LESOTHO GBV INDICATORS FOLLOW UP STUDY

2025



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GENDER LINKS LESOTHO

Gender Links (GL) is a leading Southern African women's rights organisation that works towards an inclusive, equal and just society for women and girls in all their diversity. Established in 2001 and headquartered in Johannesburg, GL is registered in ten Southern African Development Community (SADC) countries and works through partners in 16 countries across the region. GL Lesotho (GLL) is locally registered and has its own board.

GL coordinates the Southern African Gender Protocol Alliance, advocating for gender equality aligned with the Sustainable Development Goals, and produces an annual barometer tracking progress. The organisation's 50/50 Campaign promotes equal representation of women in politics and local governance, collaborating with 432 councils across the SADC region.

GL's work is organised around three thematic areas:
• Bodily autonomy, health and freedom from violence
• Economic agency and climate justice
• Voice, presence, and power

GBV Indicators Research in Lesotho
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The 2025 Lesotho Gender-Based Violence (GBV) Indicators Follow-up Study is a nationally representative survey of GBV prevalence, causes, effects, responses, support, and prevention across all ten districts of Lesotho. It is the second in a series of GBV Indicators Studies conducted by Gender Links Lesotho (GLL), building directly on the 2013 baseline study. GLL conducted the study in partnership with the Lesotho Bureau of Statistics (LBOS) and the Ministry of Gender, Youth and Social Development, funded by the European Union through a grant to GLL.

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Acronyms

Acronym	Full Term
ACE	Adverse Childhood Experience
ACRWC	African Charter on the Rights and Welfare of the Child
ALET	Association of Lesotho Theologians
Anti-GBV Forum	Anti-Gender-Based Violence Forum (also referred to as the GBV Stakeholders Committee)
ART	Antiretroviral Therapy
BOS / LBOS	Bureau of Statistics / Lesotho Bureau of Statistics
CBO	Community-Based Organisation
CDV Act	Counter Domestic Violence Act (Act No. 4 of 2022)
CES-D	Center for Epidemiologic Studies Depression Scale
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CGPU	Child and Gender Protection Unit (within LMPS)
CRC	Convention on the Rights of the Child
CSO	Civil Society Organisation
DPP	Department of Public Prosecutions
DV	Domestic Violence
DVA	Domestic Violence Act (now enacted as CDV Act 2022)
EA	Enumeration Area
EU	European Union
FBO	Faith-Based Organisation
GBV	Gender-Based Violence
GBVIMS	Gender-Based Violence Information Management System
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit (German development agency)
GL	Gender Links
GLL	Gender Links Lesotho
HIV	Human Immunodeficiency Virus
ICJ	International Commission of Jurists
IPV	Intimate Partner Violence
JTC	Juvenile Training Centre
KoBoCollect	Open-source tablet-based data collection software used in the 2025 field survey
LCA	Lesotho Communications Authority
LCE	Lesotho College of Education
LDHS	Lesotho Demographic and Health Survey
LMPS	Lesotho Mounted Police Service

LGBTIQ+	Lesbian, Gay, Bisexual, Transgender, Intersex, Queer and other gender minorities
MGYSD	Ministry of Gender, Youth and Social Development
Maputo Protocol	Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa
MRC	Medical Research Council (South Africa)
NAP	National Action Plan
NGO	Non-Governmental Organisation
NPSV	Non-Partner Sexual Violence
NUL	National University of Lesotho
OR	Odds Ratio (adjusted, from logistic regression models)
PCL-5	PTSD Checklist for DSM-5
PDA	Personal Digital Assistant (used for data collection in the 2013 baseline)
PEP	Post-Exposure Prophylaxis
PHC	Primary Health Care
PO	Protection Order
PSU	Primary Sampling Unit
PTSD	Post-Traumatic Stress Disorder
PWC	Parliamentary Women's Caucus
RC	Reproductive Coercion
RISE Project	Reform for Inclusion, Support and Empowerment project (EU-funded, launched 2025)
SADC	Southern African Development Community
SIHHBDP-PIU	Sustainable Irrigated Horticulture, Health and Business Development Programme Project Implementation Unit
SDG	Sustainable Development Goal
Seinoli	Seinoli Legal Centre (Lesotho)
SM&D	Sesotho Media and Development
SOA	Sexual Offences Act (Act No. 3 of 2003)
STI	Sexually Transmitted Infection
TFGBV	Technology-Facilitated Gender-Based Violence
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
VAW	Violence Against Women
WHO	World Health Organisation
WILSA	Women and Law in Southern Africa
WG-SS	Washington Group Short Set on Functioning (disability measurement instrument)

Definition of terms
Types of Gender-Based Violence

The following definitions describe the forms of gender-based violence measured in the 2025 Lesotho GBV Indicators Follow-up Study. They are drawn from the study's methodology (Chapter 2), the conceptual and measurement framework (Section 3.2), and the international instruments on which the survey is based.

