explore smartphone use in the future. Program managers and implementing partners felt that this would have a significant impact on service providers' willingness to use and the ease of using the system. Other KIs felt that smartphones were not feasible and should not be considered for cost and security reasons. The possibility of designing an application for use on individually-owned smartphones was also discussed, with most KIs expressing interest so long as security could be ensured. Data usage would also be a challenge, but exploring the possibility of a "zero-rated" app, as is the case with the current RIS, could allow use without charging data to the user. It was also noted that a smartphone app would not help individuals or facilities without smartphones, but the old phone or the web-based system could still be used in that situation.

Key informants made several suggestions regarding the RIS as well. One KI noted that the graphs and dashboards were useful, especially the graphs showing cases referred and completed, which drove them to

further follow incomplete cases. This KI also noted, however, that when printing out dashboard reports, the service provider and date range of the data presented was lost when the file was printed. Another KI expressed concern at the inability to refer a client to more than one service provider, which had also been a frustration expressed to this KI by service providers. Finally, the phone system only allows for a service provider to select one type of service provided. For example, the service provider must choose one service such as "counseling," even if other services, such as HIV testing, medical treatment, or financial support, were provided. This issue was identified from the beginning and addressed in training by instructing service providers to select the primary service in the drop-down menu, and manually write in the other services provided in case notes. This still poses challenges for tracking services provided over time if providers do not manually write in all services and because the dashboards will not capture the write-in options automatically.

Regarding scale-up, KIs varied on their opinions around if, and when, scale-up should occur. Most KIs felt that the GBVRSP needed to be improved or adjusted before scale-up, specifically noting that while the pilot was successful at networking providers, it lacked clear evidence that the phone system was used enough to justify scale-up. Several KIs felt that a second phase of the pilot was necessary, with GeAD running the pilot and incorporating lessons learned, before expanding the system. Another KI expressed a desire for immediate scale-up, while also recognizing that lessons learned should be incorporated while scaling. Overall, it was agreed that additional government commitment and ownership was necessary, including mobilization from the highest level from permanent secretaries down to service providers, with one KI saying, "They have to start at the ministerial level, at the head offices—ministers talking to ministers, then directors talking to directors, then down to districts." Another KI recommended a dedicated person at each ministry to be the contact person and champion of the system. Several KIs suggested adding use of the mobile referral system to the job descriptions or reporting requirements of service providers and their supervisors.

Multiple KIs also highlighted community mobilization, saying that it is critical and should be intensified. Several KIs stressed the importance of using every possible platform to reach communities—radio, pamphlets, print, and television. Other factors mentioned that could affect scale-up included network access throughout the country, necessitating engagement of multiple network providers; signing memoranda of understanding with those network provider(s); improving local capacity on knowledge and operation of the whole system, including information technology (IT); incorporating the GBVRSP into every sector's work to spread out the cost; and more training for service providers.

Referral System Usage

Between August 2016 and July 2017, 401 GBV cases were logged into the RIS. Of the referrals logged into the system, over 33 percent (n=134) were provided with a referral and approximately 30 percent (n=41) of received referrals were completed. On average, referrals were marked as complete after 39 days. Referrals are marked as complete when all services have been completed; this time has a range, as some service provision may take longer (e.g., investigating a case) than others (e.g., providing immediate medical attention). For example, referrals to healthcare workers were completed in nine days, on average, in 40 days by NGO providers, 48 days by legal/justice providers, and 60 days by social workers.

Most GBV clients were women (324/401) and over age 24 (253/401) (Figures 7 and 8). Approximately 27 percent of men and 35 percent of women were provided with a referral; a similar percentage of men as

women had completed referrals (28.6% vs. 30.1%). A higher percentage of younger clients were referred to other services and had completed referrals than older women.

Figure 7. Number of cases entered, referrals made, and referrals completed, by gender
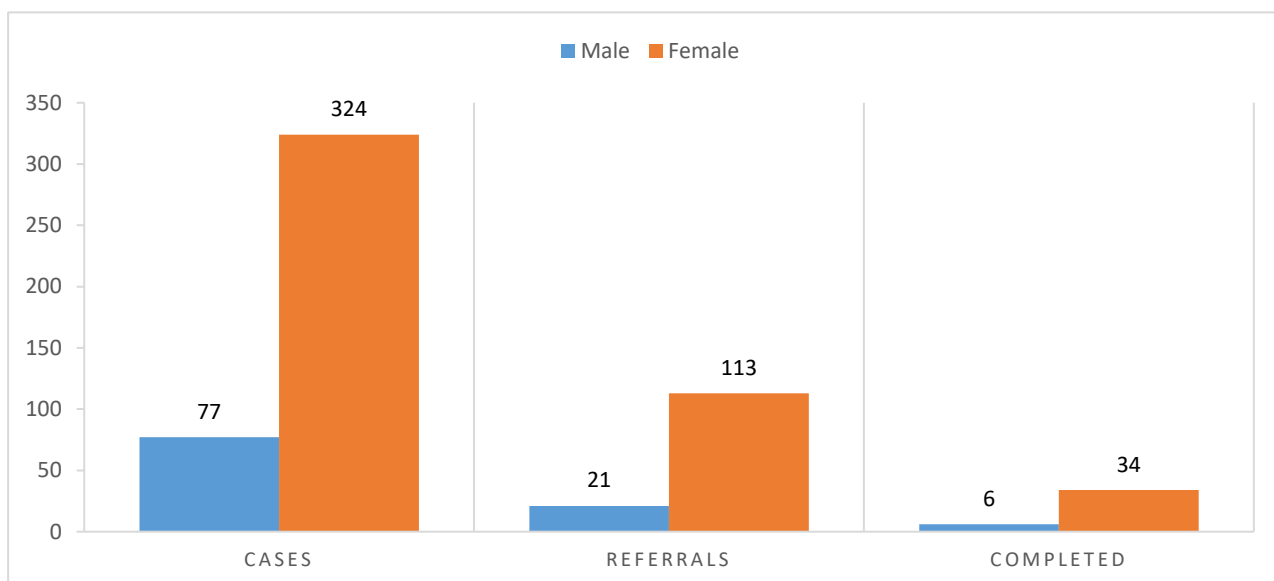
Figure 8. Number of cases entered, referrals made, and referrals completed, by age group
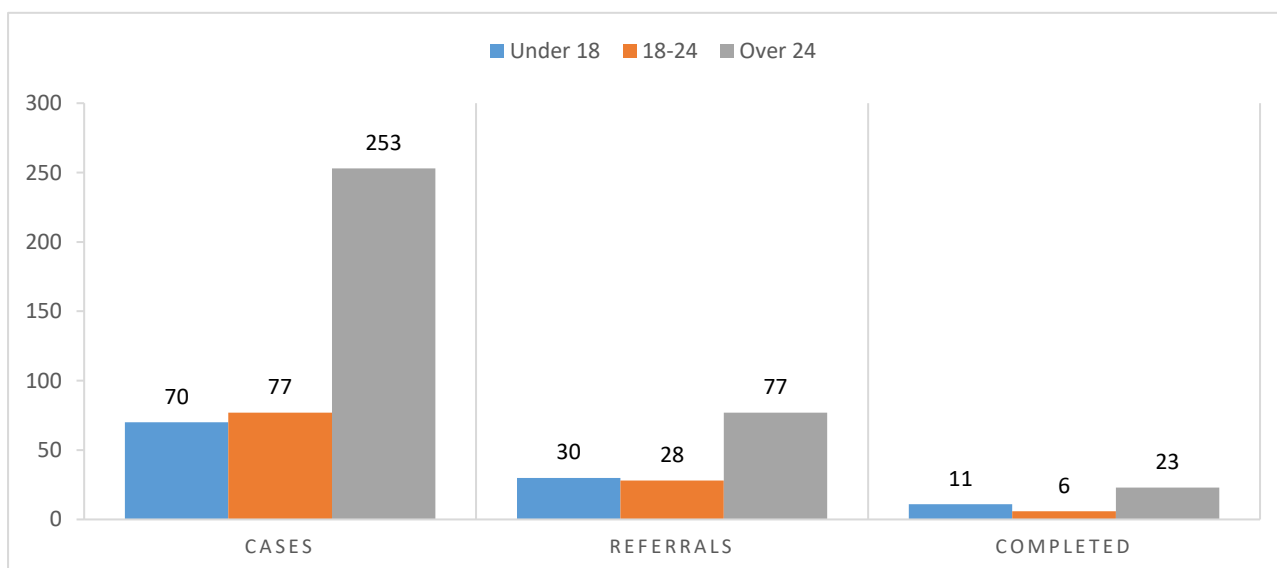
Most GBV cases entered (307/401), referrals initiated (97/134), and referrals completed (29/41) were in Maun. Fewer cases were entered in Mochudi (78/401); 38.5 percent of cases in Mochudi were referred to another provider. Only 19 percent of those referrals in Mochudi were marked as completed. Figure 8 and Table 6 illustrate the substantial difference in cases entered, referrals, and completed referrals between Maun and Mochudi. Figure 9 illustrates the number of cases entered and the number of cases referred in Maun and Mochudi. Uptake of the system was low in rural sites, with only seven cases in Artesia and nine cases in Shorobe entered into the system. However, all received referrals were completed in Shorobe (5/5).

Figure 9. Number of GBV cases and referrals sent by month and site, August 2016 to July 2017
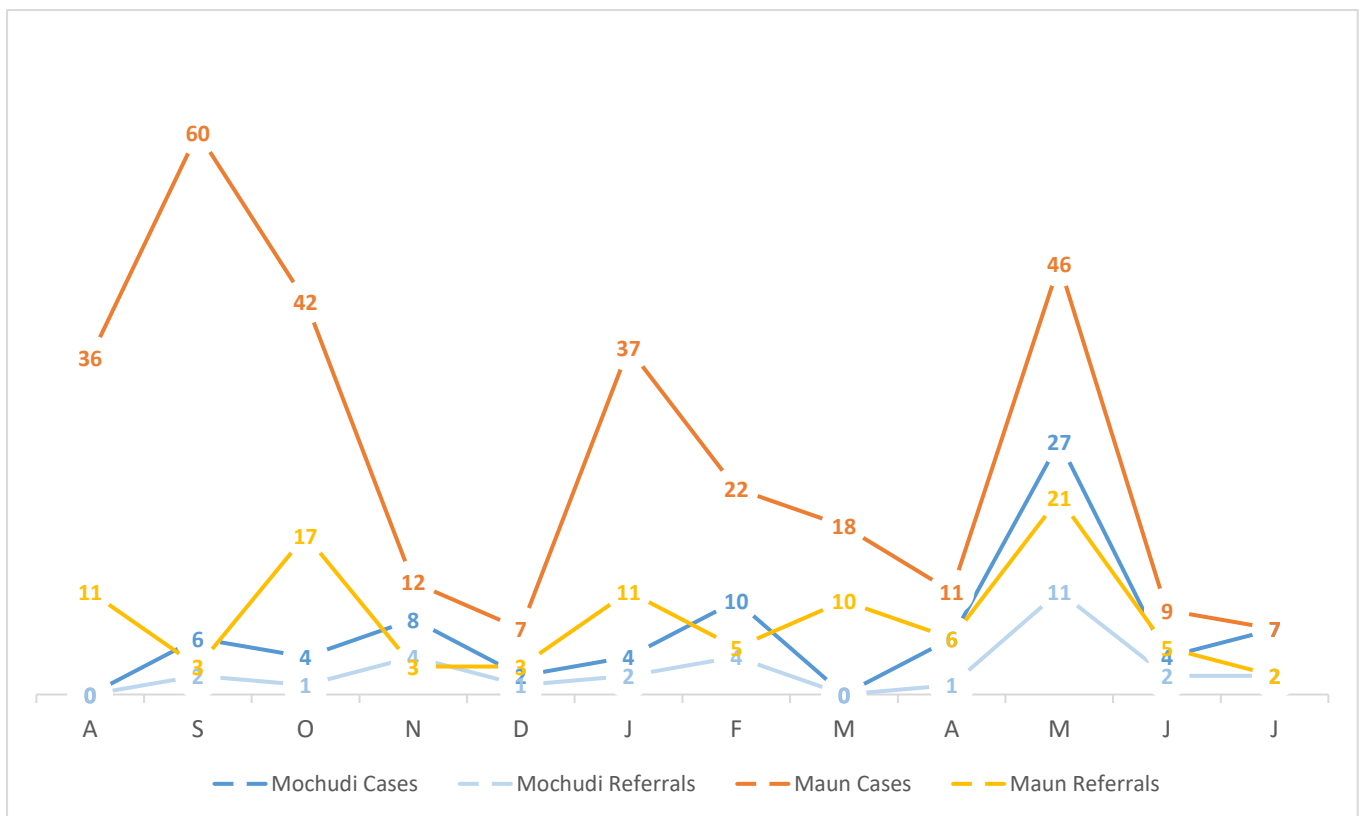
Table 6. Proportion of received referrals completed by month and site

Month	Maun	Mochudi
August 2016	3/11	0/0
September 2016	0/3	0/2
October 2016	7/16	1/1
November 2016	1/3	1/4
December 2016	1/2	0/1
January 2017	4/13	1/2
February 2017	1/5	0/4
March 2017	2/9	0/0
April 2017	4/7	1/1
May 2017	4/21	1/11
June 2017	1/4	1/2
July 2017	1/4	0/3

Uptake of the referral system also varied by provider type (Table 7). The table shows low uptake by some providers and low completion of rates of referrals, particularly among social workers (9.1%) and healthcare providers (12%).

NGOs entered most GBV cases (205/401). Healthcare providers (47.6%) and those in the legal/justice field (e.g., police) (53.3%) referred the highest *percentage* of their clients—approximately 50 percent of cases. NGOs referred approximately 25 percent of the entered cases. All three cases (3/3) entered by educators were referred, as would be expected based on qualitative interviews with those providers.

Legal/justice providers, NGOs, and social workers received 24–30 percent of the referrals. Approximately 57 percent of referrals made to NGOs were marked as completed; 32.5 percent of referrals made to legal/justice providers were marked as complete. Only 9 and 12 percent of referrals were marked as complete by social workers and healthcare providers, respectively. No referrals were made to educators, as would be expected.

Table 7. Cases entered, referrals made, and referrals completed, by provider type

	Cases Entered		Referrals Made		Referrals Received		Referrals Completed	
	#	% of total	#	% of total	#	% of total	#	% of total
Education	3	1	3	2	0	0	0	0
Health	63	16	30	22	25	19	3	8
Legal/justice	90	22	48	36	40	30	13	33
NGOs	205	51	50	37	37	27	21	53
Social welfare	40	10	3	2	33	24	3	8
Total	**401**	**100**	**134**	**100**	**135**	**100**	**40**	**100**

The desk review of implementing partners' final reports identified several challenges in implementing the GBVRSP—many of which were reflected in the service provider and key informant interviews. These included challenges with ensuring that the correct staff were trained, engaging with all sectors, finding ways to encourage uptake of the system despite being seen as additional work, logistical challenges with the mobile phones, and some cross-sector collaboration difficulties. These challenges affected both initial data entry into the RIS system as well as using the RIS to enter data on services provided to referred clients.

Making sure each agency had a sufficient number of people trained, and the correct people trained, on the system was a challenge in both northern and southern service provider points. Some sectors, such as S&CD, had very few providers granted permission to be trained on the RIS. This created a gap in the referral system for GBV clients, likely resulting in the low completion rates of referrals in the RIS. It may be that clients did receive care from social workers (as is the standard of care) but that these data were not entered into the RIS system. On the other hand, in agencies with multiple providers responsible for the RIS system, implementing partners thought that service providers felt less responsibility to use the system for entering in initial cases or data on services provided to referred clients. In general, implementing partners reported that service providers were not universally held accountable or provided support by sector management to use the RIS and that this decreased uptake of the system.

From the perspective of implementing partners, the service delivery points that attended a high volume of cases, both GBV and otherwise, had the challenge of identifying when a client needed a referral, knowing that a client had been referred through the RIS and finding the time to use the RIS system while efficiently attending cases. For SDPs with a lower volume of GBV cases, implementing partners found that service providers did not always remember how to use the RIS. In general, the RIS was viewed as additional work, as the system operated in parallel to each sector's own reporting system. This was further exacerbated by a rollout of new district reporting forms that increased provider paperwork.

