Republic of Botswana

Botswana's Gender-Based Violence Referral System Project

Operations Research Initial Report

June 2017

TR-17-189

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Mantra Solutions developed the Referral Information System and Orange Botswana partnered with MEASURE Evaluation for mobile connectivity.

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ABBREVIATIONS

CSOB	Central Statistics Office Botswana
FGD	focus group discussion
GBV	gender-based violence
GBVRSP	Gender-Based Violence Referral System Project
GeAD	Gender Affairs Department
HIV	human immunodeficiency virus
NGO	nongovernmental organization
OR	operations research
RIS	referral information system
S&CD	social and community development
SDP	service delivery points
SOP	standard operating procedure
SPI	service provider interview
SSI	Stepping Stones International
USAID	United States Agency for International Development
WAR	WoMen Against Rape
WHO	World Health Organization

EXECUTIVE SUMMARY

Introduction

The government of Botswana has committed to addressing gender-based violence (GBV) by advocating 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 the way referrals were made between GBV providers, such as police, social workers, health facilities, and domestic violence shelters, as an area of focus for improvement. The GeAD acted to address this need by planning a formal referral system for GBV survivor care and support in 2011 (United Nations Development Programme [UNDP] Botswana, 2011). In 2013, the GeAD engaged the United States 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 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 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 are to evaluate the short-term results of the pilot, inform potential scale-up, document successes and challenges, and facilitate system corrections. The OR has a quasi-experimental design, using quantitative referral data and qualitative data from key informant interviews and focus group discussions. Initial data collection took place in August 2016 in the four pilot sites and four comparison sites and will be done again in August 2017.

MEASURE Evaluation contracted with a local nongovernmental organization (NGO)—WoMen Against Rape (WAR)—to hire and direct a research team to conduct initial qualitative data collection in August 2016. This report is based on the initial data collection, which 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 describe the communities and their service providers across themes pertaining to understanding of GBV and service utilization and referrals and to document any differences between pilot communities that received community mobilization efforts and comparison sites, which received no interventions associated with the project. After end line data are collected in August 2017, we will compare the control and intervention communities along the same themes, to demonstrate the effects of implementing the RIS and to inform potential scale-up or future GBV programming.

Background

Botswana has one of the highest HIV prevalence rates 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 (Kharsany & Karim, 2016; PEPFAR, 2013). Worldwide, more than one-third of women report experiencing GBV in their lifetime, but in Botswana that figure is double (Garcia-Moreno, et al., 2014). 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). Vision 2036 lays out the development aspirations of Botswana and commits to "…empower women and make deliberate efforts to end gender discrimination and gender-based violence" (Government of Botswana, 2016).

Through its attention to GBV, the GeAD identified the need for developing a formal referral system. In 2013, the GeAD engaged MEASURE Evaluation to support its efforts to develop a referral system. Together, GeAD, USAID/Botswana, and MEASURE Evaluation developed the GBVRSP. The GBVRSP system 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 will run through August 2017 and is being carried out 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. Developing, disseminating, and training providers on SOPs[1] to ensure consistent and high-quality care for survivors of GBV
2. Facilitating collaboration among GBV service providers in the pilot areas by identifying all GBV providers in each pilot site and creating a service directory[2] that includes these providers
3. 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.
4. Conducting community mobilization activities, implemented by Stepping Stones International (SSI) in Artesia and Mochudi and WAR in Maun and Shorobe, to reduce acceptability of GBV and encourage survivors of GBV to access services.

Community mobilization efforts began in 2015. The pilot of the mobile referral information system was launched in August 2016 and will end in August 2017.

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[1] Standard operating procedures created by Management Services for Health (MSH), and trainings conducted by MEASURE Evaluation

[2] Service directories originally created by FHI 360

Operations Research Design

The OR will document the strengths and weaknesses of the system, inform potential scale up, and evaluate the short-term effects of the GBVRSP. The evaluation component will assess 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 will also document successes, challenges and how they were addressed, RIS usage, and referral initiation and completion trends over time.

The primary research questions to be answered at end line are:

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 easy is the referral system and RIS to use among GBV service providers?

The OR has 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 Ngamiland District, and Kanye and Ranaka, in Kgatleng District). Comparison sites were selected within the same districts to match cultural context and to match the rural and urban locations of the pilot sites. A second wave of data collection is planned for August 2017, when the GBVRSP pilot will be complete.

Methods for Initial Data Collection

In August 2016, researchers conducted 58 key informant interviews with service providers (approximately four to five interviews in rural sites and nine to 10 in urban sites); they also carried out 32 focus group discussions (FGDs) (four per site) with community members in pilot and comparison sites. FGDs were conducted with groups of participants 18–25 and over age 25, with separate groups for men and women. Interviews and focus groups were digitally recorded, then simultaneously translated and transcribed. Transcripts were coded in Dedoose qualitative analysis software. Code reports were generated and synthesized using matrices that allowed for comparisons among all sites, genders, provider types, and comparison or intervention sites.

Aggregated data from the referral system were analyzed to identify trends in system utilization and referral patterns. Monthly site summary reports compiled from on-site team member reports, monthly synopses of subcontractor activities and mobilization efforts, and reports of monthly GBVRSP user meetings were also analyzed to illuminate the challenges and successes of system uptake. All three types of data were then triangulated and analyzed to identify any contradictory or complementary findings.

Summary Results

The following summarizes key findings of the analysis:

GBVRSP Activity Coverage and Uptake

- Between August and December 2016, more than 1,500 people were reached with gender and GBV awareness activities in the Ngamiland intervention sites, and more than 1,100 people reached with Gender and GBV Awareness activities in Kgatleng intervention sites.

- Between August 2016 and December 2016, 179 GBV cases were entered in the system. Of these, 26 percent (n=46) were provided with a referral and 41 percent (n=14) of those referrals were completed.

- Most GBV cases entered (157/179), referrals initiated (37/46), and referrals completed (12/14) were in Maun. Although significantly fewer cases were entered in Mochudi, 40 percent of them were referred to another provider. Only 12.5 percent of those referrals in Mochudi were marked as completed. Uptake of the system was particularly low in rural sites with only two cases being entered into the system. Uptake of the system was low in rural sites, where only two cases were entered into the system.

- In urban areas, use of the system varied significantly by provider type. NGOs entered the majority of GBV cases (108/179). Health care providers and those in the legal/justice field (e.g. police) referred the highest *percentage* of their clients—approximately 50 percent of cases. NGOs and social workers referred approximately 15 percent and 12 percent of the entered cases, respectively.

- Social workers received the most referrals (15/46) followed by NGOs (13/46) and legal/justice providers (10/46). Approximately 54 percent of referrals made to NGOs and 60 percent of referrals made to legal/justice providers were marked as complete. One referral was marked completed by social workers and no referrals were marked as complete by health care providers.

Community Perceptions and Acceptance of GBV

Most FGD participants—north or south, rural or urban, male or female, intervention or comparison—had mixed feelings about GBV acceptability. There were significant differences among individuals regarding their understanding and acceptance of gender-based violence, as well as some key differences between sites by location.

- Community focus group discussions at baseline revealed a tension between knowing GBV was not permitted by law versus traditional views of gender norms that condone violence against women. While some participants held attitudes either strongly condemning or condoning violence, most felt it should ideally not happen but gave instances in which it was understandable and/or excused if the woman did something "wrong."

- Understanding of GBV varied, with a minority of participants accurately describing GBV and most responses indicating that participants lacked a thorough understanding of it. At times, GBV was described as any kind of conflict or crime, and some definitions were distorted (e.g., women denying sex or cooking is a form of abuse toward men).

- There were more urban-area FGDs in which GBV was deemed to be unacceptable as compared to FGDs in rural areas. FGDs in which all participants endorsed GBV were more likely to be in the north compared to the south. Interestingly, intervention sites were more polarized in their opinions on acceptability of GBV than comparison sites, with more intervention FGDs expressing consensus that GBV was acceptable or unacceptable and fewer FGDs expressing mixed opinions on acceptability.

- Almost universally, participants reported that survivors first reached out for help to family, followed by the tribal authority; they only reported accessing outside help from police, social workers, or hospital staff subsequently.

- Participants reported that lack of family support and empathy toward survivors was a significant barrier to accessing care and leaving abusive relationships. This was deeply tied to other barriers to accessing care such as financial dependency on the perpetrator, shame, and fear of lack of confidentiality, as well as fear of retaliation.

- There were mixed opinions on quality of care from service providers. Almost universally, there was a call for more services and more punishment for perpetrators. Males in FGDs did not report concerns about confidentiality in intervention sites, but they did report such concerns in comparison sites. Females both in intervention and comparison sites reported concerns about confidentiality. Participants also said that slow, insensitive, or inadequate responses by service providers discouraged victims of GBV from reporting.

Provider Perceptions and Handling of GBV

Service provider interviews (SPIs) demonstrated differences between intervention and comparison site providers in terms of GBV understanding, comfort in handling GBV cases, and trust and collaboration between sectors.

- Service providers in GBVRSP pilot sites had a better understanding of GBV and how to process GBV cases correctly than those in comparison sites.

- There were no differences in provider perceptions and handling of GBV by north/south or rural/urban location.

- As compared to control sites, pilot sites reported greater connection with and trust in other providers, as well as more understanding of what other providers do.

- Although some providers in the comparison sites demonstrated excellent practices and understanding of GBV, several questionable practices were named, such as having the perpetrator (instead of the service provider) take the survivor to the hospital or inviting in-laws to discuss criminal GBV cases.

- While community members cited the tribal authority as often the first point of contact for survivors, these providers seemed the least confident in managing GBV cases and thus merit extra support and training. This was the same in pilot and comparison sites.

- Most providers, whether in the pilot sites or not, reported that SOPs on care for GBV survivors did not exist or were hard to access (e.g., in locked cabinets).

Referral System Feedback

Immediately following the initial GBVRSP training, most providers were enthusiastic and positive about the new system and thought that it would improve services. There were some start-up challenges reported, such as access to phones, running out of data, and lack of network coverage. Qualitative data showed no notable differences by site or area of the pilot; however, RIS uptake varied significantly by site.

- At rollout, intervention site service providers reported overwhelmingly positive feelings toward the new GBVRSP system, as it had already led to greater collaboration and connections among service providers across sectors and the trainings had improved the quality of care survivors received. This did not differ between rural or urban sites or northern or southern sites.

- Nearly all providers reported enthusiasm and positive expectations for the RIS following trainings and rollout (although most providers had not yet had the opportunity to use the system). Overall, providers expected the phone-based referral system to be easy to use and to increase efficiency of referral and follow-up. However, care should be taken to ensure that the RIS works to complement, not replace, current client supports, such as calling providers to inform them that a new client is coming or walking survivors to the next service delivery point.

- While most of the feedback was positive, some concern was expressed that typing into the system takes a long time (several providers recommend moving to touch screen phones) and that it is not possible to create reports from mobile phones.

- Pilot monitoring data through December 2016 documented some challenges with system uptake, including challenges adopting the new system and logistical problems such as lack of network coverage, running out of data, sharing phones, and keeping phones charged.

Table 1 summarizes the main results by research question; it also highlights differences (and lack thereof) in themes among sites (i.e., intervention versus comparison, north versus south, and rural versus urban) within the summary for each research question.

