

## Chapter 18

# Integrated Approach to Combating Gender-Based Violence, Botswana

---

### 18.1 Context

Botswana has the second highest HIV prevalence in the world, at 25.4 per cent of its population aged between 15 and 49 years (2012 data) (PEPFAR 2014). The 2013 BAIS IV AIDS indicator study (Government of Botswana Central Statistics Office 2013) showed a strong gender disparity in HIV prevalence, with women at 21 per cent compared with men at 4 per cent (Botswana US Embassy 2014). According to the 2012 Gender-Based Violence Indicator Study, women in Botswana who experience GBV are 50 per cent more likely to be infected with HIV than women in non-violent relationships. More than two-thirds of females in Botswana have experienced some form of GBV in their lifetime, and 62 per cent reported being victims of intimate partner violence.

In 2001, Botswana adopted an Integrated Approach to Combating Gender-Based Violence as a key strategy espoused by the Commonwealth for its elimination. In the Botswana context, it was important that the Integrated Approach address HIV/AIDS, given the mounting evidence showing that these two epidemics intertwine and intensify each other. This case study explores the strategies, outcomes and lessons learned throughout the implementation of this approach in the context of a specific pilot project in two villages, Kasane and Molepolole.

### 18.2 Key institutional actors

In 2007, UNIFEM (now UN Women) supported the national gender machinery to design and implement a project to examine the interconnection between GBV and HIV/AIDS. The project was piloted in the villages of Kasane and Molepolole. The project resulted in the establishment and development of district gender committees and the presence of police gender focal points (GFPs) in all police stations. Local GBV and HIV/AIDS service providers were also involved.

The stage for an integrated approach on these issues was set much earlier when the Integrated Approach was first introduced in 2001. Its main focus was to develop a multisectoral and multidimensional response to GBV by creating an environment where all stakeholders would appreciate and understand the critical role they play. Furthermore, stakeholders would identify their respective contribution in the prevention and response to GBV. Specifically, the approach was intended to address the high incidence of GBV and HIV/AIDS; inadequate police response strategies, mainly in handling GBV cases; minimal level of co-ordination and collaboration on GBV services between relevant organisations and departments in Botswana; and the under-reporting of GBV.

### 18.3 Theory of change

The Integrated Approach draws on good practice for developing integrated and co-ordinated programming that engages multiple sectors across multiple levels. Importantly, it also explores ways of addressing the interrelationship between GBV, particularly VAWG, and HIV/AIDS. The specific pilot project described here sought to remove systemic barriers to access and continuity of treatment for females in the health and social sectors and within legal institutions, along with addressing sociocultural norms that contribute to the incidence of HIV and (Gender Links and Women's Affairs Department 2012) VAWG. The Integrated Approach involves cross-sectoral strategies including legal, healthcare and social services, in addition to economic empowerment. These interventions take place within the context of a strong policy and legislative framework to address GBV and HIV/AIDS, while reinforcing the understanding that policy reforms on their own are not enough to address such issues.

Specifically, the pilot project sought to address formal institutional barriers by establishing referral systems and increasing co-ordination between legal, medical and rehabilitative services for HIV/AIDS and GBV, enabling survivors who access services to be directed to healthcare, police, social services, justice and children's department services without a break in the system. The pilot, in conjunction with wider initiatives, also sought to break down sociocultural barriers through education, awareness and training initiatives, especially among the service providers, to ensure access to services by GBV survivors and, equally importantly, to shift attitudes and behaviours that perpetuate GBV.

### 18.4 Social institutions and discriminatory norms

The World Health Organization (WHO) multi-country study on women's health and domestic violence (2005) indicated that between 24 per cent and 40 per cent of all women experienced physical and/or sexual violence by an intimate partner, including forced sex (WHO 2005). Associating GBV with increased risk of sexually-transmitted infections and HIV/AIDS, the study observed that the risk occurs both through direct infections as a result of rape and coerced sex, and indirectly as a result of females' inability to protect themselves and seek healthcare. Where partner violence and sexual coercion exists, negotiation for condom use or partner's sexual behaviour is difficult, thus further increasing the risk of HIV infection (SVRI 2015).