Site summary reports suggest that service providers experienced challenges with logistics such as network or server problems, phone deactivation, sharing phones, and keeping phones charged. Older users also reported challenges in using the phone. This affected providers' data entry into the RIS for initial clients and services rendered to referred clients. Implementing partners were assigned to provide support to service providers using the RIS to address these challenges. In the south, 96 monitoring and support visits

were conducted, while only 32 were conducted in the north. While both implementing partners reported challenges arranging meetings with service providers, northern implementing partners also had challenges with staff turnover, arranging appropriate transport, and finding adequate skills on staff to provide this support.

In the initial months of the RIS pilot, there were challenges maintaining sufficient data balances. While the RIS uses very little data, and phones are provided monthly data refills, there have been challenges to ensuring that the data are only used for the RIS. Program staff worked with the mobile provider to transition the phones to a newly available service that ensured that data could be used only for the purposes of the RIS.

While implementing partners felt that the GBVRSP resulted in improvements in service provider collaboration in general, some challenges were also identified through site summary reports. While this was not reported in service provider interviews in intervention sites, implementing partners observed some reluctance by providers to refer clients to other agencies because of skepticism in the quality of the care provided. Maintaining monthly meetings with all providers seemed successful in the north but was reported as a challenge in the south. By the end of the pilot, eight monthly meetings with a total of 232 service providers were held in the north; in the south three meetings were held with a total of 42 providers.

CONCLUSIONS

This research sought to identify and describe (1) community perceptions of GBV, GBV acceptability and services; (2) providers' perceptions and feedback on GBV services in the community and the referral process; and (3) provider perceptions of the pilot GBV referral system in Botswana over the previous year of implementation of the GBVRSP pilot. Patterns in uptake and use of the RIS among providers in the intervention sites were also assessed. This is the first instance of a mobile GBV referral system being used in Botswana and one of only few in lower-income countries.

The mixed-methods approach used offers triangulated findings from qualitative data via community focus groups, individual SPIs, key informant interviews, quantitative data from the RIS, and reports from implementing partners. Overall, there were differences in provider perceptions and understanding of GBV between time points, as well as between intervention and comparison sites. Community perceptions of violence showed modest change from the initial OR report to end line, but these perceptions reflect previous GBV research in sub-Saharan Africa. Provider perceptions of the referrals system were overwhelmingly positive and hopeful at initial data collection, and remained mostly positive at end line; however, providers noted more challenges with the phones and remembering to use them than at initial data collection. Routine use of the referral system increased in some areas of the pilot but has not been systematically integrated into ongoing service provision.

GBV Understanding and Acceptability

In terms of how people understood GBV and causes of GBV, service providers were better able to define GBV, but there were instances where both community members and service providers used definitions that included any kind of violence or conflict and/or gave distorted definitions reflecting adherence to traditional gender norms. This was true at initial data collection and at end line. At end line, data revealed that justice providers, particularly police, often described GBV in less detailed ways or described it as general abuse or violence. They also more frequently expressed views that excused violence based on behaviors of the victims that invited violence. This lack of understanding of GBV and its root causes among justice service providers may point to a gap in training or a lack of targeted information and education on GBV. Additionally, since justice providers see a large proportion of GBV cases, often as the first point of contact for reporting, it is particularly important that they have a thorough understanding of GBV, as well as sensitive and appropriate procedures for identifying and referring cases.

Discussions with key informants at end line also highlighted the difficulty in translating the term GBV into the local language, Setswana, which may have contributed to confusion among community members regarding what GBV entails. Representatives from local implementing organizations emphasized that the term in Setswana used for "gender" is generally equivalent to "sex" and does not include the same cultural and structural implications which the word possesses in English. Further community awareness activities may want to consider refining this translation, or using a separate term altogether, to facilitate a deeper understanding of the complexity of GBV among community members.

GBVRSP implementing partners modeled their community mobilization activities on SASA!, a community mobilization model created by Raising Voices, a nonprofit organization in Uganda, to target the gender power norms that drive both HIV and violence against women. Research has found the SASA! model to be effective in significantly reducing IPV, IPV acceptability, and increasing access to resources in other settings (Abramsky, et al., 2014; Kyegombe, et al., 2014; Starmann, et al., 2017). In this

pilot, only modest improvements were seen in community perspectives on acceptability of GBV in intervention sites at end line. The difference in these results and previous SASA! evaluations are likely a result of both length of intervention and research design. SASA! was previously evaluated after four years, compared to this pilot's duration of one year, and used a rigorous pair-match cluster randomized controlled trial surveying over 1,500 community members at baseline and 2,500 community members at end line.

While there was variation among participants, community members' responses to acceptability of violence indicated a tension between understanding that abuse was against the law and still adhering to traditional gender norms that require obedience from women toward men and often permit violence. This tension has been expressed in other qualitative studies in sub-Saharan Africa (Laisser, Lystrom, Lugina, & Emmelin, 2011). Adherence to traditional gender norms and acceptance of violence have consistently been associated with violence perpetration (Fleming, et al., 2015; Jewkes, Flood & Lang, 2015). Other research conducted in Southern Africa has found that men often understand women's empowerment as equating to male disempowerment (Dworkin, Fleming, & Colvin, 2015). This theme was emphasized at end line in responses from participants who associated an increase in rights for women and children with heightened abuse against men and conflict in relationships. In these findings at both time points, this also resulted in misconstrued definitions of GBV; for example, deviations from traditional gender norms— such as talking back or refusing sex—were seen as a type of abuse toward men. Further, these gender norms contributed to participants' acceptance of violence—furthering entrenched attitudes that justify the perpetration of violence based on behaviors of victims that are perceived to attract violence.

These results highlight a need for further awareness-raising activities and education within the community to heighten understanding of GBV and reduce acceptability of violence. Research suggests that programming can intervene and attenuate adherence to traditional gender norms as a mechanism to reduce violence against women (Dworkin, Treves-Kagan, & Lippman, 2013). Gender transformative programming aims to foster mutual respect between men and women, promote resolution of conflict without violence, and protect the rights of all individuals. Further, identifying ways in which adhering to rigid gender norms (e.g., only women cook, and men must be the breadwinners) is harmful for both men and women helps facilitate conflict management without the use of violence or abuse. These interventions are likely most successful when operating at multiple levels, including when both community members and community leaders are engaged in this programming (United States Centers for Disease Control and Prevention [CDC], 2015). National campaigns, such as South Africa's Soul City, demonstrated success in changing community members' views on gender-based violence and could serve to reinforce efforts at the local level (Usdin, Scheepers, Goldstein, & Japhet, 2005).

Accessing GBV Services

At initial data collection and end line, providers and community members alike reported difficulties for GBV survivors in accessing services. The most commonly cited barriers to accessing services were economic dependence, shame, embarrassment, fear of retribution, or a desire to protect the perpetrator. These have been found to be common barriers to reporting violence or leaving an abusive relationship in multiple other contexts (Laisser, et al., 2011; Heise, 1998; Jewkes, 2002). Shame was deeply tied to the aforementioned gender norms that perpetuate ideas that emphasize victims' responsibility for attracting violence. The justification of violence was less common among service providers in intervention sites in

both the initial report and at end line, suggesting that GBV trainings may have improved providers' attitudes towards GBV survivors.

Economic dependence is a recurrent theme across GBV literature and an extremely pronounced theme in these data, with community members and service providers identifying economic dependency as a critical barrier to leaving an abusive relationship or seeking services. However, service providers' and community members' *responses* to women's economic vulnerability were almost entirely absent from these data. Respondents did not discuss any services, such as housing or food, available to help financially dependent women who may leave their abusive partners or whose partners are in police custody. Emerging research suggests that economic and structural-level interventions—such as cash transfer projects—can be successful in reducing intimate partner violence and removing barriers for victims to leave violent relationships and therefore merit exploration (Hidrobo, Peterman, & Heise, 2016; Kim, et al., 2007; Pettifor, 2017). Although strengthening these types of services was outside the scope of this pilot, future successful scale-up of the RIS would likely necessitate strengthening services to address financial dependence as a barrier to victims reporting and receiving assistance for GBV.

Almost universally, participants at initial data collection and end line, in both comparison and intervention sites, reported that before accessing providers, family and community leadership must be engaged. The data indicated a need to work with families and police to be more empathetic and supportive of victims of violence to help facilitate survivors accessing needed services. While the initial report suggested that this was also a concern for tribal authorities, at end line they displayed a better understanding of GBV and the referral process.

Service Provision

At initial data collection and end line, compared to comparison site service providers, providers in intervention sites generally gave more consistent answers on appropriate service provision, more frequently highlighted the need for confidentiality and rapport building with clients, and expressed more trust and collaboration with other providers. While there could have been preexisting differences between locations, it seems likely, and was expressly noted by some intervention site providers, that the mutual training and service directory led to this difference. A study of the Gender-Based Violence Information Management System, created to facilitate increased data collection and sharing of information between service providers in 20 countries, found similar results—that a formalized system increased collaboration and trust among providers (UNFPA, 2014).

The GBVRSP training focused on improving identification of GBV cases and linkages between systems; quality of service delivery was not the primary focus. Ensuring that survivors receive high-quality care from any service provider they see remains a critical component in addressing GBV. Police service providers, in particular, reflected a need for additional training on GBV causes and understanding, as evidenced by their sometimes-simplistic understanding of GBV and prevalence of attitudes that emphasized victims' responsibility for attracting violence. Additionally, both service providers and participants in FGDs often expressed concern that police providers lacked sensitivity and urgency in handling GBV cases. In-depth trainings that follow international standards of care for working with survivors of GBV should be implemented among all service providers, particularly the police. Improving service quality will be critical to ensuring the success of further use and scale-up of the GBVRSP and reducing incidence of GBV in Botswana.

Results at end line also point to a need to tailor these trainings for each service provision sector. While trainings enhanced intervention providers' understanding and identification of GBV, SPIs highlighted unique gaps in knowledge of GBV and GBV service provision among different provider types. For instance, school-based providers often demonstrated confusion regarding how to engage family stakeholders in GBV service provision, a challenge which may stem from the fact that they are primarily interacting with cases of violence against children that require a certain level of parental or guardian involvement. Individualized training may be successful at promoting a more equitable understanding of GBV across all service providers.

RIS Uptake

Use of the RIS was uneven between providers and locations. Quantitative data indicate that the system was most frequently used in the northern urban site (77% of case entries), followed by the southern urban site, then rural locations. Referral completion was 30 percent. While service providers and community members listed barriers to seeking services in general, the system did not track why referrals were not completed. As this is the first formal system in Botswana to collect data on the number of GBV cases reported and referred and referrals completed there are no data to compare if these results are an improvement upon previous rates. Further, the evaluation of the Gender-Based Violence Information Management System did not report on referral completion rates, so there is again a lack of comparison (UNFPA, 2014). Data from final reports of implementing partners also noted that sometimes clients were not identified as "referees" and, therefore, not entered into the database as having received services. Additional technical and personnel challenges may have also resulted in providing services to referred clients but not documenting this service provision in the RIS. This could be downwardly biasing referral completion numbers.

Average time for completion of a referral was 39 days at end line, similar to the 40 days reported in the initial report. There were notable differences in length of referral completion time by provider type. Referrals are marked as complete when all services are rendered to the client, as opposed to when the client arrives to begin receiving services. This may explain the difference between time for completion, as some providers, such as healthcare providers, are more likely to receive a client and complete all required services in one day, whereas others, like police, would require that the referral case stays open until the investigation is complete, which could take several weeks. Key informant interviews confirmed that the referral time, as well as low completion rates, may be tied to the longer-term services offered by some providers, such as social workers and police, who at times forget to return to the system to mark a case as complete.

Qualitative data suggested several instances of frustration with the phone platform. In this setting, touchscreen phones are currently not feasible due to costs of the phones and limitations in 3G and 4G network coverage throughout Botswana. The cost of the current phone model would make rollout throughout the entire country financially more feasible. Further, the 2G phone network covers almost the entire country, again making that phone option more sustainable and realistic for country-wide rollout. In service provision locations that had computers available, the referral system was available in an online platform about which providers were positive. In other settings, or if technology cost and network availability in Botswana change, a touchscreen phone might be more appropriate.

Future Research

Several themes, including characteristics of male victims of GBV, training for SPs in resource-constrained settings, acceptability of any kind of violence, and barriers to completing referrals, were identified during analysis as topics for future research. Although many of the examples cited among community members as constituting male victimization were likely not examples of GBV, findings from this quantitative analysis do point to recorded and referred GBV cases with male victims. Future research should explore the characteristics of GBV perpetration against male victims to better understand whether current referral structures and processes are providing sufficient support to male victims.

Findings from this analysis also highlight difficulties in providing training to service providers on GBV in cases where limited resources are available. For instance, consistent on-site support was an essential component of quality implementation of the RIS but was also difficult given the number of service providers involved in the system and constraints on available time from supporting organizations. Further strategies for supporting and training service providers on GBV in resource-constrained settings would be a useful topic of future research and may support efficient rollout of similar systems in the future.

In community member focus groups and some SPIs, there were high levels of acceptability toward other kinds of violence, such as corporal punishment in schools or the kgotla using violence to punish perpetrators. For example, FGD findings revealed that some participants did not want to go to the police to report GBV but rather preferred that the case be handled at the kgotla, which could include corporal punishment of the perpetrator. Future research can explore if and how systemic use of violence in arenas outside the home may influence efforts to reduce the acceptability of GBV. Providing alternatives to violence—both inside and outside the home—may increase acceptance of nonviolence, but this warrants additional research.

Finally, this research did not assess, from the client perspective, why some survivors of GBV fall out of care after initially reporting to a service provider, even within an enhanced referral system. The GBVRSP focused on creating strong systems between providers to formalize referral processes, increase collaboration, and improve data collection. Exploring how to improve services from the client perspective is also critical. A better understanding of client barriers and facilitators to staying in care will serve to inform best practices to ensure that survivors are able to maintain support and contact with service providers for long-term medical, legal, and emotional needs.

Final Conclusions

Overall, qualitative data demonstrate that the GBV referral system was successful in increasing intervention providers' confidence in supporting survivors of GBV and trust in other providers in their referral network. Similar improvements were not observed among service providers in comparison sites. These differences indicate success of cross-sector GBVRSP trainings, monthly GBVRSP user support meetings, and standardizing referral protocols. Quantitative RIS usage data indicate uneven uptake of the system by provider type and location, reflecting some of the concerns regarding the phone system noted in the qualitative data. While some modest improvements were seen in community focus groups in intervention sites, results indicate a need for additional community-based work to refine GBV definitions, challenge traditional gender norms, and help survivors of GBV access appropriate care despite challenging social and economic contexts.

Based on findings from the GBVRSP operations research process, we recommend that the GBVRSP pilot be continued for another year under the mantle of the Government of Botswana. Maintaining the GBVRSP was a time-intensive process that required substantial manpower and buy-in from government officials, service providers, and community members. Dedicating GBVRSP-specific staff will ensure successful continuation of the GBVRSP. Continuous trainings to account for staff turnover, monthly user support meetings, and ongoing technical assistance and support for the RIS were critical in maintaining the GBVRSP but require substantial staff time. Upon successful completion of another year operating the GBVRSP in pilot sites, the government can then use lessons learned from these initial stages of implementation to inform a nationwide strategy to improve referrals, quality of care, and community awareness of GBV.

Specific feedback on each component of the GBVRSP is also provided. At the community level, findings strongly indicate a continued need for programming to increase GBV awareness and decrease acceptability of GBV. We recommend that these activities operate from a gender-transformative lens, as well as incorporate the cultural and economic context of the community. For service providers, we recommend refining service provider trainings for sector-specific needs and challenges, emphasizing increased quality of care in service provision, continuing facilitation of cross-sector collaboration, and continuing dissemination and training on standard operating procedures for handling and referring GBV cases. Finally, for implementation of the RIS, we recommend maintaining ongoing trainings and user-support visits, ensuring the implementation of SMS reminders, improving feedback loops between providers and supporting sectors in institutionalizing the RIS in their daily work. Finally, some improvements to the functionality of the mobile system could increase provider use.