Gender-Based Violence (GBV)

Any act of violence that results in, or is likely to result in, physical, sexual, or psychological harm or suffering, including threats of such acts, coercion, or arbitrary deprivation of liberty, whether occurring in public or private life.[1] This study adopts the broader term GBV in place of the 2013 baseline term Violence Against Women (VAW), recognising that GBV affects people of all genders while falling disproportionately on women and girls. The 2025 study measures GBV across intimate partner violence, non-partner sexual violence, sexual harassment, technology-facilitated GBV, reproductive coercion, adverse childhood experiences, and child marriage.

Intimate Partner Violence (IPV)

Violence perpetrated by a current or former intimate partner[2], encompassing four sub-types: physical, emotional, sexual, and economic violence. IPV is measured among ever-partnered respondents aged 15 and older. Both lifetime and past-12-month prevalence are reported. The study measures IPV bidirectionally, capturing experience and perpetration for both women and men.

Physical IPV

Acts of physical aggression by an intimate partner, including slapping, pushing or shoving, hitting with a fist or object, kicking, dragging or beating, choking or burning, and threatening with or using a weapon (gun, knife, or other weapon)[3]. Physical IPV is classified as 'moderate' (slapping, pushing, shoving) or 'severe' (hitting, kicking, dragging, beating, choking, burning, weapon use).

Emotional IPV

Non-physical acts by an intimate partner intended to intimidate, control, humiliate, or psychologically harm[4]. Measured acts include insulting or making a partner feel bad about themselves, belittling or humiliating in front of others, deliberately scaring or intimidating, threatening to hurt the partner or someone they care about, boasting about or bringing home other partners, and stopping a partner from seeing friends or family.

Sexual IPV

Sexually coercive or violent acts by an intimate partner. Three behaviours are measured: (1) physically forced sex; (2) having sex because of fear of what the partner might do if refused (coerced sex); and (3) being forced into a sexually degrading act[5]. Sexual IPV operates along a spectrum from implicit coercion through direct force to degradation.

[1] 1993 UN Declaration on the Elimination of Violence Against Women
[2] WHO Multi-Country Study on Women's Health and Domestic Violence; GL GBV Indicators Study methodology
[3] WHO Violence Against Women instrument
[4] WHO Violence Against Women instrument
[5] WHO Violence Against Women instrument

Economic IPV

Acts by an intimate partner that control, exploit, or undermine a person's financial autonomy or access to economic resources. Measured acts include taking a partner's earnings or savings against their will, not giving money for household expenses despite having money, prohibiting a partner from working or earning money, and withholding financial support.

Non-Partner Sexual Violence (NPSV)

Sexual violence perpetrated by someone other than an intimate partner, including a stranger, acquaintance, family member, person in authority, or any other non-partner. Measured acts include: forced sex (rape), attempted rape, gang rape, and other forms of sexual assault[6]. NPSV is measured among all respondents aged 15 and older (not restricted to ever-partnered respondents).

Sexual Harassment

Unwelcome sexual conduct that creates a hostile, intimidating, or offensive environment, occurring in public spaces, workplaces, or educational settings. This includes unwanted sexual comments, gestures, touching, or advances[7]. Sexual harassment is measured among all respondents and is reported separately from IPV and NPSV because it encompasses a range of behaviours that may not constitute assault but create conditions of threat and exclusion.

Technology-Facilitated Gender-Based Violence (TFGBV)

GBV that is carried out, facilitated, or amplified through digital technologies, including mobile phones, the internet, and social media platforms. Measured for the first time in the 2025 study among internet users. Specific acts include online stalking, threatening online messages, non-consensual sharing of intimate images (sextortion), and other forms of digital abuse, including cyberstalking and revenge pornography.

Reproductive coercion

Behaviours by an intimate partner that interfere with a person's autonomous decisions about whether, when, and how to become pregnant or to continue a pregnancy[8]. Three sub-domains are identified: (1) pregnancy coercion, pressuring a partner to conceive; (2) contraceptive sabotage, tampering with or withholding birth control, including being told not to use contraception, destruction of birth control, and removal of a condom during sex; and (3) control over pregnancy outcomes, including forced pregnancy, forced miscarriage, and forced abortion.