Table 1. Results summary and site differences by research question

Research Question	Results Summary and Highlights of Site Differences
Community understanding of GBV	While some community members demonstrated a detailed understanding of GBV, most focus groups demonstrated basic or low understanding of definitions and causes of GBV. **There were no discernable differences between intervention and comparison sites; or according to district (north/south) or population (urban/rural).**
Community endorsement of GBV	Most focus group participants indicated mixed feelings about the acceptability of GBV, although there were groups in which all participants either endorsed or denounced the use of violence in relationships. More often, participants knew that GBV is illegal but cited instances where it did happen or could be acceptable. Patterns of differences between sites were inconsistent. **There were no discernable differences between intervention and comparison sites, or according to district (north/south) or population (urban/rural).**
Community perceptions on availability and quality of services	Focus group participants consistently reported family, the Kgotla, police, social workers, health facilities, NGOs, and educators as resources for GBV survivors. There are more services available in urban sites compared to rural areas, and this was reflected in FGDs. Participants had mixed feelings about the quality of services without substantial differences between intervention and control sites. **In intervention sites, males did not report concerns about confidentiality, but did in comparison sites. In both intervention and comparison sites, females reported concerns about confidentiality.**
Provider understanding of GBV	Providers in the intervention sites demonstrated more comfort defining GBV than providers in the control sites. **Victim-blaming attitudes, though uncommon, were shared more often by providers working in comparison sites than by those in intervention sites.** Compared to those in pilot sites, providers in comparison sites were more likely to report that survivors of GBV were discouraged from reporting or pursuing a case against the perpetrator because of frustrations with slow or low-quality services.
Provider comfort in delivering GBV services	**Intervention site providers gave more consistent and robust descriptions of protocols to support survivors of GBV compared with comparison site providers,** although some comparison site providers demonstrated extremely high-quality care and procedures. Data from tribal authorities, in both intervention and control sites, suggest the need to target additional training with this group.
Provider collaboration and trust	**Intervention site providers also reported more trust and collaboration with other service providers in their areas than comparison site providers.**
GBVRS/RIS feedback	Providers in intervention sites were optimistic that the GBVRS would improve collaboration between providers, improve the quality of care for GBV survivors, and be easy to use. **Initial usage data showed uneven uptake of the system. NGOs dominated system usage, while social workers had not used the system at all. Uptake was particularly low in rural sites, where only two cases were entered into the system. Substantially more cases were entered into the RIS, and a higher proportion of referrals were completed in the northern sites than in the southern sites.**

Recommendations

Based on our findings, we recommend the following:

Community Understanding and Perceptions of GBV

- On-going community mobilization **activities aimed at helping community members understand what constitutes GBV should continue**, as community FGDs suggested limited understanding of GBV. Implementing partners should reevaluate their messaging in collaboration with mobilizers to strategize how best to address distorted definitions and provide support for continued community awareness.

- **Community mobilization and awareness-raising activities should discuss inequitable gender norms that condone violence** against women; this can help to reduce women being blamed for experiencing violence and increase support for survivors of GBV to access services.

- **Activities should specifically target families and community leaders**—as these were noted as the first point of contact for survivors. This would create community champions to set positive examples of equitable gender norms and help survivors access government services.

Provider Perceptions of GBV and Processing Cases

- Our findings suggest that initial trainings on identifying GBV cases, SOPs, and the referral process were effective in increasing providers' comfort in handling GBV cases and confidence in other providers' services. As such, we recommend **ongoing trainings to ensure more providers are trained in each service delivery point**; this is especially important to account for high staff turnover. Trainings can highlight what does and does not constitute GBV and prioritization of the order of referrals when a survivor needs more than one service. In addition, sensitization trainings should continue on-site with all staff at SDPs to increase awareness of GBV and of GBV focal person(s) at the SDP.

- Provide **additional training and support to tribal authorities**; as the first point of contact for most survivors, they are fundamental in increasing the number of women who access police, medical, or social services. Creating GBV SOPs for tribal authorities could better integrate tribal authorities into the referral system and increase confidence in providing services.

- **Display posters of simplified processes and step-by-step guidance in points of service** to ensure that all service providers have access to appropriate protocols for supporting survivors of GBV. Investigate reported practices that fall outside of a high standard of care and incorporate these issues into on-going SOP updates.

- **Continue monthly meetings between service providers** in the same area so as to maintain connections and trust between institutions and providers.

GBV Referral System

- **Continue one-on-one visits with service providers** to address any logistical challenges and encourage consistent use of the new system.

- As included in the original design of the RIS, **implement SMS reminders to service providers** as "cues-to-action" for the referral system.

- **Continue efforts to follow up on uncompleted referrals** to gain better understanding of lack of completion and identify processes for getting feedback to providers on their referrals.

- While **touchscreen smartphone options** may not currently be feasible based on cost, safety concerns, safety concerns, and network coverage in the country, this **could be explored at a later date as technology progresses.** A web-based application is currently available for services providers that have access to computers and internet.

- Work with providers to **ensure that the referral system complements, but does not replace, best practices,** such as phoning the receiving provider directly to let them know that a new case is coming or walking the client over to the provider.

Conclusions

Overall, these qualitative results demonstrate a high level of initial provider enthusiasm for the GBV referral system. They also suggest that trainings improved providers' ability to identify GBV cases and increased collaboration between providers. However, RIS data usage indicates uneven uptake of the mobile RIS by provider type and urban/rural location. Findings from community FGDs show need for additional community mobilization to refine GBV definitions, challenge traditional gender norms, and help survivors of GBV access appropriate care despite challenging social and economic contexts. FGD findings also suggest that pilot and comparison site communities did not differ in terms of GBV understanding and awareness at the time of RIS launch.

A second round of data will be collected in August 2017 and an end line report will be published to compare differences between intervention and control sites regarding acceptance of GBV, knowledge of GBV services, and confidence in service provision for GBV survivors. The end line report will also describe any changes in referrals, use of the system, and perceptions of GBV since the launch of the referral system, and make recommendations for support needed, as well as technical, operational, and system changes.

INTRODUCTION

Background

Botswana is an arid, land-locked country in Southern Africa; the Kalahari Desert covers almost three-quarters of it. With a population of just over 2 million, Botswana is one of the least densely populated countries in the world. 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, 2015).

Gender inequality and GBV are critical enablers of the HIV epidemic and have been associated with HIV incidence (Andersson, Cockcroft & Shea, 2008; Jewkes & Morrell, 2010; Jewkes, Dunkle, Nduna & Shai, 2010; Dunkle et al, 2004). Thus, USAID/Botswana, working with the Government of Botswana, has identified GBV as a priority. Nearly 70 percent of women 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 fewer than 1 percent of perpetrators are prosecuted (Machisa & van Dorp, 2012). With such high rates of HIV and GBV, PEPFAR/Botswana has identified GBV as the most important cross-cutting issue in its portfolio.

The GeAD of 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.

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 in 2007, Botswana developed a National Strategy for Ending Gender-Based Violence. One of the challenges identified by the plan was the lack of coordination between 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 GBV survivor care and support. 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 GBVRSP. This system is in line with PEPFAR's strategy to strengthen the GBV referral system (PEPFAR, 2016).

This report serves as the first of two OR reports to explore and evaluate the short-term effects of the GBV referral system across comparison and interventions sites over time. It presents the following data:

- Qualitative FGDs on community awareness and the perception of GBV and GBV services. These FGDs took place after the initial community mobilization campaigns that began in 2015
- Qualitative interviews with providers on their awareness of GBV issues, self-efficacy regarding GBV service provision, and feedback on the functionality of the referral system
- Initial data on referral system usage and field reports from August to December 2016

The subsequent end-line data collection will take place at the close of the pilot in August 2017. End line analyses will document changes over time and any differences between pilot and comparison sites 12 months after the launch of the referral system.

Gender-Based Violence Referral System Project

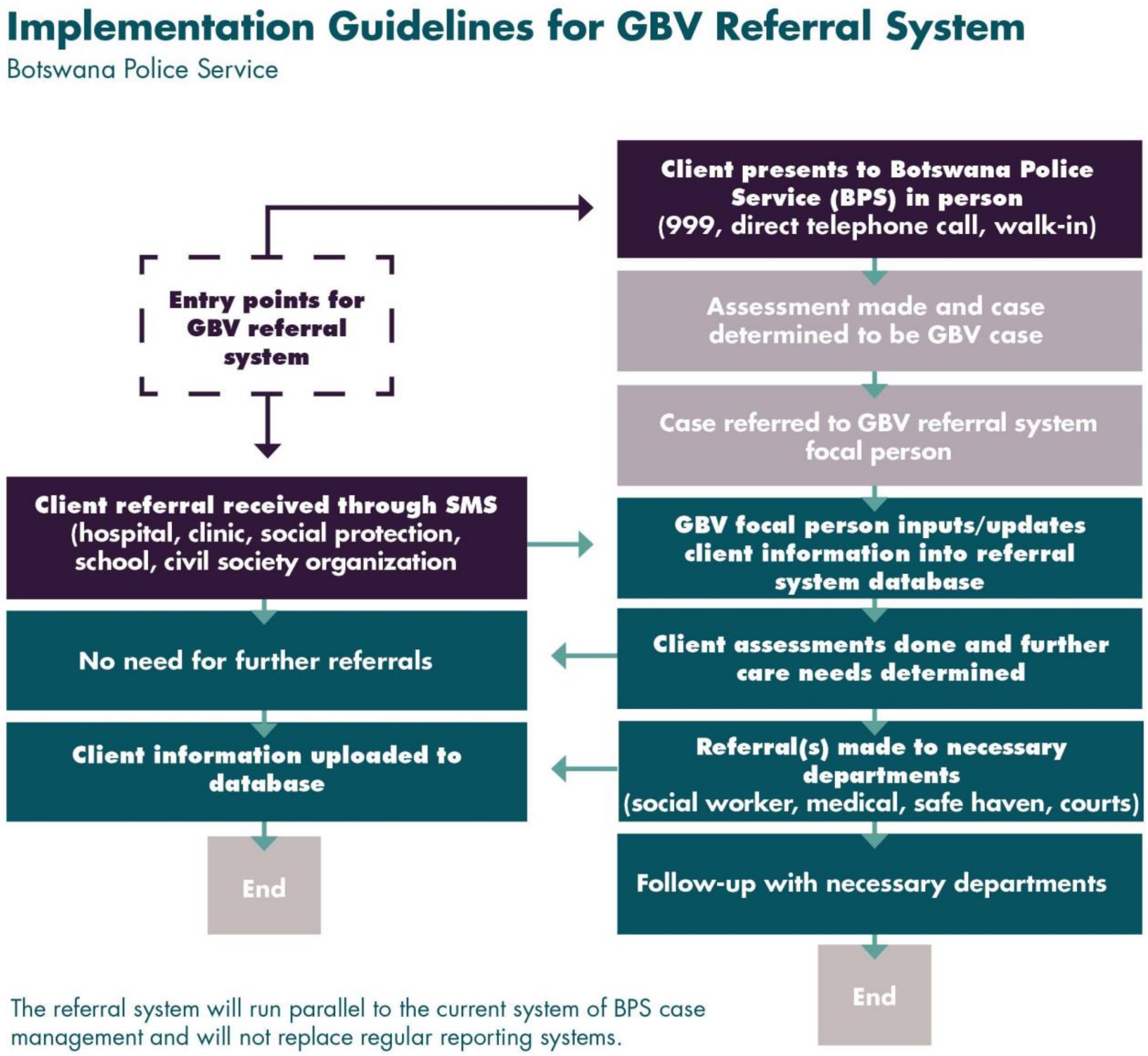
The Botswana GBVRSP is a complex intervention that is piloting a new way of connecting GBV survivors with comprehensive services. The system comprises training for service providers on GBV issues, community awareness activities at the national and community level, and the development of simple, easy-to-follow SOPs for treating and providing care to GBV survivors. The GVBRSP includes service delivery points and providers from these sectors: police, social workers, health facilities, tribal authorities, educators, and NGOs (see Figure 1). At the core of the GBVRSP is a mobile-based RIS to enable providers to make and receive referrals and to capture information on services for GBV survivors. The mobile system 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 patients 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. Figure 3 documents each component of the GBVRSP.