RECOMMENDATIONS

The purpose of conducting this operations research was to facilitate system corrections and provide feedback for potential scale-up and future GBV interventions. As such, the following recommendations are provided based on the OR findings:

1. **Implement a second year of the GBVRSP pilot under GeAD's leadership**

   1.1 Taking into account both the success of the pilot in intervention sites, as well as operational challenges, MEASURE Evaluation recommends a continuation of the pilot of the GBVRSP as the project transitions to independent implementation by GeAD. During this second pilot, we recommend **incorporating improvements into the GBVRSP** (see recommendations below). **We also recommend undertaking basic monitoring and evaluation of this second year of the pilot** to ascertain whether providers are using the RIS, referrals are being completed, monthly meetings are occurring, and adequate support is being provided from government and civil society partners.

2. **Undertake significant and targeted efforts to ensure that the system is owned and managed by the stakeholder ministries and its use is enforced within ministries at all levels**

   2.1 Given overwhelming recognition of the importance of stakeholder ownership and accountability at all levels, we recommend the following:

   - Targeted consultations with high-level government officials, including permanent secretaries, ministers, and heads of departments to share the results of the GBVRSP pilot and gain support for ongoing implementation through an adapted model of ministry ownership and implementation.
   - Support and maintain the National Reference Group, through quarterly meetings and regular communication, to act as champions of the GBVRSP and continue raising awareness and buy-in.
   - Engage ministers in each sector to support the GBVRSP through advocacy and formalize agreements to institutionalize use of the referral system within each relevant sector. Support ministry leadership to identify ways to encourage uptake of the RIS among their service providers. This should also include regular review of the RIS usage, using the data for decision making, and internal ministry communication on the importance of the RIS and GBV prevention.
   - Allocate financial resources nationally and within ministries to support the implementation and coordination of the GBVRSP.
   - Create, fund, and staff one to two **dedicated** positions at the Gender Affairs Department to oversee, manage, and facilitate the GBVRSP.

3. **Rededicate sustained and significant efforts to improve understanding of GBV, shift norms around acceptability of violence, and increase knowledge of available resources in the community.**

3.1 Given the varied understanding of GBV, its causes, and at times contradictory messages about acceptability of violence expressed by community members, MEASURE Evaluation recommends:

- Data collected from community members showed some modest effects in changing norms around GBV, but there remains a significant need to **continue and intensify activities that define GBV and its causes and address issues related to acceptability of violence.** While conducting these activities, we recommend preparing mobilizers and trainers with messaging to help counteract distorted definitions of GBV that are rooted in traditional gender norms (e.g., identifying the refusal of sex as a form of abuse)**.**
  - **Target community mobilization and awareness raising for community members and families to be more empathetic and supportive of victims.** Service providers and community members alike reported difficulties accessing GBV services, as well as a preference among families for handling instances of violence internally instead of reporting to receive services. However, participants also reported a severe lack of support from families in addressing GBV. As a result, we recommend continuing awareness-raising activities that provide support for victims of GBV while also de-stigmatizing and normalizing disclosure and help-seeking behavior**.**
  - Work **with men and women to challenge traditional gender norms that perpetuate violence against women.** *It is paramount that the staff who deliver this programming be extremely well-trained in gender equality to avoid perpetuating harmful gender norms.* One Man Can programming, designed by Sonke Gender Justice, has freely available examples of [workshops and community activities](#) that address gender norms (One Man Can, 2012). Targeting leadership with these activities can help create community champions that can model this behavior.
  - While it is important to work with both men and women, **specifically targeting men for more intensive support and engagement around GBV is critical.** Engaging men and ensuring that they understand GBV messaging, are able to navigate changing norms without feeling threatened, and develop an understanding of how sharing power is not a negative outcome will be instrumental in affecting sustainable change.
  - **Support families and parents in adopting non-violent conflict resolution strategies**. Workshops and community mobilization activities on positive parenting strategies and healthy communication in relationships can help community members put gender equitable ideas into practice while still maintaining values of respect in the household.
- **Undertake national awareness raising and GBV prevention efforts to complement local GBV activities.** This could include initiating and supporting education campaigns through mass media, radio, and print.

4. **Provide ongoing training and support to service providers to improve GBV understanding, identification, quality of service provision and referrals between providers.**

4.1 Given the overwhelmingly positive findings around increased collaboration and trust among providers in intervention sites due to monthly meetings, service directories, and regular interaction, we recommend the following:

- **Continue monthly meetings of service providers** in the same area to maintain connections and trust between institutions and providers. This was one of the biggest successes of the pilot, and maintaining this collaboration is a key part of preserving progress made during the pilot.
- **Update service directories annually** to maintain an accurate account of local providers that work on GBV and what services they offer.
- **Support a local implementing partner, district gender committees, or local gender officer in each area** to facilitate monthly meetings, update service directories, keep track of turnover of staff, stakeholder management with local management of implementing parties, and manage the WhatsApp group for service providers.

4.2 Given the continued variation in providers' understanding of GBV, appropriate services, and referral processes between baseline and end line, and expressed need from both comparison and intervention sites for more GBV training, we recommend:

- **Expand GBV training and referral system trainings for all providers in target areas** using a train-the-trainer model to ensure sustainability and cost effectiveness. These trainings serve to improve their understanding and identification of GBV, GBV service provision, and knowledge of appropriate referral processes. Universally, providers in both intervention and control sites wanted additional training on GBV and saw a need for their colleagues to undergo similar training—noting that GBV cases are complex and challenging to handle, particularly when not all providers interacting with a client have foundational knowledge of GBV and the referral process. Further, the data revealed some questionable practices, lack of sensitivity, and stigmatizing behavior by some providers. Therefore, we recommend increasing efforts to improve service delivery quality for providers, especially justice providers. Expand the current training to include in-depth skill-building, sensitivity, and case management for addressing GBV appropriately.
- **Given the importance of service quality, sectors should tailor trainings to different service provider types**, such as justice and healthcare providers. The process for handling GBV differs by sector and service, thus trainings should be customized for provider types. Police providers in particular would benefit from additional and specialized training to sensitively deal with GBV while simultaneously investigating criminal cases appropriately. Training materials should include guidance on when and how to engage family stakeholders in GBV cases appropriately, particularly when and how to engage perpetrators in a way that preserves the safety of both the victim and service provider.

4.3 Given that providing services to victims of GBV is challenging and at times painful or overwhelming for service providers, we recommend:

- **Initiating provider support groups and debriefing opportunities for service providers.** This should be in addition to the monthly meetings focused on collaboration and RIS management. Support groups should include discussion of how providers can care for and protect themselves while doing GBV work, as well as time to discuss difficult cases.

4.4 Given the importance of consistent and high-quality care provided to GBV survivors:

- **Ensure that all sectors and service delivery points have SOPs for handling GBV cases, providers are trained on the SOPs, providers are monitored on their performance related to the SOPs and given feedback,** and that they are posted at multiple locations throughout a service delivery point. This includes development of SOPs for the tribal authority, which is currently lacking.
- **Update SOPs regularly, ensuring that they follow international protocols for providing care to victims of GBV.**
- **Ensure newly hired or transferred staff are oriented in the GBV SOPs.** Frequent staff turnover requires ongoing training of incoming staff to ensure that all personnel are capable of identifying and referring GBV cases they may encounter.

5. **Address identified gaps and barriers in the mobile phone and referral information system**

5.1 Given challenges with turnover, providers forgetting how to use the system, and lack of routine system use, we recommend:

- **Continue routine service provider trainings on the RIS.** This will take into account high staff turnover and ensure that clients encounter trained providers who can identify, support, and refer GBV clients.
- **Identify and support a local GBVRSP officer to continue one-on-one visits with providers**, addressing any logistical challenges and encouraging habitual use of the new system to help increase uptake.
- **Ensure implementation of SMS reminders** are rolled out and being received by providers. This will serve as "cues-to-action" to use the phone referral system, as well as allow providers to more easily obtain follow-up information on whether and when referred clients reach their next provider.

5.2 Given the low rates of referral completion, we recommend the following:

- **Improve feedback loops to service providers**, thus increasing their trust and engagement in the larger system. This includes ensuring the SMS reminders are working, sharing data at monthly meetings on numbers of referrals made and completed in the system, and highlighting de-identified success stories.
- **Increase institutionalization of the RIS** by engaging department heads and ministers in each sector to identify ways to monitor and increase RIS uptake among service providers (related to recommendation 2.1). It is important to have support for the RIS at all levels, especially among superiors, to demonstrate the value of service providers' efforts to log and complete cases. Reminders that providing referrals is part of ongoing

job duties, and helping them to understand why and how the RIS improves this process will also improve use of the RIS.

- **Encourage use of the web-based portal, when possible.** As many service providers expressed challenges around using the small phones, we recommend local implementers promote use of the web-based portal for providers with access to computers. Other possible longer-term solutions include **exploring creation of a secure, zero-rated smartphone application for providers to use on their personal smartphones.**
- **Consider functionality adjustments to the RIS for clarity and ease of use by providers.** Specific improvements that were suggested in the results:
  - Add functionality to refer to multiple providers at one time.
  - Add capability for service providers to select more than one type of service provided.
  - Add functionality to allow a spectrum of "completion" so that providers can track when clients arrive, are receiving services, and have completed care.
  - Add feature to the RIS dashboard that maintains the date range and provider type on reports when printed. Currently the date and provider information are lost when a dashboard report is printed.
- **Explore why referrals are not being completed both from a provider and a client perspective.** Additional research is needed to understand client barriers to arriving to a referred service provider. Further research is also needed on provider barriers to providing and documenting services to those clients referred to them.
- **Explore approaches to help clients get from one service provider to the next.** Several potential approaches to improve the likelihood of clients accessing the referred provider could include peer navigation, engaging the client in their treatment plan to ensure the most appropriate referral is made, and escorting the client to the next provider.

DISSEMINATION

Data were disseminated from the initial operations report and will be disseminated from this end line operations research report. Following the initial OR data collection, phased analysis was conducted to enable timely feedback and program adjustments among implementing partners. Results were shared with implementing partners, the GeAD and funders over the course of several months, with opportunities to provide feedback. These results were used to make mid-course corrections, including tailoring community messaging, modifying delivery of RIS protocol information, and targeting additional training and support to providers. A final report on initial data collection was shared with implementing partners, the GeAD, and funders, as well as published on the MEASURE Evaluation website (available at: https://www.measureevaluation.org/resources/publications/tr-17-189_en). Several presentations on the GBVRSP and lessons learned throughout the process were made at the Sexual Violence Research Initiative biannual conference in July 2017 and to the Interagency Gender Working Group (IGWG) Gender-Based Violence Task Force meeting in June 2017.

Following end line data collection, analysis documents and initial results were shared with implementing partners, GeAD, and funders to solicit feedback. Results were used to inform recommendations for improvements to the GBVRSP as GeAD considers next steps following the pilot. The final report will similarly be shared with all relevant stakeholders and published on the MEASURE Evaluation website. Additional dissemination of the OR findings will include a webinar specifically targeting stakeholders in Botswana, including the National Reference Group, to share the results of the pilot. The report will also be shared on international monitoring and evaluation and gender-related listservs.

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APPENDIX 1. OPERATIONS RESEARCH PROTOCOL
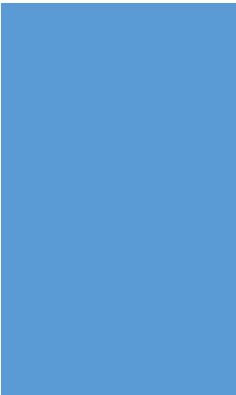
Botswana Gender-Based Violence Referral System Project

Background

The Botswana Gender-Based Violence Referral System Project (GBVRSP) is piloting a new way of delivering comprehensive services for gender-based violence (GBV) survivors in two areas of Botswana, Kgatleng District in the south, and Ngamiland District in the north. At its core, the GBVRSP has a new electronic information system for facilitating referrals. Based on simple mobile technology, the new referral information system (RIS) will track all GBV survivors who seek care at any service delivery point (SDP) within the area's care system, inclusive of all sectors and services, delivered by both government and nongovernment agencies. The RIS has been designed to facilitate referrals both across and within sectors by tracking all referrals made by a provider at an initiating SDP, alerting the receiving SDP provider about the client who has been referred and attaching a brief case history with the record of each client referred.

The other parts of the GBVRSP are the host of activities designed to support and facilitate the operation of the RIS: draft standard operating procedures (SOPs) were developed with stakeholder involvement to delineate the steps involved in handling a GBV case within each SDP, including when to interact with the new system. Awareness-raising activities about GBV and available local service provision are ongoing within each of the four target communities. Service directories for all GBV providers in the target areas were developed, one for Kgatleng, and one for Ngamiland. Staff in all SDPs using the new RIS have received training on GBV, including awareness, sensitivity training, and information on how to ensure the physical and emotional safety of clients.

The GBVRSP goal and objectives were agreed on and finalized during a series of national, subnational, and community stakeholder meetings facilitated by the Gender Affairs Department (GeAD) of the Ministry of Labour and Home Affairs (MoLHA), Government of Botswana (GOB), and MEASURE Evaluation, in 2014–2015.

GBVRSP Goals & Objectives

Overall Project Goal

To improve access to comprehensive, quality services for GBV survivors, and enhance case reporting, by strengthening stakeholder collaboration. In the long term, attaining this goal will decrease the incidence of GBV and mitigate its effects within the target communities.

Information System Objectives

1. To provide referrals to GBV clients who need services that are not available at the initiating agency at the time they present

2. To document what services were provided at the initiating agency

3. To document what services were provided at the receiving agency

4. To provide a case history base that is available to all providers within the referral system, to ensure that survivors only have to present the details of their case once

Wider Project Objectives

1. To raise awareness in the community about available services, the type of available support, and where to access it

2. To raise awareness among GBV service providers about services available outside their home agency

3. To build capacity among GBV service providers on using the referral system and referral information system.

4. To build capacity among providers about GBV and how to identify and manage a GBV case

5. To document the use of standard operating procedures (SOPs) and corresponding flow charts, including systematic data collection and use

Operations Research

Aim

The aim of the operations research (OR) is to evaluate the short-term results of the GBVRSP, facilitate mid-course corrections, and provide feedback for potential scale-up and future GBV interventions. Results will indicate areas of success attainted by the GBVRSP in the target areas, challenges encountered and how they were resolved, and the potential for the expansion of the system to the national or subnational level. Results from the OR will also inform adjustments to the referral system before or during scale-up.

The OR will employ a mix of quantitative and qualitative methods to address the research questions that evaluate the objectives of the GBVRSP. The research questions that follow are based on a process of discussion and feedback between the GeAD, USAID Botswana, and MEASURE Evaluation. Data for addressing the core objectives of the GBVRSP will be generated by the RIS. The associated research questions will be answered at the beginning and end of the pilot and will be analyzed as patterns and trends over monthly intervals. Research questions for the qualitative portion of the OR will address the supporting objectives of the GBVRSP.

Research Questions:

Quantitative Assessment (RIS Data)

- **What are the patterns and trends of referrals provided to GBV clients who need services that are not available at the initiating agency when they present?**

Example areas to be explored:

- Number of referrals in each of the four pilot areas during a month?

- Change in levels of referrals over time

- Number of referrals completed in each of the four pilot areas during a month?

- Change in levels of referral completion over time

- Change in the demand for services over time

- Patterns of demand versus supply

- Variation based on age, sex, region, urban/rural residence

- **What are the patterns and trends of initiating agencies over time?**

Example areas to be explored:

- Variation based on age, sex, region, urban and rural residence

- Variation by type of services provided

- **What are the patterns and trends of receiving agencies over time?**

Example areas to be explored:

- Variation based on age, sex, region, urban/rural residence

- Variation by type of services provided

- **What are the patterns of uncompleted referrals and what explains these patterns?**

These answers will be based the ongoing investigations conducted by the GeAD (via a secondment of WAR and SSI staff). Forms to document when referrals are not completed or handled appropriately will be used by SSI/WAR/GeAD staff during site visits.

Qualitative assessment (key informant interviews among service providers and focus group discussions among community members)

- **How has community awareness and perception of GBV and GBV services changed over time?**

Example areas to be explored:

- GBV and norms around its acceptability

- Availability of GBV services

- Quality of GBV service (sensitive, welcoming, confidentiality, etc.)

- Do people from the community recommend existing services—and how do they feel about them?