In such a scenario, creating a deeper understanding of GBV causes and strategies for prevention is as essential as developing health and social sector service responses. Patriarchal notions related to sexuality perpetuate the acceptance of violent partner behaviour when negotiating for safer sex or refusing unwanted intimacy. Men's power over women also influences women's ability to obtain a test for HIV and to seek treatment in case of infection (Jewkes, Dunkle, Nduna and Shai 2010). Prevention strategies need to address the unequal power relations between men and women, and challenge gender norms and practices that put women at a higher risk of exposure to HIV. At the same time, social norms impact on how females who experience GBV

are treated by health and social service providers and legal services. The Gender at Work Analytical Framework provides a basis for mapping the multiple strategies undertaken through Botswana's Integrated Approach:

**Women's and men's consciousness:** Like many other countries in the region, Botswana has invested in mass campaigns against GBV to challenge gender norms that condone or perpetuate violence. At the same time, community level initiatives such as awareness training and intergenerational workshops encourage individuals to reflect on their attitudes about females, violence and sexuality in ways that challenge discriminatory social norms.

**Women's access to resources and opportunities:** There is a commitment to expanding comprehensive, high quality GBV services to survivors throughout the country. Importantly, the underlying causes of females' vulnerability to GBV and HIV are also being addressed (e.g. through economic empowerment programmes that help to lessen women's economic dependence on men, and therefore men's power over women).

**Formal laws and policies:** There is a strong policy and legal framework in place that serves as an accountability mechanism for the Integrated Approach. For example, a strong legal basis for gender equality in marriage has been provided by the Domestic Violence (Amendment) Act (2008) and the Abolition of the Marital Powers Act in 2004 (Botswana Country Statement 2009). In 2007, after the successful participation of millions of civilians in 'Sixteen Days of Activism on Gender Violence', the 'National Action Plan to End Gender Violence' was drafted to continue civic engagement in discussions on intersections of HIV and GBV. Similar policy frameworks exist for HIV/AIDS, including the first and second 'National Strategic Framework' that provides the basis for co-ordinating the work of all stakeholders.

**Informal cultural norms and exclusionary practices:** Community acceptance of norms of masculine behaviour and men's use of power over women promotes power inequality between the genders, and perpetuates GBV and women's vulnerability to HIV/AIDS. Within the overall Integrated Approach there are efforts to increase the awareness of the harmful effects of GBV by supporting development and implementation of community action plans to prevent GBV and mitigate impact. The Women's Affairs Department has also worked in close association with faith-based organisations (FBOs) since 2011, under the theme 'End It Now', to combat acceptance of GBV. By making FBOs stakeholders in the process of developing resolutions and strategies to combat GBV, many traditional notions about gender stereotypes have been challenged.

## 18.5 Strategies

In 2007 the national gender machinery, supported by UNIFEM (now UN Women) designed a project to look at the interconnection between GBV and HIV/AIDS, and this was piloted in the villages of Kasane and Molepolole. The objectives of the project were to investigate the response to GBV and assess HIV/AIDS related services as a

means of better understanding the factors through which GBV intersected with the spread of HIV. Key objectives of the project included:

- Research to investigate the police response to GBV and establish a channel for networking and collaboration between GBV and HIV/AIDS service providers.
- Community dialogue on GBV services.
- Public education on GBV.
- Training and awareness raising on gender, GBV and women's economic empowerment programmes, as well as policies and laws that promote gender equality for GBV and HIV/AIDS service providers, community leaders and gender committees.

The results supported the government in designing more strategic and comprehensive cross-sectoral interventions as well as efforts to create strategic partnerships across all of society:

- Gender committees were established at district and community levels, in all police stations and crime prevention units – a structure responsible for community mobilisation on gender-related issues, particularly GBV.
- The Department of Social Services, Ministry of Health and Ministry of Education engaged community leaders (chiefs, councillors etc.) to raise sensitivity on gender and GBV issues, and to collaborate on community outreach activities.
- The government continued to support rehabilitative organisations, providing psychosocial support and places of safety for survivors of GBV.
- Strategic partnerships were formed with religious structures to campaign against GBV, particularly to reach the church-going community.
- Mobilising men on issues of GBV continued through collaboration with structures such as the HIV and AIDS Men Sector.