Figure 1. Gender-based violence service providers

Beginning in August 2016, the new RIS began tracking all GBV survivors who seek care at any service delivery point (SDP) within the catchment areas of the pilot communities, inclusive of all sectors and services, delivered by both governmental and nongovernmental agencies. 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 mobile-based RIS is being 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 system 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.

Figure 2. Example flow chart documenting RIS role in case management practices



The identification of referral sites and development of standard protocols for supporting GBV survivors within SDPs was foundational to the success of the GBVRSP and RIS launch. Service directories for all GBV providers in the target areas were developed and shared with all providers. SOPs were developed for the Department of Education, Department of Social Protection, and Botswana Police Services by Management Sciences for Health (MSH). SOPs delineate the steps involved with handling a GBV case within each SDP, including when to interact with the new RIS. The Ministry of Health developed a GBV SOP independently and no SOP was created for tribal authorities. Flow charts (see Figure 2) that highlighted how to incorporate the RIS into existing case management practices were developed for all sectors.

Before the RIS pilot, staff in all SDPs included in the pilot participated in several trainings over several months, which were led by MEASURE Evaluation, GeAD, WAR, and 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.[3] 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, originally under the umbrella of FHI 360. In March 2016, WAR and SSI became subcontractors of MEASURE Evaluation. 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 all 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 formal GBV referral system—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. The feasibility of expanding the project to the rest of the country will be discussed in the second OR report, at the conclusion of the GBVRSP. Tackling the GBV epidemic in Botswana aligns with global strategies, such as the Sustainable Development Goals; Goal 5 is achieving gender equality and empowering women and girls. GBV is recognized as a worldwide epidemic and is a major driver of the HIV epidemic. The decline in GBV in Botswana will contribute to the decline in HIV there, as well.

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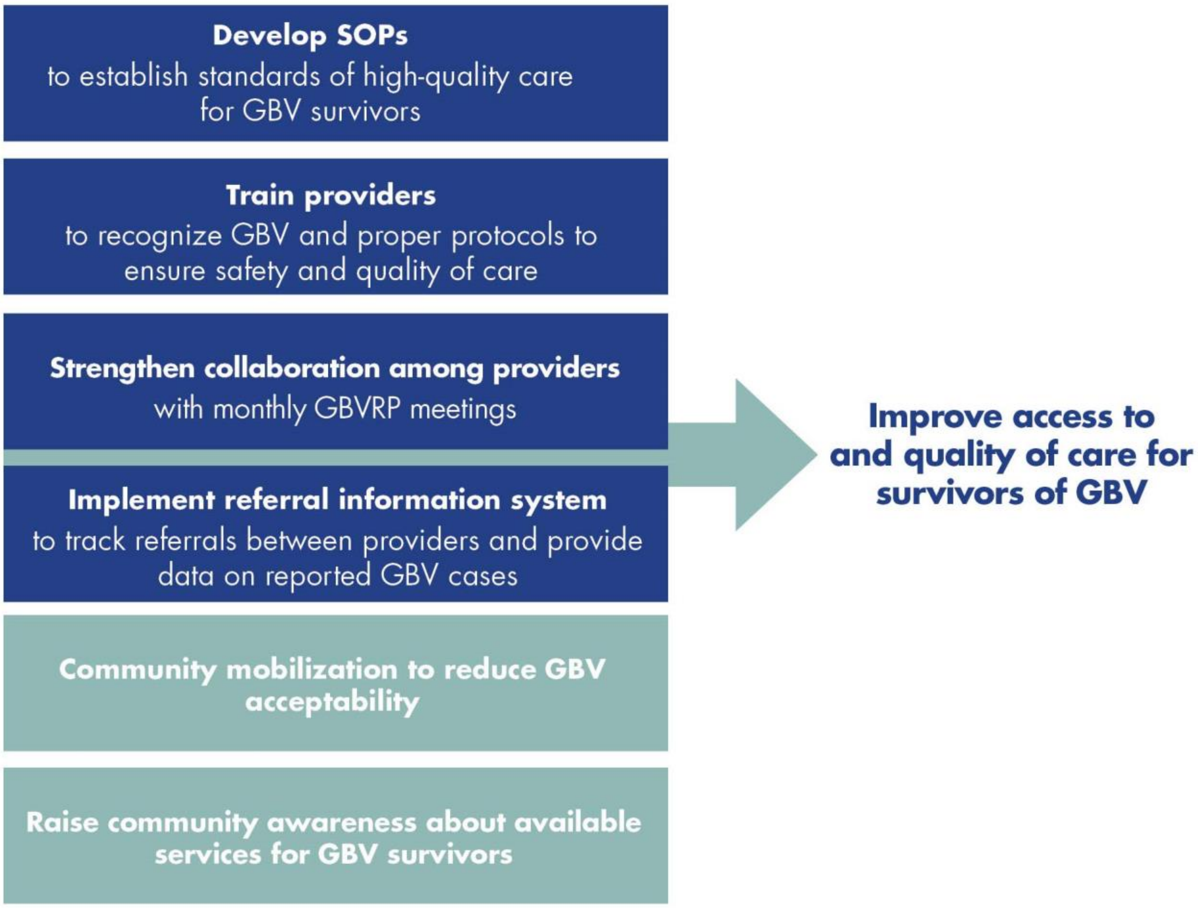
[3] For more information from Raising Voices and content from SASA!, please see http://raisingvoices.org/sasa/

Figure 3. Gender-based violence referral system project



Research Aim and Research Questions

The aim of the OR is to evaluate the short-term results of the GBVRSP, facilitating current system corrections, and to provide feedback for potential scale-up and future GBV interventions. The results of the OR will provide information to the GeAD and other stakeholders for programmatic decision making around care provision and referrals for GBV survivors. Results will indicate areas of success attained by the GBVRSP in the target areas and compare information gathered from comparison sites. Findings will also describe challenges encountered and how they were resolved, as well as the potential for expansion of the system to the national, or subnational level. The OR will employ a mix of quantitative and qualitative methods to address the research questions that evaluate the objectives of the GBVRSP.

The OR research questions were developed in collaboration with the GeAD. How has community awareness and perception of GBV and GBV services changed over time?

1. How has GBV service provider awareness and self-efficacy around GBV and provision of GBV services changed over time?
2. How easy is the referral system and referral information system to use among GBV service providers?

3. 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?
4. What are the patterns and trends of initiating agencies over time?
5. What are the patterns and trends of receiving agencies over time?
6. What are the patterns of uncompleted referrals, and what explains these patterns?

The research aims to provide information for current system corrections, for programmatic and policy decision making around GBV in Botswana, and on the potential for scale-up to the national or subnational level, or if the services should be combined with other types of services. We hypothesize an improvement 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. This would result in better overall service provision and care for survivors in pilot sites than in control areas.

METHODS

Study Design and Methods

This OR is based on a quasi-experimental design that allows for comparing change over time between intervention and comparison sites, increasing the validity of the results. Data were collected in the four pilot sites and in four comparison sites matched by district—urban or rural—meaning that there was a similar culture and GBV service provision environment (e.g., similar number of local NGOs, police stations, and clinics). Data collection began in August 2016, just after rollout of the RIS and the RIS user training. A second round of data collection is planned in the same sites, but not with the same participants, for August 2017, one year after rollout (see Figure 4).

At each of the eight sites, four community-member FGDs and five to 10 SPIs were conducted. The SPIs were conducted with providers from sectors of GBV service provision, such as 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	Guamre	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

Program monitoring data included system usage data and monthly site and sector summary reports. 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. Monthly 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.

Study Sites

Data were collected in eight sites—four in the Ngamiland and four in the Kgatleng Districts of Botswana (see Table 2). The population of the North West District in 2011 was 175,631 and the population density was 1.1 per square kilometer in 2001 (Statistics Botswana, n.d., a). There are 71 schools and 1,070 teachers, health facilities including three general hospitals, 25 clinics, 37 health posts, and 103 mobile stops, where mobile health clinics visit (Statistics Botswana, n.d., a). The major economic activities in the District include tourism, livestock rearing, handicrafts, small-scale industries, and some agriculture. Unskilled and semi-skilled laborers are employed to maintain government facilities (Ministry of Local Government, n.d.).

The population of Kgatleng District in 2011 was 91,660, and the population density was 11.52 per square kilometer in 2011, 10 times the density in Ngamiland. There is a total of 39 schools, 621 teachers, and 31 health facilities, including one hospital and 16 health posts (Statistics Botswana, n.d., b).

Table 2. Data collection sites and characteristics

District	Urban/ Rural	Site	Intervention/ Comparison	Description
Kgatleng (south)	Urban	**Mochudi***	Intervention	Mochudi is an urban village and the capital of the Kgatleng District of Botswana. With a population of 44,815 in 2011, it is the 10th largest village. In 2008, agriculture was the primary industry in the district, followed by wholesale and retail trade, and education (Central Statistics Office Botswana [CSOB], 2008. The village has 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 nine social and community development (S&CD) offices and five civil society organizations. It also has the Mochudi Main Kgotla and Village Development Committee.
		Kanye	Comparison	Kanye has a population of 47,007 making it the eighth-largest village in the country. It has 1 senior secondary school, 6 junior secondary schools, and 24 primary schools. 18 health facilities including 1 hospital and 7 clinics and 10 health posts. There are 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, 2011). Artesia is also located in the Kgatleng District. Local facilities and services include one primary and one junior secondary school, one police post, a clinic, one 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 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.
Ngamiland (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 GBVRS service directory.
		Gumare	Comparison	Gumare (population 4,556) 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, small-scale industries, and some agriculture. 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, 2011). 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) 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.

Two teams—five women and three men—collected data; 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 early August 2016. Training content included research aims, description of the referral system, ethics and informed consent, interview and facilitation techniques, and mock interviews and focus groups. Data were collected over a two-week period—one week in Ngamiland and one in Kgatleng.

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: men and women ages 18–25 years; and men and women older than 25 years. Tea and snacks were provided to focus group participants to thank them for participating.

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 to explain the purpose of the OR and to ask if they would participate. No incentives were offered to SPI participants.

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 note taking and recoding, and the other facilitated. FGDs were held outside in a space that offered privacy from other individuals and where the group could sit down. Focus groups lasted between 30 and 60 minutes on average. Most service providers were interviewed in their offices; some were conducted at partner organization sites (WAR or SSI). Interviews were, on average, 30 minutes long.

Semi-structured guides were used to ensure consistency of questions between data collectors and data collection sites. Semi-structured interview and focus group guides included questions on participant understanding of GBV, why it occurred, and why they think 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.

All interviews and focus groups were recorded and transcribed sentence by sentence. 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 four study team members. This is a rigorous and systematic process that enables 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 are based on pre-identified themes derived from the interview/focus group guides. Inductive codes are based on themes that emerge while analyzing data; ours derived from memos of a subset of transcripts. Working together, the team coded the transcript of one FGD and one SPI; thereafter they coded transcripts individually. Any questions or clarifications were flagged and discussed as a group. Throughout the process of coding, coding consistency was periodically checked and the analysis team met to discuss emerging themes. 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.