- **How has GBV service provider awareness and self-efficacy around GBV and provision of GBV services changed over time?**

Example areas to be explored:

- Understanding GBV

- Competency with handling GBV cases that present at their SDP

- Adequacy of training (on referral system and current SOPs)

- Process of using the current SOPs

- Knowledge of available services outside the scope of their home agency

- Confidence in the referral system to provide quality continuum of care for clients

- Feel more compelled to refer to other service providers due to ease of system and higher likelihood of favorable outcome

- **How easy is the referral system and referral information system to use among GBV service providers?**

  - Have the referral system (RS) and RIS improved flow of information and collaboration among services?

  - Is the RS/phone application intuitive and accessible to providers?

  - How do providers manage staff changes/turnover with regard to training and RS responsibilities?

  - Do providers feel confident in the system enough to use it?

  - What gaps in information flow are still not being addressed?

  - What parts of the system have been the easiest to use? The most difficult?

  - Was the case history easy to enter and use, and was it useful?

  - Has there been any pushback by service providers over duplication of reporting on case management and RS?

Study Design

Using a combination of quantitative and qualitative data, the operations research will assess whether or not the objectives of the GBVRSP have been met, what elements of the program were successful or challenging, and what lessons were learned to inform potential scale-up or future programming decisions. All quantitative data will be generated by the RIS from August 2016 to July 2017. In target and comparison areas, qualitative data will be collected from GBV service providers through individual interviews (key informant interviews [KIIs]) and from community members in focus group discussions (FDGs).

Quantitative data will be collected and analyzed over the course of the project. Qualitative data will be collected at the start of the RIS and at the conclusion of the project, providing a comparison between the start and end of the program. Data will be collected in the four intervention areas, as well as in four comparison areas similar to intervention areas where the GBVRSP has not been implemented.

Quantitative Data: Provided by the RIS

The quantitative data will be derived from the RIS. Data will be collected for 12 months, from the beginning of the pilot in August 2016 through the end in July 2017.

The following two indicators will be analyzed at monthly intervals over the life of the pilot:

Referral Initiation:

Definition: The proportion of eligible clients referred from the initiating service. A client is eligible for referral if the person is in need of services that are not available at the time the person presents for service at the agency.

Numerator: # of eligible clients referred from initiating service

Denominator: Number of eligible clients seen at initiating service

Disaggregation by:

- Initiating service (e.g., school, police, health)

- Type of service(s) provided to client

- Type of service to which client is referred

- Client characteristics (gender, age)

Referral Completion:

Definition: Proportion of referred clients that completes referral at receiving service

Numerator: # of referred clients seen at receiving service

Denominator: Number of clients referred from initiating service

Disaggregation by:

- Initiating service (e.g., school, police, health)

- Type of service(s) provided

- Client characteristics (gender, age)

Qualitative Data: Primary data collection

Four types of qualitative data will be used:

1. Reports generated throughout the pilot

    a. Narrative documents describing the way activities were implemented, such as trainings and workshops, monthly user support meeting minutes, or monthly reports

    b. Reports or documentation of the circumstances and resulting actions that take place when results of the RIS mandate investigation (data gaps, etc.) that will be gathered from monthly check-ins with the activity lead on what, if any, issues arose that month and how they were addressed

2. Descriptions of each of the eight sites in the operations research. These include the four intervention sites—Mochudi (urban) and Artesia (rural) in the south, Maun (urban) and Shorobe (rural) in the north—and the four comparison sites—Kanye (urban) and Ranaka (rural) in the south, Gumare (urban) and Tsao (rural) in the north.

3. Service provider interviews (SPIs) in each of the eight sites, at baseline and endline. Service providers will be interviewed individually in each site. The sample will be drawn to cover as many types as possible from each site (e.g., from various sectors of service provision such as police, teachers, NGOs).

4. FGDs of four different types of community members in each of the eight sites, at baseline and endline: adult women, adult men, young women (ages 18–24), and young men (ages 18–24)

See Appendix A for a matrix detailing what data will be used to answer the research questions. The design for qualitative data collection at the evaluation baseline and endline is depicted in Figure 1.

Service providers will be selected based on the type of service they provide, with the goal for including the widest variety of GBV service providers as possible. In the intervention sites, providers will be working with the project and will be approached by the research team. The list of trained providers will be used to select providers for interview. Providers in the comparison sites will be approached by a staff member from the GeAD initially, to explain the purpose of the OR and to engage them. Once providers are contacted, they will be given a brief description of the OR and asked if they would like to participate. After agreeing, the consent form will be read and oral consent will be acquired.

People from the community will be contacted by a local community leader to ask if they would participate in a FGD to last between an hour to an hour and a half. Once they agree, the research team will approach them and gain informed consent by reading the consent form.

Semi-structured interview guides will be used for both service provider interviews and FGDs.

Data Analysis

Quantitative data will be analyzed using descriptive methods to present patterns and trends of referrals made and completed by location, age, sex, and provider type over time. Microsoft Excel will be used for analysis.

For the qualitative component, all interviews—whether group or individual—will first be recorded and transcribed sentence by sentence. Interviews in Setswana will be simultaneously translated and transcribed. Word files will be labeled with a coding system to denote location and type of interview; no names or other identifying information will be used.

Qualitative analysis will be focused on identifying broad themes. Data will be analyzed using Dedoose software, which allows for sophisticated data encryption to assure data security with multiple users, much like a Google platform. The relevant evaluation domains will be identified, with themes identified within each domain. Researchers will collaboratively develop a codebook using a combination of deductive and inductive based on the interview/focus group guides and memos of a subset of transcripts. The group will then code two transcripts together to ensure consistent application of codes. Individual researchers will then code all transcripts, flagging any questions or clarifications to discuss as a group. Matrices will next be developed to compare themes across sites, gender, and age groups. Prior to developing first drafts of the qualitative findings, researchers will process the memos, coded transcripts, and matrices through analytic memos.
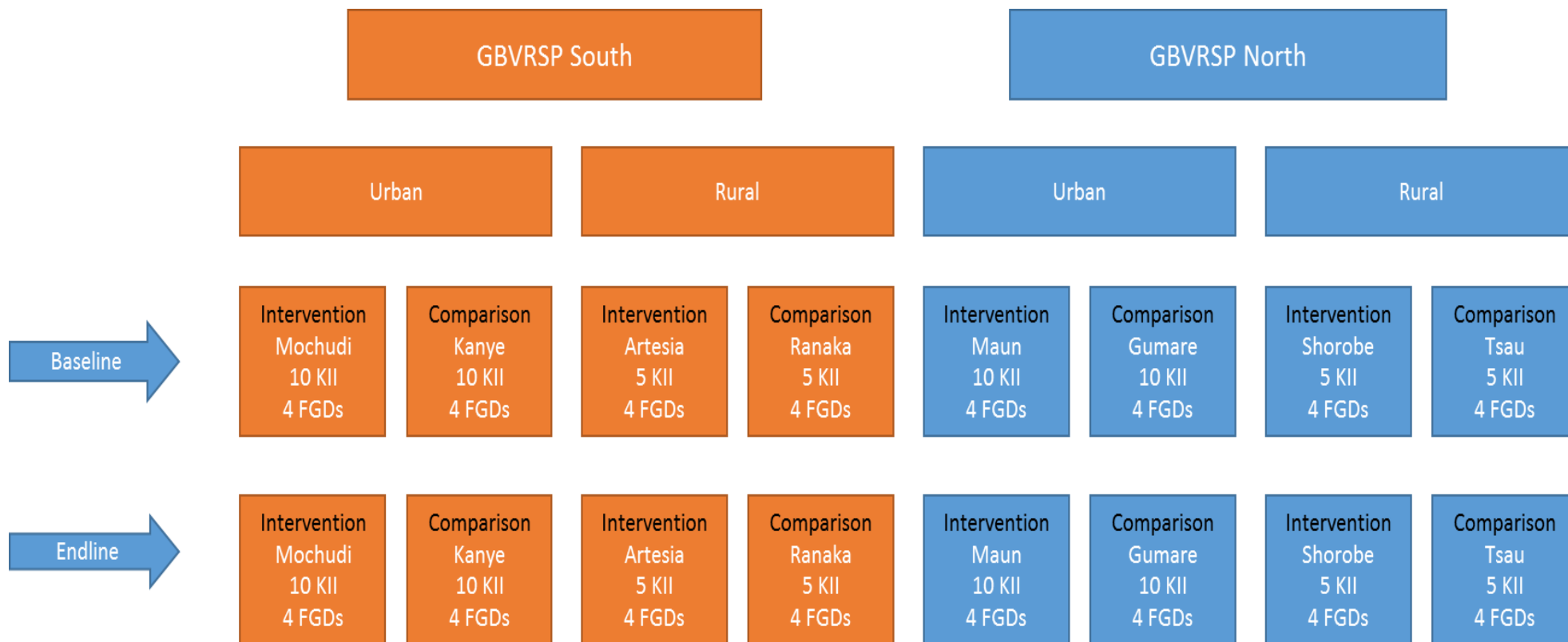
Figure 1. Study design for qualitative data collection

KII: Key informant interviews to be conducted with GBV service providers across sectors and types of agencies

FGD: Focus group discussions with community members (girls, boys, women, and men), who will be interviewed in groups of four to eight

Ethical Considerations

The study will obtain informed consent from all participants. Interviewers will explain the study and review the written informed consent document, which will be distributed to participants. Participants will be asked to give verbal consent to avoid documenting any identifying information.

Qualitative interviewers were trained on ethical considerations concerning research with human subjects, ensuring privacy and confidentiality during interviews and focus groups, ensuring data confidentiality, and obtaining informed consent.

Data from the referral system is stored in a secure online system and will be analyzed in aggregate using de-identified data.

All study procedures and instruments were approved by the Republic of Botswana's Ministry of Health, Health Research and Development Division. Due to the nature of the operations research, to explore how the referral system project is working, the study was given a "nonresearch status" by the Institutional Review Board at University of North Carolina at Chapel Hill.

Study Limitations

Key limitations for the qualitative component (FGDs and interviews with service providers) include the recruitment processes and sample, social desirability, and the timeline of system rollout and data collection. The first round of data collection began after the system rollout and trainings began, making a true pre-intervention baseline impossible. Many of the providers had not used the system at the time of data collection, but most had received training on GBV and future use of the system; thus, it is possible it could have increased their baseline knowledge and comfort discussing or providing services around GBV. Nevertheless, the initial data collection will still provide a rich comparison of initial project during rollout and one year after initiation. Furthermore, control sites did not receive any of the referral system or GBV trainings, offering a comparison group.

For FGDs, the selection process is convenience sampling from the kgotla, which could be a biased sample between individuals who are not frequently at the kgotla. Social desirability may play a role in FGDs if participants do not voice their opinions or beliefs if they feel their views are less unpopular or in contradiction to more popular views of gender norms or understanding of GBV during discussion.

While recruitment of service providers for interviews aimed to include the widest range of GBV service providers, it is possible that potential participants could have been systematically excluded, for example, if there was a systematic difference in service providers who were unavailable to be interviewed. In addition, because questions focus on the provider experience with the referral system, participants may choose to report more positive responses due to social desirability.

Limitations on the use of monitoring data include concerns about quality and accuracy. For example, if a provider sees a GBV client but fails to record it in the referral system, this would lead to underreporting. Another limitation is the structure of the referral system, which requires providers to prioritize and refer for one service at a time. Providers are able to add additional referrals in provider notes for the subsequent provider to refer to the additional service(s) needed. Another alternative is initiating multiple referrals at the first provider under multiple case numbers; however, this is not advised, as it could lead to double counting. Double counting is also managed during analysis by reviewing referral initiation time stamps and matching case information.

The triangulation of multiple methods of inquiry, however, will help to minimize these limitations. Monitoring data, monthly user meeting reports, site visit checklists, and data auditing reports will be considered in the context of qualitative data collected from providers and community members, and vice versa. This triangulation will provide a richer understanding of the strengths, challenges, and potential for the GBV referral system.

Dissemination

Dissemination of the baseline and endline results are planned for January 2017 and November 2017. The baseline report will be shared with GeAD, USAID, and implementing partners to be used in any necessary course corrections and to inform program planning, as well as planning for the endline data collection.

The endline report will be completed and disseminated in November 2017. A webinar will be held in November for USAID/Botswana, GeAD, implementing partners, and key stakeholders. Presentations by MEASURE Evaluation and GeAD will include an overview of the referral system, followed by presentation of OR results and discussion of how results can be used to inform program planning.

Botswana OR Timeline

Deliverable/Activity	Who	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Notes
Analysis and coding of baseline data	STK, AC, GRAs	X	X	X												
Draft baseline report	All				X	X										
Solicit feedback on baseline report	AC					X										Solicit feedback form JC, JF, Helen, Shelah, USAID, GeAD
Incorporate feedback into baseline report	AC, STK					X										
Report review, edits, and design	KM					X										
Publish and finalize report	AC, KM					X	X									
Monitor quantitative data	AC, JC			X	X	X	X	X	X	X	X	X				
Begin process of applying for IRB extension in BW	AC, STK							X								

Botswana OR Timeline

Deliverable/Activity	Who	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Notes
Update data collection tools for baseline	AC, STK, JC								X	X						
Secure subcontracts for data collection	AC, JC									X	X					
Conduct data collector training	AC, JF										X					Last week of July?
Data collection	AC, JF, data collectors											X				Estimating first two weeks of August
Translation and transcription	TBD											X				Tentative: second two weeks of August
Data collection and transcript quality control	AC, STK											X				
Analysis and coding of endline data	AC, STK, TBD											X	X	X		
Report writing	AC, STK, JC											X	X	X		

Botswana OR Timeline

Deliverable/Activity	Who	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Notes
Share report for feedback	AC													X		
Incorporate feedback into final report	AC														X	
Report review/edits by KM	KM														X	
Finalize and publish	AC, KM														X	Final report is due Nov 30, 2017

AC=Abby Cannon
JF=Jessica Fehringer
JC=Jen Curran
STK=Sarah Treves-Kagan
GRA=graduate student assistants
KM=Knowledge management

Appendix A. Mapping Research Questions to Data

Research Question(s)	Indicator/Information Needed	Data Source	Who	When
• What are the patterns and trends of referrals provided to GBV clients who need services that are not available at the initiating agency when they present? • What are the patterns and trends of initiating and receiving agencies over time? • What are the patterns of uncompleted referrals, and what explains these patterns?	Referral initiation: Proportion of eligible clients referred from the initiating service	RIS	Jen and Ankit	Monthly
	Referral completion: Proportion of referred clients who complete referral at receiving service	RIS	Jen and Ankit	Monthly
	Patterns of uncompleted referrals and explanation	RIS and data quality survey	GeAD and Jen	Monthly
• How easy is the referral system and referral information system to use among GBV service providers? • How has GBV service provider awareness and self-efficacy around GBV and provision of GBV services changed over time?	Narrative documents describing the ways activities are implemented (e.g., trainings and workshops, community mobilization)	• Monthly user meetings/reports • Monthly supervisory visits to service providers • Community mobilization and training reports • Ad hoc support as needed • Monitoring tools	Jen and Ankit Implementing partners	Monthly and quarterly

	Narrative reports of the circumstances and resulting actions that take place when RIS mandate investigation (data gaps, etc.)	• Monthly user meetings/reports, • Monthly supervisory visits to service providers • Ad hoc support as needed • Reports on investigation/resolution of RIS issues	Jen, et al. Implementing partners	Monthly
	Service provider interviews in all 8 sites	Baseline and endline service provider interviews	Abby/OR team	August 2016 August 2017
• How has community awareness and perception of GBV and GBV services changed over time?	FGDs with community members in 8 sites	Baseline and endline data collection	Abby/OR team	August 2016 August 2017
	Descriptions of 8 sites in OR	Baseline	Helen	Fall 2016

APPENDIX 2. DATA COLLECTION TOOLS

INITIAL FOCUS GROUP DISCUSSION GUIDE

Introduction: Hello, my name is _____, and I am working with the Gender Affairs Department of the Ministry of Labour and Home Affairs and Women Against Rape. As you know, we are conducting group interviews with community members about what they know about gender-based violence, and the kinds of available services in your community. I would like to read our consent form so that you understand our study and how we will protect the confidentiality of your answers. May I begin?

Read consent form, and give out printed consent (in Setswana).

Hand out gender-based violence phone number.

This conversation is about your beliefs and knowledge, and not about your experience, or the experience of anyone you know, with gender-based violence. If you feel you need to share something personal, please talk privately with our staff after the focus group.

We are handing out this telephone number to everyone. It is a gender-based violence hotline, which is available 24 hours a day. We want you to take it in case you or anyone you know may need help. If you would like to talk more about this, please ask any of our staff after the focus group is over.

