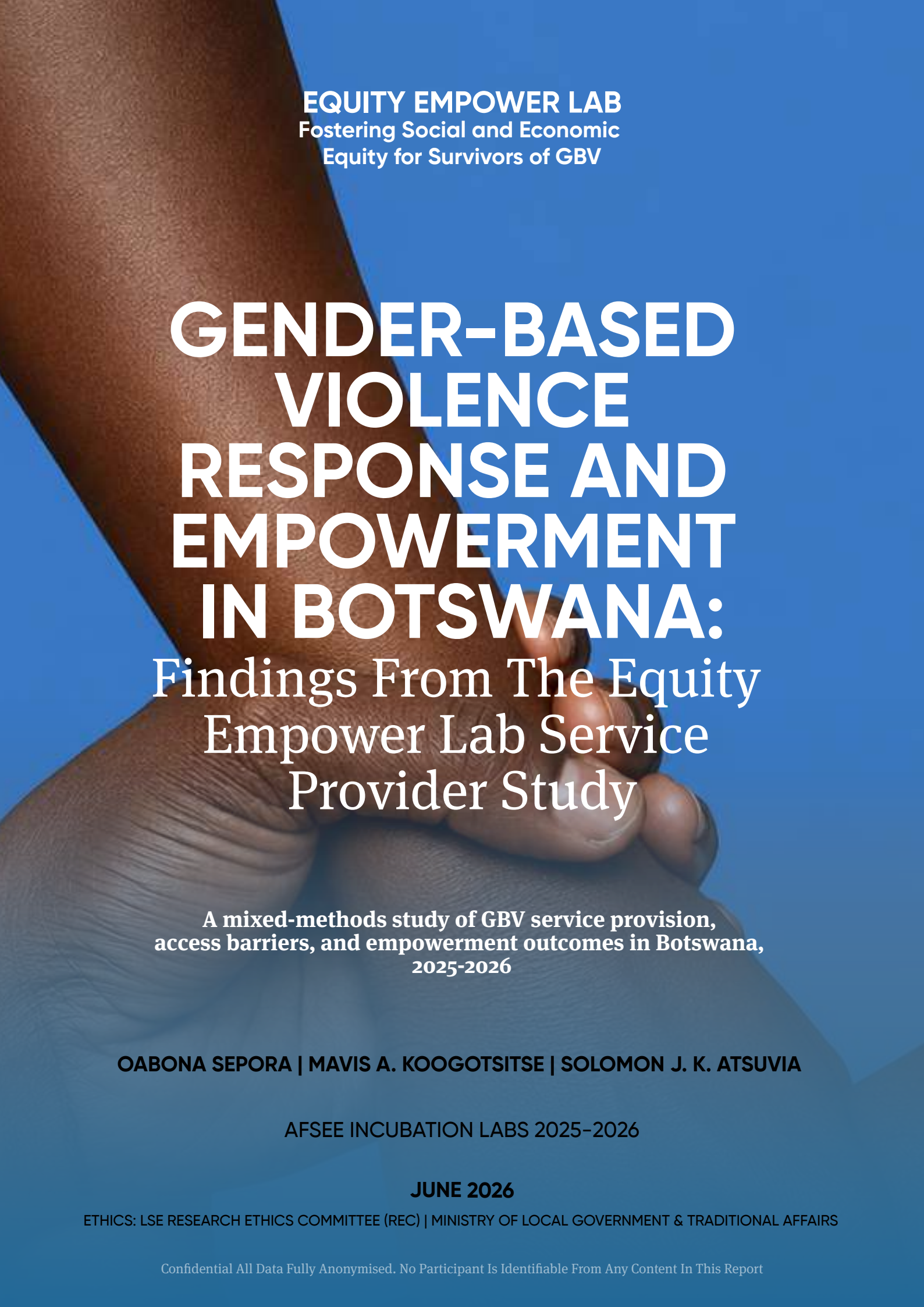


EQUITY EMPOWER LAB
Fostering Social and Economic Equity for Survivors of GBV

GENDER-BASED VIOLENCE RESPONSE AND EMPOWERMENT IN BOTSWANA:

Findings From The Equity Empower Lab Service Provider Study

A mixed-methods study of GBV service provision, access barriers, and empowerment outcomes in Botswana, 2025-2026

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AFSEE INCUBATION LABS 2025-2026

JUNE 2026

ETHICS: LSE RESEARCH ETHICS COMMITTEE (REC) | MINISTRY OF LOCAL GOVERNMENT & TRADITIONAL AFFAIRS

Confidential All Data Fully Anonymised. No Participant Is Identifiable From Any Content In This Report

EXECUTIVE SUMMARY

This report presents findings from the Equity Empower Lab GBV Response and Empowerment Study, a convergent mixed-methods investigation of gender-based violence service provision in Botswana conducted between January 2026 and March 2026. Drawing on 60 structured surveys and 45 in-depth interviews with GBV service providers across police, health, legal, NGO, and community sectors, the study examined service capacity, access barriers, inter-agency coordination, economic empowerment, and policy implementation.

Study Purpose and Design

The study employed an intersectional feminist framework to assess the readiness and effectiveness of Botswana's GBV response system, with particular attention to the experiences of LBT women, women with disabilities, rural women, sex workers, and migrant women. Service providers rather than survivors were the study population, enabling examination of systemic and institutional dimensions of the GBV response.

Major Findings

1. GBV is recognised as severe and underreported, yet systems fall short: 94.7% of survey respondents agreed that GBV is a serious problem in their communities (Q6r, mean=4.74/5.00), and 93.0% confirmed that GBV is significantly underreported (Q7r, mean=4.58/5.00). This professional consensus contrasts sharply with national data showing GBV prevalence reported in surveys is 24 times higher than cases reported to police (UNDP Botswana, 2024).

2. Specialist training is critically deficient: Only 34.7% of respondents indicated they had received recent specialised GBV training (Q19r, mean=2.82/5.00), placing training as the weakest element of the Service Provision Quality Index (SPQI=3.58). Disability-inclusive facilities were reported by 41.8% of respondents (Q18r, mean=3.24/5.00), leaving the majority of service points inaccessible to survivors with physical disabilities.

3. Economic dependency is the dominant structural trap: 86.8% of respondents agreed that financial dependency prevents survivors from leaving abusive relationships (Q33r, mean=4.38/5.00), making economic entrapment the most strongly endorsed finding in the survey. Yet only 58.2% of organisations provide any form of economic empowerment support (Q28_EmpSupport), and provision is heavily concentrated in NGOs (81.8%) compared to police (18.2%).

4. A significant policy-implementation gap exists: Service providers demonstrated reasonable policy awareness (Q37r, mean=3.65/5.00) but substantially lower confidence in implementation (Q38r, mean=2.94/5.00), producing a gap of 0.71 scale points, which exceeds the 0.5-point threshold for a significant deficit. This finding is corroborated across qualitative data, with providers consistently reporting that laws exist but enforcement and operationalisation fail survivors.

5. LBT women face compounded institutional hostility: Qualitative data from providers working with or encountering LBT clients uniformly described stigma, police dismissal, and fear of disclosure as barriers preventing LBT women from accessing services. Providers across sectors acknowledged limited knowledge of LBT-specific needs, with 32.1% selecting LBT inclusion as a priority capacity-building need.

6. The referral system is fragmented and unevenly functional: The Coordination Effectiveness Index (CEI=3.64/5.00) sits in the strong range overall, yet qualitative accounts described significant handoff failures, accountability gaps, and survivors being lost between sectors. Q49r (data systems to track survivor journeys, mean=2.20/5.00) and Q50r (LBT-inclusive collaboration, mean=2.48/5.00) were the lowest-rated items across the entire survey.

Priority Recommendations

1. Government of Botswana: Immediately establish funded, mandatory specialised GBV training for all frontline service providers across police, health, and social welfare sectors, with LBT-inclusive modules and disability-competency standards.

2. Ministry of Gender and Local Government: Create an integrated national GBV case management and data system that tracks survivors across all referral points to close the accountability gap in inter-agency handoffs.

3. GBV Service Providers: Expand economic empowerment programmes beyond skills training to include microcredit, job placement, and savings groups, with specific targeting of rural and LBT survivors.

4. Donors and Funding Partners: Prioritise infrastructure funding for shelters (identified as a gap by 52.6% of respondents), disability-accessible facilities, and staff wellness programmes to address the systemic resource deficit.

5. Civil Society and Advocacy Organisations: Lead community-based awareness campaigns addressing the underreporting gap, with particular focus on rural communities and marginalised populations whose GBV experiences remain invisible in official data.

Limitations

This study sampled service providers rather than GBV survivors; findings therefore reflect institutional perspectives rather than survivor-centred experiential accounts. The quantitative sample (n=58 coded) is modest, limiting statistical power for subgroup analyses. All findings relate to the Gaborone-centred service system; rural and remote district services are represented but not fully profiled. Missing data in 8.6% of the survey sample was addressed through pairwise exclusion, and results for the Policy Implementation Index are interpreted with caution given a low internal consistency coefficient (alpha=0.444).



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List of Abbreviations

AFSEE
Atlantic Fellows for Social and Economic Equity

AGYW
Adolescent Girls and Young Women

BDP
Botswana Democratic Party

BOCHAIP
Botswana Christian AIDS Intervention Programme

BOFEPUSU
Botswana Federation of Public Service Unions

CBO
Community-Based Organisation

CEI
Coordination Effectiveness Index

CSI
Collaboration Strength Index

DVA
Domestic Violence Act (Botswana, 2008)

EEI
Economic Empowerment Index

EEL
Equity Empower Lab

GBV
Gender-Based Violence

GCP
Gender and Child Protection Unit (Botswana Police)

HRDC
Human Research Development Council (Botswana)

IGO
Intergovernmental Organisation

IPV
Intimate Partner Violence

LBT
Lesbian, Bisexual, and Transgender

LBTIQ
Lesbian, Bisexual, Transgender, Intersex, and Queer

LSE
London School of Economics and Political Science

NGO
Non-Governmental Organisation

NPO
Non-Profit Organisation

PII
Policy Implementation Index

REC
Research Ethics Committee

SADC
Southern African Development Community

SPQI
Service Provision Quality Index

SSA
Sub-Saharan Africa

List of Abbreviations

UNAIDS
Joint United Nations Programme on HIV/AIDS

UNDP
United Nations Development Programme

UNFPA
United Nations Population Fund

UNESCO
United Nations Educational, Scientific and Cultural Organization

WHO
World Health Organization

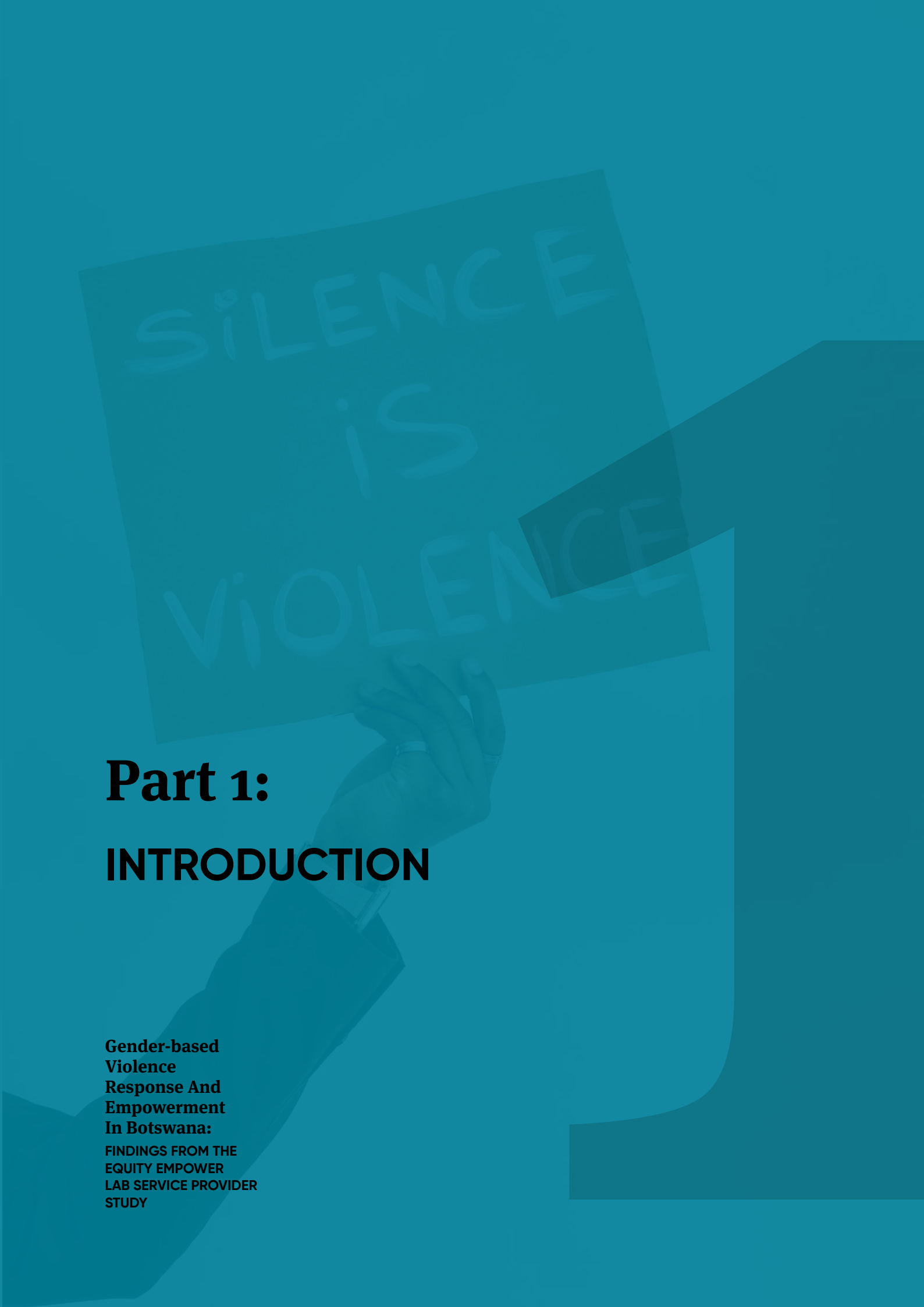


Acknowledgements and Ethics Statement

This study was conducted by the Equity Empower Lab as part of the AFSEE Incubation Labs 2025 2026 programme. This research data collection was made possible thanks to funding from the Atlantic Fellows for Social and Economic Equity (AFSEE) programme, based at the International Inequalities Institute at the London School of Economics and Political Science

Sincere thanks are extended to all GBV service providers who participated in this study. Their commitment to survivor-centred practice under resource-constrained conditions reflects the professionalism and dedication that Botswana's GBV response system depends upon. All participants are identified in this report by anonymised codes only. The study was approved by the LSE Research Ethics Committee (reference: 597906), Ministry of Local Government and Traditional Affairs (Ref Number CLG 14/14/3/1), Ministry of Youth and Gender Affairs (Ref 6/1/6 II (59), Botswana Police Service (Ref: POL 39/13/3 V III (53) and Gaborone City Council (Ref: GCC 1/17/ 2 III (139). All data collection followed approved protocols. Participant confidentiality is protected through anonymisation of all identifiable details. Survey data were coded to remove all personal and institutional identifiers at the point of entry. Interview transcripts were anonymised prior to analysis. Raw data are stored in password-protected, encrypted storage accessible only to named team members. This report contains no content that could identify any individual participant or their organisation.





Part 1:

INTRODUCTION

Gender-based Violence Response And Empowerment In Botswana:

FINDINGS FROM THE EQUITY EMPOWER LAB SERVICE PROVIDER STUDY

Gender-based violence remains one of the most pervasive human rights challenges in Botswana and across sub-Saharan Africa. Despite a legal and policy framework that includes the Domestic Violence Act of 2008, a dedicated Gender and Child Protection Unit within the Botswana Police Service, and an expanding network of NGO service providers, survivors continue to face formidable barriers in accessing protection, justice, and recovery. Official statistics consistently understate the scale of the problem: national survey data show that GBV prevalence as reported in household surveys is 24 times higher than the number of cases formally reported to police (UNDP Botswana, 2024). More than two-thirds of women in Botswana have experienced some form of gender violence in their lifetime (UNDP, 2024), and during a single two-week period in late 2024, 93 cases of rape and 10 femicides were recorded (VOA News, 2025).

The persistence of this gap between GBV's actual scale and the system's response is not a failure of awareness. Service providers at all levels know that GBV is serious, widespread, and underreported. The failure is structural: a system constrained by chronic under-resourcing, inadequate training, fragmented inter-agency coordination, and policy frameworks that are not consistently operationalised. For women whose identities intersect multiple axes of marginalisation, the system's failures compound: LBT women, women with disabilities, migrant women, sex workers, and rural women face additional layers of institutional hostility, stigma, and exclusion that the mainstream GBV response system is not designed to address.

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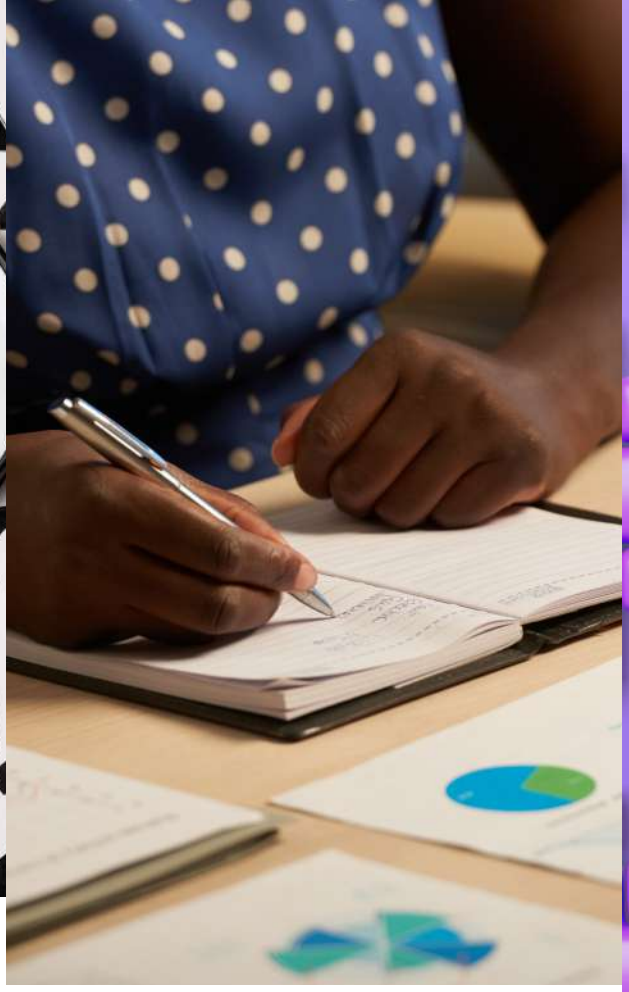


1.1
Study Objectives

The Equity Empower Lab GBV Response and Empowerment Study was designed to assess the readiness, capacity, and effectiveness of GBV service provision in Botswana from the perspective of service providers. The study pursued the following objectives:

1. To assess the capacity and quality of GBV service provision across sectors in Botswana.
2. To identify the structural, institutional, and attitudinal barriers that prevent marginalised women from accessing GBV services.
3. To examine the quality and effectiveness of referral systems and inter-agency coordination.
4. To evaluate economic empowerment programming and its adequacy in supporting survivor recovery.
5. To assess the degree of alignment between policy and legal frameworks and actual service delivery practice.
6. To identify what works, where bright spots exist in the system, and the conditions that enable effective GBV response.