RIS usage was examined to identify trends in use and referral completion over time, by site, by provider type, and by client type. Monthly 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.

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 and was given "nonresearch status" by the Institutional Review Board at the University of North Carolina at Chapel Hill, USA.

RESULTS

Overall, 59 in-depth interviews and 32 focus groups were conducted in eight sites. Service provider interviewees were predominately female (n=39); 20 men were interviewed. Table 3 documents the number of SPIs by type for each site.

Table 3. Number of interviews and focus groups by site

				Service Provider Interviews						
District	Urban/ Rural	Site	**Focus Group**	Health Sector	Justice	NGO	School	Social Worker	Tribal Authority	**Total**
Kgatleng (South)	Urban	**Mochudi***	**4**	**2**	**1**	**1**	**2**	**2**	**1**	**9**
		Kanye	4	2	2	3	2	0	1	10
	Rural	**Artesia**	**4**	**1**	**1**	**0**	**1**	**1**	**1**	**5**
		Ranaka	4	1	1	0	2	0	1	5
Ngamiland (North)	Urban	**Maun**	**4**	**1**	**2**	**3**	**2**	**1**	**1**	**10**
		Gumare	4	1	2	3	3	1	1	11
	Rural	**Shorobe**	**4**	**1**	**2**	**0**	**0**	**1**	**0**	**4**
		Tsau	4	1	1	0	1	1	1	5
Total			32	10	12	10	13	7	7	59

*Shaded rows with bolded font indicate intervention sites.

Program monitoring data show that, between August and December of 2016, more than 1,500 people have been reached with gender and GBV awareness activities in the northern intervention sites and more than 1,100 people reached with gender and GBV awareness activities in southern intervention sites. Since May 2016, 115 service providers from all sectors had been trained on GBV awareness, the GBV referral system, and SOPs. Between August and December 2016, 179 GBV cases were logged into the system, 26 percent (n=43) were provided with a referral and 30 percent (n=14) of referrals were completed.

Below we report detailed results of our main research questions: (1) differences and trends 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) data on referral system usage and field reports. Table 4 summarizes differences between sites for each research question; more detailed results are documented in subsequent sections.

Table 4. Summary of results and site differences by research question

Research Question	Results Summary and Highlights of Site Differences
Community understanding of GBV	While some community members demonstrated a detailed understanding of GBV, most focus groups demonstrated basic or low understanding of definitions and causes of GBV. **There were no discernable differences between intervention and comparison sites or according to district (north/south) or population (urban/rural).**
Community acceptability of GBV	Most focus group participants indicated mixed feelings about the acceptability of GBV, although there were groups in which all participants either endorsed or denounced the use of violence in relationships. More often, participants knew that GBV is illegal but cited instances where it did happen or could be acceptable. Patterns of differences between sites were inconsistent. **There were no discernable differences between intervention and comparison sites, or according to district (north/south) or population (urban/rural).**
Community perceptions on availability and quality of services	Focus group participants consistently reported family, the Kgotla, police, social workers, health facilities, NGOs, and educators as resources for GBV survivors. There are more services available in urban sites compared to rural areas, and this was reflected in FGDs. Participants had mixed feelings about the quality of services without substantial differences between intervention and control sites. **In intervention sites, males did not report concerns about confidentiality, but they did in comparison sites. In both intervention and comparison sites, females reported concerns about confidentiality.**
Provider understanding of GBV	Providers in the intervention sites demonstrated more comfort defining GBV than providers in the control sites. **Victim-blaming attitudes, while uncommon, were shared by providers in comparison sites more than in intervention sites.** Compared to those in pilot sites, providers in comparison sites were more likely to report that survivors of GBV were discouraged from reporting or pursuing a case against the perpetrator because of frustrations with slow or low-quality services.
Provider comfort in delivering GBV services	**Intervention site providers gave more consistent and robust descriptions of protocols to support survivors of GBV compared with comparison site providers,** although some comparison site providers demonstrated extremely high-quality care and procedures. Data from tribal authorities, in both intervention and control sites, suggest the need to target additional training with this group.
Provider collaboration and trust	**Intervention site providers also reported more trust and collaboration with other service providers in their areas than comparison site providers.**
GBVRS/RIS Feedback	Providers in intervention sites were optimistic that the GBVRS would improve collaboration between providers, improve the quality of care for GBV survivors, and be easy to use. **Initial usage data showed uneven uptake of the system. NGOs dominated system usage, while social workers had not used the system at all. Uptake was particularly low in rural sites, where only two cases were entered into the system. Substantially more cases were entered in the RIS, and a higher proportion of referrals were completed in northern sites than in southern sites.**

Awareness and Perception of GBV and GBV Services among Community Members

Overall, we found a wide range of GBV definitions and opinions regarding the acceptability of violence among both men and women. The reported causes of GBV were fairly uniform, as was the community response, which relies heavily on family and tribal authorities to resolve conflicts in relationships. The socioeconomic environment, characterized by high rates of poverty and adherence to traditional gender norms, shaped many of the participants' views on GBV, GBV acceptability, and accessing services. **There were no notable differences between intervention and comparison sites, by north/south or urban/rural location for themes on GBV definitions and causes and GBV service availability and quality. There were, however some differences in GBV acceptability by north/south and urban/rural location and small differences in quality perceptions by gender.**

Defining GBV and Identifying Causes

In general, we found **a lack of clarity around defining GBV**. The types of violence most frequently identified were physical, sexual, and emotional violence. Participants often included violence against children as a form of GBV. A handful of participants demonstrated a thorough understanding of GBV—referencing abuse of power. One young women from an urban area in Kgatleng defined GBV, saying:

> *We know there are basic human rights, but another person may choose to abuse someone and not take into consideration that they have rights. For example, you could be in a relationship with someone and you are the one who is unemployed and the man expects the woman to be submissive towards him and he may then become emotionally or verbally abusive. The declaration of human rights stated by the United Nations has stated these rights, which we should follow.*

However, most participants had less precise definitions, often including any kind of violence (e.g., crime in the community) in their definition. Others also included any kind of conflict (e.g., not getting along with your partner, bullying between students, unfair treatment in the workplace) as GBV. Many men (and some women) described refusing to have sex or to cook as a type of abuse women inflict upon men. For example, young men from an urban area in Ngamiland said:

> Respondent 1: *For example, naturally the man is the provider, this is written in the Bible. Women can abuse men through words and disrespect the men even though she's unemployed. Women also abuse men through refusing to have sex with him.*
>
> Respondent 2: *A woman refusing to cook is also a form of abuse.*

As explained in more detail in subsequent sections, this lack of clarity and distortion of the definition of GBV affected when and why participants thought engaging with community services was appropriate. In some cases, participants discussed seeking the help of the police for issues that would not be considered GBV. For example, one participant advised another focus group member to call the police if his wife burned the dinner instead of using violence against his wife. Conversely, several participants discussed women not accessing services because they thought GBV was "normal."

Participants' understanding of the causes of GBV were consistent across focus groups. Most commonly, participants cited the economic context of high rates of unemployment and female dependence on men. Some participants described the powerlessness of women in relationships because of economic dependence and men's subsequent abuse of power. Interestingly, one male focus group participant reported frustration around feeling exploited for money and another about not being able to provide for his family due to lack of employment opportunities as also causing them to be violent.

Participants also cited alcohol use as a driver of GBV, as well as violence as a learned behavior from parents or elders. Some participants' understanding of the causes of GBV fit squarely in traditional gender norms, such as talking back, refusal of sex, false accusations from women, and women's desire for equality. Two young women from a rural area in Ngamiland said:

> Respondent 1: *I agree with what has been said. Women are people that shout at their partner as they don't have the physical capability to fight with a man. Shouting infuriates men and pushes them to beat their female partner. Women can also be perpetrators…they violate their partners…*
>
> Respondent 2: *For example, when a woman starts an argument by asking her male partner why he came home later than usual. Men don't like to be asked such questions. The woman provokes her partner by raising her voice and continuing to ask him to answer the question. The man eventually gets infuriated and beats his partner.*

GBV Acceptability

Most focus groups—north or south, rural or urban, male or female, intervention or comparison—had mixed feelings about GBV acceptability. There were, however, some notable differences between sites. There were more focus groups in urban areas in which GBV was deemed to be unacceptable (5/16) compared to rural areas (1/16). Focus groups in which all participants endorsed GBV were more likely to be in the north (5/16) compared to the south (2/16). Interestingly, intervention sites were more polarized in their opinions on acceptability of GBV than comparison sites, with more intervention FGDs expressing consensus that GBV was acceptable or unacceptable and fewer focus groups expressing mixed opinions on the acceptability.

We explored this range of opinions in more depth. There were a handful of participants who were very adamant that violence was always unacceptable. A young man from an urban area in Kgatleng said:

> *There is no reason why anyone should be beaten. If a man beats his wife in front of their kids and boy child sees this, the boy will be led to think that it okay for people to be beaten. The boy can become a bully as he's exposed to physical violence in the home. The boy can be an abuser in the future. There is no reason for us to abuse women.*

Many participants knew that violence was against the law or that it was not supposed to happen but cited many examples when it did happen. There was also tension expressed by many participants who thought violence should not happen but also that women should obey their husbands. Both men and women, especially in rural areas, thought violence was an acceptable way to teach a female partner "a lesson," or as a way to ensure she did not make "mistakes" again. Some men also felt that their financial contribution to the family or partnership meant that they were allowed to use violence. One older male participant in a rural village in Kgatleng said, "If I marry a woman, I did not get her for free; I paid lobola for her, so why should she disrespect me?"

Community participants also reported conflict between messages around reducing violence against women and gender equality and religious views that endorse women obeying their husbands. Interestingly, even among those who cited examples where violence was acceptable in a relationship, participants almost universally said that perpetrators were (or should be) shamed in their community, sometimes by being beaten at the Kgotla, or arrested. Participants expressed frustration that perpetrators were not punished enough and that either the police did not follow through on a case or perpetrators often returned to the community after a short stay in prison. “Victim-blaming” was used to justify the acceptability of GBV in some instances but not others. In these cases, participants emphasized the woman’s role in why the violence happened, i.e., violence was acceptable if she had done something to “deserve” the violence. Here an older man in a rural area of Kgatleng expresses frustration that violence used as a mechanism to punish a wife is described as abuse:

> *Women have tendencies of using inappropriate words towards us, and this can be the sole cause of why fights begin in the household. You can take care of your partner and she still does not obey you. This is a sign of disrespect, when you take matters into your own hands; she is quick to say you have abused her.*

This quote exemplifies how programming to reduce the acceptability of GBV must take inequitable gender norms into account in order to be successful. For this participant, gender norms around a wife’s proper behavior support the acceptability of using violence to control her if she does not “obey” him. The perpetrator avoids culpability by blaming the victim, and does not feel obligated to change his behavior.

Availability and Quality of GBV Services

Almost universally, participants named family and the Kgotla as appropriate places for victims of GBV to seek initial help. This exchange between two young women in an urban area in Kgetleng was illustrative of what most participants said when asked where they thought women and girls should report gender based violence:

> Respondent 1: *They should report at the Kgotla.*
> Respondent 2: *No, I think they should tell a relative first They are the ones who will then report to the Kgotla. If they fail to resolve this issue, then the police should be involved.*

After discussing the family or Kgotla as points of help for survivors of GBV, accessing care at the police, hospital/clinic, or from a social worker were the next most cited available services. Some focus group participants also named NGOs, such as WAR, SSI, and the Botswana Network of People Living With HIV/AIDS, which provides HIV testing and counseling. The lack of clarity about how to define GBV also led to confusion about when it was appropriate to use those services. As mentioned earlier, one participant relayed an instance of calling police when his wife burned the food.