General probe: is there anything more you can say about that?

Turn on the tape recorder.

Please start by stating:

- Your name (interviewer only)
- Type of FGD (girls, boys, women, men)
- Name of town or village
- Number of people in the group
- Age range of group members (youngest and oldest)

Research Question: How have community awareness and perception of gender-based violence and gender-based violence services changed over time?

---

1. What do you think gender-based violence is?

2. Do you think gender-based violence is a problem in Botswana?

3. Does any of this kind of thing happen in your community?

- Why do you think it takes place?

Be careful to not <u>elicit</u> anything personal about group members or people they know.

4. Is there any reason why a male partner should be able to beat his girlfriend or wife?
    (Read each probe separately for discussion.)

    How about:

- If she burns the food?
- If she does not obey him?
- If she is sleeping with another man?

5. If a woman or girl experiences physical gender-based violence in your community, what would she do?

- Why would she do that?
- Who would she turn to?

6. What do families in your community do if someone in their household experiences physical gender-based violence?

- Why would they do this?
- What usually happens to the person who perpetrates the physical gender-based violence in your community?
- What if it was sexual gender-based violence?
- Why would this happen?

7. If a woman or girl is sexually violated in your community, what would she do?

- Why would she do that?
- Who would she turn to?

8. What do families in your community do if someone in their household experiences sexual gender-based violence?

- Why would they do this?

9. Do you think that women and girls should report gender-based violence to the police or someone else?

10. What do you think are some reasons a woman or girl would not want to report violence?

11. Given that a woman wants to report a case of violence, what are some reasons she may not do so?

12. What are some reasons a woman would report a case of violence?

13. Why do some women report cases, while others do not?

14. Do you think these reasons and barriers have changed over the past few months? How?

15. What services are available in this community and this area to address gender-based violence?

    How good are these resources?

- Sensitive
- Confidential
- Good quality

16. Would you recommend existing services? Why or why not?

 Is there anything else anyone would like to share?

ENDLINE FOCUS GROUP DISCUSSION GUIDE

Introduction: Hello, my name is _____ and I am working with the Gender Affairs Department in the Ministry of Nationality, Immigration, and Gender Affairs and Women Against Rape. As you know, we are conducting group interviews with community members about what you know about gender-based violence and the kinds of available services in your community. I would like to read our consent form to confirm that you agree to be interviewed.so that you understand our study and how we will protect the confidentiality of your answers. May I begin?

Read consent form, give out printed consent (in Setswana)

Hand out gender based violence phone number

This conversation is about your beliefs and knowledge, and not about your experience, or the experience of anyone you know, with gender based violence. If you feel you need to share something personal, please talk privately with our staff after the interview.

We are handing out this telephone number to everyone. It is a Gender Based Violence hotline, which is available 24 hours a day (WoMen Against Rape . We want you to take it in case you, or anyone you know may need help. If you would like to talk more about this, please ask anyone of our staff after the interview is over.

General probe: do you have any questions?

Turn on the tape recorder.

Please start by stating:

- Your name (interviewer only)

- Type of FGD (girls, boys, women, men)

- Name of town or village

- Number of people in the group

- Age range of group members (youngest and oldest)

Research Question: How have community awareness and perception of gender-based violence and gender-based violence services changed over time?

1. How would you describe gender-based violence?

- If not mentioned, probe for who perpetrates GBV.

- If not mentioned, ask if there are different types of GBV?

2. Do you think gender based violence is a problem in Botswana?

3. Does GBV happen in your community?

- What types of GBV are most common in your community?

- Why do you think GBV occurs?

- How do community members typically respond to instances of GBV?

Be careful to not ask anything personal about group members or people they know

4. Do you believe there is any reason or situation where it is acceptable for a man to beat his partner?

(Read each probe separately for discussion.)

How about:

- If she burns the food?

- If she does not obey him?

- If she is sleeping with another man?

Do you believe there is any reason or situation where it is acceptable for a woman to beat her partner? If yes, please explain.

5. If someone experiences physical gender based violence in your community, what would that person do?

- Why would they do that?

- Who would they turn to?

6. What do families in your community do if someone in their household experiences physical gender based violence?

Why would they do this?

7. What usually happens to the person who perpetrates the physical gender based violence in your community?

- What if it was sexual violence?

- What would happen to the person who perpetrates?

8. If someone is sexually violated in your community, what would that person do?

- Why would they do that?

- Who would they turn to?

9. What do families in your community do if someone in their household experiences sexual gender based violence?

- Why would they do this?

10. Who do you think people in your community should report gender based violence to?

11. What do you think are some reasons a person would not want to report violence? Is it different for men/boys and women/girls? Why?

12. Given that a person wants to report a case of violence, what are some reasons they may not do so?

13. What are some reasons a person would report a case of violence?

14. Why do some people report cases, while others do not?

15. Do you think these reasons and barriers have changed over the past year? How? Why?

16. What services are available in your community and this area to address gender based violence?

- Do you know how to access them?

Do you think these resources are:

- Sensitive?

- Confidential?

- Good quality?

17. Which services, if any, would you recommend? Why would you recommend those services? Why would you not recommend those other services?

18. If someone was referred to these services, why might they decide not to go?

19. What community resources exist, if any, to learn about GBV?

a. Can you tell me more about what these groups are? Activities they do?

b. Have people here been involved? How?

c. How widespread are these groups/activities in the community?

20. Have you seen or heard about any changes in your community related to GBV over the past year?

21. Have you seen or heard about any changes among service providers for GBV in your community in the past year?

22. Have you heard of the GBV referral system?

Is there anything else anyone would like to share?

Thank you!

INITIAL SERVICE PROVIDER INTERVIEW GUIDE: INTERVENTION SITES

Introduction: I am working with the Gender Affairs Department of the Ministry of Labour and Home Affairs and Women Against Rape. As you know, we are conducting interviews with people who provide services to people affected by gender-based violence (GBV). I would like to read our consent form so that you understand our study and how we will protect the confidentiality of your answers. May I begin?

Read consent form and give out written consent.

Turn on the tape recorder.

Please start by stating:

- Your name (interviewer only)
- Type of service provider (sector: e.g., health, police, NGO, education, social work, tribal administration)
- Agency name
- Title in agency
- Place (town or village name)
- Sex of person
- Age of person

- Please briefly describe your role as a GBV service provider.

Research questions: How have GBV service provider awareness and self-efficacy around GBV and provision of GBV services changed over time?

Understanding GBV

- Please describe what you think a GBV case is.
- What do you think are some of the reasons why GBV occurs?
- What do you think are some reasons a woman or girl would not want to report this type of violence?

1. To police
2. To a health worker
3. To their family
4. To their teacher

- What do you think are some reasons a woman would report a case of violence?

- Why do you think some women are able to report that they have experienced GBV, while others are not?

Competency with handling GBV cases that present at their SDP

- Can you please describe what you do, including all the steps you take, when you have a client/patient who has experienced GBV?

- Please tell us how you feel about handling a GBV case—for example, do you understand why all the steps that you just described are needed?

<u>Adequacy of training</u>

- Can you please tell us what trainings you attended on the new referral system?

- How did you feel about the trainings that you attended?

- How did you feel about using the referral system after attending the trainings?

- Why do you think the new referral system was being implemented?

<u>Process of using the standard operating procedures</u>

- If I came to your office, where would I find a copy of the new standard operating procedures pertaining to handling a GBV case?
  (If they can tell you where, skip question 14; if they cannot, ask question 14.)

- Have you ever seen a copy of the SOPs?

- How confident do you feel that everyone in your institution understands that there are standard operating procedures for handling a GBV case?

- Can you please explain why you do or don't feel confident?

<u>Knowledge of available SDPs that provide services outside the scope of their home agency</u>

- Please tell me what types of GBV services are available in your community?

- What types of services would you refer your clients to, and why do you make these referrals?

<u>Feelings about the referral system to provide quality continuum of care for clients</u>

- How has the new referral system made a difference to the types of services provided to your GBV clients?
- Do you think it has made a difference? In what ways? Or why not?

- With the new system in place, how confident do you feel that women will get all the services they need? Please describe why you feel this way.

Research question: How easy is the referral system and referral information system to use among GBV service providers?

- Do you think the new referral system has improved flow of information and collaboration among service providers? Please explain.

- How user-friendly is the phone application for providers?

- How accessible is the phone to you when you are at work?

- Have you encountered any difficulties in using the new referral system?

- If yes, how often have you had difficulties?
    - Access to the physical phone
    - Access to the electronic system on the phone (logging in)
    - Uploading data
    - Downloading clients

- How do providers manage staff changes/turnover with regard to training and referral system responsibilities?

- Do you have confidence in the system? Please explain why or why not?

- Was the case history easy to enter and use, and was it useful?

- Have service providers had any concerns over duplication of usual case reporting and reporting with the new referral system together within your institution?

- Is there anything else you would like to add?

ENDLINE SERVICE PROVIDER INTERVIEW GUIDE: INTERVENTION SITES

Introduction: I am working with the Gender Affairs Department of the Ministry of Nationality, Immigration, and Gender Affairs.   As you know, we are conducting interviews with people who provide services to people affected by gender-based violence (GBV).   I would like to read our consent form so that you understand our study and how we will protect the confidentiality of your answers. May I begin?

Read consent form, give out written consent.

Turn on the tape recorder.

Please start by stating:

- Your name (interviewer only)
- What sector do work in (sector: e.g., health, police, NGO, education, social work, tribal administration)
- Agency name
- Title in agency
- Place (town or village name)
- Sex of person
- Age of person

1. Can you please describe your specific role and responsibilities in providing services for GBV survivors?

RQ: How has GBV service provider awareness and self-efficacy around GBV and provision of GBV services changed over time?

Understanding GBV

2. How would you define gender-based violence?
3. How common is GBV in this area?
    a. About how many cases do you see per month?
4. How do you typically identify GBV cases/incidents in your work?
5. Do you think it's easy to distinguish which cases/incidents are GBV? Why or why not? What would help make it clearer?
6. Do you think people in your community know what GBV is?
7. What do you think are some of the reasons why GBV occurs?
8. How does someone typically respond when they experience GBV? Probe: Do they tell anyone? Would they seek services?
9. What do you think are some reasons a person would not want to report this type of violence to the police for example?
    a. Or to a social worker?
    b. Or a health worker?
    c. Or the family?
    d. Or a teacher?
    e. Or the kgosi?
10. What do you think are some reasons a person would report a case of GBV?

11. What do you think is the difference between people who have experienced violence who do report compared with people who've experienced violence who don't report?

12. Can you think of a situation in which you would not encourage a survivor to report GBV to the police?

Competency with handling GBV cases that present at their SDP

13. Can you please describe all the steps you take when you have a client/patient who has experienced GBV?
    a. Do you understand why you take all the steps that you just described?

14. Please tell us how you feel about handling a GBV case.
    a. For example, how confident do you feel about handling these cases?

Adequacy of training

15. As part of your work with the referral system have you attended any workshops or trainings on GBV?

16. Can you please tell us what workshops or trainings you attended on the GBV referral system?

17. What was most helpful about the trainings?

18. Are there ways the trainings could be improved in the future? Please explain.

19. How did you feel about using the referral system after attending the trainings?
    a. Did the trainings prepare you to use the GBV referral system?

20. How often have you attended user support meetings?

21. What was helpful about the meetings?

22. How could the meetings be more helpful?

23. How often has program staff called or come to your institution to offer support and/or refresher trainings on use of the phone/application?

Process of using the standard operating procedures (don't ask Tribal Authority this question)

24. If I came to your office, where would I find a copy of the draft standard operating procedures pertaining to handling a GBV case?

(Skip to question 26 if they cannot answer question 24.)

25. Have you ever seen a copy of the draft standard operating procedures for your sector?

26. How confident do you feel that everyone in your institution is aware that there are standard operating procedures for handling a GBV case?

    a) Can you please explain why you do or don't feel confident?

Knowledge of available SDPs that provide services outside the scope of their home agency

27. Please tell me what types of services are available to survivors of GBV in your community?

28. Are all those service providers participating in the referral system?

29. Do you think there are any GBV service providers that are not included in the referral system? If so, why?

30. When you make referrals for your GBV clients, which service do you most commonly refer to and why?

31. Are there service providers you avoid referring clients to? Please explain.

Feelings about the referral system to provide quality continuum of care for clients

32. Have you used the referral system? If you have used it, how often? If no please explain why you haven't used it?

33. What do you like about the GBV referral system?

34. Is there anything about the GBV referral system that you don't like?

35. How best can we improve the referral system?

36. In what way has the GBV referral system made a difference in the services or quality of care that GBV clients receive?

    a. Has the GBV referral system changed the flow of care from different sectors from health to police, etc. for survivors? If so, how?
    b. (*If not mentioned*) Do you think the system has improved the flow of information and collaboration between providers? Please explain.

37. With the mobile system in place, how confident do you feel that GBV survivors will get all the services they need? Please describe why you feel this way.
    (Probe if necessary: Do you feel that survivors will get all the help they need from the services that you refer to?)

RQ: How easy is the referral system and referral information system to use among GBV service providers?

38. How easy is the phone application to use? Do you have suggestions for improvement?
    a. Tell me about your experience entering case histories.
        - How useful is it for the next provider to have the case history in advance of the client appointment?

39. Have you encountered any difficulties using the referral system?

    a. If yes, how often have you had difficulties with:
- Access to the physical phone
- Access to the web-based system
- Access to the application on the phone (logging in)
- Uploading data
- Downloading clients
- Lack of data
- Remembering to use the system

40. How are staff changes/turnover managed in regard to training and referral system responsibilities?

41. How much confidence do you have in the system? Please explain.

42. Before this mobile referral system, how would you make a GBV referral?
    a) How does the process used to make a referral through the mobile system compare to the previous method? Please explain.
    b) Has using the referral system added to your workload? If yes, please explain.

43. Why do you think the new referral system is being implemented?

44. Is there anything else you would like to add?

Thank you very much for your time!

INITIAL SERVICE PROVIDER INTERVIEW GUIDE: COMPARISON SITES

Introduction: I am working with the Gender Affairs Department of the Ministry of Labour and Home Affairs and Women Against Rape. As you know, we are conducting interviews with people who provide services to people affected by gender-based violence. I would like to read our consent form so that you understand our study and how we will protect the confidentiality of your answers. May I begin?

Read consent form and give out written consent.

Turn on the tape recorder.

Please start by stating:

- Your name (interviewer only)
- Type of service provider (sector: e.g., health, police, NGO, education, social work, tribal administration)
- Agency name
- Title in agency
- Place (town or village name)
- Sex of person
- Age of person

45. Please briefly describe your role as a provider of services for GBV survivors.

Research question: How has GBV service provider awareness and self-efficacy around GBV and provision of GBV services changed over time?

Understanding GBV

1. Please describe what you think a GBV case is.
2. What do you think are some of the reasons why GBV occurs?
3. What do you think are some reasons a woman or girl would not want to report this type of violence?

    - To police
    - To a health worker
    - To their family
    - To their teacher

4. What do you think are some reasons a woman would report a case of violence?

5. Why do you think some women are able to report that they have experienced GBV, while others are not?

Competency with handling GBV cases that present at their SDP

6. Can you please describe what you do, including all the steps you take, when you have a client/patient who has experienced GBV?

7. Please tell us how you feel about handling a GBV case—for example, do you understand why you all the steps that you just described are needed?

<u>Training</u>

8. Can you please tell us about any trainings you attended on GBV in the last year?

9. Do you feel like you would be able to do your job better if you had more training in GBV?
   - Why? Or why not?

<u>Standard operating procedures</u>

10. Does your facility/organization have standard operating procedures pertaining to handling a GBV case?

   - If so, is this written down anywhere? Could I please see them? Could you please describe what they are?

<u>Knowledge of available SDPs that provide services outside the scope of their home agency</u>

11. Please tell me what types of GBV services are available in your community?

12. What types of services do you refer your clients to, and why do you make these referrals?

<u>Feelings about referrals to other service providers</u>

13. How confident do you feel that women will get all the services they need? Please describe why you feel this way.

Is there anything else that you would like to tell us?

Thank you!