1.2

Research Questions

The study was guided by the following primary research questions:

i. What is the current capacity of GBV service providers in Botswana to respond to survivors across all demographic groups?

ii. What structural, attitudinal, and institutional barriers prevent marginalised women from accessing GBV services?

iii. How effectively do referral systems and inter-agency coordination mechanisms function in practice?

iv. What economic empowerment programmes exist, and how adequate are they for supporting survivor recovery?

v. Where is the gap between policy intent and implementation practice, and what drives it?



1.3 Significance of the Study

This study makes several original contributions. First, it shifts the analytical lens from survivors to service providers, examining the system rather than only its recipients. Second, it explicitly applies an intersectional feminist framework to assess service inclusivity, generating evidence on the experiences of LBT women that is largely absent from the existing Botswana GBV literature. Third, it produces six composite indices that enable cross-sectoral and longitudinal comparison of GBV service system performance. Fourth, it addresses the policy-implementation gap directly, providing evidence to guide accountability mechanisms. Fifth, the convergent mixed-methods design integrates quantitative scale assessments with qualitative institutional accounts, producing a more complete picture than either method alone could achieve.



Part 2

LITERATURE REVIEW AND POLICY CONTEXT

2.1 GBV IN BOTSWANA: SCALE, FORMS, AND DRIVERS

Botswana is classified as an upper-middle-income country, yet its gender-based violence indicators align with patterns found across lower-income sub-Saharan African settings. Over 67% of women in Botswana have experienced some form of gender violence in their lifetime, and 34% of women aged 15-49 have experienced physical or sexual violence by a partner at least once (UNDP Botswana, 2024). In the 12 months to a national prevalence survey, 29% of women reported intimate partner violence, while only 1.2% reported a case to police in the same period, producing a staggering 24:1 ratio of prevalence to formal reporting (UNDP Botswana, 2024). This ratio reflects not the rarity of GBV but the pervasive barriers to disclosure, which include fear of retaliation, economic dependency, stigma, and lack of trust in institutional responses.



Botswana is classified as an upper-middle-income country, yet its gender-based violence indicators align with patterns found across lower-income sub-Saharan African settings.

GBV in Botswana is driven by intersecting structural factors: patriarchal norms that position male authority as natural and female subordination as acceptable; economic inequalities that trap women in dependency relationships; inadequate legal enforcement; and a cultural landscape in which GBV disclosure remains heavily stigmatised. The Domestic Violence Act of 2008 was a landmark achievement, expanding protections and establishing mechanisms for protection orders. However, implementation has been uneven, particularly in peri-urban and rural areas where physical and institutional resources are limited (GOV.UK Country Policy Note on Botswana GBV, December 2024).

2.2
LEGAL AND POLICY FRAMEWORK



Botswana's primary legislative instrument addressing domestic violence is the Domestic Violence Act (DVA) of 2008, which establishes protection orders, mandates police response, and creates obligations for service providers. The Penal Code criminalises rape, defilement, and indecent assault but has been criticised for inadequate sentencing provisions and for treating GBV primarily as a criminal rather than a systemic issue. The Public Health Act and National HIV/AIDS Policy integrate GBV as a health risk factor, while the National Gender Policy commits the government to gender equality in service delivery.

Despite this framework, significant gaps persist. The law is silent on intimate partner violence outside of cohabiting relationships in many provisions. LBTIQ persons have no specific legal protections from GBV, and same-sex relationships remain legally fraught despite a 2019 High Court ruling decriminalising consensual same-sex intimacy. Civil society organisations including LEGABIBO have documented the continuing absence of LBTIQ-inclusive protection in the DVA, the Marriage Act, and public health frameworks (Additional Interviews, 2026). The Botswana GBV bill reported as pending by some providers as of early 2026 remains in progress, with timeline uncertainty.

2.3
MARGINALISED WOMEN AND GBV: LBT, DISABLED, RURAL, MIGRANT



Intersectional feminist theory, as elaborated by Crenshaw (1989, 1991) and applied to GBV contexts by Sokoloff and Dupont (2005), foregrounds the compounded vulnerability created by overlapping identity categories. In the Botswana context, LBT women face barriers that are qualitatively different from those faced by heterosexual women: their relationships may not be legally recognised, their disclosures may be met with denial or dismissal, and they may face corrective violence with no recourse in law or practice. Service providers in this study consistently acknowledged limited knowledge of LBT-specific GBV dynamics, a finding consistent with Decker et al. (2015) who document the 'invisibility' of LBT GBV in African service systems.

Women with disabilities face physical access barriers, communication barriers, and attitudinal barriers. In this study, only 41.8% of respondents reported disability-friendly facilities, meaning the majority of service points cannot adequately serve survivors with physical or sensory disabilities. Migrant women face language barriers, documentation concerns, and fears of deportation that suppress disclosure. Rural women face geographic isolation from formal services and stronger community pressure to resolve GBV privately (UNICEF/SADC, 2024). These are not marginal concerns: the service providers in this study reported working with all of these populations, confirming that the GBV response system encounters intersectionally marginalised survivors regularly.

2.4

GBV SERVICE DELIVERY: EVIDENCE FROM SUB-SAHARAN AFRICA

Evidence from comparable settings in sub-Saharan Africa highlights recurring patterns relevant to Botswana's challenges. South Africa's Thuthuzela Care Centres, widely cited as a model of integrated one-stop GBV service delivery, demonstrate that co-locating police, health, legal, and counselling services significantly reduces re-traumatisation and improves case completion rates (National Prosecuting Authority South Africa, 2021). In Kenya, inter-agency GBV referral systems implemented with dedicated case management software have reduced case attrition by an estimated 35% (WHO, 2023). The SADC Protocol on Gender and Development calls on member states to enact one-stop service centres and integrated GBV response frameworks by 2030, setting a regional benchmark that Botswana has not yet met (SADC, 2021).

A common finding across SSA settings is the training gap: service providers' knowledge of GBV protocols, trauma-informed approaches, and LBT-inclusive practice is consistently inadequate, particularly in police and health sectors where turnover is high and GBV training is not embedded in pre-service education (WHO Global and Regional Estimates, 2021). This study's finding of 34.7% training coverage in Botswana aligns with this regional pattern.



2.5

ECONOMIC EMPOWERMENT AS GBV PREVENTION AND RECOVERY



The relationship between economic disempowerment and GBV vulnerability is well-established. Grabe et al. (2015) and Schuler et al. (2020) demonstrate that land rights, credit access, and income security reduce both the incidence of IPV and the likelihood of survivors remaining in abusive relationships. In the Botswana context, 86.8% of survey respondents in this study agreed that financial dependency prevents survivors from leaving their abusers, confirming the centrality of economic entrapment. Yet the economic empowerment programmes available through GBV service providers are heavily skewed toward skills training (selected by 59.6% of organisations providing any support) while microloans (3.4%), savings groups (1.7%), and job placement (10.3%) remain severely underprovided.International evidence suggests that standalone skills training without accompanying capital access, childcare support, and safety planning has limited impact on survivors' long-term economic independence (Kim et al., 2022). The concentration of any economic support in NGOs, with police providing empowerment services in only 18.2% of cases, further limits survivors who first access the system through law enforcement.

2.6
GAPS ADDRESSED BY THIS STUDY

This study directly addresses several gaps in the existing literature. First, there is limited published evidence on GBV service provider capacity in Botswana specifically, with most national-level analysis focusing on survivor-reported experiences or legal framework reviews. Second, no published composite index-based assessment of the Botswana GBV service system has been identified in the literature. Third, quantitative and qualitative integration of provider perspectives on LBT-specific barriers in the Botswana context is absent from the peer-reviewed literature. Fourth, the policy-implementation gap has not been previously quantified. This study addresses each of these gaps through its mixed-methods design and its explicit intersectional analytical framework.



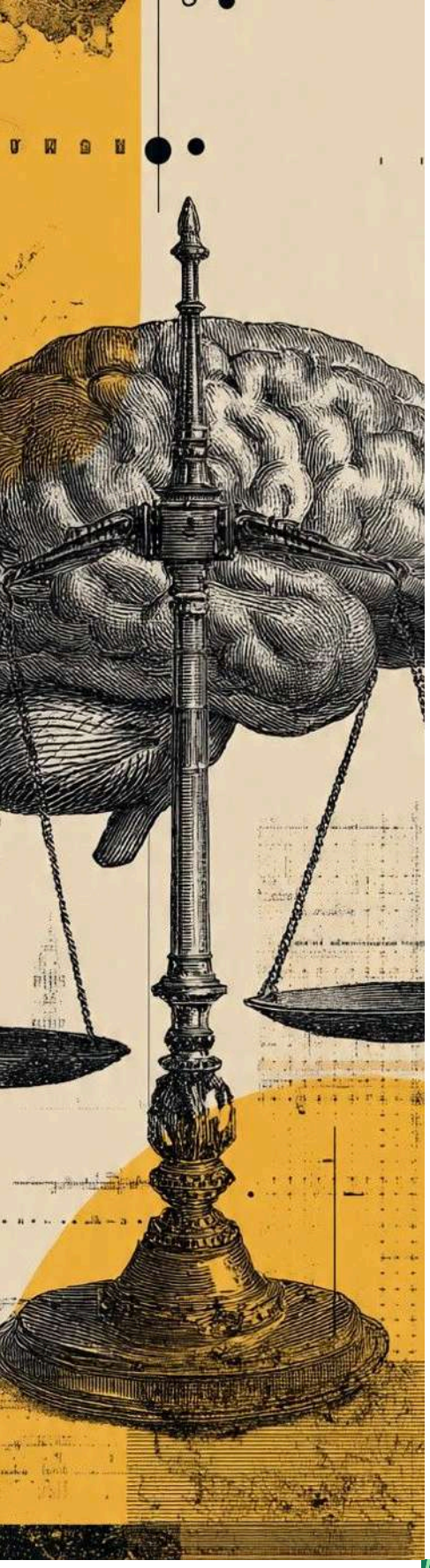
Part 3

METHODOLOGY

3.1 Research Design

The study employed a convergent mixed-methods design, in which qualitative and quantitative data were collected in parallel and analysed separately before integration at the reporting stage. The design was selected to capture both the distributional patterns of GBV service system performance (breadth, via quantitative survey) and the meaning, context, and institutional dynamics underlying those patterns (depth, via qualitative interviews). Integration followed a triangulation approach, with findings assessed for convergence, complementarity, and divergence as set out in Section 4.4 of the Analysis Workplan. The study's theoretical framework combined intersectional feminism (Crenshaw, 1989; Collins, 2000) with a survivor-centred approach to GBV analysis.



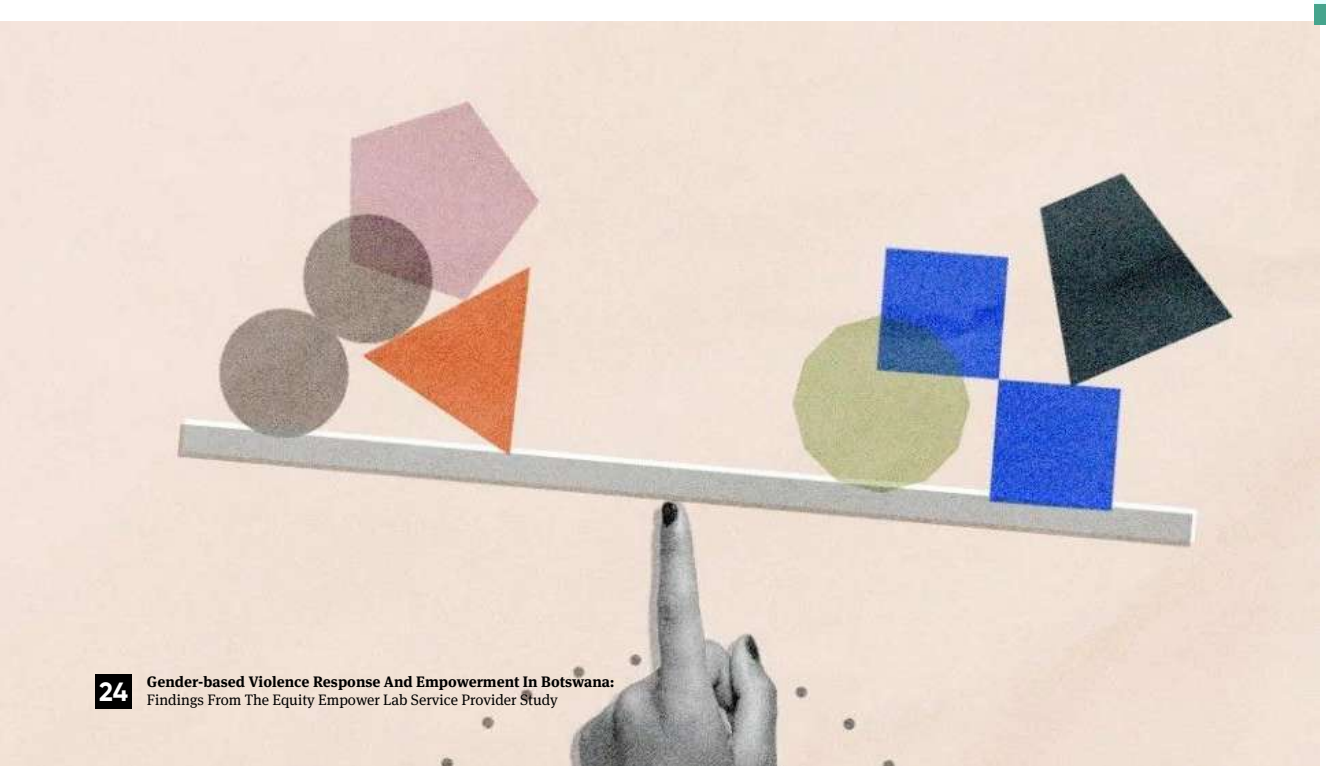


3.2 Ethical Approval and Protocols

Ethical approval was granted by the LSE Research Ethics Committee and Ministry of Local Government & Traditional Affairs alongside Botswana Police Service, Gaborone City Council and Ministry of Youth and Gender Affairs . All participants provided informed consent. Participants were advised that participation was voluntary, that withdrawal carried no penalty, and that all data would be anonymised. Sensitive content, including accounts of sexual violence and LBT persecution, was handled in accordance with trauma-informed interview protocols. No participant is identifiable from any content in any output of this study. Institutional names are replaced by generic sector descriptors throughout. Data are stored in password-protected encrypted storage accessible only to named team members and will be deleted following final report approval per ethics protocols.

3.3 Quantitative Component

A structured survey questionnaire was administered to 60 GBV service providers across Botswana, covering seven sections: respondent profile; GBV context and perceived severity; service provision capacity; coordination and empowerment; policy and systems; collaboration; and capacity-building needs. The questionnaire used a combination of ordinal Likert scales (1-5), binary Yes/No items, categorical frequency scales, and multi-response selection items. Sixty questionnaires were administered; 58 were coded into the dataset. Two questionnaires were excluded from coding due to insufficient completion. A further four to five respondents had specific sections missing (Q010, Q034, Q037, Q043, Q055), with missing data addressed through pairwise exclusion in composite score calculations. Analysis was conducted in SPSS, with recoded variables (_r suffix) removing Not Applicable responses (coded 9) to enable valid composite calculation. Six composite indices were constructed and assessed for internal consistency using Cronbach's alpha.