Participants listed significant 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. This was reported by women in both intervention and control sites and men in comparisons sites, but not men in intervention sites. Many participants said that many 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 to do so to avoid breadwinners being arrested and losing their livelihoods. Participants also said victims of GBV were discouraged from reporting by slow, insensitive, or inadequate responses by service providers. For example, a male participant for an urban area in Kgatleng said:

> *When someone gets raped and goes to the police station, they find special constables and a sergeant. These people* [the police] *are not trained to handle such cases. Rape victims have to queue just like any other clients. The victims end up changing their mind about reporting the case because there's no privacy at the police station and they don't want others knowing what happened to them.*

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; were no longer being cared for financially; needed medical care; or were afraid for their lives because the abuse had escalated dramatically. Despite most participants being able to name several reasons that would inhibit a woman from leaving an abusive relationship, victim-blaming sentiments were present. One young woman from a rural community in Ngamiland said, "If a victim doesn't report the case, it means she likes what is happening."

When asked about the quality of GBV services, participants provided mixed opinions. A handful of participants provided examples of receiving high quality care. For example, one young woman in an urban area in Ngamiland said, "I would recommend [the services in the community] because I know people that have gotten help and their lives have improved. This shows that the services are good."

More often, participants recommended services but were unenthusiastic about their quality. This is exemplified by an exchange between young men in a rural area of Kgetleng:

> Respondent 1: *Yes, I would recommend getting medical assistance as they are the ones who best know how to handle and help in such a situation. They may be a bit slow, but I would recommend them…*
>
> Respondent 2: *I too, would also recommend* [the Kgotla] *even though they believe in corporal punishment.*
>
> Respondent 3: *The police get assistance from volunteers who are involved with the Kgotla. Although I think they like beating people too much, I would still recommend them.*

Participants highlighted the importance of receiving assistance from a service provider who was sensitive to the needs of a survivor of GBV. As mentioned above, the extent of participants' concern about confidentiality was a barrier to care. Specifically, participants mentioned feeling ashamed for others to know they had experienced violence. As previously noted, participants felt frustrated that police were perceived as not "doing enough" to punish perpetrators. Many participants advocated beating perpetrators at the Kgotla as punishment for unjustly using violence against their partners. This survivor's quote about dissatisfaction with services available to GBV survivors exemplifies the feeling around lack of punishment for perpetrators and wanting instead the traditional flogging punishment of the Kgotla as an appropriate consequence for perpetrators.

> *I'm not satisfied because sometimes when a victim is seriously wounded, they* [the perpetrators] *don't get the punishment they deserve. I've once had my finger broken and I've lost teeth and my perpetrator only got beaten five times.*—Rural young woman, Kgatleng

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

We found that service providers had varying degrees of comfort discussing GBV and describing standards of care for GBV providers. Generally, providers in the intervention sites demonstrated more comfort with these topics than providers in the control sites. Intervention site providers also reported more trust and collaboration with other service providers in their areas than comparison site providers.

Understanding GBV

Definitions of GBV varied among service providers, with some offering clear descriptions of power dynamics between men and women, while others described GBV broadly as physical or verbal abuse between two persons. The role of gender was described in some interviews but not most, and one service provider was uncomfortable being asked to describe GBV. In intervention sites, judicial service providers had the least nuanced understanding of the causes of GBV, while social workers had the most. In the comparison sites, tribal authorities seemed to have the least nuanced understanding of GBV and its causes; providers in other sectors varied. Here, a tribal leader shares his understanding of GBV, demonstrating some distorted definitions of abuse and adherence to inequitable gender norms:

> *There are many types of abuse. A man can physically abuse a woman. An example would be an employed man who doesn't give his partner money nor support her. When a woman complains about this, the man physically abuses her. This is one type of abuse. Other types involve sex. In my opinion, when one is deprived of sex by their partner, this is a form of abuse as this can cause the victim to become stressed. This can cause marriages to breakdown as the victim will leave their partner.*

In this example, the tribal leader mirrors some community members' confusion about what constitutes violence. Refusal of sex is not a form of GBV; the distortion of the definition of GBV seems rooted in inequitable norms, in which men are entitled to sex with their female partners. This example also mirrors the concerns that community members reported about provider sensitivity. Community members reported that survivors are discouraged by the reporting process and drop their cases when they interact with a provider who does not follow standard protocol. While this example is from a provider specifically identified to handle GBV cases, this was a concern for any other provider that community members might interact with in the process of reporting GBV.

Like the community members who participated in focus groups, service providers were consistent in identifying causes of GBV. Some providers described culture or traditional ideas of the role of men and women as the causes of GBV. Others noted childhood exposure to GBV, alcohol, poverty, and personality differences. Some clinicians were not confident describing GBV or its causes. In comparison sites, there were a couple of providers who either defined GBV or the causes of GBV using "victim-blaming" ideas, suggesting that the woman can be to blame for experiencing violence, or defining refusal of sex as a form of GBV toward men. For example, a healthcare provider said,

> *What can I say? GBV mostly affects women as the victims. It's not like I'm against alcohol, but we have to make sure that we are careful about the way we dress, behave, and do everything. Women should remember that they are women. Women have to reflect on their sexuality with everything they do.*

Responses such as this were less common in the intervention sites.

As seen in the community focus groups, providers in both the intervention and comparison sites most commonly described shame, financial dependency, and fear of retaliation as barriers to reporting GBV. Providers also reported that women, especially young women, fear that they will not be believed by their families or were actively discouraged from reporting by their families. Family support (or lack thereof) was identified as a significant barrier to or facilitator of reporting. Here, a social worker describes the challenges women face in reporting:

> *…Sometimes, in the case where a female victim runs away from her partner, her family may wrongly request her to return to her husband. The family wants the woman to be submissive, as the GBV case embarrasses the family as the victim has fled from her husband and abandoned her marriage. Marriage and the family's reputation are highly valued by people. When one abandons her marriage, or goes through a divorce, the family will consider this as a negative thing and believe the victim is in the wrong.*

Also mirroring community perceptions, providers reported that facilitators of reporting were women being "fed up" with the abuse or being educated and empowered to believe that women should not be subjected to violence. Victims of emotional abuse were also viewed as less likely to report it than victims of physical abuse, due to a lack of understanding of GBV on the part of the victim.

Several service providers noted that students were reluctant to report abuse to teachers because of a lack of trust, because some teachers were known not to maintain confidentiality or were seen as harsh disciplinarians. One service provider mentioned that students may not report to teachers because the teachers could be the perpetrator(s).

In the intervention sites, a small number of providers mentioned that concerns regarding confidentiality or familiarity with service providers were barriers to reporting; however, most facilitators of and barriers to reporting were attributed to the victim, rather than being a product of the quality or availability of services and service providers. In the comparison sites, providers were more likely to report that survivors of GBV were discouraged from reporting or pursuing a case against the perpetrator because of frustrations with slow or low-quality services.

Competency with Handling GBV Cases that Present at Their SDP

With some exceptions, intervention site providers were more comfortable and detailed describing processes for handling GBV cases than providers in comparison sites. Here, a clinician in an intervention site provides a thorough explanation of the process undertaken when a survivor of GBV arrives for services.

> *First of all, I introduce myself and the client will introduce herself to me. After introductions, I will try to build a rapport, making them feel free and comfortable to disclose anything to me. I then collect history. All history that I am supposed to collect starting with biography data, social history, physical… everything. After collecting history, I do the physical examination and identify whether there are injuries. When I pick injuries, I treat them. I treat pain and psychologically, I give counselling. After counselling I explain to the patient what is going to happen next—that I will refer them to the police or social worker. If they are coming from the police, I refer them to the social worker.*

However, several providers named some procedures that seemed questionable in terms of providing high-quality care for GBV survivors; this was most common in one of the comparison sites. One police officer reported that a GBV survivor had to give their statement in front of all of the police officers—which would undermine the survivor's confidence in confidentiality, in addition to being against protocol and ethical standards. Furthermore, the same police officer reported being present (in the same room) during the medical exam of a rape survivor. A different police officer reported giving advice that reinforced inequitable gender norms. Several providers from different sectors also held victim-blaming attitudes that would likely undermine a survivor receiving sensitive and high-quality care. For example, an educator said, "I firstly interview the victim so I can establish if this is indeed a GBV case and the role that the victim had in the situation. If they played a role, I then point this out but it doesn't necessarily mean they are to blame to what has happened."

Many providers in the interventions sites reported that the GBVRSP trainings increased their knowledge and understanding of GBV. However, awareness and use of SOPs varied; most service providers either used SOPs infrequently or had never seen them. Several service providers who had attended the trainings indicated a lack of confidence in other colleagues within their organizations to handle GBV cases and understand SOPs due to lack of similar training. Several interviewees mentioned that information from trainings was not being communicated to other staff and suggested that trained service providers should train other colleagues on GBV. Almost all providers, at both intervention and control sites, expressed a desire for more training for their colleagues and other staff that support GBV clients. Some providers in the comparison sites had not received any GBV-specific training at all. In comparison sites, providers almost universally did not have access to or use written SOPs; some, however, did have processes that they felt confident were consistently followed by themselves or their colleagues.

Like participants in the community focus groups, providers often reported that families preferred to resolve GBV-related issues either within the family or with the Kgotla. Interestingly, results indicate that some tribal authorities reported having very few cases or only dealing with GBV if they sought out the survivor themselves after hearing about the issue from others. All interviewees representing the area's tribal authority reported referring to or working with police, social workers, and/or clinicians for some cases. However, they also reported that they either did not have SOPs or that SOPs are not used or understood. Interviewees also noted that victims who seek help at the Kgotla often do not want to involve police, but rather, prefer that the perpetrator be "warned" or punished.

Some interviewees from the Kgotla demonstrated comfort in listening to and supporting their community members regarding GBV. For example, a Kgosi reflected on the unique nature of helping a survivor of GBV: "One thing I can highlight is the importance of getting the victim to express their feelings and make decisions because if the case involves a lover, you cannot tell them what to do, you can only guide them." However, with some exceptions, the tribal authorities interviewed had the least understanding of how to handle GBV cases. Some important sensitivities and nuances regarding GBV were not evident in interviews with many of the representatives from the Kgotla. For example, one interviewee reported that if a community member came to the Kgotla because she experienced physical abuse, the Kgotla members would have her partner (i.e., the perpetrator) take her to the health facility for treatment. This falls outside of best practice, as the survivor may be at continued risk for additional violence from the perpetrator. Further, the perpetrator may prevent the healthcare or other providers from providing all the appropriate care including referrals to the police. Indeed, some participants specifically noted that GBV was very complex and that they would appreciate more training. One participant from the tribal authority said:

> *I have a small role to play considering the little knowledge I have about what is going on in the world, particularly this country. If I had participated in training, I'd have more knowledge. Chiefs are people that are informed by those that come to them, as well as through their experience of growing up in that particular area. It is sometimes challenging for me to identify a gender-based violence case.*

Training would also need to address the tension between the Kgotla's role in trying to preserve marriages and family structures and protecting women and if necessary, helping them leave abusive relationships.