ENDLINE SERVICE PROVIDER INTERVIEW GUIDE: COMPARISON SITES

Introduction: I am working with the Gender Affairs Department of the Ministry of Nationality, Immigration and Gender Affairs and Women Against Rape. As you know, we are conducting interviews with people who provide services to people affected by gender-based violence (GBV). I would like to read our consent form so that you understand our study and how we will protect the confidentiality of your answers. May I begin?

Read consent form, give out written consent.

Turn on the tape recorder.

Please start by stating:

- Your name (interviewer only)
- What sector do work in (sector: e.g., health, police, NGO, education, social work, tribal administration)
- Agency name
- Title in agency
- Place (Town or village name)
- Sex of person
- Age of person

46. Can you please describe your specific role and responsibilities in providing services for GBV survivors?

RQ: How has GBV service provider awareness and self-efficacy around GBV and provision of GBV services changed over time?

Understanding GBV
47. How would you define gender-based violence?
48. How common is GBV in this area?
    a. About how many cases do you see per month?
49. How do you typically identify GBV cases/incidents in your work?
50. Do you think it's easy to distinguish which cases/incidents are GBV? Why or why not? What would help make it clearer?
51. Do you think people in your community know what GBV is?
52. What do you think are some of the reasons why GBV occurs?
53. How does someone typically respond when they experience GBV? Probe: Do they tell anyone? Would they seek services?
54. What do you think are some reasons a person would not want to report this type of violence to the police for example?
    a. Or to a social worker?
    b. Or a health worker?
    c. Or the family?
    d. Or a teacher?
    e. Or the kgosi?
55. What do you think are some reasons a person would report a case of violence?

56. What do you think is the difference between people who have experienced violence who do report compared with people who've experienced violence who don't report?

57. Can you think of a situation in which you would not encourage a survivor to report GBV to the police?

Competency with handling GBV cases that present at their SDP
58. Can you please describe what you do, including all the steps you take, when you have a client/patient who has experienced GBV?
    a. Do you understand why you take all the steps that you just described?

59. Please tell us how you feel about handling a GBV case.
    a. For example, how confident do you feel about handling these cases?

Training
60. Can you please tell us about any workshops or trainings you attended on GBV in the last year?

61. Do you feel like you would be able to do your job better if you had more training in GBV?
    - Why? Or why not?

Standard operating procedures
62. Does your facility/organization have standard operating procedures pertaining to handling a GBV case?

    - If so, is this written down anywhere? Could I please see? Could you please describe what they are?

Know of available SDPs that provide services outside the scope of their home agency
63. Please tell me what types of services are available to survivors of GBV in your community?

64. When you make referrals for your GBV clients, which service do you most commonly refer to and why?

65. Are there services or providers you avoid referring clients to? Please explain.

66. Have you seen or heard about any changes among service providers for GBV in your community in the past year?

Feelings about referrals to other service providers
67. How confident do you feel that GBV survivors will get all the services they need? Please describe why you feel this way.
    (Probe if necessary: Do you feel that survivors will get all the help they need from the services that you refer to?)

Is there anything else that you would like to tell us?

Thank you!

APPENDIX 3. CONSENT FORMS

Service Provider Consent Form

Government of Botswana Gender Affairs Department, Ministry of Nationality, Immigration and Gender Affairs
Consent to Participate in a Research Study
Service Providers

Consent Form Version Date: _____
Principal Investigator: Elizabeth L. Motshubi
Principal Investigator Department: Gender Affairs
Principal Investigator Phone number: +267 73288993 / +267 74583260
Principal Investigator Email Address: emotshubi@gov.bw
_____

1) Title of Study: Operations research on the GBV Survivor Referral System Project (GBVRSP)

2) Introduction (voluntary participation, right to withdraw)
You are being asked to take part in a research study. To join the study is voluntary.
You may refuse to join, or you may withdraw your consent to be in the study, for any reason, without penalty.

Research studies are designed to obtain new knowledge. This new information may help people in the future.   You may not receive any direct benefit from being in the research study. There also may be risks to being in research studies.

We will read this consent for to you, and you will receive a copy of this consent form. You should ask the researchers named above, or staff members who may assist them, any questions you have about this study at any time.

3) Purpose of this study
The purpose of this research study is to evaluate the whether or not a project called the GBVRSP has improved the quality of care and support provided to GBV survivors in garget areas, by raising awareness in communities about GBV in general and available services, training service providers on GBV and standard operating procedures for GBV cases, and implementing a mobile-based referral information system.

4) Who is eligible for this study?
All GBV service providers living in this area are eligible for the study.

5) Study Procedure
If you decide to be in this study, you will be one of approximately 80 (eighty) people in this research study. We want to find out about your experiences with the care and support services you provide, along with any referrals to other agencies that provide care needed not available at your facility. If you want to be in the research study, I will ask you some questions today about your experiences. We expect that this will take about 1 hour.

If you agree to participate in the research, I will ask you some questions today and record the conversation with a tape recorder. I will be asking you about GBV, GBV care and support services, and the referral system you use in order to see that people get the care they need.

6) What are the possible risks or discomforts involved from being in this study?
Some questions may make you uncomfortable. You have the right to refuse to answer any question you do not want to answer. You are free to decide if you want to be in this research. Your decision will not affect your job.

7) What are the possible benefits from being in this study?
This research is designed to benefit Botswana by understanding the best way to ensure that people get the all the services they need when the have experienced any type of GBV. You may not benefit personally from being in this research study. The information you provide will help the Government of Botswana make policy and program decisions about a GBV services.

8) What if we learn about new findings or information during the study?
You will be given any new information gained during the course of the study that might affect your willingness to continue your participation.

9) Costs and Compensation
It will not cost you anything to be in this study.   There will be no compensation for participating in the study.

10) How will your privacy be protected?
We will protect the information about you and your part in this research to the best of our ability. We will not record your name or where you live. We will not discuss your answers with anyone. We will be using a tape recorder to tape the interview. The only other people who might hear the information on the tape recorder are the investigators directly involved in this study. The information will be transcribed into a computer file. The computer files will be protected and only accessible by the study investigators. The information on the computer will be password protected. Only the study investigators will know the password and be able to access the data. Once the data has been entered into the computer, the recordings will be destroyed.

Participants will not be identified in any report or publication about this study.

11. Right to withdraw You can withdraw from this study at any time, without penalty. The investigators also have the right to stop your participation at any time. This could be because you have had an unexpected reaction, or have failed to follow instructions, or because the entire study has been stopped.

12) What if you have questions about this study?
You have the right to ask, and have answered, any questions you may have about this research. If you have questions, complaints, concerns, or if a research-related injury occurs, you should contact the researchers listed on the first page of this form.

13) Future usage The information that we gather may be used for research papers in the future. There will be no way to identify and individual person who participated in the study.

14) Contacts for questions If you have questions, you may contact Elizabeth L. Motshubi at +267 72954435 or by email at emotshubi@gov.bw.

Participant's Agreement:

I have heard the information provided above. I have asked all the questions I have at this time. I voluntarily agree to participate in this research study.

Focus Group Consent Form - English

Government of Botswana Gender Affairs Department, Ministry of Labour and Home Affairs
Consent to Participate in a Research Study
Focus Group Discussion (FGD) Participants

Consent Form Version Date: 1 June 2016
Principal Investigator: Elizabeth L. Motshubi
Principal Investigator Department: Department of Gender Affairs
Principal Investigator Phone number: +267 73288993 / +267 74583260
Principal Investigator Email Address: emotshubi@gov.bw

_____

1) Title of Study: Operations research on the GBV Survivor Referral System Project (GBVRSP)

2) Introduction (voluntary participation, right to withdraw)
You are being asked to take part in a research study. To join the study is voluntary.
You may refuse to join, or you may withdraw your consent to be in the study, for any reason, without penalty.

Research studies are designed to obtain new knowledge. This new information may help people in the future.   You may not receive any direct benefit from being in the research study. There also may be risks to being in research studies.

We will read this consent for to you, and you will receive a copy of this consent form. You should ask the researchers named above, or staff members who may assist them, any questions you have about this study at any time.

3) Purpose of this study
The purpose of this research study is to evaluate the whether or not a project called the GBVRSP has improved the quality of care and support provided to GBV survivors in garget areas, by raising awareness in communities about GBV in general and available services, training service providers on GBV and standard operating procedures for GBV cases, and implementing a mobile-based referral information system.

4) Who is eligible for this study?
Youth ages 18–-24 and adults 25 and above living in this area are eligible for this study.

5) Study Procedure
If you decide to be in this study, you will be one of approximately 80 (eighty) people in this research study. We want to find out about your experiences with the care and support services you provide, along with any referrals to other agencies that provide care needed not available at your facility. If you want to be in the research study, we will meet with approximately 6–-7 other people and have a group discussion. The discussion will be based on some questions we will ask. We expect that this will take about one and one half hours.

If you agree to participate in the research, we will meet in the group today and record the conversation with a tape recorder. We will be asking you what you know about GBV, GBV care and support services in this area.

6) What are the possible risks or discomforts involved from being in this study?
Some questions may make you uncomfortable. You have the right to refuse to answer any question you do not want to answer. You are free to decide if you want to be in this research. Your decision

will not affect your job.

7) What are the possible benefits from being in this study?
This research is designed to benefit Botswana by understanding the best way to ensure that people get the all the services they need when the have experienced any type of GBV. You may not benefit personally from being in this research study. The information you provide will help the Government of Botswana make policy and program decisions about a GBV services.

8) What if we learn about new findings or information during the study?
You will be given any new information gained during the course of the study that might affect your willingness to continue your participation.

9) Costs and Compensation
It will not cost you anything to be in this study. There will be tea and snacks served at the group meeting.

10) How will your privacy be protected?
We will protect the information about you and your part in this research to the best of our ability. We will not record your name or where you live. We will not discuss your answers with anyone. We will be using a tape recorder to tape the interview. The only other people who might hear the information on the tape recorder are the investigators directly involved in this study. The information will be transcribed into a computer file. The computer files will be protected and only accessible by the study investigators. The information on the computer will be password protected. Only the study investigators will know the password and be able to access the data. Once the data has been entered into the computer, the recordings will be destroyed.

Participants will not be identified in any report or publication about this study.

11. Right to withdraw You can withdraw from this study at any time, without penalty. The investigators also have the right to stop your participation at any time. This could be because you have had an unexpected reaction, or have failed to follow instructions, or because the entire study has been stopped.

12) What if you have questions about this study?
You have the right to ask, and have answered, any questions you may have about this research. If you have questions, complaints, concerns, or if a research-related injury occurs, you should contact the researchers listed on the first page of this form.

13) Future usage The information that we gather may be used for research papers in the future. There will be no way to identify and individual person who participated in the study.

14) Contacts for questions If you have questions, you may contact Elizabeth L. Motshubi at +267 72954435 or email her at emotshubi@gov.bw.

Participant's Agreement:

I have heard the information provided above. I have asked all the questions I have at this time. I voluntarily agree to participate in this research study.

Focus Group Consent Form - Setswana

GOROMENTE WA BOTSWANA, LEPHATA LA TSA MERERO YA SECHABA, BOAGEDI LE BONG, LEKALANA LA MERERO YA BONG (GOVERNMENT OF BOTSWANA GENDER AFFAIRS DEPARTMENT, MINISTRY OF NATIONALITY, IMMIGRATION AND GENDER AFFAIRS)

Tumalano ya go tsaya karolo mo dipatlisisong
Badiredi ba Ditlamelo

Letsatsi la Ditumalano: _____
Motlhotlhomise mogolo: Elizabeth L. Motshubi
Lephata la motlhotlhomisi mogolo (le eteletseng Dipatlisiso; Lephata la tsa Merero ya Bong
Mogala wa Motlhotlhomise mogolo: +267 73288993 / +267 74583260
email aterese ya motlhotlhomise mogolo: emotshubi@gov.bw

1) Setlhogo sa Dipatlisiso: Dipatliso ka Tsamaiso ya Kgokagano ya Ditlamelo tsa Batswasetlhabelo ba Kgokgontsho ya Bong

2) Thito/Tshimologo (go ithaopa go tsaya karolo, tshwanelo ya go ka ikgogela morago)
O kopiwa go tsaya karolo mo dipatlisisong. Go tsaya karolo ke ka boithaopo.
O ka ikgethela go ka se tsenelele dipatlisiso, kana wa tlogela fagare ga dipatlisiso, ka mabaka ape fela go sena molato.

Dipatlisiso di direletswe go anywa kitso. Kitso e ntsha e, e ka thusa batho go ya pele. O ka seka wa bona mosola wa go tsenelela dipatlisiso. Gongwe go ka nna diphatsa go tsenelela dipatlisiso tse.

Re tlaa go balela tumalano e, mme o fiwe moriti wa yone. O ka botsa batlhotlhomise ba ba nankotsweng fa godimo, kana badiredi ba ba bathusang sepe fela se o ka batlang go se itse ka Dipatlisiso.

3) Moono wa Dipatlisiso tse
Moono wa dipatlisiso tse ke go sekaseka fa Kgolagano ya Ditlamelo tsa Batswasetlhabelo ba Kgokgontsho ya Bong e tokafaditse matshelo a bone mo dikgaolong tse di tlhophilweng, ka go anamisa dikitso mo metseng ka Kgokgontso ya Bong le ditlamelo tse di teng, le go rutuntsha badiredi ka Kgokgontsho ya Bong le ditsamaiso tse di lolameng go lwantsha Kgokgontsho ya Bong, le gone go simolodisa kgolagano ya ditlamelo ka mogala wa letheka.

4) Ke mang yoo ka tsayang karolo mo Dipatlisisong tse?
Badiredi botlhe ba ba lwantshang kgokgontsho ya bong mo kgaolong e ba ka tsaya karolo mo dipatlisisong tse

5) Tsmaiso ya Dipatlisiso
Fa o tsaya tshwetso ya go tsaya karolo mo Dipatlisisong tse, o tla bo o le mongwe wa ba ba masome a robabobedi (80) ba ba tsayang karolo. Re bolelele ka maitemogelo a gago mo ditirelong tse lo di fang batho go akaretsa le kwa lo ba romelang teng go bona thuso e lo ka tswang lo sena yone mo ditirelong tsa lona. Fa o batla go tsaya karolo, ke tla go botsa dipotso ka maitemogelo a gago. Re solofela fa potsolotso e tla a tsaya oura e le nngwe.

6) Ke eng se se ka nnang diphatsa fa o tsaya karolo mo dipatlisisong tse?
Dipotso dingwe di ka nna tsa dira gore o seka wa ikutlwa o gololesegile. O na le tshwanelo ya go araba potso e pe fela e o sa batleng go ae araba. O na le tshwanelo ya go tsaya tshwetso ya gore a a batla go tsaya karolo mo Dipatlisisong tse. Tshwetso ya gago ga e kake ya ama tiro ya gago.

7) Mosola wa go tsaya karolo mo dipatlisiosong tse ke eng?

Dipatlisaso tse di diriletswe go solegela Batswana mosola ka go tlhaloganya tsela e e botoka e batho ba ka bonang ditirelo fa ba amilwe ke kgokgontsho ya mofuta mongwe le mongwe. Gongwe go tsaya karolo mo diplatlisong tse gago nke go go solegele molemo ka bo wena. Dikitso tse o tla di fang, di tla thusa Goromente wa Botswana go tla ka mananeo a a lebaneng ka ditirelo tsa kgokgontsho.

8) Go tla nnang jang fa re ka lemoga dikitso tse disa fa re ntse re tsweletse le dipatlisiso tse?

O tla fiwa dikitso dipe fela tse disa tse di ka lemogiwang fa dipatlisiso tse di ntseng di tsweletse tse gongwe di ka amang go tswelela gago le dipatlisiso tse.

9) Madi a o tla a lopiwa le phimolo dikeledi/dikatso

Ga ona go batliwa madi ape go tsaa karolo mo Dipatlisisong tse. Ga o na go phimolwa dikeledi / go atswiwa ka sepe go tsaa karolo mo Dipatlisisong tse.

10) Sephiri sa gago se tla sirelediwa jang?

Re tla sireletsa kitso epe e e amanang le wena le go tsaa karolo mo dipatlisiso tse ka gotlhe mo re go kgonang. Ga re nke re kwale leina la gago le fa e le fa o nnang teng. Ga re nke re buisane le ope ka dikarabo tsa gago. Re tla bo re dirisa sekapamantswe go gatisa puisano. Batho ba banngwe b aba ka reetsang puisano ke batlhotlhotlhomisi ba bangwe b aba amanang le dipatlisiso tse. Dikarabo tsotlhe di tla tsenngwa mo khomputareng di be di sirelediwa go bonwa ke batlhotlhomisi ba bangwe ba ba amegang. Fa dikarabo tsotlhe di sena go gatisiwa mo khomputareng, dikgatiso tsotlhe di tla phimolwa/sotlhwa mo sekapamantsweng.