Adverse Childhood Experiences (ACEs)

Potentially traumatic events occurring before the age of 18, measured using a standardised instrument adapted from the original US CDC-Kaiser ACE Study[9]. ACE domains include: (1) physical abuse; (2) emotional abuse; (3) sexual abuse; (4) neglect; (5) household dysfunction (parental substance abuse, mental illness, incarceration); and (6) witnessing intimate partner violence between caregivers. ACEs are among the most robust predictors of adult GBV, both as survivors and perpetrators. The study reports both individual domain prevalence and cumulative ACE scores (0, 1, 2, 3, 4+).

[6] WHO Multi-Country Study
[7] ILO Convention 190
[8] Tarzia and Hegarty (2021)
[9] Felitti, V.J. et al. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. American Journal of Preventive Medicine, 14(4), 245-258.

Child marriage

A formal marriage or informal union in which one or both parties are under the age of 18[10]. Classified as a harmful practice and a form of GBV. The 2025 study measures child marriage prevalence as part of the aggregate Any GBV measure.

Any GBV (Aggregate Measure)

A single composite indicator that captures any experience of gender-based violence across all domains measured in the survey: intimate partner violence (physical, emotional, sexual, or economic), non-partner sexual violence, reproductive coercion, sexual harassment, technology-facilitated GBV, and child marriage. A respondent is classified as having experienced 'Any GBV' if they report at least one act across any domain. This comprehensive measure provides the headline prevalence figure (66.7% of women; 46.2% of men).

Lifetime prevalence

The proportion of respondents who report having experienced (or perpetrated) the specified act at least once in their lifetime[11]. Denominators are ever-partnered women and men aged 15 and above for IPV-related measures, and all respondents aged 15 and above for NPSV, sexual harassment, and other non-partner forms of GBV.

Past 12-Month prevalence

The proportion of respondents who report having experienced (or perpetrated) the specified act at least once in the twelve months immediately preceding the survey[12]. This measure captures active, ongoing violence and is a more sensitive indicator of current risk than lifetime prevalence.

IPV Typology (Bidirectional framework)

A classification of intimate partner violence relationships into four mutually exclusive categories based on whether each partner experienced and/or perpetrated violence[13]: (1) Survivor only, that is, experienced IPV but did not perpetrate; (2) Perpetrator only, refers to those who perpetrated IPV but did not experience; (3) Both (mutual/bidirectional), includes both experienced and perpetrated IPV; (4) Neither, means no IPV reported in either direction. This typology replaces the binary victim/perpetrator framing and enables analysis of the overlap between experience and perpetration.

Institutional GBV

Gender-based violence perpetrated within or by institutional settings, including shelters, care facilities, and state institutions.[14] This encompasses abuse of power by service providers, violence between residents in sheltered accommodation, and systemic failures that re-traumatise survivors seeking help.

[10] UNICEF Definition
[11] Standard epidemiological definition
[12] Standard epidemiological definition
[13] Johnson, M.P. (2008). A Typology of Domestic Violence: Intimate Terrorism, Violent Resistance, and Situational Couple Violence. Boston: Northeastern University Press.
[14] Bloom, S. (2008). Violence Against Women and Girls: A Compendium of Monitoring and Evaluation Indicators. Chapel Hill, NC: MEASURE Evaluation/USAID.

Foreword



Twelve years ago, the first Gender-Based Violence Indicators Study conducted by Gender Links Lesotho (GLL) in partnership with the Lesotho Bureau of Statistics confronted this country with an uncomfortable truth: that 86 per cent of women had experienced some form of gender-based violence in their lifetime, and 40 per cent of men had perpetrated violence against women. Those figures were not a condemnation of the Basotho people. They were a call to action, a call that the Government of Lesotho, civil society, the international community, and ordinary Basotho women and men have been answering ever since.

The 2025 GBV Indicators Follow-up Study shows that the call to action has produced results. Lifetime IPV among women has fallen from 62% to 45.7%. Past-year Intimate Partner Violence (IPV) has nearly halved. The previous near-unanimous view that wives should "obey" their husbands has dropped to about one in three women and one in two men. The Counter Domestic Violence (CDV) Act of 2022 enshrines, for the first time in our legal history, protection against domestic violence in all its forms: physical, sexual, emotional, economic, and technology-facilitated. A Parliamentary Women's Caucus with 43 women members has emerged as the most consistent political voice demanding accountability for GBV. These are real achievements, and they deserve to be named.