Issues of confidentiality and privacy surfaced in multiple interviews. Many service providers in intervention areas were able to describe the importance of taking clients to a private area, as well as building rapport and providing a supportive environment, then referring to appropriate services. Counselors and social workers in intervention areas discussed interviewing clients in private; however, some clinicians described challenges due to a lack of private rooms in the surgical ward, which may hinder disclosure. Similarly, providers reported that formal proceedings at the court and Kgotla were public (although conversations with the chief or tribal administration staff could also happen confidentially). Many providers—especially in the comparison sites—reported bringing together the perpetrator, in-laws, and tribal authority as part of the process. This could be problematic given the context described by many community members and providers, who reported that families often discouraged women from reporting, or shamed them, threw them out of the family, or did not believe them. As previously mentioned, this could also increase the risk of additional violence from the perpetrator. Further, many providers, including Dikgosi, police, social workers, and school-based providers reported that their first step was often informing the perpetrator that their behavior was illegal. Only a handful of providers specifically noted that there were challenges for the GBV survivor if the perpetrator and family were brought in for group discussion.

Collaboration and Trust between Providers

Police, medical providers, social workers, and schools are the most commonly cited providers to whom other SPs referred their clients. Several providers in urban areas mentioned local shelters (there are two in the country, one in Maun and one in Gaborone). Providers in the rural areas noted that there was no shelter, but they felt there should be. For example, a police officer said: "...[I]f I get such kinds of reports here…where am I going to take that victim to? Nowhere! A child gets here being a victim of GBV, where will I take him or her to? Nowhere!"

Most providers in the intervention sites described the referral system as having already increased their knowledge about what other services are available and increased collaboration. One participant who worked at an NGO said, "Initially, we weren't sharing information with hospitals, for example, but now due to the introduction of the new service, it is easier to access information. We have referral meetings where we share challenges and lessons learnt." While providers in the comparison sites also regularly made referrals to other providers, in general, there seemed to be less understanding of what services those providers offer. On the other hand, there were a few examples of service providers having close working relationships with other providers in the area that involved regular phone communication.

There are varying beliefs on whether GBV victims receive the services they need. Most providers believe they do receive the services they need, especially if clients go to the places where they are referred. Participants in the intervention sites were generally positive about other service providers' services and believed the referral system will continue to increase access to services as well. Here, a participant from the tribal authority describes improvements in collaboration between providers because of the GBVRSP and how that has resulted in increased quality of care for GBV survivors:

> *I think capacity building of the service providers has improved, service providers are now collaborating with one another…they previously used to work in silos, as the main objective is to assist clients. The mentality is no longer about the service provider and their pride…the focus is now on clients.*

However, several providers mentioned that they do not know if clients receive needed services and what quality the services are because they do not hear back from clients. Some service providers expressed frustration when women do not complete referrals or do not want the full spectrum of recommended services.

In the comparison sites, however, there was greater distrust and dissatisfaction with other providers' service quality. Providers gave anecdotal evidence of police taking a long time, of unresolved cases, or of police or healthcare workers not dealing with clients sensitively. This was an especially salient concern among the providers based in schools, as exemplified by this quote from an educator:

> Service Provider: *The collaboration is good because service providers accept our cases when we refer them. They attend to the cases although they are delayed. There's a lot of backlog.*
>
> Interviewer: *Do service providers make time to come together to discuss challenges such as backlogs and propose solutions?*
>
> Service Provider: *We do talk but people point fingers…that is the challenge. We encourage one another to attend to cases.*

Some concerns about the quality of other service providers existed in the intervention site but to a lesser degree. One provider indicated concern that clients may not receive immediate attention from other service providers, with the example given of police not answering their phones, thus decreasing clients' likelihood of reporting. Here, a social worker describes feeling confident in his/her own ability to provide services but uncertainty about service quality at other SDPs:

> *I am confident about handling GBV cases but the major problem is that handling GBV cases involves dealing with different stakeholders and you don't know how they will deal with cases. There's a variety of service providers that do things differently, for example, the police. I'm not sure how the police handle victims and if they know that victims shouldn't be addressed the same as criminals. I feel responsible for the type of service that other service providers offer clients especially if I referred the client there… If I refer a client to the police and the police don't speak to the client with sensitivity, I'd feel responsible, as the client trusted that I'm referring him or her to the right channels.*

Feedback on GBVRSP and RIS

Based on the GBVRSP and RIS training, service providers were overwhelmingly optimistic that the referral system would facilitate better collaboration and assistance for clients and follow-up. Service providers mentioned feeling more connected to other providers, being more aware of what services are available, and liking the ability to track data, in addition to the decreased likelihood of losing information. Most providers agreed that the referral system's ability to record case histories and decrease the number of times a victim must tell his/her story was a noteworthy benefit, as described by a justice service provider here:

> *The new referral system is good. It saves time and prevents interrogations when the client is referred from service provider to service provider as they each know the victim's case… When most victims come to report, they don't want to be asked many questions by different people. The new referral system is good for them, as service providers already know their case history.*

Providers also mentioned they liked the ability to prepare for clients before they arrived, which was made possible by the referral system and case notes. Several service providers mentioned they hope more people will become aware of the system or that the system will be rolled out more widely so that more collaborators are included.

Multiple service providers indicated that educating and empowering women and the community will be an integral step in making sure the system works. If people are unaware that GBV is not allowed, they will probably also be unaware that services are available to help, and thus will not access those services. It was felt that as more people are educated about and become aware of the system, the system will be able to help more people. Some service providers felt that the system will increase access to services, which will result in more people coming forward to report.

Figure 5. Mobile referral information system

Referral System 2.4 - Login

User Name: dept1

Password:

Select Form

Client Registration

(12/19) Client Registration - Referral Syste...

Sex

○ Male
○ Female
○ Other
● No Selection

Data collection for this report was conducted just after most providers had been trained on the RIS phone system; as such, most providers had not yet had the opportunity to use the system. However, some anticipated concerns arose during interviews. The most common concern among providers (6/28) was server or network problems when trying to upload information in real time, as well as during the training. Of the four providers that had explicitly reported using the phone since the training, three had had challenges with the server or network. While an initial issue with the server occurred during training, issues were resolved by shifting to a secure, cloud-based server that is accessible 24 hours a day, seven days a week. The network provider in Botswana has wide coverage; however, there are occasional incidents of coverage outage for very short periods of time. Site visit reports found subsequent data uploading or downloading challenges to be related to either running out of data or network coverage.

Five providers also noted that a touchscreen would be easier or that the current system's technology was difficult to use. A web-based application was developed at the same time as the phone system; users with reliable computers and internet have moved over to this system to reduce typing burden. Monthly site summary reports found that sites with computers have had success using that version of the referral system.

Four service providers were concerned that the system would not decrease the burden of time; two of these providers noted that they need to record cases on paper as well as in the phone system. Here a service provider in the Justice sector describes the process of integrating the RIS phone into the current protocols of care:

> *I think that using the phone is a long process. You first have to attend to the client and then use the phone to refer the client. I believe that it is a time-consuming process. Previously, I used to write the case down and then refer the client. Now we have to listen to the client, write down the case, and then get into the phone and refer the client. It is time-consuming.*

Several providers indicated that the referral system *will* save time in paperwork, as well as time spent escorting clients to the next place of referral. While this may save time, this could be a negative unintended consequence of the system, as personally escorting clients to the next provider—in addition to entering case information into the RIS—would be beneficial for clients. Another concern mentioned was patient discomfort with providers using the phone—either because they are wary of the technology or because of the challenge of simultaneously supporting the client and entering data. Best practices for incorporating the RIS into case management practices are discussed during trainings and monthly user meetings.

Concern over what happens when the individual trained on the system is not available arose in multiple interviews. Providers note that having only one person trained on the system, as well as only one phone, may cause problems if that person is out due to illness, leave, or has been transferred. In some cases, providers noted that other providers are able to step in if the trained individual is not available, while others reported that the GBV client may not be seen. This is more likely related to SDP protocol around who can attend to a GBV client and feedback on the GBVRSP as a whole, as opposed to the RIS specifically. Another provider, however, indicated she was not concerned with staff turnover, as the system is easy enough that new staff members can easily learn it. Several social workers were concerned about forgetting how to use the system if they did not do it frequently and because trainings are infrequent and not attended by all staff.

Since the first round of data collection, program staff have increased training for service providers. The initial round of training aimed to ensure that at least one provider per site was trained; the initial trainee was ideally meant to be a GBV focal person from each agency but this was not always the case due to availability or management decisions. Providers trained in the first round were also encouraged to train their colleagues. Subsequent rounds of training have been provided with additional staff to facilitate having multiple providers trained on providing GBV care and using the RIS. As staff turnover was anticipated by the GBVRSP project staff, staff turnover is monitored and ad hoc GBVRSP/RIS trainings for new service providers are held when necessary. Large-scale trainings are planned to correspond with large-scale staff transfers that happen annually throughout the country. Finally, ongoing site visits and monthly meetings with referral system members are another mechanism the project team uses to provide additional training when necessary.

Some providers indicated that the phone was kept in a locked cabinet that was not accessible if the key holder was unavailable; a few providers did not yet have a phone at the time of interview. Concerns around sharing password-protected phones with other colleagues were also mentioned.

One provider was concerned about not being able to follow up on clients sent through the RIS or not receiving notification when the client received the referred service. This should be addressed with the upcoming rollout of the SMS notification system, which will notify providers when a referral is complete. Another noted concern was about whom to refer to first when the client needs more than one referral, due to the inability of the system to allow multiple concurrent referrals.

Initial Referral System Usage

Between August and December 2016, 132 survivors were helped through the GBV referral system, with 179 GBV cases logged into the RIS (one survivor can open more than one case). Of the referrals logged into the system, almost 26 percent (n=46) were provided with a referral and 41 percent (n=14) of received referrals were completed. On average, referrals were marked as complete after 40.2 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).

Most GBV clients were women (140/179) and over age 24 (118/179) (Figures 6 and 7). Approximately 20 percent of men and 27 percent of women were provided with a referral; interestingly, a higher percentage of men had completed referrals than women (37.5% vs. 30.6%). While a higher percentage of younger clients were referred to other services, their referrals were less likely to be completed than older women.