## 18.6 Outcomes to date

Among the many outcomes to which the Integrated Approach has contributed, four are emphasised below.

**Police reforms and capacity building:** In response to the pilot project, district gender committees and police GFPs were established in all police stations. Another significant result was the mainstreaming of gender into police work, with a strong component on response to GBV. Key outcomes of the mainstreaming exercise included incorporation of gender within the police training curriculum for both in-service and pre-service training, leading to systematic GBV training for police officers, and the development of tools that facilitate capture of gender-disaggregated data.

Importantly, in 2008 the Domestic Violence Act No. 10 was passed providing survivors of domestic violence with access to HIV prevention, treatment, care and

support services. Police response and ability to refer survivors to appropriate services is paramount.

From 2008 to 2011, about 195 police officers received gender sensitivity training through GFPs. Furthermore, the Police College training module now includes GBV. The Police Department also undertook development and utilisation of a GBV data collection tool to facilitate capturing of sex-disaggregated data. The Police Department started documentation of female sex workers' experiences, in order to be able to provide adequate multi-pointer services. Development of a Police Gender Strategy is ongoing.

**Public awareness, education and training:** Public education and awareness-raising campaigns on GBV were intensified, resulting in the initiation of *Dipitso* (national consultations) on GBV. The results of the feasibility study on the institutional response to and justification for the GBV Referral System were shared and discussed at these consultations, which resulted in national stakeholders endorsing the establishment of such a system. Momentum generated from this process resulted in the resuscitation of civil society action, including the media, towards awareness raising on GBV and related factors. The national consultations also endorsed the establishment of a GBV Referral System through a pilot exercise to establish GBV referral mechanisms, including guidelines, institutional protocols and a national database on GBV.

In 2012, training of *Dikgosi* (community leaders) began in mainstreaming of gender into the customary justice system. Some 112 *Dikgosi* developed a gender-mainstreaming curriculum, with a module on GBV and human rights resolutions, for addressing GBV and gender inequality.

**Integrated research and database:** One key strategy used to address the lack of information on GBV was the regularisation of research on different GBV issues to establish or strengthen baseline information. As an initiative to support the operationalisation of the Domestic Violence Act 2008, research was conducted to identify gaps and challenges that hinder effective implementation of this Act by different service providers. This resulted in the development of regulations to standardise and provide further guidance on its implementation.

The first ever, national study (GBV Indicators Study) to establish the prevalence of VAWG was conducted in 2011–12. This gave rise to a greater demonstration of commitment to addressing GBV and more engagement of stakeholders in government, parastatal and private sector organisations, institutions of learning, non-governmental and community-based organisations, as well as FBOs. This study also served as a springboard for addressing other forms of violation of women's rights, such as unequal rights to inheritance. Together, these initiatives will support monitoring systems to track the incidence of GBV, improve inter-agency management and multisectoral reporting, and monitor achievements of programmes related to GBV.

**Responding to the multiple causes of women's vulnerability to GBV:** Different studies point to the economic dependence of women on men as a factor strongly associated to GBV. The GBV indicator study revealed that economic dependency on

men contributes to women's under-reporting of incidents of violence and withdrawal of reported cases. The dependence of women on men for economic reasons was also identified in the national HIV/AIDS response as a factor that increases the vulnerability of women and girls to HIV infection (Government of Botswana 2008). One of the strategies adopted by the government to address the rising prevalence of such violence due to this factor is increased provision of support for women's income-generating activities for economic independence.

In addition, the government (through the Ministry of Local Government and Rural Development) provides a safety net, including food baskets and facilitation of foster care services, to curb GBV and the HIV/AIDS vulnerability of children from child-headed households. In 2012 and 2013, two National AIDS Council Sectors (Women Sector and Men Sector) developed national HIV/AIDS strategies to address the respective vulnerabilities of women and men to HIV/AIDS and GBV. Additional activities included enrolling men as partners for the promotion of gender equality and elimination of GBV, as well as enrolling prominent males as advocates and creating exclusive platforms for discussing female and male related issues.