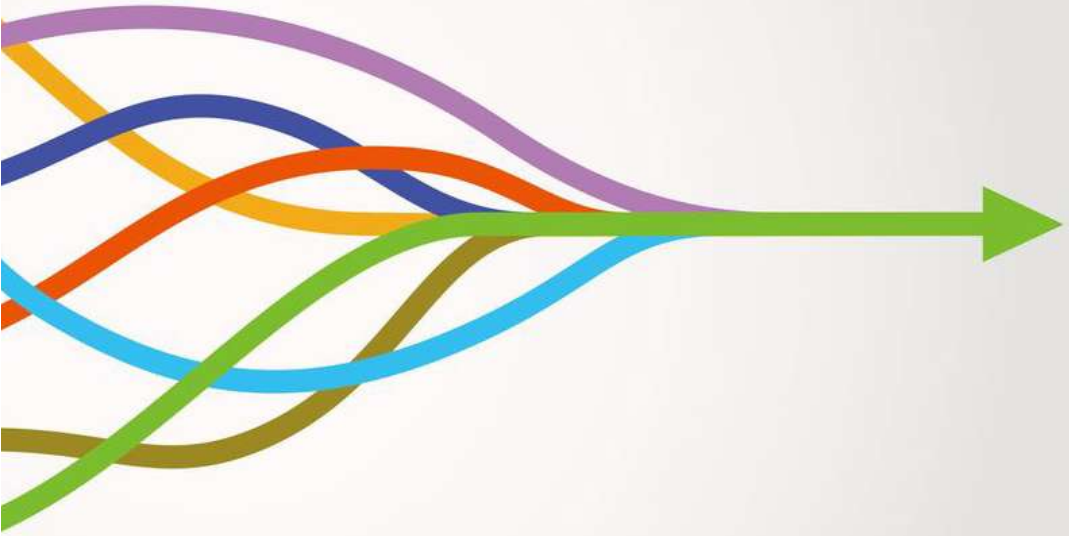


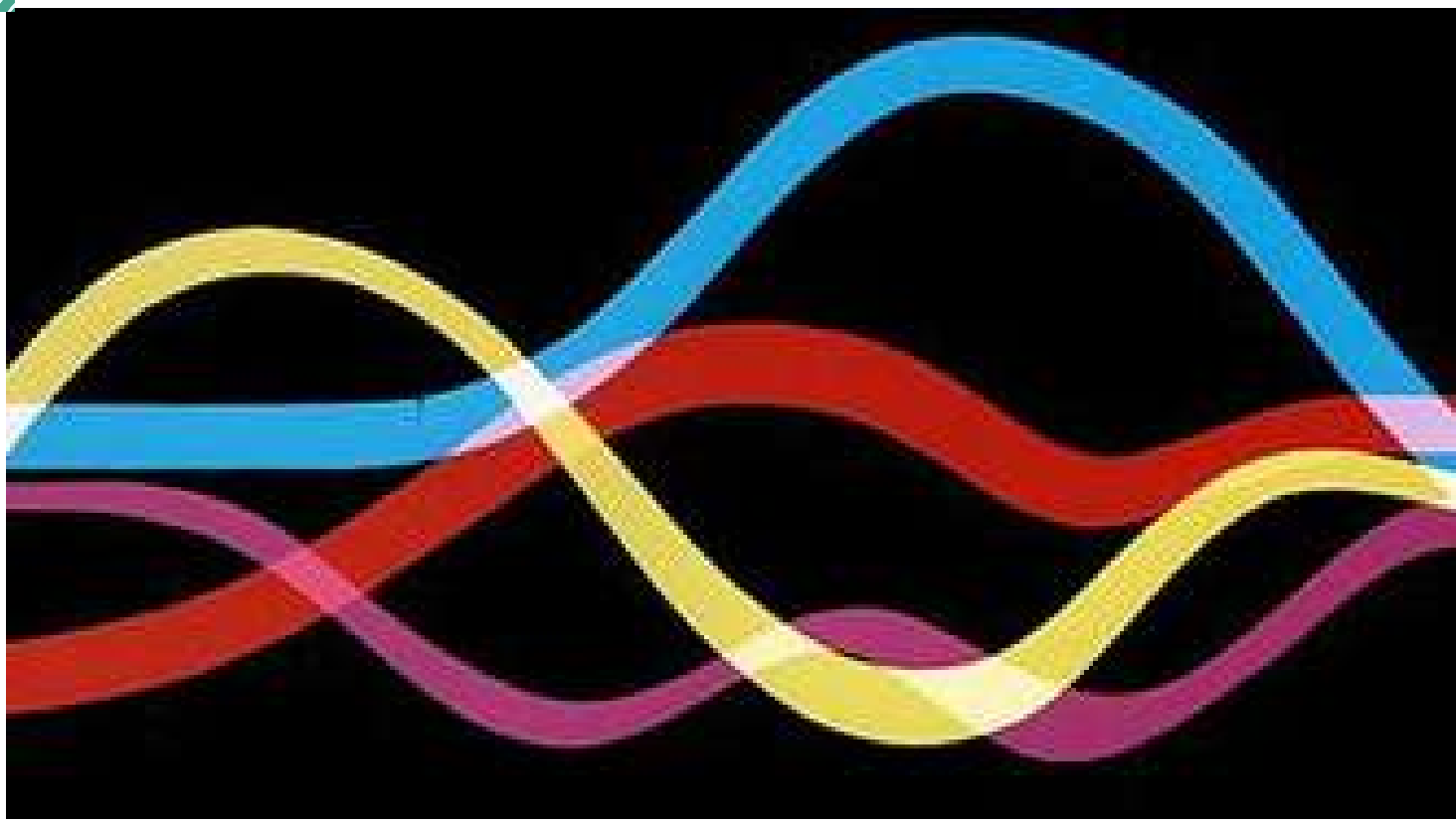
3.4 Qualitative Component

In-depth interviews were conducted with 45 GBV service providers using a semi-structured interview guide covering eight thematic areas. Interviews were conducted in English and Setswana as required, recorded with participant consent, and transcribed. Analysis followed the reflexive thematic analysis framework of Braun and Clarke (2021), using NVivo for data management and coding. The broad thematic framework was pre-defined from the study objectives; sub-themes and codes emerged inductively from the data. Anonymisation assigned each participant a code (P01-P45); all quotes in this report are attributed by sector, experience band, and geography only, never by name or institution.

3.5 Integration and Triangulation

At the reporting stage, quantitative and qualitative findings were systematically triangulated across six themes. For each theme, the team assessed convergence (where both data streams point in the same direction), complementarity (where qualitative data adds depth to quantitative patterns), and divergence (where the two streams appear to conflict, requiring interpretive explanation). Triangulation statements for each theme are incorporated in Parts 4 and 5.





3.6 Rigour

Credibility was established through prolonged engagement with the data, peer debriefing among the analysis team, and negative case analysis. Transferability is supported by thick description of the research context and participant profiles. Dependability is maintained through a full audit trail including version-controlled coding frameworks, analytical memos, and this study's documented procedure record (EEL_Analysis_Procedure_2026.docx). Confirmability is addressed through team reflexivity journaling.

3.7 Limitations

Key limitations include: the focus on service providers rather than survivors, which limits direct survivor voice; a modest quantitative sample (n=58) with limited statistical power for subgroup analyses; geographic concentration in Gaborone and accessible peri-urban areas; and the low internal consistency of the Policy Implementation Index (alpha=0.444), which is flagged wherever PII results are reported.





Part 4

DATA PRESENTATION AND ANALYSIS

4.1
RESPONDENT PROFILE

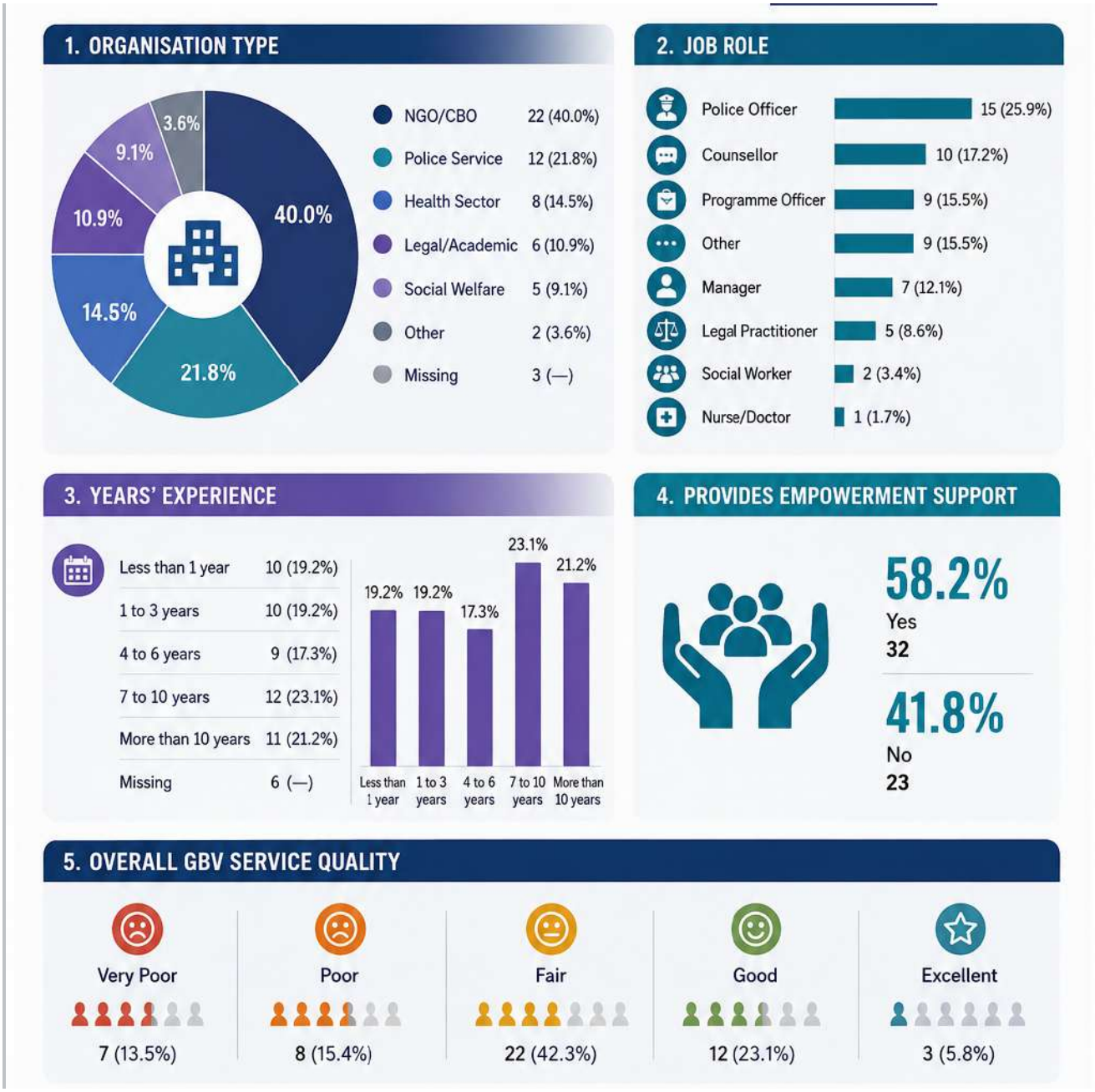
4.1.1
Survey Respondents (n=58 coded)

Table 4.1 summarises the professional and demographic profile of the 58 coded survey respondents.

Table 4.1: Demographic and Professional Profile of Survey Respondents

Variable	Category	Frequency (n)	Valid %
Organisation Type	NGO/CBO	22	40.0%
	Police Service	12	21.8%
	Health Sector	8	14.5%
	Legal/Academic	6	10.9%
	Social Welfare	5	9.1%
	Other	2	3.6%
	Missing	3	—
Job Role	Police Officer	15	25.9%
	Counsellor	10	17.2%
	Programme Officer	9	15.5%
	Other	9	15.5%
	Manager	7	12.1%
	Legal Practitioner	5	8.6%
	Social Worker	2	3.4%
	Nurse/Doctor	1	1.7%
Years' Experience	Less than 1 year	10	19.2%
	1 to 3 years	10	19.2%
	4 to 6 years	9	17.3%
	7 to 10 years	12	23.1%
	More than 10 years	11	21.2%
	Missing	6	—
Provides Empowerment Support	Yes	32	58.2%
	No	23	41.8%
Overall GBV Service Quality	Very Poor	7	13.5%
	Poor	8	15.4%
	Fair	22	42.3%
	Good	12	23.1%
	Excellent	3	5.8%

Table 4.1: Demographic and Professional Profile of Survey Respondents (n=58).
Note: Missing data (n=3 for Q1_OrgType, n=6 for Q3_YearsExp, Q55_Quality; n=3 for Q28_EmpSupport) addressed through pairwise exclusion. Valid % based on valid N for each variable.



The survey sample was dominated by NGO and CBO respondents (40.0%) and police officers (21.8%), reflecting the dominant institutional actors in Botswana's GBV response system. Police officers constituted the largest single job role (25.9%), followed by counsellors (17.2%) and programme officers (15.5%). The experience profile was broadly distributed: 44% had four or more years of GBV-specific experience, and 21.2% had more than a decade in the field. Most respondents rated the overall quality of GBV services as Fair (42.3%), with fewer than one in three rating services as Good (23.1%) or Excellent (5.8%). A combined 28.8% rated services as Poor or Very Poor.

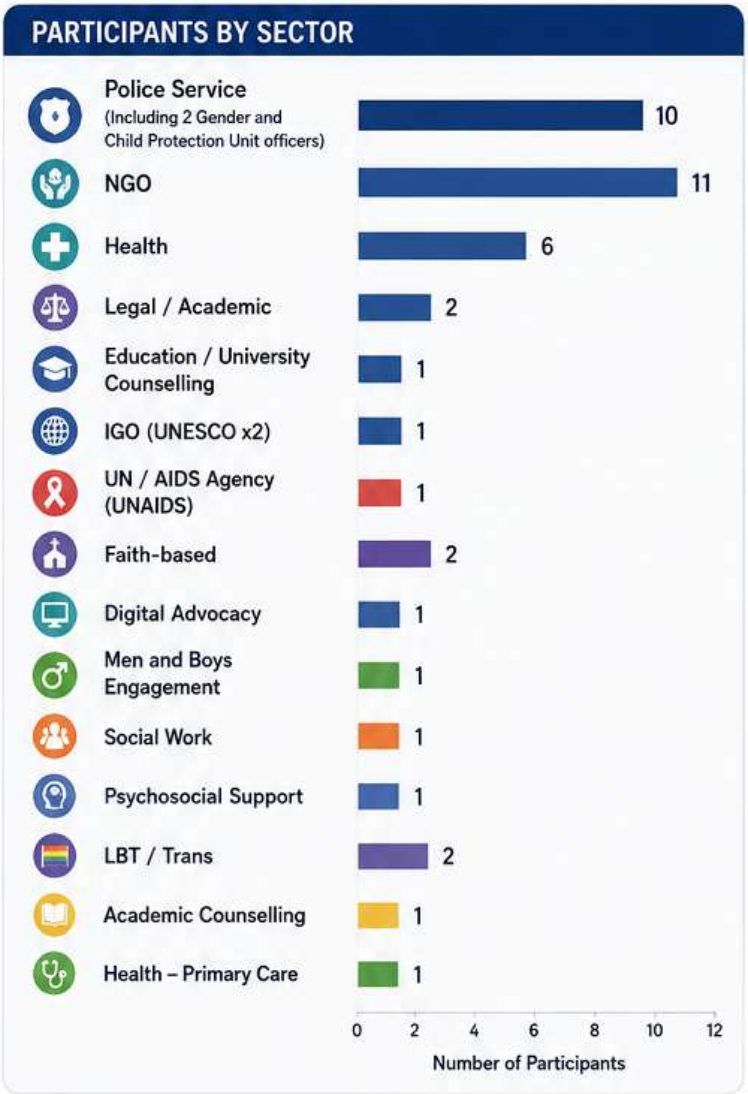
4.1.2
Interview Participants

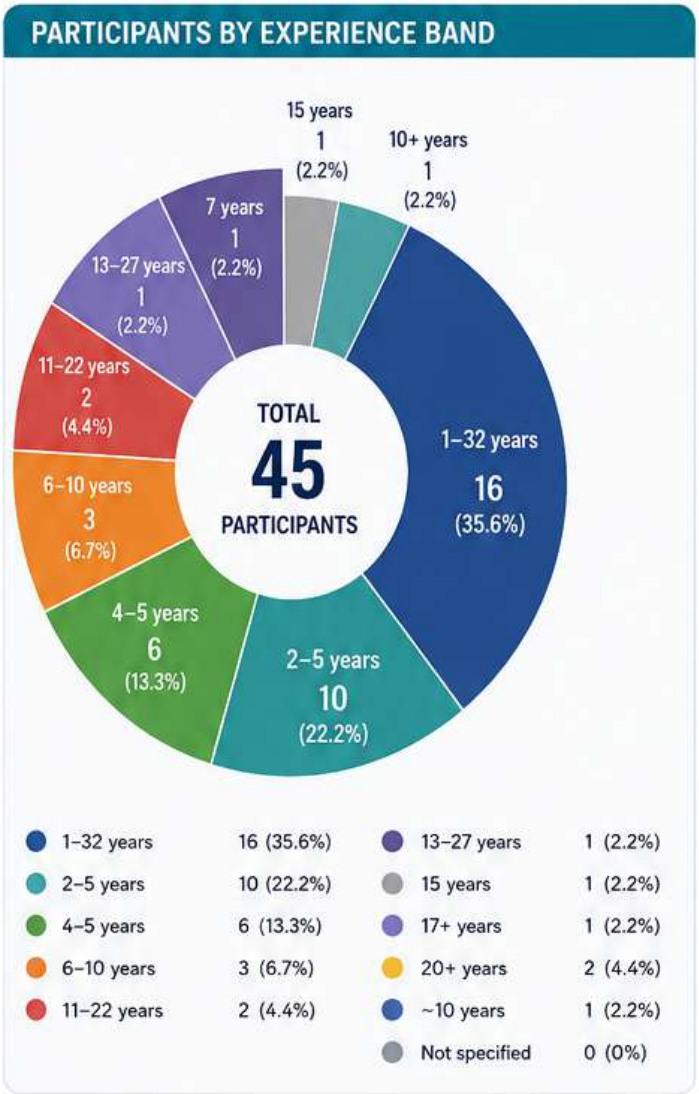
Participant Code	Sector	Geography	Experience Band
P01–P08	Police Service (including 2 Gender and Child Protection Unit officers)	Urban Gaborone	1–32 years
P01–P08	Police Service (including 2 Gender and Child Protection Unit officers)	Urban Gaborone	1–32 years
P12–P14	Legal / Academic (UB Legal Clinic)	Urban Gaborone	2 years each
P15	Education / University counselling (UB Guidance and Counselling)	Urban Gaborone	15 years
P16–P18	NGO -- Disability Focus (Disabled Council x2; Autism Botswana)	Urban Gaborone	4–5 years
P19–P23	NGO -- General GBV / Empowerment (BOCHAIP, BOFEPUSU, Friends of Diversity x2, YWCA)	Urban Gaborone	11–22 years
P24–P25	IGO (UNESCO x2)	National	13–27 years
P26	UN / AIDS Agency (UNAIDS)	National	17+ years
P27–P28	NGO -- LBT Rights (LEGABIBO x2)	National	2–5 years
P29	Academic / Counselling (BAISAGO) [NEW]	Urban Gaborone	~10 years
P30	Faith-based (BCC, ordained minister) [NEW]	Urban Gaborone	20+ years
P31	NGO -- Psychosocial Support (BGBVC) [NEW]	Urban Gaborone	2–5 years
P32–P33	Health -- Primary Care (Bontleng Clinic: information provider; matron) [NEW]	Urban Gaborone	14–27 years

4.1.2
Interview Participants CONT'D

Participant Code	Sector	Geography	Experience Band
P34-P35	NGO -- LBT / Trans (Botswana Trans Initiative: first contact; linkage officer) [NEW]	Urban Gaborone	4-5 years
P36-P40	Health -- Primary Care (Broadhurst3 Clinic: nurse; liaison officer; referral officer; nurse x2) [NEW]	Urban Gaborone	6-24 years
P41	Faith-based / Holistic Advocacy (Abethu Faith Based Organisation) [NEW]	Urban Gaborone	Not specified
P42	Digital Advocacy / LGBTIQ+ (Karuza Speaks) [NEW]	Urban Gaborone	7 years
P43-P44	NGO -- Men and Boys Engagement (MBGE: M and E officer; assistant team leader) [NEW]	Urban Gaborone	10+ years
P45	NGO / Social Work (social worker accounts, composite of 2 participants) [NEW]	Urban Gaborone	2-6 years
TOTAL: 45	All major sectors represented (police, health, legal, disability, NGO/CBO, IGO/UN, LBT NGO, faith-based, digital advocacy, men and boys engagement, social work / academic)	Urban Gaborone and national	1-32 years

Note: P45 represents a composite participant code covering two social work accounts collected in the same session. All other codes represent individual participants. [NEW] denotes participants added to the analysis in the July 2026 revised edition.


PARTICIPANTS BY SECTOR
Police Service (Including 2 Gender and Child Protection Unit officers) 10
NGO 11
Health 6
Legal / Academic 2
Education / University Counselling 1
IGO (UNESCO x2) 1
UN / AIDS Agency (UNAIDS) 1
Faith-based 2
Digital Advocacy 1
Men and Boys Engagement 1
Social Work 1
Psychosocial Support 1
LBT / Trans 2
Academic Counselling 1
Health – Primary Care 1
0 2 4 6 8 10 12
Number of Participants


PARTICIPANTS BY EXPERIENCE BAND
15 years 1 (2.2%)
10+ years 1 (2.2%)
7 years 1 (2.2%)
13–27 years 1 (2.2%)
11–22 years 2 (4.4%)
6–10 years 3 (6.7%)
4–5 years 6 (13.3%)
2–5 years 10 (22.2%)
1–32 years 16 (35.6%)
TOTAL 45 PARTICIPANTS
1–32 years 16 (35.6%)
2–5 years 10 (22.2%)
4–5 years 6 (13.3%)
6–10 years 3 (6.7%)
11–22 years 2 (4.4%)
13–27 years 1 (2.2%)
15 years 1 (2.2%)
17+ years 1 (2.2%)
20+ years 2 (4.4%)
~10 years 1 (2.2%)
Not specified 0 (0%)

4.2
THE GBV LANDSCAPE: Context, Prevalence, and Underreporting

4.2.1 Perceived Severity and Underreporting

Service providers demonstrated near-universal professional consensus on the severity of GBV and the scale of underreporting. Table 4.3 presents descriptive statistics for the GBV Context and Vulnerability Index items (Q6r-Q13r).