Figure 6. Cases entered, referrals made, and referrals completed, by gender

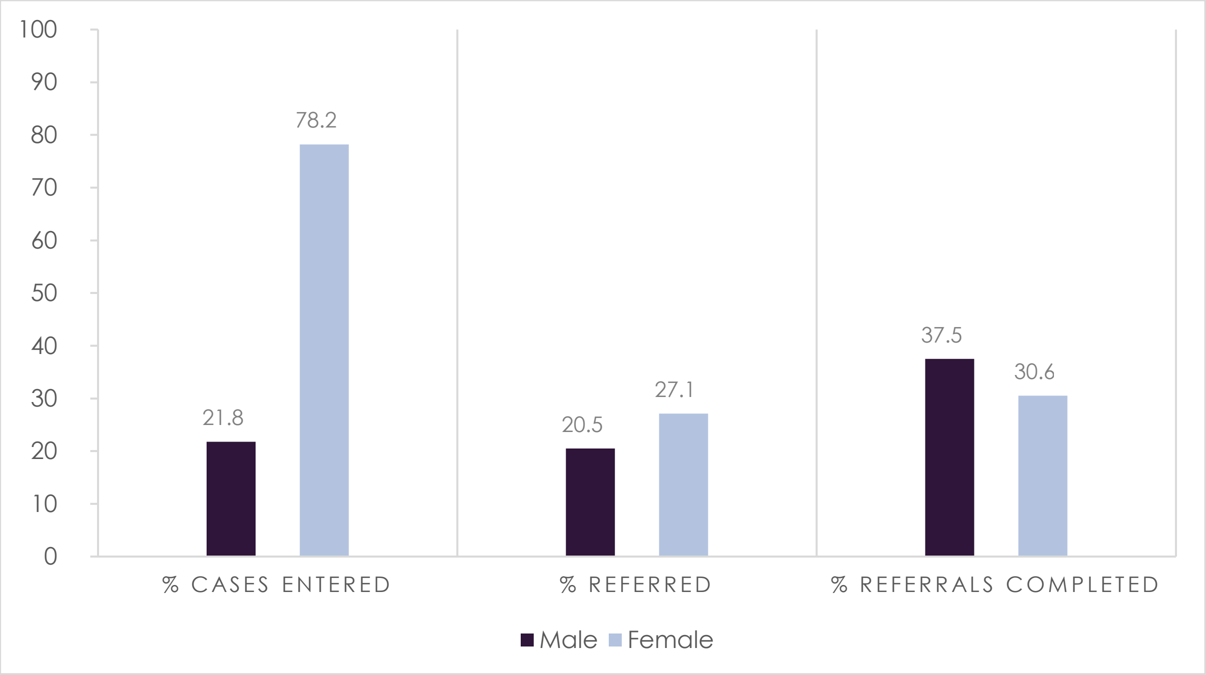
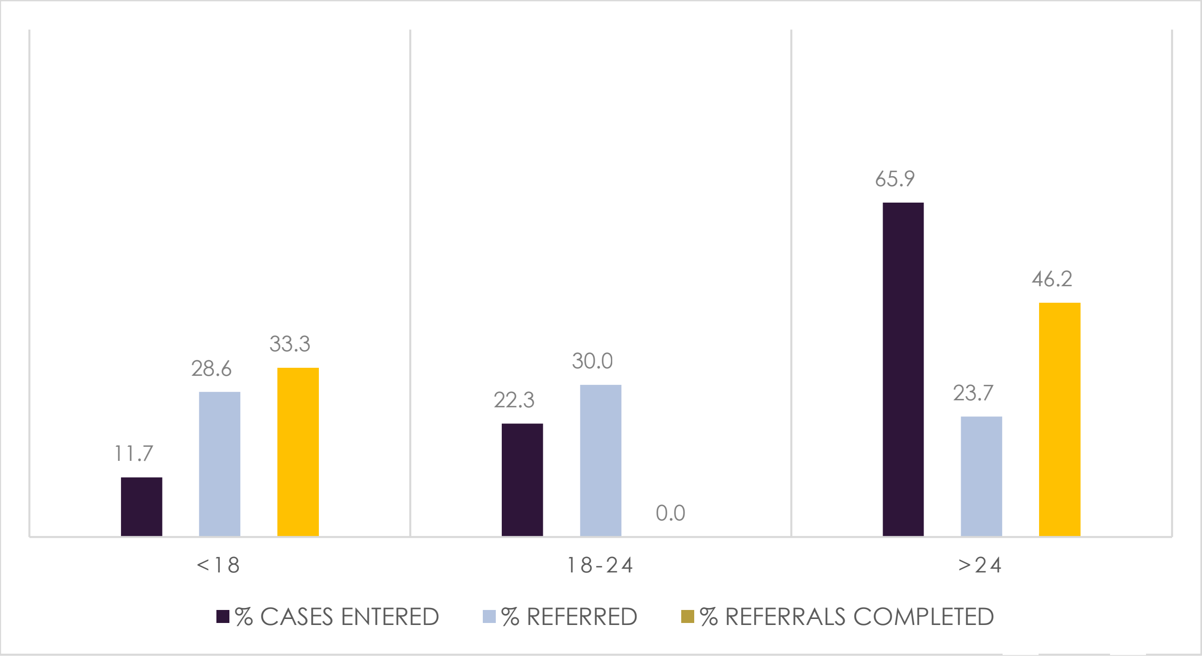


Figure 7. Cases entered, referrals made, and referrals completed, by age group



Most GBV cases entered (157/179), referrals initiated (37/46), and referrals completed (12/14) were in Maun. Significantly fewer cases were entered in Mochudi; 40 percent of them were referred to another provider. Only 12.5 percent of those referrals in Mochudi were marked as completed. Figure 8 and Table 5 illustrate the substantial difference in cases entered, referrals, and completed referrals between Maun and Mochudi. Uptake of the system was particularly low in rural sites, with only two cases being entered into the system.

Figure 8. Number of GBV cases and referrals sent by month and site

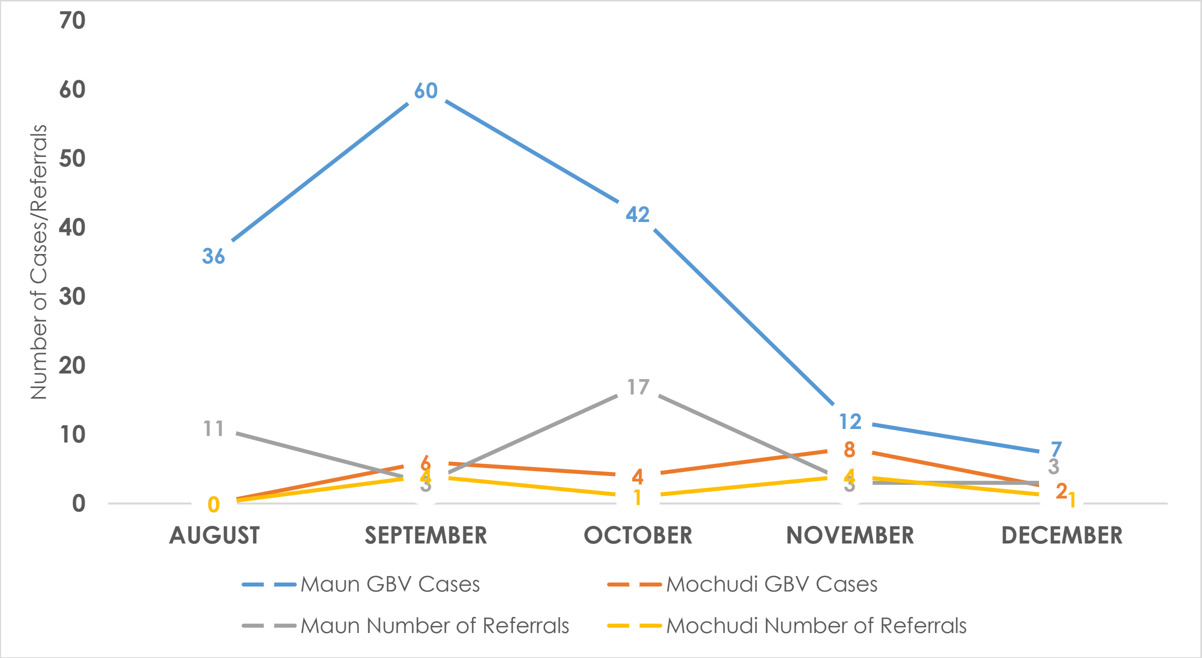


Table 5. Proportion of received referrals completed by month and site

Month	Maun	Mochudi
August	3/11	0/0
September	0/3	0/2
October	7/16	1/1
November	1/3	0/4
December	1/2	0/1

Uptake of the referral system also varied by provider type (Table 6). The table shows low uptake by some providers and low completion of rates of referrals, particularly among health and nongovernmental providers.

NGOs entered most GBV cases (108/179). Healthcare providers and those in the legal/justice field (e.g., police) referred the highest *percentage* of their clients—approximately 50 percent of cases. NGOs and legal/justice providers each referred approximately 35 percent of the entered cases. Both cases (2/2) entered by educators were referred, as would be expected based on qualitative interviews with those providers.

Social workers received the most referrals (15/44) followed by NGOs (13/44) and legal/justice providers (10/44). Approximately 54 percent of referrals made to NGOs and 60 percent of referrals made to legal/justice providers were marked as complete. One referral was marked as complete by social workers and no referrals were marked as complete by healthcare providers. No referrals were made to educators, as would be expected.

Table 6. Cases entered, referrals made, and referrals completed, by provider type

	Cases entered		Referrals made		Referrals received		Referrals completed	
	#	%	#	%	#	%	#	%
Education	2	1	2	4	0	0	0	0
Health	21	12	10	22	6	14	0	0
Legal/justice	31	17	16	35	10	23	6	60
NGOs	108	60	16	35	13	29	7	54
Social welfare	17	10	2	4	15	34	1	6
Total	179	100	46	100	44	100	14	100

Monthly reports (through December 2016) based on site visits by in-country partners identified several challenges—many of which were predicted by the qualitative data—that may be resulting in low uptake by some providers and low completion of rates of referrals. Making sure each agency has a sufficient number of people trained on the system is a challenge in both northern and southern service provider points. Furthermore, ensuring that the appropriate people in each agency are trained is a challenge due to high rates of staff relocation. In Maun, where the number of GBV cases reported is relatively high, providers reported needing additional personnel to handle the backlog of cases. Additional trainings are being scheduled.

Some challenges were reported by service providers adopting the new system. As had been suggested in the qualitative data, some providers find that it is not always appropriate to use a phone when helping a client, especially when the client is highly traumatized. Monthly site summary reports suggest that service providers are not checking phones with high regularity. Improved notification processes are being implemented to encourage checking the phones more regularly. Logistics such as network or server problems, sharing phones, and keeping phones charged have also been reported. Investigations of network problems suggest that this is predominately an issue of maintaining sufficient data on the phone. While the RIS uses very little data, and phones are provided monthly data refills, there have been challenges ensuring that the data are only used for the RIS. Program staff are working with the mobile provider to transition the phones to a newly available service that would ensure that data can be used only for the purposes of the RIS.

Some challenges with cross-sector collaboration have been identified through monthly site summary reports. Gaps in the referral system have been reported, especially between tribal authorities and police.

There have also been challenges maintaining monthly meetings with all providers. Providers also reported frustration about not being able to use the RIS to follow up on clients or the referrals made. After a referral is entered, a provider can use the RIS to view a flowchart of where the client's case file is (e.g., health facility) but not whether or not the case has been completed or any information about the case. This limitation was included intentionally because the RIS was designed as a system to replace paper referral forms (and not case management documentation); thus, the RIS prioritizes confidentiality of the patient's files. The SMS reminder system, which is scheduled to be implemented, will update providers if their client's case has been received or started by the subsequent provider.

DISCUSSION

This research sought to describe (1) community perceptions of gender based violence, GBV acceptability and services; (2) provider's perceptions and feedback on GBV services in the community and the referral process; and (3) provider perceptions of the new GBV referral system in Botswana. We also assessed initial patterns in uptake and use of the GBV referral system among providers in the intervention sites. This is the first instance of a mobile GBV referral system being used in Botswana, and to the best of our knowledge, in any country.

The mixed-methods approach we used offers triangulated findings from qualitative data via community focus groups, individual SPIs, quantitative data from the new RIS, and monthly site summary reports. Overall, we found that community and provider perceptions and understanding of GBV were similar, and to previous GBV research in sub-Saharan Africa. Provider perceptions of the referrals system were overwhelmingly positive and hopeful; however, uptake and routine use of the referral system has been uneven. Differences in what providers reported qualitatively versus their actual system usage could be due to timing of data collection, which occurred just after providers were trained on the referral system but before most providers had used the system. This discrepancy will be explored in end-line data collection.