Batsaya karolo ga ba nke ba tlhagisiwa/supiwa mo ripoteng kana phatlalatso epe fela e e amanang le dipatlisiso tse.

11) Tswanelo ya go ikgogela morago

O ka ikgogela morago mo dipatlisisong tse nako nngwe le nngwe e o eletsang go dira jalo go sena dikatlholo dipe. Batlhotlhomisi le bone bana le tshwanelo ya go emisa potsolotso nako nngwe le nngwe. Se e ka nna ka mabaka a gore o itsere ka tsela e e sa solofelwang, kgotsa o paletswe kego sala morago ditsamaiso, kgotsa ka gore dipatlisiso di emisitswe

12) O dira jang fa o na le dipotso ka dipatlisiso?

O na le tshwanelo ya go botsa, o bo o fiwa dikarabo ka potso nngwe le nngwe e e amanang le dipatlisiso tse. Fa o na le dipotso, matshwenyego, kgotsa o bone kgobala fa o ne o tsaa karolo mo dipatlisisong tse, tsweetswee itshwaraganye le opefela yo leina la gagwe le leng mo tsebeng ya ntlha ko godimo.

13) Tiriso mo nakong e e tlang: Dikarabo tse re di tsayang di ka dirisiwa mo dipatlisisong tse dingwe mo nakong e e tlang. Ga gona jaaka go ka golaganngwa dikarabo tse le ope fela yo o tsereng karolo mo Dipatlisisong tsa gompieno.

14) Fa o na le dipotso o ka itshwaraganya le **Elizabeth L. Motshubi** at **+267 73288993 / +267 74583260** email: **emotshubi@gov.bw**

Tumalano ya motsaya karolo:

Ke utlwile se se buiwang. Ke boditse dipotso totlhe tse ke ne ke tlhoka go di botsa. Ke dumela go tsaa karolo mo Dipatlisisong tse.

APPENDIX 4. ABRIDGED EVALUATION CONTRACTORS TEAM BIOGRAPHIES

Helen Apps

Helen Anne Apps works at WoMen Against Rape as a research advisor. Her work in GBV has included exploring public understanding of common and customary law as they apply to defilement (statutory rape) and the development of community-led safe spaces for survivors of violence. She is involved in GBV training and is working to develop WARs capacity to conduct GBV research.

Shelah S. Bloom

Dr. Shelah S. Bloom, research assistant professor of maternal and child health, has more than 25 years of experience working in the field of international health. Her work has focused on the effects of gender on various reproductive health outcomes in Asia and Africa, including maternal health, HIV/AIDS, and gender-based violence (GBV). Currently, she is working on improving the monitoring and evaluation of programs to prevent and respond to GBV in Africa by developing and implementing new information systems at the national level.

Abby Cannon

Abby Cannon is the Gender Specialist for USAID's MEASURE Evaluation Project within the Carolina Population Center at the University of North Carolina. She works to integrate gender across project technical areas, monitoring and evaluation (M&E) systems, and capacity building. Her research focuses on the intersection of gender and health within HIV, women's economic empowerment, gender-based violence, and trafficking in persons. Abby's experience with gender and health includes domestic and international work, as well as direct service, monitoring and evaluation, and research. Abby holds an MPH and MSW from the University of North Carolina.

Jen Curran

Jen Curran, MS, was an M&E Technical Specialist with MEASURE Evaluation. Ms. Curran has more than 12 years of experience implementing and evaluating global health and development programs in Africa and Asia. She has extensive field experience in Southern Africa in HIV prevention, prevention of mother-to-child transmission, and mobile health. Ms. Curran has worked in all stages of the research and project/program implementation process including the design and implementation of research projects and development of programs in 19 countries.

Meghan Cutherell

Meghan Cutherell received her master's degree in public health from the University of North Carolina at Chapel Hill in the Department of Maternal and Child Health. She has over seven years' experience managing global health projects and facilitating program M&E and operations research, specifically in the areas of family planning and gender. Her expertise includes both quantitative and qualitative research methods and her most recent projects include facilitation of qualitative research into the barriers to accessing family planning services among urban refugee populations in Egypt and quantitative data analysis of long-acting reversible contraception removals in the Sindh province in Pakistan.

Jessica Fehringer

Jessica A. Fehringer, PhD, MHS, Gender Portfolio Manager. Dr. Fehringer is responsible for the oversight of gender-related research activities as well as for leading or co-leading several evaluation and research projects in South Asia and sub-Saharan Africa. She has a PhD from Johns Hopkins University School of Public Health in Population, Family and Reproductive Health. She has worked in international public health for over 15 years and has designed and implemented qualitative and quantitative research and evaluation in South and Southeast Asia, South America, and sub-Saharan Africa. She is currently leading a quasi-experimental mixed-methods evaluation examining the MNCH/FP and health service impacts of integrating gender and social inclusion into health governance activities in Nepal; leading an experimental impact evaluation of a household economic strengthening and HIV health services project in Rwanda; and acting as gender advisor and qualitative lead for the design and survey implementation of a mixed-methods quasi-experimental evaluation examining the gender dimensions of impacts of groundnut value chain interventions in Zambia.

Peggie Ramaphane

Peggie Ramaphane has been directing the vision and strategy of WoMen Against Rape from 2009 to date. This involved mobilizing resources for the organization, ensuring project and service delivery to survivors of gender-based violence, and gender education to the general community of Botswana. WAR partnered with Raising Voices, Uganda, in 2010 and started implementing the SASA! approach to preventing and responding to violence against women and children. SASA! is based on the theory of change and the socio-ecological model that highlight the multiple levels and interactive effects of the environment in which the individuals live. Peggie has represented WAR at various gender platforms such as the Botswana National Gender Technical Working Group, delegation to the UNCSW and led the 16 Days Campaign over the years. WAR was the first organization to research and highlight the connection between HIV, GBV, and alcohol abuse, which were later recognized by the National AIDS Coordinating Agency as the drivers of HIV in Botswana.

Kate Scurria

Kate Scurria worked with Measure Evaluation, managing the GBVRS implementation on the ground in Botswana. She worked closely with the Gender Affairs Department and implementing partners, SSI and WAR, to design and facilitate service provider trainings; coordinate monitoring, evaluation, and reporting; standardize tools and document best practices. She has been working in sub-Saharan Africa since joining the Peace Corps in 2010 and specializes in grassroots capacity building, gender programming, and system strengthening. She is passionate about gender equality; economic and social empowerment; and community-led sustainable development.

Sarah Treves-Kagan

Sarah Treves-Kagan, MPH, has more than ten years of experience in the field of health disparities and violence prevention. She has conducted research, advocacy, service-delivery and government programming on sexual assault, gender-based violence, and youth homicide in domestic and international settings. Her research specifically focuses on structural approaches to reducing violence against vulnerable populations using both qualitative and quantitative data. Sarah is a doctoral student in the Gillings School of Global Public Health. She received her MPH in Maternal and Child Health at the University of California, Berkeley, and her BA from the University of Michigan.

APPENDIX 5. CONFLICT OF INTEREST STATEMENTS

We attest that we have no conflict of interest related to evaluating the GBVRSP.

_____ December 4, 2017

Helen Apps   Date

_____ December 4, 2017

Shelah S. Bloom   Date

_____ December 4, 2017

Abby Cannon   Date

_____ December 4, 2017

Meghan Cutherall   Date

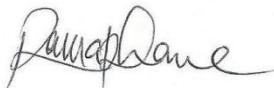_____ December 4, 2017

Jessica Fehringer   Date

_____ December 4, 2017

Peggie Ramaphane   Date
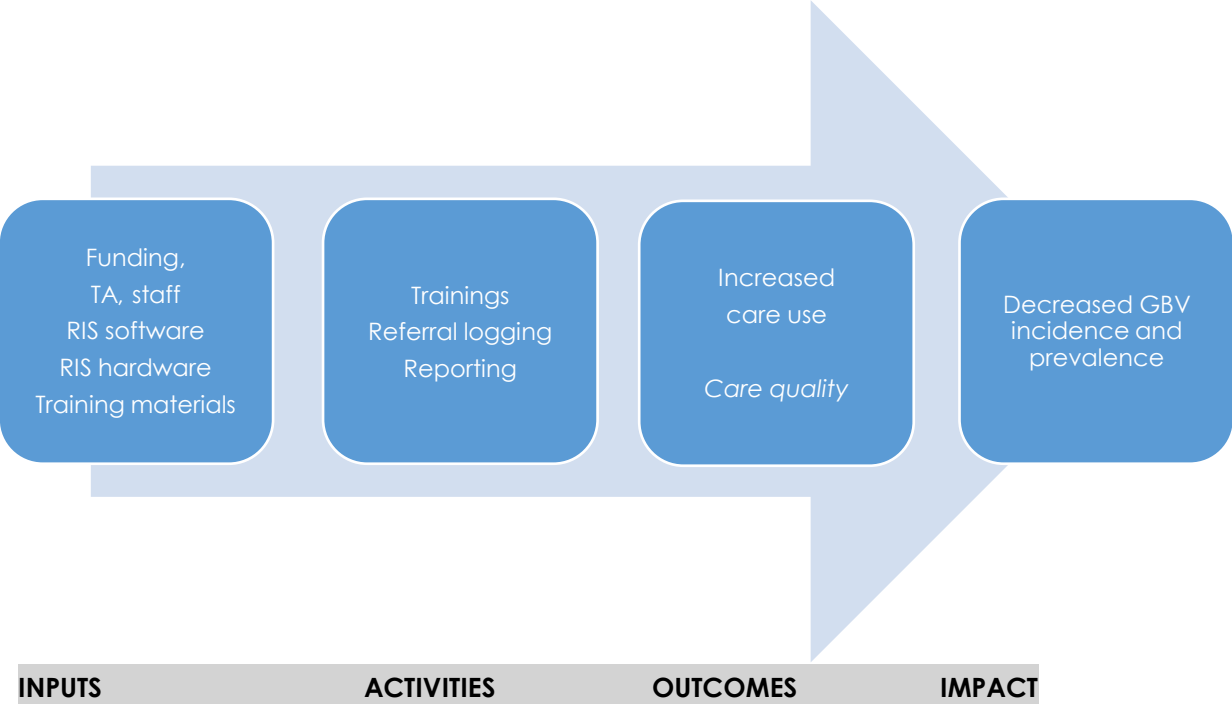

_____ December 4, 2017

Sarah Treves-Kagan   Date

APPENDIX 6. OPERATIONS RESEARCH COSTS

The total amount budgeted for the OR was $183,746.

APPENDIX 7. RESULTS FRAMEWORKS/LOGICAL FRAMEWORKS

Funding, TA, staff RIS software RIS hardware Training materials	Trainings Referral logging Reporting	Increased care use *Care quality*	Decreased GBV incidence and prevalence
INPUTS	**ACTIVITIES**	**OUTCOMES**	**IMPACT**

Logic model for the Botswana GBV referral information system

APPENDIX 8. FUNDING DOCUMENTS

MEASURE Evaluation Phase IV

Country Work Plan Narrative
YEAR 3:
October 2016–September 2017

FINAL

Botswana

Table of Contents

Introduction

Botswana is an arid land-locked country in Southern Africa, with almost three-quarters of the country encompassed by the Kalahari Desert. With a population of just over 2 million, the country is considered one of least densely populated countries in the world. While Botswana has made significant progress in many development indicators, and is considered to be an upper-middle income country by the World Bank[5], it has the second highest HIV prevalence rate in the world with an estimated 21.9% of adults infected[6]. USAID/Botswana is focused on working with the Ministry of Health and key stakeholders to improve health services to provide comprehensive HIV/AIDS prevention, care and treatment[7].

USAID/Botswana, working with the Government of Botswana, has identified gender based violence (GBV) as a priority area, due to the high prevalence. Nearly 70% of women reported experiencing GBV at some point during their lifetime, and 30% reported that an incident had occurred during the past year.[8] The link between GBV and HIV/AIDS is a clear and strong one; in 2015 PEPFAR/ Botswana identified GBV as the most important crosscutting issue in their portfolio. PEPFAR implemented a strategy that enlisted the support of several implementing partners to strengthen the GBV referral system through in-service training for service providers on GBV issues, community awareness activities at the national and site level, and the development of simple, easy-to-follow, standard operating procedures (SOP) for treating and providing care to GBV survivors.

This work plan details continued efforts to pilot a GBV referral system.

Background: MEASURE Evaluation Phase IV

In November 2013, MEASURE Evaluation conducted a scoping visit to Botswana to meet with the Gender Affairs Department (GeAD), housed within the Ministry of Labour and Home Affairs to discuss the provision of technical assistance to the Government of Botswana's response to GBV. In March 2014, it was decided that the technical assistance MEASURE Evaluation would provide would be to assist them in the development of a referral system to support GBV survivors in two pilot districts. After 2 months of stakeholder workshops and meetings, the GeAD, with MEASURE Evaluation technical support, decided to develop a mobile-based referral system to enable service providers to make referrals more effectively and more efficiently through the use of a simple mobile phone. Not only would the proposed system allow GeAD to preserve more human resources, but it would also enable GeAD to gather information on GBV service provision, and allow for better access to services for survivors of GBV by transferring crucial information about a client from provider to provider. The Referral Information System will enable GeAD to get near real-time data in order to make important decisions regarding programming and resource allocation.

From May to August 2014, MEASURE Evaluation worked with USAID/Botswana and the GeAD to develop a stakeholder-driven, sustainable, and responsive mobile referral system. In April 2015, at the beginning of Phase IV, MEASURE Evaluation went back to Botswana to reengage stakeholders, the

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[5] World Bank Botswana Data: http://data.worldbank.org/country/botswana
[6] UNAIDS Botswana Report 2013: http://www.unaids.org/en/regionscountries/countries/botswana
[7] USAID Botswana: http://www.usaid.gov/botswana/our-work
[8] Machisa, Mercy and Roos van Dorp. The gender-based violence indicators study, Botswana. 2010.

Ministry of Labour and Home Affairs, and the GeAD for the beginning of the pilot phase-in (originally planned for 6-month phase-in). In December 2015, the GeAD was ready to begin the planning process for operationalizing the GBV Referral Pilot. In January and February 2016, MEASURE Evaluation and Mantra Solutions developed both a web-form, to be used in conjunction with or instead of a mobile phone, as well as a dashboard and reporting system for Referral System information. In April 2016, MEASURE Evaluation, along with Mantra Solutions the application developer, went to Botswana to set up the system and begin training the first group of users in Maun and Mochudi. Trainings continued over the next few months until the soft launch of the system on August 1st, 2016. In June 2016, MEASURE Evaluation subcontracted two on-the-ground partners to assist the GeAD and MEASURE Evaluation in supporting the pilot of the Referral System.

The pilot began in August 2016 and will continue through September 2017. During the pilot phase, approximately 12 months, MEASURE Evaluation will work closely with all stakeholders to collect information on how the system is being used by service providers, how the system is affecting the demand for GBV services, and if the system provides a more formalized, effective efficient means to facilitate referrals between service providers than before the pilot where no formalized system was in place.

Throughout the pilot, MEASURE Evaluation, GeAD and partners Stepping Stones International and Women Against Rape will be collecting data on the referral system through regular user support meetings, ad hoc and planned site visits, investigations of referral abnormalities, community outreach and awareness activities and quarterly stakeholder meetings. Information from these meetings and workshops will be used by the partners to discuss potential mid-course corrections or additions to the referral system. In addition, the Operations Research will include all of this information as well as a baseline and endline phase of research to evaluate the effectiveness of the referral system to give the GeAD the information they need to decide whether the system should be nationally scaled up at the end of the pilot phase.

The primary objective of MEASURE Evaluation Phase IV is to enable countries to strengthen their systems to generate high quality health information that is used for decision making at local, national, regional and global levels. MEASURE Evaluation applies a systems approach to achieve this objective in a sustainable way. One application of this approach is to develop and adapt methods and tools to address gaps in health information. Achievements in the four result areas shown below contribute to the overall project objective. In Botswana, MEASURE Evaluation's work under this SOW will address result areas 1, 2 & 3.