Table 4.3: GBV Context and Vulnerability Index

Item	Variable	N	Mean	SD	Top-Box %	Bottom-Box %
GBV is a serious problem in communities I serve	Q6r	57	4.74	0.81	94.7%	3.5%
GBV cases are significantly underreported	Q7r	57	4.58	0.87	93.0%	3.5%
Survivors face barriers that prevent help-seeking	Q8r	57	3.98	1.14	73.7%	8.8%
GBV is increasing in the communities I serve	Q9r	56	4.14	1.17	82.1%	10.7%
Economic inequality drives GBV vulnerability	Q10r	54	4.06	1.22	75.9%	14.8%
LBT women face higher GBV risk	Q11r	55	3.87	0.98	65.5%	7.3%
Women with disabilities face higher GBV risk	Q12r	57	4.37	0.92	91.2%	5.3%
Rural women face higher barriers to accessing help	Q13r	56	4.41	0.95	89.3%	5.4%
GBV Context and Vulnerability Index (composite)	GBV_ Context	58	4.28	0.64	—	—

Table 4.3: GBV Context and Vulnerability Index — Descriptive Statistics (Q6r-Q13r). Top-box = % Agree/Strongly Agree. Bottom-box = % Disagree/Strongly Disagree. Composite GBV_Context = mean of all 8 items. Scale: 1=Strongly Disagree to 5=Strongly Agree. Cronbach's alpha = 0.789.

SUMMARY OF SURVEY RESULTS

ITEM	VARIABLE	N	MEAN (out of 5)	SD	TOP-BOX % (Strongly Agree)	BOTTOM-BOX % (Strongly Disagree)
GBV is a serious problem in communities I serve	Q6r	57	4.72	0.81	94.7%	3.5%
GBV cases are significantly underreported	Q7r	57	4.58	0.87	93.0%	3.5%
Survivors face barriers that prevent help-seeking	Q8r	57	3.98	1.14	73.7%	8.8%
GBV is increasing in the communities I serve	Q9r	56	4.14	1.17	82.1%	10.7%
Economic inequality drives GBV vulnerability	Q10r	54	4.00	1.22	75.9%	14.8%
LBT women face higher GBV risk	Q11r	55	3.87	0.98	65.5%	7.3%
Women with disabilities face higher GBV risk	Q12r	57	4.37	0.92	91.2%	5.3%
Rural women face higher barriers to accessing help	Q13r	56	4.41	0.95	89.3%	5.4%
GBV Context and Vulnerability Index (composite)	GBV_ Context	58	4.28	0.64	—	—

Key Finding 4.1

Near-universal professional consensus exists on GBV severity (94.7% top-box, Q6r) and underreporting (93.0% top-box, Q7r), with a composite GBV Context score of 4.28/5.00. Providers are in no doubt about the scale of the problem. The challenge is systemic response, not awareness.

The GBV Context composite (4.28/5.00) sits firmly in the strong/positive range, reflecting a consistent professional understanding of GBV as a pervasive and serious problem. Highest agreement was on the severity of GBV (Q6r, mean=4.74) and underreporting (Q7r, mean=4.58). The risk profiles for specific groups were also strongly endorsed: 91.2% agreed that women with disabilities face elevated GBV risk (Q12r), and 89.3% agreed that rural women face higher barriers to accessing help (Q13r). The elevated vulnerability of LBT women received somewhat lower agreement (Q11r, 65.5% top-box, mean=3.87), which may reflect lower familiarity with LBT-specific GBV dynamics among some providers rather than disagreement on the principle.

Qualitative data strongly corroborated the severity finding. Providers described GBV as both a daily institutional reality and a chronic community crisis. One participant stated: 'GBV cases are difficult but we try to assist our clients as we can. There is more room to improve on responding to GBV cases' (P09, health sector, urban). A police service provider described the scale: 'GBV cases are taken very seriously by police officers and our superiors' (P07, police, urban), while simultaneously acknowledging structural barriers to follow-through. A provider with 27 years of experience drew a link between information access and reporting: 'If the society or people at large have knowledge and they are aware of GBV, they could be able to report cases of GBV' (P25, IGO sector, national).

4.3 SERVICE PROVISION CAPACITY AND INSTITUTIONAL READINESS

4.3.1 Service Provision Quality Index

The Service Provision Quality Index (SPQI) captures self-reported capacity across seven dimensions: information access, affordability, physical accessibility, disability-friendly facilities, specialised training, non-discriminatory practice, case-recording systems, and confidentiality protocols.

Table 4.4: Service Provision Quality Index

Item	Variable	N	Mean	SD	Top-Box %	Bottom-Box %
Information on GBV services is accessible to survivors	Q16r	56	3.46	1.03	50.0%	16.1%
Services are free or affordable to survivors	Q17r	56	3.89	1.12	67.9%	12.5%
Services are physically accessible	Q18r (physical)	55	3.24	1.43	41.8%	32.7%
Specialised GBV training received recently	Q19r	49	2.82	1.41	34.7%	40.8%
Services are welcoming and non-discriminatory	Q20r	56	3.93	1.36	69.6%	21.4%
Clear internal GBV protocols are in place	Q21r	54	3.39	1.35	46.3%	25.9%
Confidentiality is consistently maintained	Q22r	53	4.23	1.20	81.1%	13.2%
Service Provision Quality Index (SPQI)	SPQI	58	3.58	0.87	—	—

Table 4.4: Service Provision Quality Index — Descriptive Statistics (Q16r-Q22r). SPQI composite = mean of all 7 items. Scale: 1=Strongly Disagree to 5=Strongly Agree. Cronbach's alpha = 0.852. Top-box = % Agree/Strongly Agree. Bottom-box = % Disagree/Strongly Disagree.

Key Finding 4.2

The SPQI of 3.58/5.00 masks critical internal variation. Confidentiality protocols (mean=4.23) and affordability (mean=3.89) were the strongest-performing dimensions. Specialised GBV training (mean=2.82, 34.7% top-box) and disability-accessible facilities (mean=3.24, 41.8% top-box) were the weakest placing the majority of service points inadequately prepared for both specialist responses and inclusive service delivery.



The SPQI of 3.58/5.00 indicates the service system overall sits at the lower end of the strong/positive range. Confidentiality maintenance was the strongest-performing item (Q22r, mean=4.23; 81.1% top-box), and affordability of services also performed well (Q17r, mean=3.89; 67.9% top-box). These are foundational elements that function reasonably across sectors.

The critical weaknesses are training and physical accessibility. Only 34.7% of respondents reported having received specialised GBV training (Q19r, mean=2.82, N=49). Notably, Q19r had the largest number of missing responses among SPQI items (9 missing), which may indicate non-response among providers who are particularly undertrained. Physical and disability-friendly access (Q18r, mean=3.24; 41.8% top-box; 32.7% bottom-box) was the most divisive item, with approximately one in three respondents actively disagreeing that services are physically accessible. This confirms that a substantial proportion of service points cannot serve survivors with mobility or sensory impairments.

The cross-tabulation of training status (Q19) by organisation type showed a significant difference (chi-square=20.572, df=5, p=.001), with NGOs reporting substantially higher training provision compared to police stations, though the presence of expected cell counts below 5 in 75% of cells warrants cautious interpretation. Qualitatively, this pattern was consistent: 'We need to train our police officers how to help or first-hand receive a GBV case' (P02, police, urban); 'We need training and knowledge on GBV so that we best serve our community and victims of GBV' (P11, health, urban).



4.4 ACCESS BARRIERS FOR MARGINALISED SURVIVORS

4.4.1 Barrier Frequency Ratings

Survey respondents rated the frequency with which specific barriers prevent marginalised groups from accessing services. Q23 (asked as a single composite barrier frequency item) produced a mean of 4.60/5.00 (N=40, SD=1.08; 92.5% top-box), indicating that the overall barrier burden is rated as severe. Qualitative coding identified the dominant barriers as economic dependency, stigma, fear of retaliation, provider attitudes, and physical/geographic access.

Key Finding 4.3

The overall access barrier score of 4.60/5.00 (92.5% top-box) indicates that service providers near-universally recognise access barriers as frequent and serious. Economic dependency (86.8% agree barriers are driven by financial entrapment, Q33r), stigma, and fear of institutional discrimination were the most consistently identified barriers across both quantitative and qualitative data.

The multi-select empowerment barriers question (Q35) identified the most frequently cited structural barriers to economic empowerment specifically: lack of skills and vocational training was selected most often (59.6% of respondents); lack of access to capital followed (48.9%); discrimination in economic participation was third (44.7%); safety concerns were fourth (38.3%); and childcare barriers were identified by 27.7%. These barriers align closely with the international evidence base, confirming that Botswana's economic empowerment gap is structural rather than programme-specific.





4.4.2
LBT Women and Other Marginalised Groups

Qualitative data across sectors produced a consistent picture of institutional hostility, stigma, and exclusion facing LBT women who attempt to access GBV services. Multiple police-sector providers acknowledged that LBT persons face stigma and discrimination at reporting points: 'The LGBTQI community experience stigma and discrimination by the police' (P05, police, urban). Legal providers noted that fear of disclosure, rather than absence of GBV, explains the low visibility of LBT cases: 'LBTQI persons do not report cases of GBV as they fear to be judged and stigmatised by the police officers' (P12, legal, urban). LBT-serving providers described structural inadequacy: 'There are lack of inclusive policies for LBT women and there is lack of confidentiality on providing services to LBT women' (P22, NGO/LBT, urban).

Notably, several providers from police and health sectors reported never having encountered an LBT case, which is itself an indicator of systemic exclusion rather than absence of LBT GBV: 'I have not received yet any LBT women who came to report in our station' (P08, police, urban). This pattern points to institutional design that renders LBT GBV invisible within official data systems, consistent with Q49r (data systems for tracking survivor journeys, mean=2.20/5.00), the lowest-scored item in the entire survey.

4.5 REFERRAL SYSTEMS AND INTER-AGENCY COORDINATION

4.5.1 Coordination Effectiveness Index

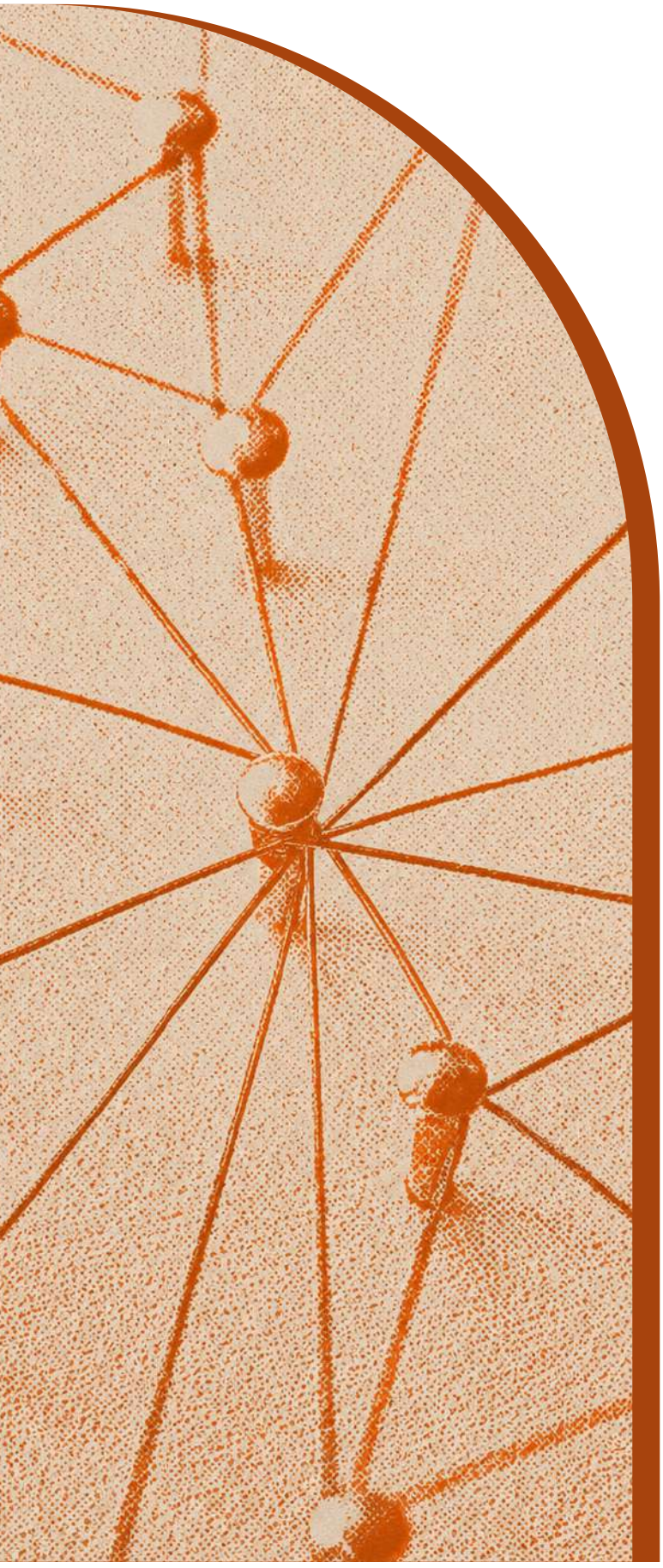
The Coordination Effectiveness Index (CEI) captures perceived effectiveness of inter-agency referral and collaboration across four dimensions.

Table 4.5: Coordination Effectiveness Index

Item	Variable	N	Mean	SD	Top-Box %	Bottom-Box %
Coordination with health services is effective	Q24r	56	3.73	1.10	60.7%	10.7%
Coordination with legal services is effective	Q25r	54	3.72	1.02	61.1%	9.3%
Referral pathways are well-defined and followed	Q26r	54	3.54	1.13	61.1%	14.8%
Clear protocols for inter-agency referral exist	Q27r	53	3.55	1.31	58.5%	20.8%
Coordination Effectiveness Index (CEI)	CEI	57	3.64	0.86	—	—

Table 4.5: Coordination Effectiveness Index Descriptive Statistics (Q24r-Q27r). CEI composite = mean of all 4 items. Respondents Q034, Q037, Q043 excluded from CEI calculation (missing items). Cronbach's alpha = 0.748.





The CEI of 3.64/5.00 indicates the coordination system as a whole sits in the positive range, with coordination with health services (Q24r, mean=3.73) rated marginally more effective than clarity of referral protocols (Q27r, mean=3.55). The between-item variation is modest; the more informative signal comes from the qualitative data, which consistently described coordination as formally present but operationally inconsistent.

Qualitative accounts painted a more fragmented picture than the survey means suggest. Police providers described coordination as functional but irregular: 'We do have collaboration with NGOs to assist on investigating the cases. We also have social workers that lack the seriousness to be fast to attend the case we refer to them' (P05, police, urban). Health providers noted gaps in feedback loops: 'We do not usually get feedback from the police officer if we report a case, hence our referrals are not working as they should' (P11, health, urban). Legal providers identified time delays as the critical failure point: 'There is limited collaboration with other stakeholders, hence we do not have solid referral pathways' (P13, legal, urban). The SPSS correlation between SPQI and CEI (Pearson r=0.518, p=.000) confirms that organisations with stronger service provision capacity also report more effective coordination, suggesting that resource deprivation undermines both simultaneously.

4.6 ECONOMIC EMPOWERMENT AND SURVIVOR RECOVERY SUPPORT

Economic empowerment emerged as the most critical gap between what survivors need and what the GBV service system provides. The Economic Empowerment Index (EEI=3.57/5.00, N=54) sits in the positive range at the composite level, yet this masks severe variation within the scale.

Table 4.5: Coordination Effectiveness Index

Item	Variable	N	Mean	SD	Top-Box %	Bottom-Box %
Economic empowerment programmes are accessible to survivors	Q30r	50	2.88	1.12	26.0%	32.0%
Vocational/skills training is available	Q31r	52	2.83	1.22	25.0%	36.5%
Survivors are connected to income-generating opportunities	Q32r	51	3.35	1.29	47.1%	23.5%
Financial dependency prevents survivors from leaving (AGREE = problem)	Q33r	53	4.38	1.20	86.8%	11.3%
Economic empowerment is essential to GBV recovery	Q34r	46	4.39	0.86	87.0%	2.2%
Economic Empower-ment Index (EEI)	EEI	54	3.57	0.80	—	—

Table 4.6: Economic Empowerment Index — Descriptive Statistics (Q30r-Q34r). EEI composite = mean of all 5 items. Respondents Q034, Q037, Q043, Q055(if confirmed) excluded. Cronbach's alpha = 0.705.

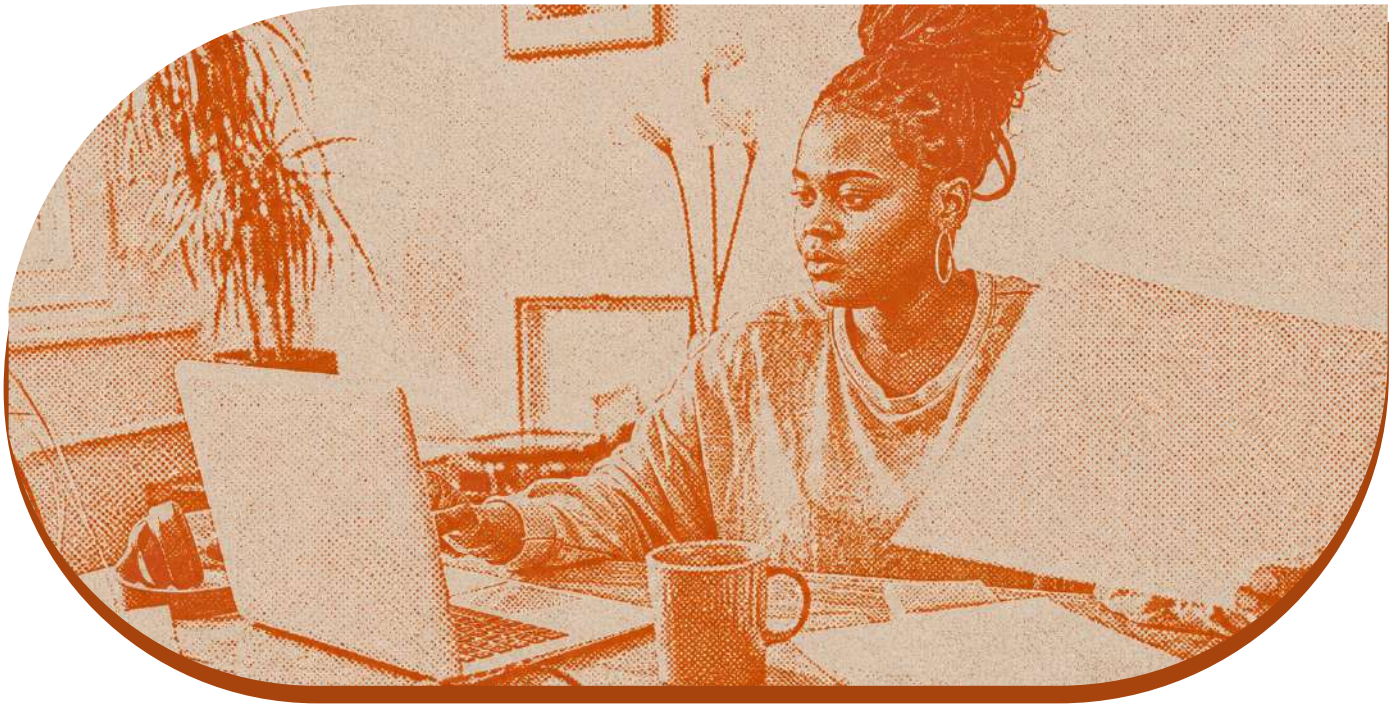


Key Finding 4.4

The paradox of economic empowerment: 86.8% agree that financial dependency traps survivors (Q33r) and 87.0% agree economic empowerment is essential to recovery (Q34r), yet only 26.0% agree empowerment programmes are accessible (Q30r) and 25.0% agree vocational training is available (Q31r). The system knows what is needed but cannot provide it.