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 described definitions that included any kind of violence or conflict and/or gave distorted definitions reflecting adherence to traditional gender norms. While there was variation among participants, community members' responses 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 has consistently been associated with violence perpetration (WHO, 2010; Fleming et al., 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). In our data, this resulted in misconstrued definitions of GBV; for example, deviation 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—creating a strong victim-blaming narrative.

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 resolving 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 (CDC, 2015). Calls with implementing partners on the ground suggest that their current activities respond to these findings (Personal communication, 2017a, 2017b). Furthermore, research has found that communities who receive the SASA! community mobilization intervention report reductions in GBV (Abramsky, et al., 2014; Kyegombe, et al., 2014; Starmann, et al., 2017).

Providers and community members alike reported significant difficulties for GBV survivors in accessing services. The most commonly cited barriers to accessing services were economic dependency and shame, according to providers and community members alike. This has been found to be a common barrier 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 of victim blaming. The local economic context permeated the FGDs and attenuated some of the victim-blaming perceptions. While economic dependence is a recurrent theme across GBV literature, it was interesting to note that service providers' or community members' response to women's economic vulnerability was almost entirely absent from our 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 merit exploration (Hidrobo, Peterman, & Heise, 2016; Kim, et al., 2007).

Almost universally, participants reported that before accessing providers, family and community leadership must be engaged. The data indicated a need to work with families and tribal authorities to be more empathetic and supportive of victims of violence. However, findings revealed that tribal authorities were less likely to feel confident identifying and providing services for GBV. This may be in part due to the lack of clear SOPs for the tribal authority. Creating GBV-specific SOPs for tribal authorities may improve the quality of care received by GBV survivors, increase leader's confidence in providing services to GBV, and facilitate engaging with other providers for referrals. This will be fundamental for increasing the number of clients who access police, or medical or social services through the tribal authority.

Compared to control 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 seemed more likely to trust and collaborate 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. One exception was the judicial service providers in the intervention sites, some of whom lacked a clear understanding of GBV, warranting additional follow-up with these providers. The training provided in the GBVRSP 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, as well as to ensuring the success of the GBVRSP.

Uptake of the RIS was uneven between providers and locations. 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 other settings, or if technology cost and network availability in Botswana change, a touchscreen phone might be more appropriate.

The average time to completion for referrals was over 40 days. Interpreting this average time is challenging, as referrals are marked as complete when all services are rendered to the client, as opposed to when the client arrives to begin receiving services. For example, a health facility may receive a referral, receive the client, and complete all required services in one day. However, a police investigation would require that the referral case stays open until the investigation is complete, which could take several weeks. The end line evaluation will explore time to arrival and time to completion for referrals more in-depth.

Our research has some limitations. The first round of data collection started after the system rollout and community awareness and trainings began. WAR and SSI have been implementing GBV community mobilization activities in their respective communities since 2015. 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, this report is not a pre-intervention baseline but provides some initial insights into successes and challenges to the GBVRSP. Many of the providers in the intervention sites had not used the system at the time of data collection, but most had received training on GBV and future use of the system. Control sites, however, did not receive any of the referral system or GBV trainings, thus offering a comparison group. The differences demonstrated between intervention and comparison site providers suggest that GBVRSP trainings have increased their knowledge and comfort discussing or providing services around GBV. However, it is possible that some of those providers were involved in initial GeAD conversations and that their comfort discussing these issues is influenced by that participation. Nevertheless, we would expect providers in the pilot sites to be equally involved in those previous conversations and therefore do not think this has biased our results.

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 to more popular views of gender norms or understanding of GBV. This may be a limitation of provider interviews as well; providers may have reported positive responses about the launch of the referral system due to social desirability.

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, we are confident that our results are not biased by this potential limitation. In addition, because questions focus on the provider experience with the referral system, participants may choose more positive responses in anticipation of their social desirability.

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 our findings. Both consistencies and conflicts among data sources provide a richer demonstration of the referral system's strengths and areas for improvement.

Future Research

Several themes, including acceptability of violence outside the home, alcohol use, and religion, were identified during our analysis as topics for future research.

In our community member focus groups and some SPIs, we found 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.

Furthermore, the relationships between alcohol use and GBV and religious views and GBV merit exploration. Participants reported that alcohol was involved in many incidents of violence. As such, some harm reduction programming to reduce alcohol use may be beneficial. Community participants also reported that religious views sometimes contradicted messages about the value of reducing violence against women and supporting gender equality; few providers mentioned this issue. Future work could focus on **engaging with religious leaders** to develop ways consistent with religious teachings that they can talk to community members about resolving conflicts within intimate partnerships peacefully and respectfully.

Recommendations

Community Understanding and Perceptions of GBV

Continue community mobilization activities and provider trainings that define GBV. While conducting these trainings, 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).

We also recommend **working with men and women to challenge traditional gender norms that perpetuate violence against women.** *It is paramount that the staff who deliver this programming are extremely well trained in gender equality and do not end up 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.

Target community mobilization and awareness-raising for families and tribal authorities to be more empathetic and supportive of victims. Due to difficulties accessing GBV services reported by providers and community members alike, it is important to continue raising awareness and support for victims of GBV while also de-stigmatizing disclosure and help-seeking behavior.

Due to frequently cited economic dependency, we recommend **prioritizing education of community members and service providers on services available to women in abusive relationships, such as housing or food services.**

Provider Perceptions of GBV and Processing Cases

Provide ongoing GBV training for all service providers, even those who do not typically handle GBV cases. The stark difference in providers' understanding of GBV, appropriate services, and referral processes between intervention and control sites indicates the importance of GBV training for all service providers. Judicial service providers in particular reflected a need for additional training on GBV causes and understanding. Universally, providers in both intervention and control sites wanted additional training on GBV and wanted their colleagues to undergo similar training–noting that GBV cases were particularly complex and challenging to handle. Community members and providers also echoed that when GBV survivors engaged with a provider who was unfamiliar with GBV standard care and treatment protocols, they were discouraged by a lack of sensitivity, confidentiality, and/or urgency on the part of the provider.

As the first point of contact for GBV survivors, **providing additional training and support for tribal authorities is paramount.** Creating GBV SOPs for tribal authorities could better integrate tribal authorities into the referral system and increase confidence in providing services. This will be fundamental for increasing the number of survivors who access police, medical, or social services.

Ensure protocols for GBV service provision are available, accessible, and understood by providers. We recommend developing SOP posters with simplified processes and step-by-step guidance to ensure that all service providers have access to appropriate protocols for supporting survivors of GBV. These SOP posters should be posted in multiple locations throughout a service delivery point.

Ensure that SOPs follow international best practices (WHO, 2013). Some providers reported practices that fall outside of a high standard of care (e.g., having the perpetrator instead of the service provider take the survivor to the hospital; police asking victims to describe their story in front of other officers); these should be investigated, and recommended practices should be incorporated into ongoing SOP updates.

Continue monthly meetings of service providers in the same area to maintain connections and trust between institutions and providers. We saw more trust and collaboration in intervention site providers compared to comparison sites; continuation of monthly meetings and updated service directories will bolster this trust and collaboration.

GBV Referral System

Continue routine service provider trainings on GBV and the RIS. This will take into account high staff turnover and ensure that clients encounter trained providers who can identify and support GBV clients. Relatedly, **ensuring service directories are continuously updated** will be important to ensuring smooth referral processes. Data also revealed some confusion in the process of multiple referrals, so we recommend future trainings highlight and/or practice prioritizing referral order for clients who need multiple referrals.

Continue identifying and addressing barriers to RIS uptake, especially in rural areas and among certain service providers, such as healthcare providers and social workers. Some providers reported that entering data in the phone was burdensome. Monthly site summary reports have found that sites with computers have had success using that version of the referral system; this could be encouraged for sites having challenges with phones. While touchscreen phones are not currently feasible due to cost, network limitations, and safety concerns, this should be kept in mind as technology availability changes or if this program is to be implemented in other settings.

Continue one-to-one visits with providers to address any logistical challenges and encourage habitual use of the new system to help increase uptake of the system. **Implementation of SMS reminders** will serve as "cues-to-action" to use the phone referral system.

Identify processes to get service providers feedback on their referrals on a regular basis; this will be important in maintaining confidence in the system and ensuring patients get the services they need. Initial monthly site summary reports collected after rollout found that some providers were frustrated with a lack of feedback about referrals.

Continue efforts to follow up on uncompleted referrals to gain better understanding of lack of completion and increase follow up with locations and provider types that show low levels of system uptake. Due to the low rates of referral completion, particularly from social workers and health providers, and in rural areas, we recommend increased follow-up in specific sectors that seem to be having additional trouble with completion. This will help elucidate whether the lack of completion is due to the client not arriving at the receiving agency or if the provider is failing to log the referral and services completed into the system. Also, provide clarification about when a referral is marked as complete (e.g., when a client arrives at the service point or when all services have been rendered and the case is complete).

Ensure that the referral system compliments, but does not replace, some previously existing client supports, such as phoning the receiving provider directly to let them know a new case is coming or walking the client over to the provider. We recommend creating and disseminating guidelines on maintaining best practices for service provision while also taking advantage of the phone-based referral system.

Conclusions

Overall, qualitative data demonstrate that enthusiasm for the GBV Referral System was high when it was launched. Providers in intervention sites reported greater confidence in supporting survivors of GBV and trust in other providers in the area compared to service provider in control sites. These differences indicate initial success of standardizing protocols with SOPs and increasing collaboration through the service directory and cross-sector GBVRSP trainings.

Quantitative RIS usage data indicate uneven uptake of the system by provider type and location. Continuing trainings to account for staff turnover will be critical to maintain initial success of GBVRSP trainings; furthermore, continued technical assistance and support to incorporate the RIS into GBV protocols can serve to increase the uptake of the RIS.

Community member focus groups indicate a need for additional community mobilization work to refine GBV definitions, challenge traditional gender norms, and help survivors of GBV access appropriate care despite challenging social and economic contexts. While there were differences between urban and rural and northern and southern locations, the lack of consistent and robust differences across intervention and control sites prevents us from drawing conclusions related to intervention community mobilization efforts at this time. There were also marked differences between individuals' understanding of GBV, suggesting that engaging with programs that challenge the acceptability of violence is important and that increased efforts are warranted to ensure intervention communities are consistently exposed to these messages.

Throughout the pilot, GeAD, MEASURE Evaluation, and partners WAR and SSI will collect 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 corrections or additions to the referral system.

A second round of data will be collected in August 2017, and an end line report will be published to describe changes in referrals, use of the system, and perceptions of GBV since the launch of the referral system, as well as propose recommendations for system changes. These data will allow comparisons across intervention and control sites and document changes over time.

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APPENDIX 1. 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?

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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?

APPENDIX 2. 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 you all the steps that you just described are needed?

Adequacy of training

- 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?

Process of using the standard operating procedures

- 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?

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

- 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?

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

- 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?

APPENDIX 3. 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

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

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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 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?

Training

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?

Standard operating procedures

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?

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

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

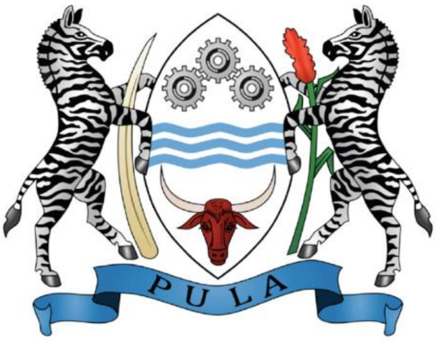
12. What types of services do you refer your clients to, and why do you make these referrals?

Feelings about referrals to other service providers

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!



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