> Result 1: Strengthened collection, analysis and use of routine health data;
>
> Result 2: Improved country-level capacity to manage health information systems, resources and staff;
>
> Result 3: Methods, tools and approaches improved and applied to address health information challenges and gaps;
>
> Result 4: Increased capacity for rigorous evaluation

4BW-001 M&E Support to Botswana for Gender and GBV

Activity Leader: Jen Curran
Other Staff: Abby Cannon, Jessica Fehringer

Objectives:

1. Provide technical assistance (TA) to the GeAD to manage and implement the GBV referral system;
2. Conduct Operations Research (OR) on the pilot of the mobile-based GBV Referral System in two selected districts;
3. Work with Government of Botswana partners to finalize Standard Operating Procedures for GBV case management and referrals.

Background:

Under Measure Evaluation Phase III, the Botswana USAID Mission requested support for monitoring and evaluation of GBV in the country. The GeAD, housed within the Ministry of Labor and Home Affairs, had initiated steps to put into place a pilot referral system in two districts: Kgatleng and Ngamiland. The focus was started in the towns of Mochudi and Maun, where existing services are located. These towns also provide services to the surrounding villages in the districts, and the referral system is being designed to service individuals living in these villages as well. USAID/Botswana contracted both FHI 360 and Management Sciences for Health (MSH) during 2015 for activities to support the piloting of referral system. FHI 360 was contracted to provide various communications and community outreach and awareness areas in the two pilot districts. MSH was contracted to work with the main Government of Botswana GBV stakeholders to develop GBV Standard Operating Procedures (SOPs) for GBV case management. A mobile-based referral information system was developed for use in a 12-month pilot in 4 communities in Botswana: the urban village of Mochudi and the rural village of Artesia in Kgatleng in the south, and the town of Maun and the village of Shorobe in Ngamiland in the north

In August 2016, the mobile-based referral system was launched after being phased in over four months through MEASURE Evaluation and its in-country subcontractors. Set up included first identifying GBV Focal Persons for each institution identified in a service directory developed in 2015 by FHI 360, trainings to include all GBV service providers in the pilot areas on the use of the referral system application, simplified Standard Operating Procedures on case management, and general GBV assessment and awareness. MEASURE Evaluation subcontractors (Stepping Stones International [SSI] and Women Against Rape [WAR]) will continue to provide support in the communities and service providers on the referral system through the pilot phase.

Throughout the pilot, MEASURE Evaluation, GeAD and partners Stepping Stones International and Women Against Rape will be collecting data on the referral system through regular user support meetings, ad hoc and planned site visits, investigations of referral abnormalities, community outreach and awareness activities and quarterly stakeholder meetings. Information from these meetings and workshops will be used by the partners to discuss potential mid-course corrections or additions to the referral system.

In addition, the Operations Research will include all of this information as well as a baseline and endline phase of research to evaluate the effectiveness of the referral system to give the GeAD the information they need to decide whether the system should be nationally scaled up at the end of the pilot phase. The system and corresponding TA provided since 2014 by MEASURE Evaluation and partners should provide GeAD with enough support and knowledge to be able to scale the pilot by October 2017 if desired.

Year 3 Work Plan

<u>Objective 1</u>

Summary:

Working with the GeAD, MEASURE Evaluation will continue to support the GBV referral information system. MEASURE Evaluation and Mantra Solutions (MEASURE Evaluation's subcontractor) will work with the Ministry of Labour and Home Affairs' (MLHA) IT technical staff to build the capacity of staff to house and maintain the server housing the GBV referral database. Mantra Solutions will develop a user manual for MLHA staff and will conduct an in-country training with relevant staff.

Concurrently, MEASURE Evaluation will provide training and technical assistance to the GeAD to support their M&E staff to understand the database, how to report back to stakeholders, and how to interpret and use results to provide useable feedback to service providers in the pilot areas including any interventions in the referral system that need to take place. MEASURE will be monitoring the database for any abnormalities in reporting and will report to GeAD and SSI/WAR to follow up with relevant stakeholders to understand any issues or concerns and provide appropriate interventions. MEASURE Evaluation and GeAD will also host quarterly GBV Referral System National Reference Group meetings as well as quarterly update meetings with district level (Kgatleng and Ngamiland) sector heads that includes (Ministry of Education and Skills Development (MOESD), Department of Social Protection (DSP), Botswana Police Service (BPS), Ministry of Health (MoH), Tribal Administration).

MEASURE Evaluation will continue to support through its subcontractors, SSI and WAR, the following:
1. Ongoing training for GBV focal persons
2. Regular updating of the GBV Service Directory
3. Monthly supervisory visits to all service providers in pilot areas.
4. Hosting of monthly user support meetings in each pilot area.
5. Ad hoc support to users
6. Documentation of needs for potential mid-course corrections or additions to the referral system
7. Ongoing GBV community awareness activities and promotion of post GBV care services

On-going user support meetings and scheduled service provider site visits will yield valuable information on the utility of and updates needed for efficient operation of the Referral System. Information gathered at these meetings will be reported back to MEASURE Evaluation. MEASURE Evaluation and Mantra Solutions will design, when possible, technical updates and solutions to the referral system and corresponding dashboards on an ongoing basis, based on the findings from the operations research, ongoing user meetings and in consultation with GeAD and USAID/BW.

Task 1.1: Provide TA to the Ministry of Labour and Home Affairs IT technical staff to maintain server housing the Referral Information System database, and understand and document these challenges;

Task 1.2: Provide TA to GeAD to undertake quantitative data monitoring. Levels and patterns of GBV cases and their referrals logged into the system will be monitored monthly in each area. Quantitative data collected and reported by the Referral System includes:
  i. Number of GBV cases reported within the pilot areas
  ii. Number of referrals initiated within the pilot areas
  iii. Number of completed referrals in the pilot areas

Additionally, we will explore trends over time to understand time between referrals as well as general pathways for referrals, which could then lead to institutionalization of GBV referral pathways between providers.

This task provides the quantitative information for the operations research.

Task 1.3: Provide Technical Assistance training of the GeAD M&E staff to create reports, interpret data, and provide interventions when needed to service providers

Task 1.4: Management of GBV Referral System in-country subcontractors including ongoing ToTs, regular work plan review, and capacity building.

Task 1.5: Updates to the GBV RS based on operations research findings.

Task 1.6: Quarterly review and update meetings hosted by MEASURE and GeAD for GBV RS National Reference Group and district-level sector heads.

Task 1.7: Supervise ongoing (monthly) GBV awareness and outreach programs through MEASURE subcontractors in Ngamiland and Kgatleng districts

Objective 2

Summary:

The Operations Research was designed to collect qualitative and quantitative data on the short term results of the referral system. The quantitative data will be collected and analyzed regularly from the referral system-generated data housed in the database. Additionally, qualitative data collected at baseline and endline through qualitative methods such as Key Informant Interviews and Focus Group Discussions will serve to generate information on the short term results of the system. The quantitative data will be automatically collected by the database and analyzed by the Gender Affairs Department. The qualitative data will include the following:

1. Reports generated throughout the pilot. These are:
    b. Narrative documents describing the way activities were implemented, such as trainings and workshops.
    c. Narrative reports of the circumstances and resulting actions that take place when results of the GBV referral system mandate investigation (data gaps, etc.). *This is covered by Task 1.3.*
2. Descriptions of each of the eight sites in the operations research. These include the four intervention sites: Mochudi (urban) and Artesia (rural) in the south, Maun (urban) and Shorobe (rural) in the north; and the four comparison sites: Kanye (urban) and Ranaka (rural) in the south, Gumare (urban) and Tsau (rural) in the north.
3. Service Provider Interviews (SPIs) in each of the four intervention sites and four non-intervention sites at endline. Service providers will be interviewed individually in each site. The sample will be drawn to cover as many types as possible from each site (e.g., from various sectors of service provision such as police, teachers, NGOs).
4. Focus Group Discussions (FGDs) of four different types of community members in each of the eight sites, at endline: adult women, adult men, young women (aged 18-24), young men (ages 18-24).

Baseline data collection began under the Year 2 Scope of Work. The below research activities will continue in year 3.

Task 1.7: Develop descriptive reports for each of the eight sites in the operations research

Task 1.8 Conduct service provider interviews in each of the four intervention sites at endline.

Task 1.9: Conduct Focus Group Discussions in each of the eight sites at endline.

Task 1.10: Endline data collection. This will be a repeat of the baseline data collection.

See task 1.2 for the description of the quantitative data to be analyzed as part of the operations research.

Objective 3

Summary:
MSH was contracted by USAID/Botswana in 2015 to develop SOPs for case management of GBV survivors. MSH worked with the MOESD, BPS, DSP, and GeAD through various meetings and workshops to develop these SOPs which would then be disseminated to all service providers throughout the country. These SOPs were drafted by MSH in 2015 and preliminary Technical Working Groups and basic flow charts were developed through stakeholder meetings with the relevant ministries and working groups.

USAID/Botswana has asked MEASURE Evaluation to (as applicable) develop, update, finalize and have approved by the relevant ministries and departments the SOPs for GBV Case Management for Service Providers. After the initial draft SOPs were created and the phase in of the referral system was initiated USAID/Botswana, GeAD and MEASURE Evaluation became aware that there were certain key pieces of the SOPs needed to be developed or reconfigured and finalized to fit the needs of the service providers and the referral system; this would provide for more in-depth case management procedures for each department.

Data captured through the Operations Research baseline and ongoing qualitative data captured through user meetings will be used as well to provide insight into potential additions or amendments to the existing SOPs. MEASURE Evaluation, through in-country collaboration and coordination will update, refine and finalize these SOPs for DSP, MOESD and BPS. Additionally, quality assurance and monitoring tools will also be included in the SOPs in order for each ministry to be able to monitor the data they are collecting. Training materials will be developed along with a training plan for the eventual roll-out of the SOP service standards for GBV nationwide.

Task 1.11: Development or updating and finalization of the SOPs for DSP, MOESD and BPS to include: screening, case management, key related services for referral, case reporting, and evidence collection procedures. Including gaining relevant ministries' and departments' approval for documents.

Task 1.12: Create quality assurance and monitoring tools for DSP, MOESD and BPS to collect and monitor GBV data that is being collected.

Task 1.13: Development of training materials for the SOPs for eventual roll-out nationwide.

Proposed Timelines and Deliverables

The pilot began in August 2016 and will continue through September 2017. The GBV Referral System pilot will run for 12 months and will end on July 31st, 2017. The endline data collection will begin in early August 2017. The final report for the GBVRS Operations Research will be delivered November 30, 2017.

Activities	Responsible Entity	FY16-–17 Timeframe				Deliverable
		Oct-–Dec 15	Jan- – March 17	April-–June 17	July-– Sept 17	
4BW-001 GBV Referral System						
1.1 Provide TA to the Ministry of Labour and Home Affairs IT technical staff to maintain server housing the Referral Information System database	Jen Curran	X	X			Training and User Manual for MLHA IT staff to manage and maintain RS server.
1.1.2 In-country training for MLHA IT staff on management of server.	MANTRA Solutions		X			In-country Training for MLHA IT staff
1.2 Quantitative data monitoring	TBD	X	X	X	X	Findings report
1.3 Provide Technical Assistance training of the GeAD M&E staff to create reports, interpret data, and provide interventions when needed to service providers	Jen Curran MEval Consultant	X	X			
1.4 Management of GBV Referral System in-country subcontractors including ongoing ToTs, regular work plan review, and capacity building.	Jen Curran MEval Consultant	X	X	X	X	
1.5: Updates to the GBV RS based on operations research findings	Jen Curran Mantra Solutions TBD	X	X	X	X	Updated GBV referral information system based upon feedback from monthly support meetings and OR.
1.6: Quarterly review and update meetings hosted by MEASURE and GeAD for GBV RS National Reference Group and district-level sector heads.	Jen Curran GeAD	X	X	X	X	Meeting reports

1.7: Develop descriptive reports for each of the eight sites in the operations research	Abby Cannon	X	X	X	X	Site descriptive reports
1.8: Conduct service provider interviews in each of the four sites.	Abby Cannon Jessica Fehringer MEval Consultant				X	Service provider interviews
1.9: Conduct Focus Group Discussions in each of the eight sites.	Abby Cannon Jessica Fehringer MEval Consultant	X			X	Focus Group Report
1.10: Endline data collection	Abby Cannon Jessica Fehringer MEval Consultant				X	*Endline study report finalized by the end of November 2017
1.11 Finalization of SOPs for DSP, MOESD, and BPS	Jen Curran	X	X	X	X	Final approved SOP documents
1.12 Quality Assurance and Monitoring tools for GBV case management	Jen Curran		X	X	X	QA and Monitoring Tools
1.13 Training Materials for SOP trainings	Jen Curran			X	X	Training Materials

Budget Summary

Items	Assumptions	Amount $
Personnel	17 months LOE for 6 staff	$270,160
Travel	7 international trips total ranging from 8-14 days Including international and domestic travel to conduct trainings, facilitate meetings and for data collection.	$133,512
Subcontracts	Sub-Agreements for supporting GBV referral system and operations research. (Includes SSI, WAR, and consultant fees)	$328,440
ODC	Meetings with national and local stakeholders and partners; and other support to subcontractors; printing and shipping of gender analysis report	$65,185
Total		$797,298

Staffing Plan and Management Plan

Name	Role/Title	Technical/Managerial Focus
Country based Staff		
No project staff will be resident in Botswana.		
US-based Advisors		
Jen Curran	M&E Activity Lead	GBV referral system management
Abby Cannon	Researcher	OR management
Jessica Fehringer	Senior Gender Specialist	Technical Advisor
Stephanie Watson-Grant	Country Portfolio Manager	Management oversight

Jen Curran, MS is currently an M&E Technical Specialist with MEASURE Evaluation. Ms. Curran has over 12 years of experience implementing and evaluating global health and development programs in Africa and Asia. She has extensive field experience in Southern Africa in HIV prevention, PMTCT, and mobile health. Ms. Curran has worked in all stages of the research and project/program implementation process including the design and implementation of research projects and development of programs in 19 countries.

Abby Cannon, MPH, MSW, is the Gender Specialist for MEASURE Evaluation at the University of North Carolina. She joined the MEASURE Evaluation team in 2010 and has since spearheaded efforts to integrate gender across project technical areas, international health information systems, and capacity building. Her research focuses on the intersection of gender and health within HIV, gender-based violence, and trafficking in persons. Ms. Cannon also works to strengthen the collection and use of sex-disaggregated and gender-sensitive data within national and local health information systems. Ms. Cannon's experience with gender and health includes domestic and international work, as well as direct service, monitoring and evaluation, and research.

Jessica A. Fehringer, PhD, MHS, is the senior technical advisor for the operations research (OR). Her responsibilities for this work include providing technical expertise for the development and implementation of the OR design, as well as contributing to the report and dissemination. Dr. Fehringer is responsible for oversight of gender-related research activities as well as for leading several evaluation and research projects in S. Asia and sub-Saharan Africa. She has worked in international public health, with a focus on the empowerment of marginalized groups, for over 15 years. She has designed and carried out qualitative and quantitative research and evaluation in South and Southeast Asia, South America, and sub-Saharan Africa on a number empowerment and health topics, including the influence of relationship power dynamics on HIV prevention and treatment and gender-based violence.

Stephanie Watson-Grant, DrPH will serve as the Country Portfolio Manager (CPM). As CPM, Dr. Watson-Grant will work closely with the team on work planning, reporting, and budgeting. She will monitor compliance with MEASURE Evaluation Phase IV Agreement conditions and approved work plan deliverables. Dr. Watson-Grant has more than ten years of experience in the field of international health and development. Her areas of expertise are HIV planning and program implementation, HIV M&E systems assessment, management of USAID-funded projects, survey planning and implementation, capacity building and training, and measurement of country ownership.

APPENDIX 9. STATEMENT OF DIFFERENCE

The evaluation team and pilot implementers recommend allocation of dedicated financial resources nationally and within ministries to support the implementation and coordination of the GBVRSP in the short-term. Once ministry ownership of the system has solidified, costs should be absorbed into regular ministry budgets.

GeAD and USAID/Botswana disagree with this recommendation. It is their opinion that ministries should do what is required within already allocated budgets and incorporate system protocols in their regular trainings.

Republic of Botswana