The economic empowerment section reveals the starkest internal contradiction in the entire dataset. Providers overwhelmingly recognise economic dependency as the primary structural trap (Q33r, mean=4.38; 86.8%) and economic empowerment as essential to recovery (Q34r, mean=4.39; 87.0%). Accessibility of empowerment programmes (Q30r, mean=2.88; 26.0% top-box) and availability of vocational training (Q31r, mean=2.83; 25.0% top-box) received the lowest scores in the index, with over one-third of respondents actively disagreeing that these services are available.

The type of empowerment support available is heavily skewed: of organisations providing any economic support, 26 (the majority) offered skills training, but only 2 provided microloans, 5 provided business support, 6 provided job placement, and just 1 offered savings groups. A significant economic empowerment gap exists for the most capital-intensive and potentially transformative forms of support. Qualitative data from providers echoed this: 'We need women empowerment so that more women can be independent from the dominance of men' (P10, health, urban); 'Collaborations that is much needed is the women empowerment which no one is talking about as much' (P20, NGO, urban).



4.7
POLICY, LEGAL FRAMEWORKS, AND DATA SYSTEMS

4.7.1
Policy Implementation Index

The Policy Implementation Index (PII) assesses provider perceptions of policy awareness, implementation confidence, accountability mechanisms, and legal adequacy.

Table 4.7: Policy Implementation Index

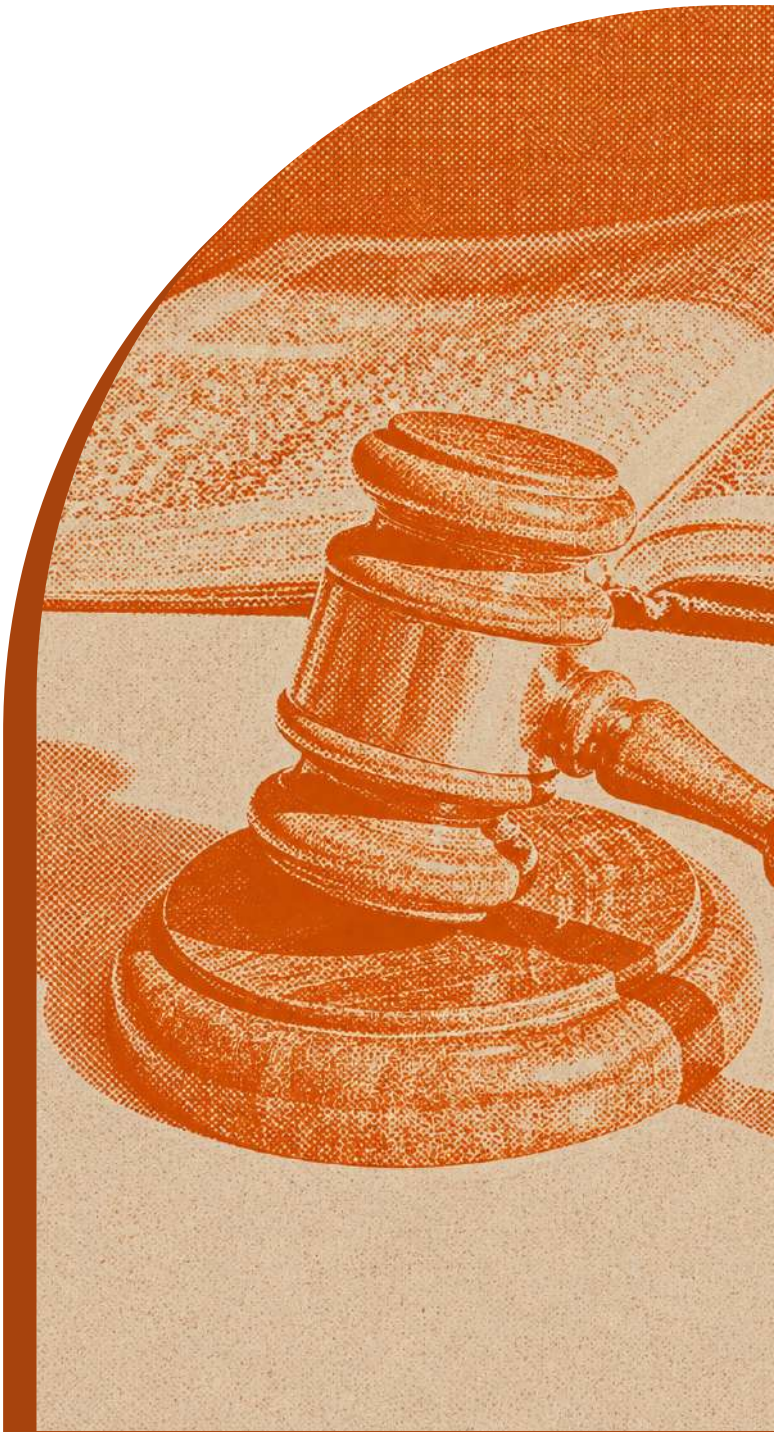
Item	Variable	N	Mean	SD	Top-Box %	Bottom-Box %
I am aware of the key GBV-related policies and laws	Q37r	54	3.65	1.12	53.7%	11.1%
I am confident these policies are being implemented	Q38r	53	2.94	1.20	34.0%	34.0%
Accountability mechanisms for GBV response exist and function	Q43r	51	3.65	1.31	56.9%	23.5%
The legal framework adequately protects GBV survivors	Q44r	51	3.29	1.25	41.2%	27.5%
Policy and Systems Index (PII)	PII	54	3.50	0.95	—	—
POLICY-IMPLEMENTATION GAP (Q37r mean - Q38r mean)	Gap	—	0.71	—	—	—

Table 4.7: Policy Implementation Index — Descriptive Statistics. NOTE: Cronbach's alpha = 0.444, below acceptable threshold. PII results are interpreted with caution throughout. Policy-implementation gap = Q37r mean minus Q38r mean = 0.71, exceeding the 0.5-point significance threshold.



Key Finding 4.5

A 0.71 scale-point gap separates policy awareness (Q37r, mean=3.65) from implementation confidence (Q38r, mean=2.94). More than one-third of respondents both agreed with high policy awareness AND disagreed that policies are being implemented. This is the quantitative signature of the policy-implementation chasm.



The policy-implementation gap of 0.71 scale points is the single most policy-relevant quantitative finding of the study. Providers know the policies exist; they do not believe the policies are being implemented. This gap was consistently corroborated qualitatively: 'Botswana laws only say women's day without protecting the women from GBV acts' (P05, police, urban); 'In Botswana, laws are failing the victim. The system is failing to protect the victim' (P15, education, urban); 'The penal codes they do not offer much help to victims of GBV' (P13, legal, urban).

Critical policy gaps identified in Q45 (multi-select) included: funding inadequacy (76.3% of respondents), absence of adequate shelters (52.6%), legal framework gaps (52.6%), inadequate law enforcement capacity (42.1%), and absence of LBT-specific legal protection (21.1%). The latter figure, while the lowest-ranked, represents a gap with disproportionate impact on the most marginalised GBV survivors.

4.8 CAPACITY-BUILDING NEEDS AND STAFF WELLBEING

The capacity-building needs section (Q53cb) asked respondents to select their priority training and development needs. Table 4.8 presents findings ranked by frequency.

Table 4.8: Capacity-Building Needs Ranked by Frequency of Selection

Priority Capacity-Building Area	Variable	N Selecting	% of Respondents (n=53)
Counselling and trauma support	Q53cb_Counselling	35	66.0%
Legal literacy	Q53cb_LegalLiteracy	31	58.5%
Child protection	Q53cb_ChildProtection	23	43.4%
Staff wellness	Q53cb_StaffWellness	23	43.4%
Disability inclusion	Q53cb_DisabilityInclusion	22	41.5%
Case management	Q53cb_CaseMgmt	18	34.0%
LBT inclusion	Q53cb_LBTInclusion	17	32.1%
Monitoring and evaluation	Q53cb_ME	12	22.6%
Economic empowerment practice	Q53cb_Empowerment	8	15.1%

Table 4.8: Capacity-Building Needs Ranked by Frequency of Selection (n=53 valid respondents, Q53_ Capacity multi-select). Respondents could select multiple options.



Counselling and trauma support was identified as the top capacity-building priority by 66.0% of respondents. This finding aligns with the qualitative data's recurring emphasis on trauma-informed practice: 'We need more trained social workers to assist in counselling the victims of GBV' (P09, health, urban). Legal literacy (58.5%) reflects providers' recognition that understanding the legal framework is a prerequisite for effective service navigation, while the high selection of disability inclusion (41.5%) and LBT inclusion (32.1%) confirms that providers are aware of their inadequacy in serving these populations. Staff wellness, selected by 43.4%, signals an under-acknowledged dimension of GBV response sustainability: secondary traumatisation and burnout among providers are real constraints on service quality. Q52r (staff wellness support, mean=4.56/5.00) indicates high importance placed on wellbeing, while Q53r (actual staff wellness provision, mean=2.78/5.00) reveals a substantial gap between what providers consider important and what is resourced.

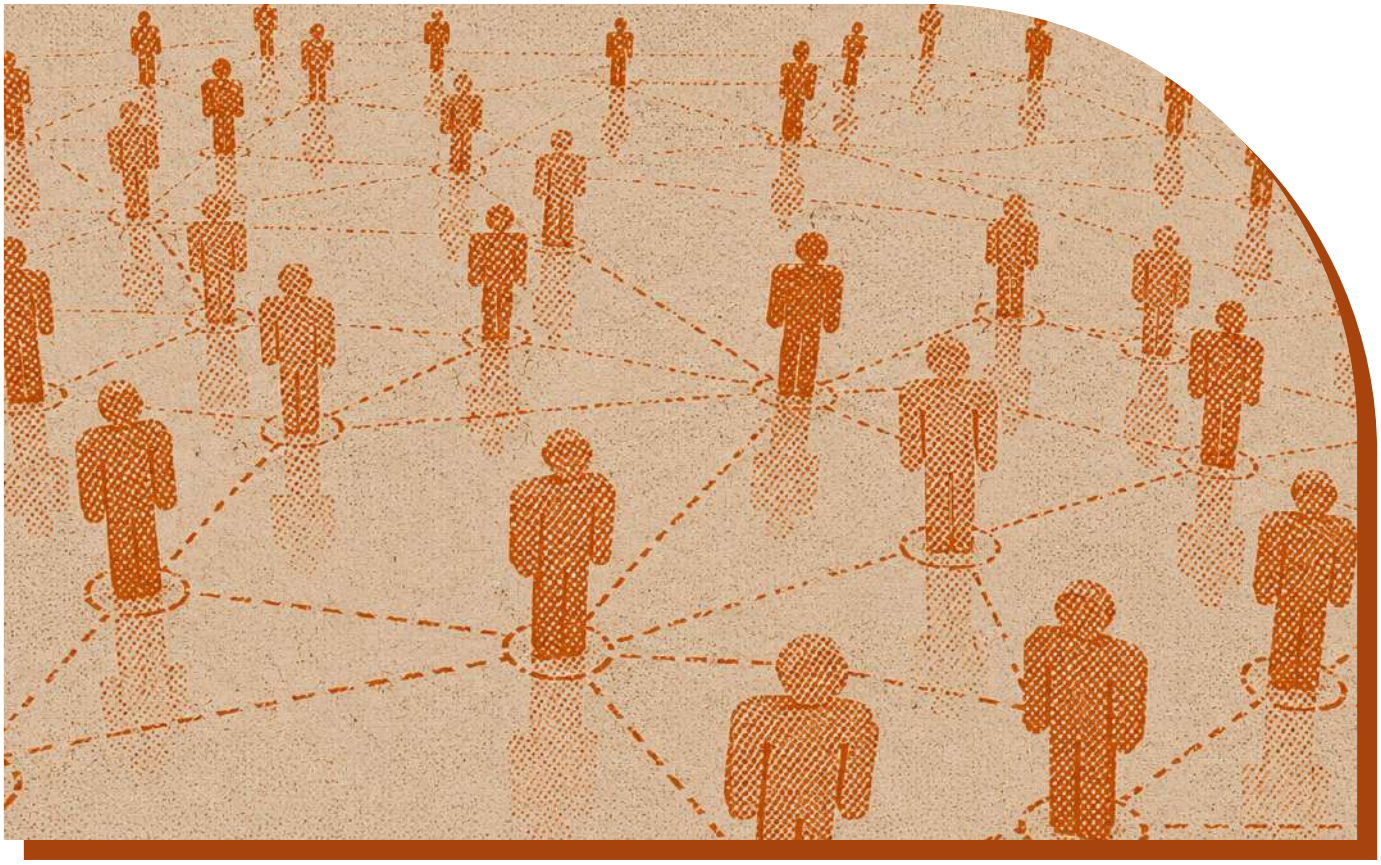


4.9
COLLABORATION STRENGTH INDEX AND CROSS-SECTORAL PATTERNS

The Collaboration Strength Index (CSI=3.68/5.00, N=56, alpha=0.896) was the strongest index overall, indicating that providers broadly report positive inter-sectoral collaboration relationships. Q46r (willingness to collaborate, mean=4.56) and Q51r and Q52r (both above 4.5) were the highest-rated items in the survey. The lowest-rated item in the entire CSI, and indeed in the survey as a whole, was Q49r (data systems to track survivor journeys across sectors, mean=2.20/5.00; 68.6% bottom-box), confirming that while relationships and willingness to collaborate are positive, the operational infrastructure for case continuity is critically absent.

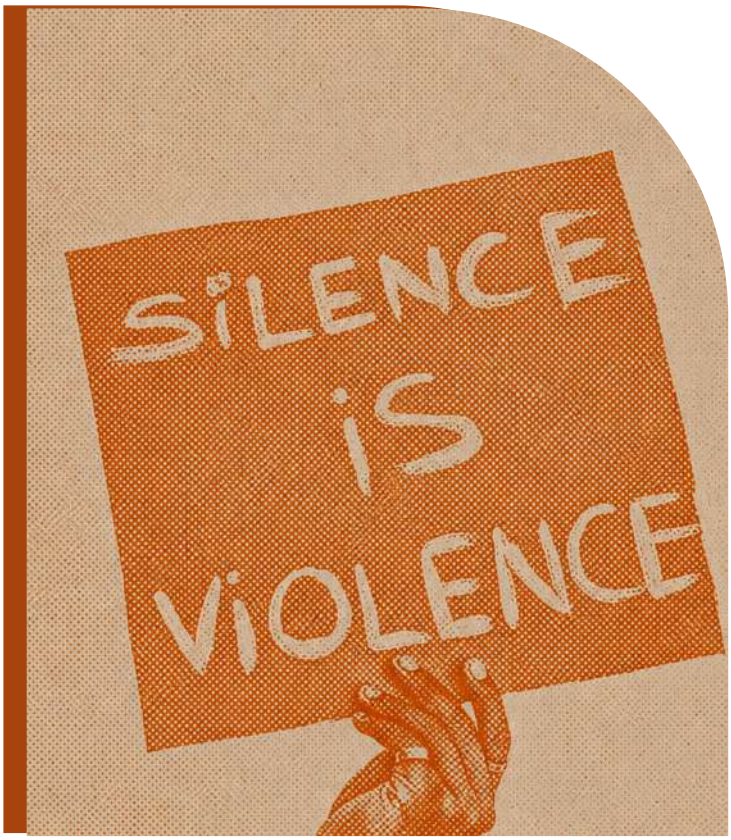
4.10
Qualitative Themes: Cross-Cutting Analysis

The six qualitative themes are presented below. Each narrative is grounded in the full qualitative dataset of 45 participant accounts (P01-P45). Thematic saturation is robust across all six themes. The expanded dataset strengthens analysis of LBT-specific dynamics, faith-sector perspectives, men and boys engagement, and health-sector diversity, each of which was thinly evidenced in the preliminary analysis.



THEME 1:
The Structural Architecture of Silence

Across police, health, legal, and NGO sectors, providers described a GBV landscape in which the conditions for silence are structurally reproduced. The dominant dynamic was economic dependency: financial reliance on an abusive partner suppresses disclosure because reporting threatens the material survival of the survivor and her children. As one health provider observed: 'I think we fail the victim as the perpetrator is the provider and can threaten the dependency of the victim on them as they will no longer provide for them, hence the victim ends up dropping the cases' (P11, health, urban). Multiple police providers described the practical consequence: 'Many cases are withdrawn from the police by the victim' (P05, police, urban), a pattern that statistical data corroborate, with Q33r (mean=4.38) confirming near-universal provider recognition of economic entrapment.



Stigma was the second structural pillar of silence. Providers across sectors described community-level stigma that punishes disclosure: cultural norms frame GBV as a private matter, and women who report are perceived as disloyal or shameful. 'There is stigma, and there is cultural barriers also that put strain on GBV cases as many women are afraid to report incidents of GBV' (P23, NGO, urban). Institutional silence was a third dimension: case withdrawal systems, slow court proceedings, and perpetrators returning on bail before cases are resolved create a message that the system cannot protect survivors who speak. The bail bond system was identified by multiple police providers as a specific structural mechanism that silences survivors: 'We have delays on the legal court proceedings and the perpetrators are given bail bond, hence putting the victim in danger' (P02, police, urban). The statistical evidence confirms the pattern: Q9r (mean=4.14) indicates perceived increasing GBV incidence, while Q8r (mean=3.98) confirms barriers to help-seeking as significant.

Negative case: Not all providers described silence as total. P25 (IGO, 27 years' experience) noted a generational shift: 'I do not think there is as much discrimination among LGBTQ community as it used to be', suggesting evolving norms. This minority position does not contradict the structural analysis but adds temporal nuance.