## 18.7 Lessons learned and the way forward

Through its various strategies, Botswana has contributed to knowledge building on integrated approaches to dealing with GBV and HIV/AIDS. The reflections of the national gender machinery provide important practical lessons on both the challenges and ways forward in attempting to put into practice the aspiration of working in an integrated and co-ordinated way to address these issues:

- National women's machineries (NWMs) have important knowledge and skill sets that are crucial to integrated approaches to GBV, but they rarely have the resources to direct these processes as effectively as they would wish. Implementing integrated approaches requires NWMs to engage other stakeholders with relevant skills and experience to build capacity or support the process.
- Creating think tanks and multidisciplinary teams, though costly, can help to remedy the absence of models that are specific to the context and realities of each country situation. This also enables the broadest sectoral engagement possible to support fully integrated approaches.
- Complex issues require multidimensional, well-designed and well-funded development programmes. This requires nimble programme management and monitoring with an ongoing assessment of progress, being prepared to adjust programmes when necessary, and a willingness to address significant issues as they emerge.
- As new, unanticipated issues emerge, these need to be prioritised by key stakeholders, keeping in mind the overall scope of the original plan.
- Changes in GBV and HIV, and the gender-related social norms that underpin their prevalence, are not achievable within the timeframe of a typical programme framework. Short-term outcomes like those described in this case study may be

intermediate steps along the way and can contribute to an understanding of how change happens in social norms and behaviours related to GBV.

## References

- Commission of Status on Women (CSW) (2009), 'Botswana Country Statement, 53rd Session of the Commission of Status on Women', New York, available at [http://www.un.org/womenwatch/daw/csw/csw53/statements\\_missions/Botswana.pdf](http://www.un.org/womenwatch/daw/csw/csw53/statements_missions/Botswana.pdf) (accessed 10 October 2015).
- Botswana US Embassy (2014), 'National 16 Days Commemoration 2014', available at: <http://botswana.usembassy.gov/national-sixteen-days-commemoration-2014.html> (accessed on 14 May 2015).
- Gender Links and Women's Affairs Department, Botswana (2012), *Gender-Based Violence Indicators Study Botswana*, available at: [http://www.bw.undp.org/content/botswana/en/home/library/democratic\\_governance/gender-based-violence-indicators-study-botswana.html](http://www.bw.undp.org/content/botswana/en/home/library/democratic_governance/gender-based-violence-indicators-study-botswana.html) (accessed on 20 May 2015).
- Government of Botswana (2008), *Botswana HIV/AIDS impact Survey III RESULTS*, available at: [www.gov.bw/Global/NACA%20Ministry/wana/BAIS%20III\\_Stats%20Press.pdf?epslanguage=en](http://www.gov.bw/Global/NACA%20Ministry/wana/BAIS%20III_Stats%20Press.pdf?epslanguage=en) (accessed on 18 May 2015).
- Government of Botswana Central Statistics Office (2013), 'Botswana Aids Impact Survey (BAIS IV) 2013', available at: [www.cso.gov.bw/index.php/summary-statistics/18-demography/94-botswana-aids-impact-survey-bais-iv-2013](http://www.cso.gov.bw/index.php/summary-statistics/18-demography/94-botswana-aids-impact-survey-bais-iv-2013) (accessed on 18 May 2015).
- Jewkes, R K, K Dunkle, M Nduna and N Shai (2010), 'Intimate Partner Violence, Relationship Power Inequity, and Incidence of HIV Infection in Young Women in South Africa: A Cohort Study'. *The Lancet* Vol. 376 No. 9734: 41–48.
- Sexual Violence Research Initiative (SVRI) (2015) <http://www.svri.org/documents/prevalence-pathways> (accessed on 10th October 2015).
- United States President's Emergency Plan for AIDS Relief (PEPFAR) (2014), *Botswana 2014 Country Operational Plan Executive Summary*, available at: [www.pepfar.gov/countries/cop/240120.htm](http://www.pepfar.gov/countries/cop/240120.htm) (accessed on 14 May 2015).
- World Health Organization (WHO) (2005), *WHO Multi-Country Study on Women's Health and Domestic Violence against Women*, available at: [www.who.int/gender/violence/who\\_multicountry\\_study/Introduction-Chapter1-Chapter2.pdf](http://www.who.int/gender/violence/who_multicountry_study/Introduction-Chapter1-Chapter2.pdf) (accessed on 14 September 2015).