The expanded dataset adds two analytical dimensions to the silence analysis. First, the procedural deterrence mechanism is specified with greater precision by health and academic providers. A clinic liaison officer described a safety failure that makes health facilities themselves sites of fear for survivors:

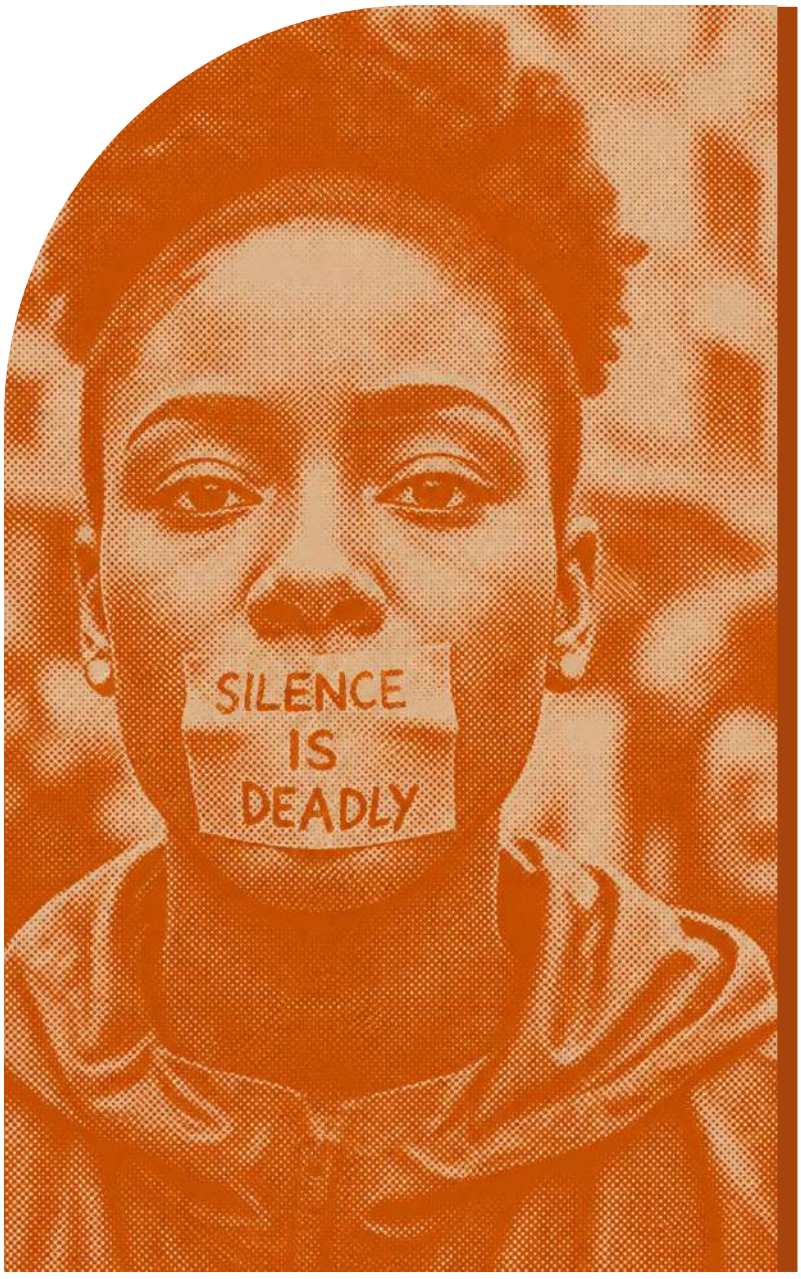
"Limited security in clinics; there has been incidences where perpetrators come to the clinic to attack and intimidate victims" (P37, health, urban)

An academic counsellor with nearly a decade of practice identified the systemic slowness of law enforcement as a structural enabler of silence:

"The law enforcers are not enforcing much of the law maybe due to lack of education from the society, lack of knowledge regresses efforts to combat GBV" (P29, academia/counselling, urban)

Second, the faith-based accounts reveal a dimension of silence that operates at the level of cultural framing rather than institutional barrier. A faith leader described the disclosure gap not as fear of the system but as failure to recognise GBV as a reportable matter at all:

"Most victims do not report hence become a barrier to justice and interventions themselves" (P41, faith-based, urban)



A digital advocacy provider extended this observation to system design: a reporting infrastructure built for a normative survivor will not reach those whose identities, relationships, or cultural contexts are outside its design assumptions (P42, digital advocacy, urban). These additions confirm that the architecture of silence is reproduced through multiple reinforcing mechanisms -- economic, institutional, cultural, and procedural -- each of which requires a distinct response.

THEME 2:
Layered Marginalisation Identity, Stigma, Institutional Hostility



The barriers faced by LBT women were described as qualitatively different from those facing heterosexual survivors: not merely more barriers, but barriers that are embedded in the service system itself. Police providers who might be the first point of contact for any survivor were consistently identified as sources of hostility toward LBT persons: 'The LGBTQI community experience stigma and discrimination by the police' (P05, police, urban); 'The LBT women receive judgement when they come to report a case' (P01, police, urban). This institutional hostility functions as a deterrent before any formal reporting process begins.

LBT-serving providers elaborated on the specific dynamics: 'LBTQI persons do not report cases of GBV as they fear to be judged and stigmatised by the police officers' (P12, legal, urban). The LEGABIBO participants described systemic exclusion: 'Service providers, especially police, are not trained on addressing queer cases' (P27, NGO/LBT, national), and 'The law is silent on LGBTQ communities — Domestic Violence Act, Marriage Act, Public Health Act' (P27). Friends of Diversity providers confirmed: 'Policies favour heterosexual and there is lack of sensitive personnel who assist the LGBTI people when they report cases of GBV' (P21, NGO/LBT, urban).

'Policies favour heterosexual and there is lack of sensitive personnel who assist the LGBTI people when they report cases of GBV'

(P21, NGO/LBT, urban)

Disability-related marginalisation was present across the data, though with less specificity than LBT themes. Disability-focused NGOs noted language and access barriers ('We have a language barrier as many of our deaf clients can't be heard when they experience GBV', P17, NGO/disability), while survey data confirm that 41.5% of providers selected disability inclusion as a priority training need and 32.7% of respondents actively disagreed that their services are physically accessible (Q18r bottom-box). Quantitative triangulation: Q11r (LBT elevated risk, mean=3.87) and Q12r (disability elevated risk, mean=4.37) both indicate majority provider recognition of these groups' heightened vulnerability.

The additional participant dataset deepens the marginalisation analysis in three directions. First, the trans-specific experience emerges as a distinct phenomenon, with identity document conflicts acting as a mechanism of institutional exclusion independent of attitudinal bias:

"It is difficult sometimes for Trans people to access services without being ridiculed because of their conflicting identity with the ID document"

(P35, NGO/LBT, urban)

"It is difficult sometimes for Trans people to access services without being ridiculed because of their conflicting identity with the ID document" (P35, NGO/LBT, urban)

Second, the absence of SOGIESC training was confirmed across all new data sectors as a systemic enabling mechanism for institutional marginalisation. A health provider at a public clinic stated directly that no Key Population training existed at their facility (P32, health, urban), and a Botswana Trans Initiative provider framed SOGIESC training as the foundational structural intervention required before any other LBT-inclusive improvements can be sustained (P34, NGO/LBT, urban). Third, attitudinal bias by service providers was identified not only as an attitudinal failure but as a clinical harm: the Karuza Speaks account documented healthcare workers denying or delaying PEP, PrEP, and STI treatment to LBT survivors based on personal biases (P42, digital advocacy, urban), extending institutional hostility into direct health risk. A social work provider confirmed the systemic dimension:

"The legal and administrative systems fail LBT people, the system is heteronormative and automatically alienates minority and most at risk populations" (P38, NGO/social work, urban)

A positive counter-case is analytically significant: one health facility (P40, health, urban) reported receiving and treating LGBTQ+ patients respectfully, confirming that institutional culture is not fixed. Where leadership actively commits to inclusion, different practice outcomes follow. This positive variance does not contradict the structural analysis but identifies the conditions under which institutional hostility can be reduced.

THEME 3:
The Fragmented Response System

Service providers described a GBV response system that is structurally disaggregated: each sector operates with its own protocols, resource constraints, and institutional priorities, without the integration required to provide coherent support to survivors. The most vivid institutional expression of this fragmentation was the widespread absence of a one-stop service model. Multiple police providers identified this as the critical structural deficit: 'We also lack the one-stop model where we have all stakeholders that work with GBV cases' (P01, police, urban); 'We should have system access, we could change how we receive cases of GBV. We also need to have a One Stop Model on dealing with GBV cases' (P19, NGO, urban).

'We lack infrastructure and resources to effectively conduct investigation into this thing of GBV'

(P01, police, urban)

'We should have system access, we could change how we receive cases of GBV. We also need to have a One Stop Model on dealing with GBV cases'

(P19, NGO, urban).

Resource fragmentation compounded structural fragmentation. Providers across sectors described chronic inadequacy of basic operational resources: police without transport, health facilities without post-rape kits, NGOs without adequate office space, shelters at capacity. 'We lack infrastructure and resources to effectively conduct investigation into this thing of GBV' (P01, police, urban). This resource poverty has direct consequences for service coherence: when police cannot transport survivors to health facilities, and when health facilities have no dedicated GBV space, the inter-agency pathway breaks down at its operational joints.

These additions require a rethinking of fragmentation as a two-dimensional problem: not only the disaggregation of existing formal actors, but the exclusion of community-level actors with significant reach and preventive capacity.

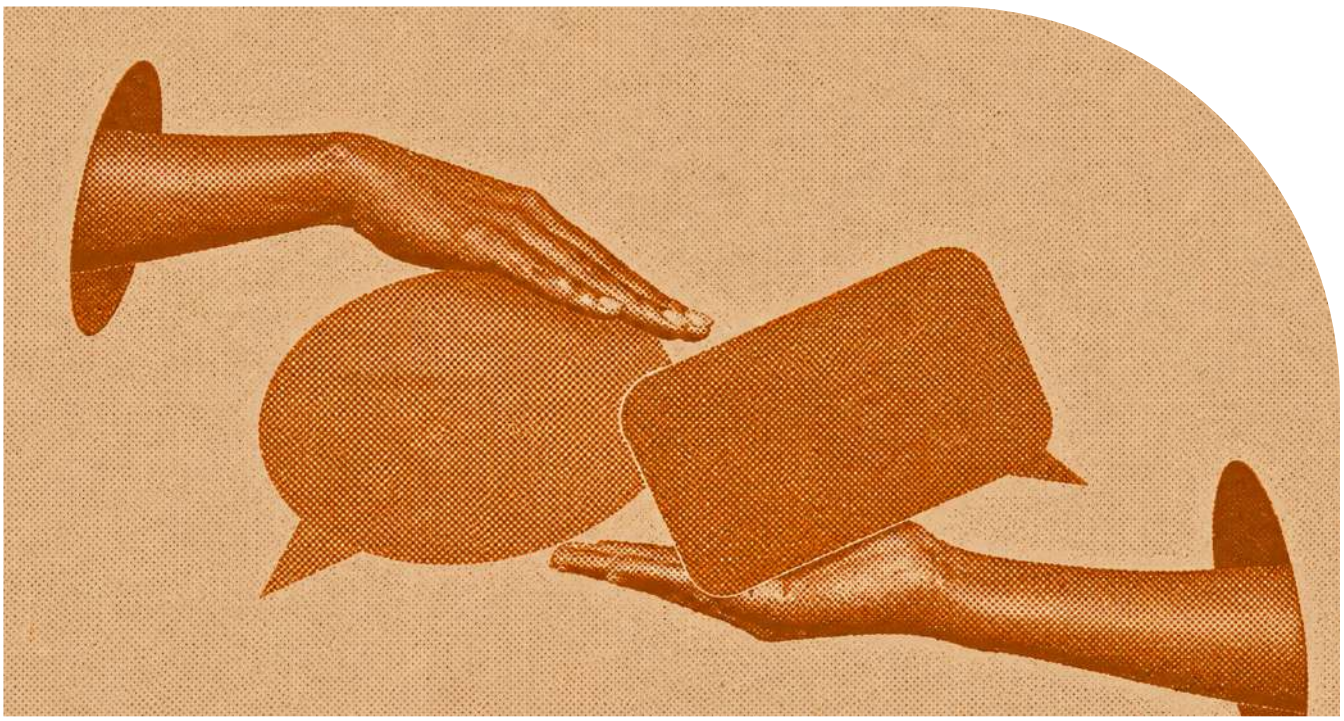
Heteronormative design assumptions were identified as a structural dimension of fragmentation: the default design of services assumes a heterosexual survivor in a cohabiting relationship, rendering LBT GBV, disability-specific needs, and rural inaccessibility as design afterthoughts rather than design requirements. The UNAIDS provider described this as a 'one blanket approach' that fails disaggregated populations: 'Strategies do not profile communities; service providers are not trained to deal with marginalised populations' (P26, UNAIDS, national).

The additional participant dataset also reveals two sectors of the GBV response landscape that were absent from the preliminary analysis: faith-based organisations and men and boys engagement organisations. Both represent significant community reach without integration into the formal GBV response system, constituting a structural gap rather than a peripheral omission.

Faith institutions reach community members that formal GBV services do not reach, yet a minister with over two decades of advocacy experience described the silo mentality that prevents faith institutions from functioning as system assets: "There is a lot of working in SILOs and gatekeeping of funds/grants by CSOs" (P30, faith-based, urban). The same provider confirmed the enabling role of patriarchal church structures: "Normalising abuse and cultural gender norms; even in church most women are open and accepting of male pastors than female pastors" (P30). The Abethu Faith Based Organisation described a complementary gap: faith communities lack the training and infrastructure to respond effectively when GBV disclosures are made to them (P41, faith-based, urban). Faith institutions operating outside formal referral networks means that GBV disclosures made in faith contexts are not systematically channelled toward formal services.

A clinic security failure was identified across multiple health facility accounts: "There has been incidences where perpetrators come to the clinic to attack and intimidate victims" (P37, health, urban). A matron with 27 years of nursing experience confirmed this as a pattern (P33, health, urban). When health facilities the primary entry point for GBV survivors seeking clinical care cannot guarantee physical safety, the deterrent effect on disclosure extends into everyday care settings. Men and boys engagement organisations were confirmed as entirely absent from formal GBV referral networks despite having an explicit prevention mandate and established community reach: "Not seeing the national referral system move forward" (P44, NGO/men and boys, urban). These additions require a rethinking of fragmentation as a two-dimensional problem: not only the disaggregation of existing formal actors, but the exclusion of community-level actors with significant reach and preventive capacity.

THEME 4:
The Broken Referral Chain



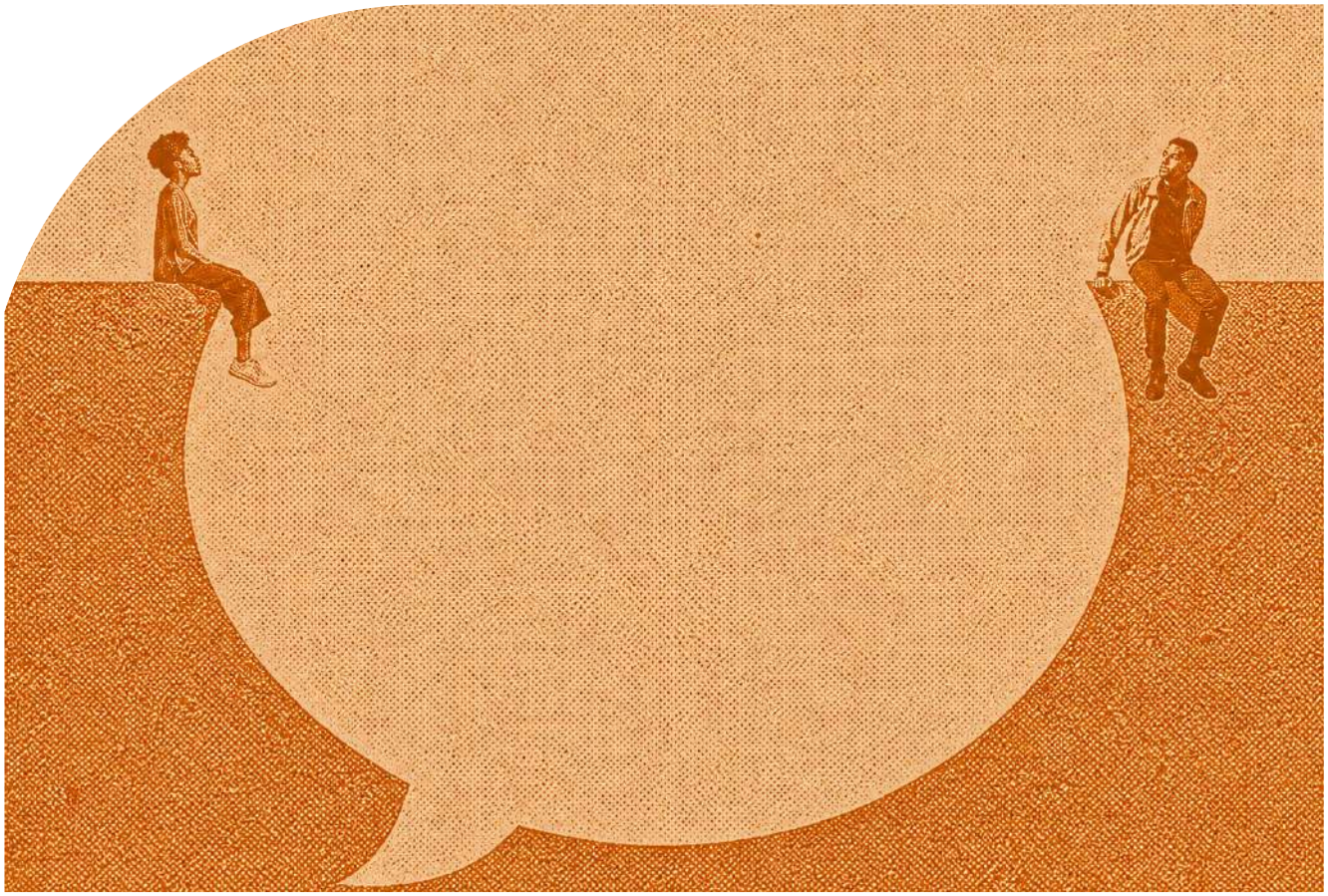
While survey data place the CEI at 3.64/5.00, qualitative accounts describe referral in practice as fragile, inconsistent, and often the point at which survivors are lost from the system. The dominant failure mode was the absence of formal handoff mechanisms and feedback loops. Health providers received no information from police about case outcomes. Police did not consistently know what happened after survivors were referred to health or legal services. Legal providers described delays so significant that survivors disengaged before case completion. 'It takes time to be responded to when we want to refer a victim of GBV, maybe to police or NGOs' (P13, legal, urban).

Secondary traumatisation through referral was also described: survivors being required to recount trauma at each institutional stop, without case notes following them through the system. Q49r (data systems to track survivor journeys, mean=2.20/5.00) is the statistical expression of this failure. With no shared case management system, each institution treats the survivor as a new arrival rather than as a person already in a support process. The burden of this falls on the survivor, who must maintain continuity that the system does not.

A minority counter-case (P07, police, 32 years' experience; P01, police, 13 years) described functional referral relationships: 'We have a good working and referral system with social workers concerning cases of GBV.' These providers tended to be those with long institutional experience and established personal networks across sectors, suggesting that referral effectiveness in the current system is dependent on individual relationships rather than institutional design.

The additional participant dataset adds two structural findings to the referral analysis. First, the absence of a shared case management system was independently confirmed across social work and NGO accounts as the root cause of referral discontinuity: "There is no uniform case management process" (P45, NGO/social work, urban), and collaboration was described as programme-based rather than mandate-based (P38, NGO/social work, urban). This finding explains the CEI paradox: coordination relationships are rated positively because they exist and are valued, while referral outcomes are poor because the relationships do not translate into shared infrastructure, case tracking, or accountability. Digitalisation of referral was identified by a men and boys engagement provider as the systemic intervention most needed to prevent secondary traumatisation through referral: "Digitalisation where the next service provider upon referral can easily access the case and avoid the client from reliving their story" (P44, NGO/men and boys, urban).

Second, transport barriers were confirmed across multiple health and NGO accounts as a structural impediment that breaks the referral chain before it has begun: "Transport challenges police not being able to come pick up the victims" (P31, NGO, urban). The transport failure is most acute at the police-health interface and is most severe in peri-urban and outlying areas. Together, the case management and transport findings confirm that the referral chain is broken at both ends: at the handoff point (no shared records) and at the physical journey point (no transport). Addressing the referral chain requires both a digital case management infrastructure and a funded transport protocol.



THEME 5:
Economic Disempowerment as Structural Entrapment

The relationship between economic dependency and GBV was the most statistically robust finding in the quantitative data (Q33r, mean=4.38; 86.8% top-box) and the most frequently elaborated theme in qualitative accounts. Providers across all sectors described variations on the same dynamic: the abuser is the economic provider; disclosure or departure threatens material survival; survivors return or remain because they have no economic alternative. 'Financial barriers impede us from assisting GBV victims to be financially independent from the abuser' (P12, legal, urban); 'Stereotypes are the main barrier that deter women from being successful in their own right. Also dependence of women on men also contributes to the increase in GBV cases' (P20, NGO, urban).

'We also need to change policy on the socioeconomic laws which disenfranchise women in order to help them to be less dependent on men'

(P20, NGO, urban)



The structural dimension of this entrapment extends beyond individual relationships. Gendered labour market exclusion, women's underrepresentation in property and land rights, and the absence of social protection safety nets create a material landscape in which leaving an abusive relationship means potential destitution. The empowerment programme data reflect the inadequacy of the current response: skills training is by far the most common provision (selected by 26 organisations), but skills without capital access, childcare, and safety do not produce economic independence. 'We need women empowerment so that more women can be independent from the dominance of men' (P10, health, urban); 'We also need to change policy on the socioeconomic laws which disenfranchise women in order to help them to be less dependent on men' (P20, NGO, urban).

The additional participant dataset adds two dimensions to the economic analysis. First, perpetrator economic coercion is specified as an active tactic rather than a structural condition. A social work provider described the deliberate withdrawal of economic support as a coercive mechanism:

"I think we fail the victim as the perpetrator is the provider and can threaten the dependency of the victim on them as they will no longer provide for them" (P45, NGO/social work, urban)

An NGO provider added a court process dimension: slow divorce proceedings leave survivors without economic support for the duration of the case, reinforcing the calculation that remaining in the relationship is financially less risky than leaving it (P31, NGO, urban). This means the legal system, designed to protect survivors, inadvertently reinforces economic entrapment when proceedings are delayed.

Second, the men and boys engagement accounts introduced a preventive economic dimension absent from the preliminary data. The MBGE providers described engagement of men and boys in equitable economic participation as a structural component of GBV prevention, not simply a behavioural one: "Engage men and boys in contribution to prevention of HIV and GBV" (P44, NGO/men and boys, urban). Disrupting the normative equation between masculine authority and household economic control is a structural precondition for reducing coercion-based entrapment. Current programme design almost entirely neglects this prevention dimension, focusing on survivor empowerment without addressing the conditions of perpetrator control that make empowerment insufficient on its own.

"I think we fail the victim as the perpetrator is the provider and can threaten the dependency of the victim on them as they will no longer provide for them"

(P45, NGO/social work, urban)



THEME 6:
What Works Bright Spots in a Challenged System

Despite the pervasive challenges documented in Themes 1-5, the data also identified conditions and practices that constitute effective GBV response. Several specific institutional features were identified as strengths. The Gender and Child Protection Unit within Botswana Police was acknowledged by multiple providers as an important structural advance: 'When we have cases of GBV reported here in our station, we tend to protect the victim and the perpetrator and try to listen to both of them and try assist them by counselling them' (P03, police, GCP unit). Police-NGO collaboration, while inconsistent, was identified as functional in specific contexts: 'We work closely with NGOs, which is very effective and helpful' (P02, police, urban).



NGO capacity for counselling, referral linkages, and specialised support was consistently recognised as a bright spot. The YWCA's comprehensive model was described: 'We provide women empowerment on issues affecting them and we do offer shelter to them when they have GBV cases reported to us. We have different programmes that we have in place to offer support to the people who experienced GBV. We also offer counselling and it's free to the public' (P23, NGO, urban). The existence of legal clinics providing court-order assistance was cited as effective ('We have legal system in place to help victims of GBV and we have relationship with the courts', P13, legal). The conditions for effectiveness identified across the data included: consistent institutional leadership; multi-sector partnership; adequate physical resources; staff with specialised training and personal commitment; and survivor-centred rather than process-centred institutional cultures.

The additional participant dataset reveals four additional bright spots not visible in the preliminary analysis, each representing a distinct sector of effective GBV reach. Youth-friendly health services constitute a structural innovation at clinic level: "Youth friendly services assist with reaching youth, by giving them a safe space to freely access services without shame" (P37, health, urban). The principle of purpose-designed spaces reducing shame and exposure is generalisable to other marginalised populations. An emergency response culture at clinic level provides a second health-sector bright spot: "We always treat GBV cases with emergency and quick response" (P39, health, urban). Combined with this provider's report of treating LGBTQ+ patients respectfully, this account demonstrates that individual facility culture can diverge positively from sector norms where leadership commits to it.

Faith-queer reconciliation represents a strategically significant bright spot in the faith sector. The Abethu Faith Based Organisation's One Body Supplement initiative brought together pastors and queer communities to address the intersection of faith, gender, and sexuality (P41, faith-based, urban), demonstrating that faith-queer partnerships are possible and productive. A BCC provider confirmed the advocacy potential of faith leadership when appropriately trained and supported: "All pastors and faith leaders should be trained to provide necessary and unbiased assistance" (P30, faith-based, urban). These accounts indicate that faith institutions are not uniformly obstacles to GBV response; they are under-resourced actors whose reach and moral authority could be channelled into effective community-level response with appropriate training and integration into formal referral networks.

One Body Supplement initiative brought together pastors and queer communities to address the intersection of faith, gender, and sexuality

(P41, faith-based, urban)

"All pastors and faith leaders should be trained to provide necessary and unbiased assistance"

(P30, faith-based, urban).

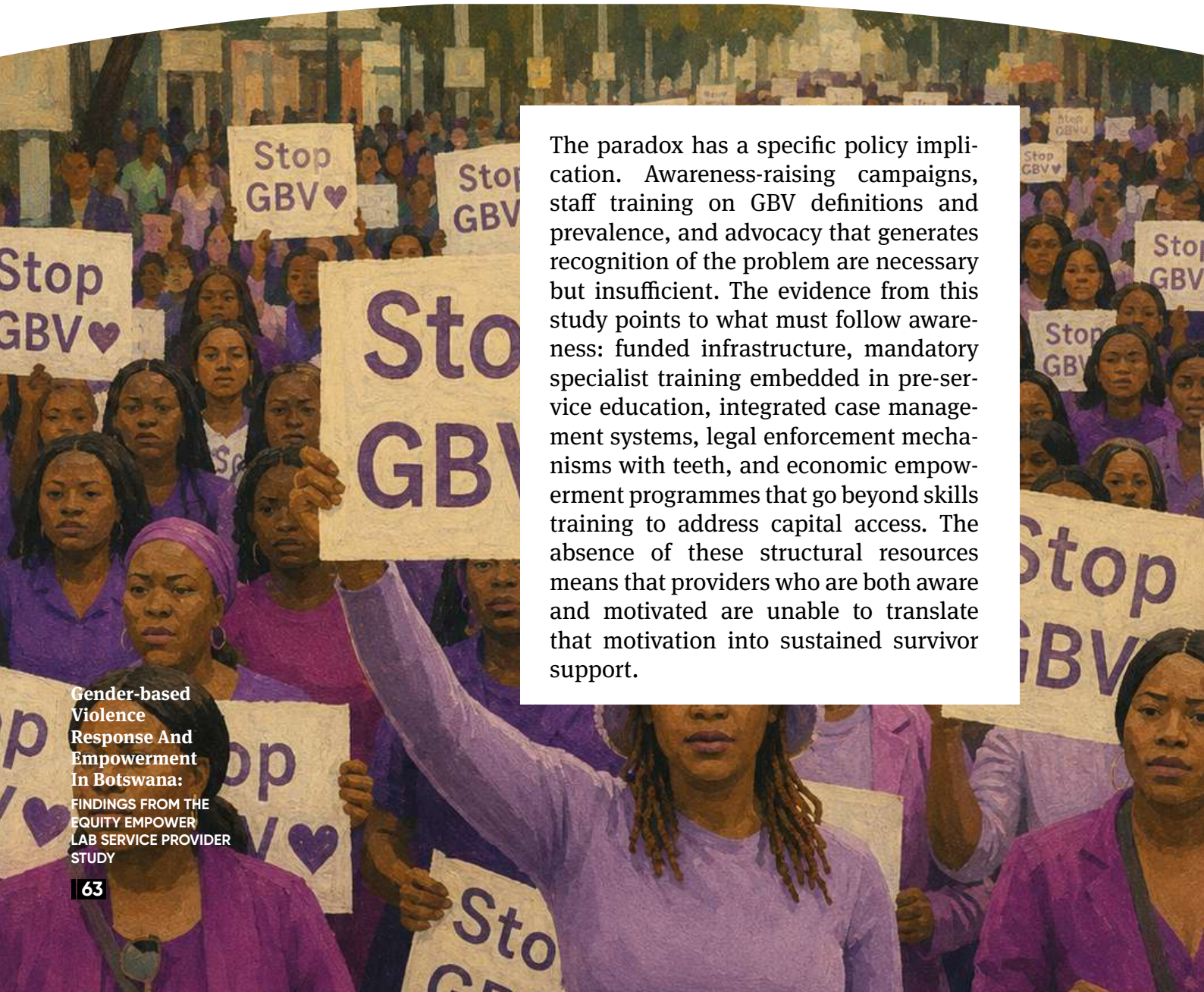
Digital advocacy constitutes a fourth bright spot for populations excluded from formal services. The Karuza Speaks account described using digital platforms to educate LGBTIQ+ communities and hold duty-bearers publicly accountable (P42, digital advocacy, urban). Digital platforms operate in the gap between formal service design and community reach, particularly for LGBTIQ+ survivors for whom formal services remain hostile. Men and boys prevention programming, though absent from current referral architecture, represents an emerging effectiveness domain with demonstrated community reach (P43, P44, NGO/men and boys, urban). These four additions require the bright spots analysis to be extended from a narrow focus on formal institutional effectiveness to include community-level, digital, and faith-based mechanisms that reach populations the formal system consistently fails.



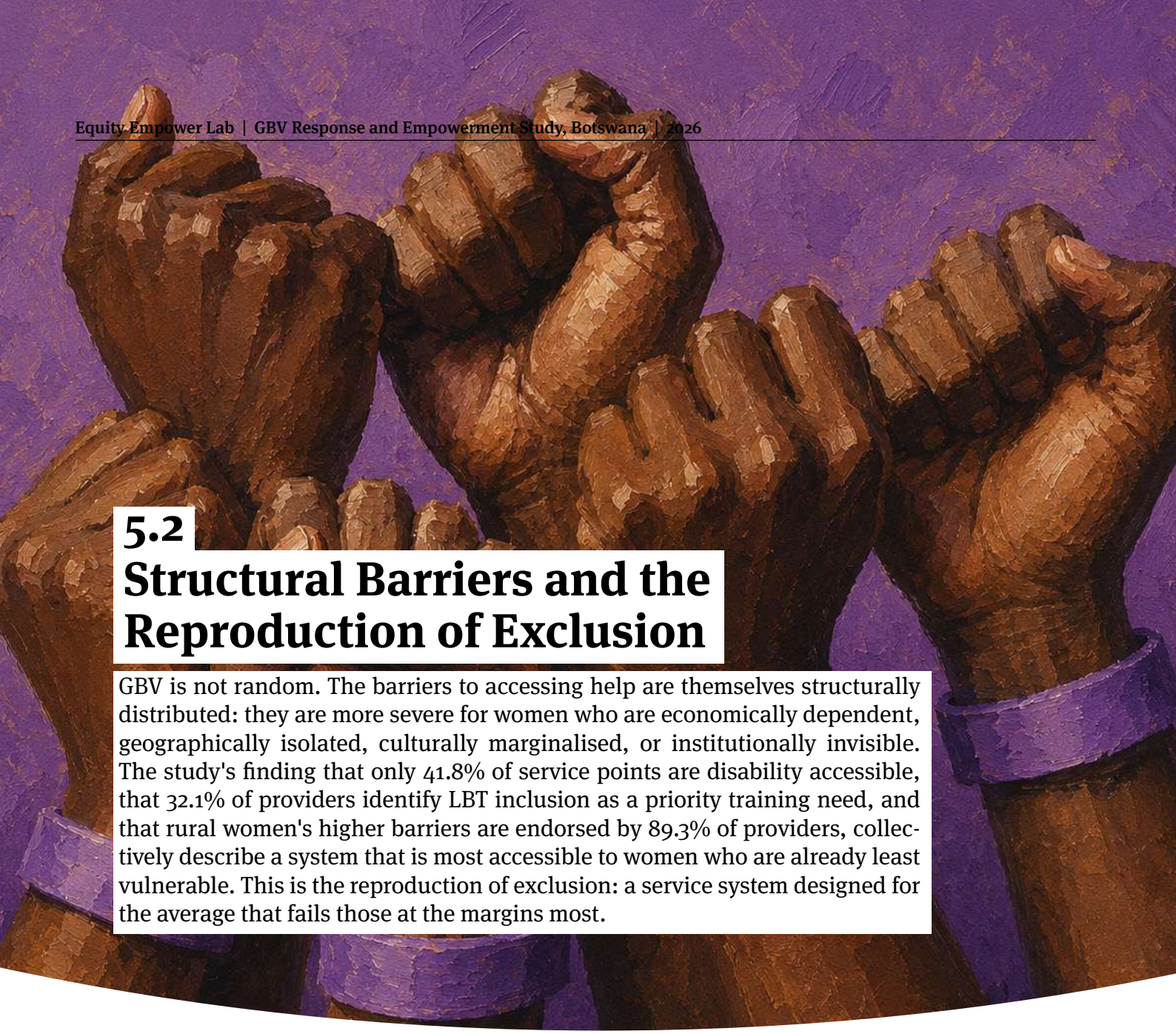
Part 5
DISCUSSION

5.1 The Paradox of Awareness Without Action

Perhaps the most significant finding of this study is the consistency of the gap between knowledge and practice. Service providers know GBV is serious: 94.7% agree it is a major problem. They know survivors face significant barriers: Q23 scored 4.60/5.00. They know LBT women face elevated risk: Q11r endorsed by 65.5%. They know economic dependency is the central structural trap: Q33r at 86.8%. And they know that policies are not being implemented: the 0.71 gap between policy awareness and implementation confidence is both statistically significant and practically damning. This is not a system hampered by ignorance. It is a system hampered by the absence of the resources, structures, and accountability mechanisms that would translate knowledge into action.



The paradox has a specific policy implication. Awareness-raising campaigns, staff training on GBV definitions and prevalence, and advocacy that generates recognition of the problem are necessary but insufficient. The evidence from this study points to what must follow awareness: funded infrastructure, mandatory specialist training embedded in pre-service education, integrated case management systems, legal enforcement mechanisms with teeth, and economic empowerment programmes that go beyond skills training to address capital access. The absence of these structural resources means that providers who are both aware and motivated are unable to translate that motivation into sustained survivor support.



5.2 Structural Barriers and the Reproduction of Exclusion

GBV is not random. The barriers to accessing help are themselves structurally distributed: they are more severe for women who are economically dependent, geographically isolated, culturally marginalised, or institutionally invisible. The study's finding that only 41.8% of service points are disability accessible, that 32.1% of providers identify LBT inclusion as a priority training need, and that rural women's higher barriers are endorsed by 89.3% of providers, collectively describe a system that is most accessible to women who are already least vulnerable. This is the reproduction of exclusion: a service system designed for the average that fails those at the margins most.

Addressing this requires designing from the margins rather than for the average. If the service system is designed to work for LBT women, women with disabilities, rural women, and migrant women, it will by definition also work for all other survivors. The one-stop service model proposed repeatedly by providers in this study is one operational expression of this principle: bringing services to where survivors are, rather than requiring survivors to navigate a fragmented system under conditions of acute vulnerability.

5.3 Intersectional Vulnerability: Compounded Marginalisation

The intersectional feminist framework that guides this study generates a specific analytical claim: the barriers faced by LBT women are not simply an additive combination of the barriers faced by women generally and the barriers faced by LBTIQ persons generally. They are qualitatively different because they are produced by the interaction of gendered violence with a service system that is institutionally organised around heterosexual relationship models. This study's data provide empirical support for this claim: the invisibility of LBT GBV in police data (multiple police providers reporting never having encountered an LBT case), the absence of LBT-specific legal protections, and the explicit fear of police hostility as the dominant barrier to LBT disclosure all describe not a quantitatively larger barrier but a qualitatively different institutional experience.

The same intersectional logic applies to disability. A survivor with a physical disability who cannot access a physically inaccessible police station or health clinic does not simply face one more barrier than a non-disabled survivor: she faces a complete system shut-out at the entry point. The fact that 32.7% of respondents actively disagreed that their services are physically accessible is an indicator that substantial portions of the survivor population simply cannot enter the formal GBV response system.





5.4 4 Economic Disempowerment as the Infrastructure of Entrapment

The study produces what may be its most actionable finding in the economic domain. The gap is not between understanding and action in the abstract: 86.8% know that economic dependency traps survivors, and 87.0% know that economic empowerment is essential to recovery. The gap is between knowledge and resource: skills training is available, but capital, microcredit, savings groups, and job placement are effectively absent. This is not primarily a programme design problem; it is a funding problem. The interventions known to address economic entrapment require sustained funding over medium-to-long timeframes, with individual survivor accompaniment rather than cohort training. The donors and funders who provide the majority of GBV programme funding must recognise economic empowerment not as a supplementary programme but as a core component of GBV response.

5.5
The Policy-Implementation Chasm

The 0.71-point policy-implementation gap is the study's most direct contribution to the policy accountability discourse. Botswana's policy framework is not absent. The Domestic Violence Act, national gender policy, police protocols, and health sector guidelines create a normative architecture for GBV response. What providers report is that this architecture is not consistently operationalised. Court delays, bail conditions that return perpetrators to the same community as survivors, inadequately enforced protection orders, and services that exist on paper but are not resourced in practice all describe a system where policy intent and institutional reality diverge.

Addressing this chasm requires accountability mechanisms that are both formal and functional. Formal accountability requires GBV response standards, mandatory training completion requirements, inspection and audit mechanisms, and case outcome reporting. Functional accountability requires adequate staffing and resourcing so that providers can meet standards, protected reporting channels for providers who identify system failures, and survivor feedback mechanisms. Neither of these accountability architectures currently exists in a coherent, funded form in Botswana's GBV system.



Part 6

CONCLUSIONS AND RECOMMENDATIONS



6.1
Summary Conclusions

The following ten conclusions summarise the study's principal findings. Each is grounded in specific quantitative or qualitative evidence from the study.

1. Botswana's GBV response system operates under conditions of near-universal provider awareness of the problem's severity and near-universal inadequacy in resource provision to address it.

2. Only 34.7% of GBV service providers have received specialised GBV training, creating a workforce that is institutionally present but clinically under-equipped.

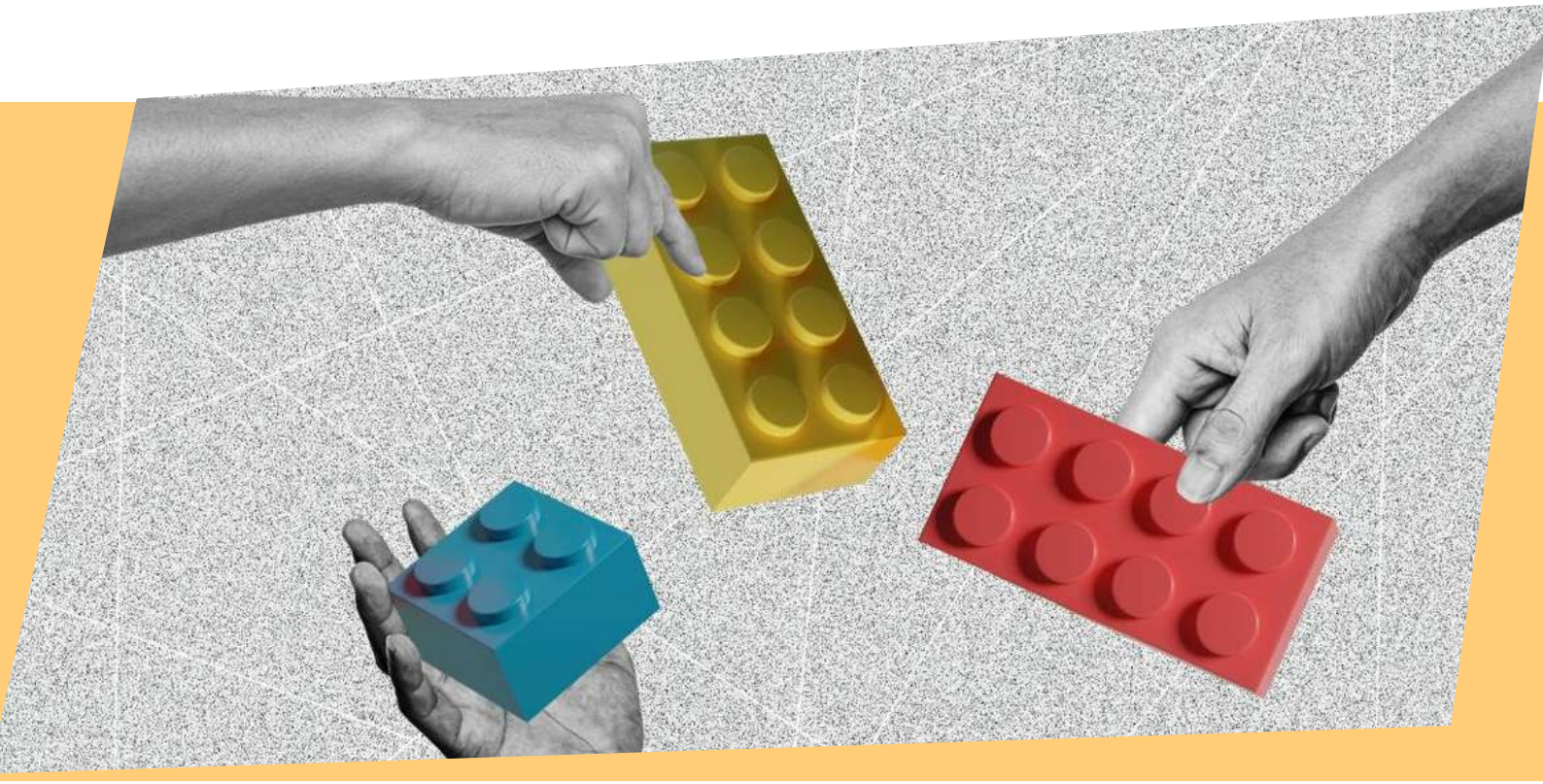
3. Economic dependency is the dominant structural mechanism trapping survivors in abusive relationships, yet economic empowerment provision is fragmented, under-funded, and predominantly limited to skills training without capital access.

4. A 0.71 scale-point gap between policy awareness and implementation confidence is the quantitative expression of Botswana's policy-implementation chasm, indicating that providers know what the policy requires but have limited confidence it is being delivered.

5. LBT women face compounded institutional hostility that renders them effectively invisible to formal GBV data systems, with police providers across the sample acknowledging stigma and discrimination as barriers to LBT disclosure.



6.1
Summary Conclusions



6. More than half of GBV service points lack disability-accessible facilities, systematically excluding a significant portion of the survivor population at the entry point.

7. Inter-agency collaboration is characterised by positive relationships and willingness to coordinate, but undermined by the absence of shared case management infrastructure, feedback loops, and formal handoff protocols.

8. Funding inadequacy was identified as a critical policy gap by 76.3% of respondents the most frequently selected policy gap item indicating that resource insufficiency is the primary constraint on system improvement.

9. Bright spots in the system the Gender and Child Protection Unit, specialised NGO counselling, legal clinic court-order services, and effective police-NGO partnerships demonstrate that effective GBV response is achievable where institutional leadership, specialist training, and adequate resources co-exist.

10.GBV survivors in Botswana encounter a system designed for the average that systematically fails those at the margins: the structurally appropriate response requires designing services that include and prioritise the most marginalised.

6.2 Recommendations

The following recommendations are addressed to four stakeholder groups. Each recommendation is evidence-grounded and assigned a suggested timeframe.

Table 6.1 Recommendations to Government of Botswana

#	Recommendation	Evidence Base	Timeframe
1.	Mandate and fund specialised GBV training for all frontline providers across police, health, and social welfare, embedded in pre-service curricula at police college, IHS, and university programmes	Q19r mean=2.82; 34.7% training coverage	Short-term (12 months)
2.	Establish a national integrated GBV case management and tracking system to enable coordinated survivor follow-through across sectors	Q49r mean=2.20 (lowest-scored item); qualitative accounts of feedback loop failures	Medium-term (24 months)
3.	Allocate dedicated budget for LBT-inclusive and disability-inclusive GBV service infrastructure, including adapted shelter provision	Q49r, Q50r; 52.6% identify shelter gaps; 32.7% lack accessible facilities	Medium-term
4.	Enforce bail and protection order provisions more rigorously, particularly the return of perpetrators to shared communities before case resolution	Qualitative consensus across police, legal, health sectors	Short-term
5.	Initiate revision of the Domestic Violence Act and Public Health Act to explicitly include LBTIQ persons in protection provisions	LEGABIBO qualitative data; Q45_LBTProtection (21.1% identify gap)	Medium-term





Table 6.2 Recommendations to GBV Service Providers

#	Recommendation	Evidence Base	Timeframe
1.	Establish sector-specific peer learning networks to build capacity in trauma-informed counselling, LBT-inclusive practice, and disability competency without waiting for formal government training programmes	Q53cb_Counselling (66.0%); LBT and disability training needs	Short-term
2.	Develop and adopt a standardised inter-agency referral protocol with named case handoff responsibilities, confirmation procedures, and survivor consent at each transition point	CEI=3.64 with qualitative fragmentation; Q49r mean=2.20	Short-term
3.	Conduct organisational GBV policy audits that explicitly assess LBT and disability inclusion in service protocols, physical access, and training requirements	Q11r, Q12r, Q18r; qualitative accounts of exclusion	Short-term
4.	Establish staff wellbeing and secondary trauma support programmes as a standard operational requirement, not an optional addition	Q52r (importance=4.56) vs Q53r (provision=2.78)	Medium-term

Table 6.3 Recommendations to Donors and Funding Partners

#	Recommendation	Evidence Base	Timeframe
1.	Prioritise funding for shelter infrastructure and disability-accessible service facilities as foundational infrastructure, not programmatic add-ons	76.3% identify funding gap; 52.6% identify shelter gap	Immediate
2.	Fund comprehensive economic empowerment programmes that include capital access (microloans, savings groups), not only skills training	Q30r/Q31r means below 3.0; programme type data showing only 2 organisations providing microloans	Short-term
3.	Require LBT-inclusive and disability-inclusive service design as a funding condition, with accountability for inclusive service delivery in reporting frameworks	Q49r, Q50r; qualitative data on LBT exclusion	Immediate
4.	Invest in monitoring and evaluation capacity across the GBV sector, addressing the 22.6% who identify M&E as a priority capacity need	Q53cb_ME; national data system gap	Medium-term

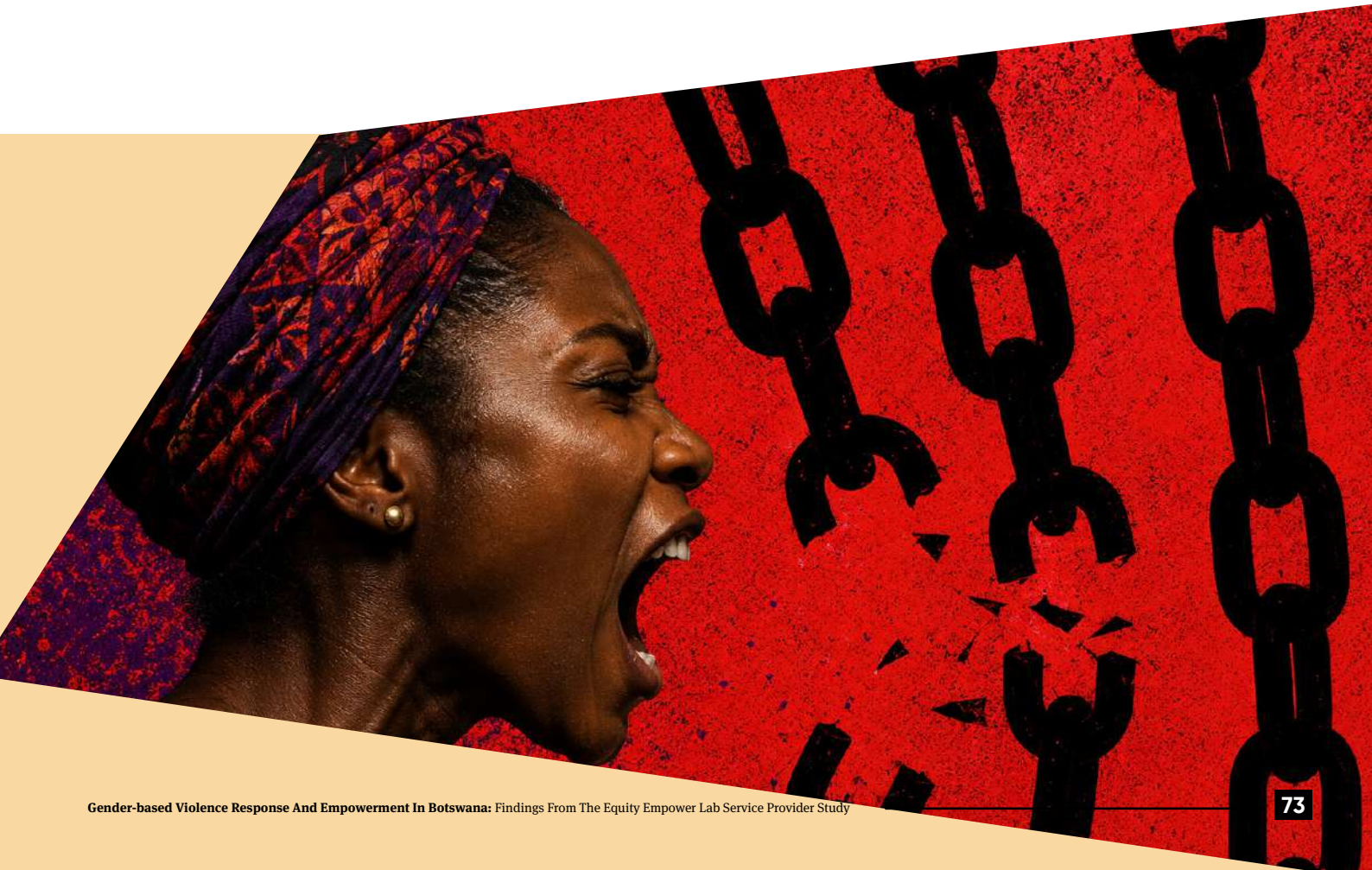




Table 6.4 Recommendations to Civil Society and Advocacy Organisations

#	Recommendation	Evidence Base	Timeframe
1.	Lead community-based GBV awareness campaigns prioritising rural communities and the underreporting gap, using community-led approaches	Q7r=4.58; 24:1 prevalence-to-reporting ratio; Q13r=4.41	Short-term
2.	Advocate for a national multi-sectoral GBV platform that includes community and survivor voice alongside institutional actors, ensuring 'nothing for us without us'	UNAIDS qualitative input; LEGABIBO qualitative input	Medium-term
3.	Document and publish case studies of effective multi-sector collaboration and bright-spot services to support evidence-based advocacy for the one-stop model	Theme 6 findings; GCP unit effectiveness	Short-term
4.	Build coalitions between disability-ocused, LBT-rights, and mainstream GBV organisations to present a unified intersectional advocacy agenda	Themes 2 and 3; Q53cb gaps across categories	Medium-term

6.3
Areas Requiring Further Research

1. A survivor-centred study using participatory research methods with GBV survivors in Botswana, including LBT survivors and survivors with disabilities, to generate evidence that centres lived experience alongside institutional perspectives.

2. A longitudinal follow-up study in 24 months to assess whether the policy-implementation gap has narrowed following the findings of this study and any resulting policy changes.

3. A controlled evaluation of the impact of comprehensive (multi-component) economic empowerment programmes on GBV survivor outcomes in Botswana, addressing the evidence gap on what works beyond skills training.





4. A rural and peri-urban GBV service capacity study replicating this study's methodology in districts outside Gaborone, where the evidence base is entirely absent.

5. An institutional analysis of the conditions enabling GBV response effectiveness, using the bright spots identified in this study as case study sites, to identify replicable models of effective GBV service integration.



6.4
Closing Statement

Gender-based violence is not a problem of individual failure. It is a product of structural conditions: economic inequality, patriarchal norms, institutional inadequacy, legal ambiguity, and resource scarcity. Botswana's service providers who contributed to this study are working under those structural conditions every day. Their professionalism, dedication, and knowledge are not in question. What this study has documented is that their capacity to translate that commitment into sustained, inclusive, and effective survivor support is constrained by structures that policy, funding, and advocacy can change. The evidence is here. The responsibility is collective.

References

ACADEMIC AND RESEARCH SOURCES

Braun, V. and Clarke, V. (2021) Thematic Analysis: A Practical Guide. London: SAGE.

Collins, P.H. (2000) Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment. 2nd ed. New York: Routledge.

Crenshaw, K. (1989) Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics. University of Chicago Legal Forum, 1989(1), pp.139-167.

Crenshaw, K. (1991) Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color. Stanford Law Review, 43(6), pp.1241-1299.

Decker, M.R., et al. (2015) Violence Victimisation, Sexual Risk and Sexually Transmitted Infection Symptoms Among Female Sex Workers in Mexico. Sexually Transmitted Infections, 91(3), pp.226-232.

Grabe, S., et al. (2015) The Role of Women's Economic Empowerment on Violence and Health. American Journal of Community Psychology, 55(3-4), pp.363-374.

Kim, J., et al. (2022) Economic Empowerment and Gender-Based Violence: A Systematic Review. Journal of Global Health, 12(1), pp.1-16.

Schuler, S.R., et al. (2020) Women's Economic Decision-Making Power in Bangladesh and the Risk of Intimate Partner Violence. Social Science and Medicine, 265, 113379.

Sokoloff, N.J. and Dupont, I. (2005) Domestic Violence at the Intersections of Race, Class, and Gender. Violence Against Women, 11(1), pp.38-64.

Policy and Legal Documents

Botswana (2008) Domestic Violence Act, Chapter 08:05. Gaborone: Government of Botswana.

GOV.UK (2024) Country Policy and Information Note: Women Fearing Gender-Based Violence, Botswana, December 2024. London: UK Visas and Immigration. Available at: https://www.gov.uk/government/publications/botswana-country-policy-and-information-notes [Accessed June 2026].

SADC (2021) SADC Protocol on Gender and Development: Progress Report 2021. Gaborone: Southern African Development Community.

Statistical and Data Sources

UNDP Botswana (2024) Gender Based Violence Indicators Study Botswana. Gaborone: United Nations Development Programme. Available at:

https://www.undp.org/botswana/publications/gender-based-violence-indicators-study-botswana [Accessed June 2026].

UNFPA Botswana (2024) The Botswana Gender Based Violence Indicators Study. Gaborone: United Nations Population Fund. Available at: https://botswana.unfpa.org/en/publications/botswana-gender-based-violence-indicators-study [Accessed June 2026].

UNICEF and SADC (2024) Press Release: Improved Legislation, Policies, and Budgets to Address Gender-Based Violence. Gaborone: UNICEF. Available at: https://www.unicef.org/botswana/press-releases [Accessed June 2026].

WHO (2021) Global and Regional Estimates of Violence Against Women: Prevalence and Health Effects of Intimate Partner Violence and Non-Partner Sexual Violence. Geneva: World Health Organization.

Online and Institutional Sources

National Prosecuting Authority South Africa (2021) Thuthuzela Care Centre Programme Report. Pretoria: National Prosecuting Authority.

VOA News (2025) Botswana Records Grim Gender-Based Violence Statistics. Available at: https://www.voanews.com/a/botswana-records-grim-gender-based-violence-statistics [Accessed June 2026].

WHO (2023) GBV Case Management and Referral Systems: Evidence Brief. Geneva: World Health Organization.