But progress is not the same as sufficiency, and the 2026 study is unflinching in identifying where Lesotho falls short. Nine in ten women who experience intimate partner violence still do not report it to the police. Fewer than 2% of survivors use shelters; only found in the capital city, Maseru. Key provisions of the CDV Act remain only partially implemented: while a family court mechanism was operationalised within the existing court structure, it was subsequently suspended owing to insufficient judicial capacity, and the Act's regulations, institutional structures, and designated funding streams have yet to be fully established. Although other forensic services remain operational, DNA forensic analysis has been suspended following damage to the national forensic laboratory, requiring specimens for DNA processing to be sent to South Africa pending the procurement of replacement equipment.

The follow-up study is unique in that it not only considers women's experience (and men's perpetration) of violence but also considers men's experience (and women's perpetration of violence). In that sense, this study is truly an interrogation of gender violence, rather than violence against women. The results confirm that GBV disproportionately affects women. But a quarter of men also report experiencing GBV. This too is a call to action. GBV in all its forms must be addressed. Only 12.1% of Basotho adults know that the CDV Act, the law enacted to protect them, even exists. These are not abstract failures. They are failures experienced by specific women and men in specific communities across our ten districts, every day.

As the Ministry of Gender, Youth and Social Development, we receive this report not as a critique but as a roadmap. The recommendations contained in Chapter 10 are structured for accountability: they name the responsible institution, set a timeframe, and specify a measurable milestone so

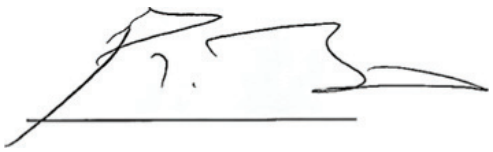
that the 2031 follow-up study can assess what was delivered. We accept the accountability framework. We commit to promulgating the CDV Act's family court rules. We commit to investing in the Anti-GBV Forum as a properly resourced, government-mandated coordination body. We commit to expanding GBV psychosocial support and to developing shelter capacity outside Maseru. And we commit to participating in the Parliamentary Women's Caucus GBV Implementation Tracker as a public accountability mechanism.

These commitments will only hold if they are backed by a budget, monitored by civil society, and held to account by our legislature. The Ministry of Gender, Youth and Social Development welcomes that accountability. We are one actor in a system that includes Government Ministries, Departments and Authorities, traditional and religious leaders, civil society organisations, development partners, the private sector, Academia and, most importantly, the survivors and their families whose experiences this study documents. No ministry can end GBV alone. But every ministry has a defined responsibility, and this report, for the first time, says clearly what that responsibility is, and by when it should be discharged.

I wish to record the Government of Lesotho's deep appreciation to Gender Links Lesotho for producing this landmark study; to the European Union, for the generous funding that made this research possible and to the Lesotho Bureau of Statistics, our indispensable partner in ensuring that these findings are nationally representative and methodologically rigorous. We also thank the enumerators, supervisors, and field teams who collected data across all ten districts in conditions that were sometimes difficult and always sensitive; and to the 4,254 women and men across Lesotho who shared their experiences, including experiences of violence, of shame, of help-seeking, and of resilience, so that the rest of us might understand and act.

The 2013 study set the baseline. The 2025 study measures how far we have come. The test of this report will be what happens before the next study. Let us resolve that the next audit finds fewer gaps. Let us resolve that the next study can record not just the reduction of violence but the construction of a system that reliably protects every Mosotho woman, man, and child from harm.

Honourable Pitso Lesaoana



Minister of Gender, Youth and Social Development
Kingdom of Lesotho

July 2026

Executive Summary



Berea District data collection team poses for a photo before the GBV survey pre-test session, Maseru, November 2025. *Photo: Ntolo Lekau*

Key findings

- Two in three women (66.7%, compared to 86% in 2013) experienced GBV in their lifetime.
- Nearly half of women (45.7%, compared to 62% in 2013) experienced intimate partner violence.
- The 2023-24 LDHS shows that attitudes that justify wife-beating have halved since 2004, 25% of men and 19% of women justify wife-beating under at least one circumstance (down from 51% and 48%).
- Afrobarometer (2022) found that 53% of Basotho view domestic violence as a private family matter rather than a criminal issue.
- CGPU administrative data show high reported case volumes: in the first nine months of 2024, the CGPU recorded 454 adult GBV cases (266 sexual offences; 126 IPV cases) and 364 child GBV cases (284 sexual offences).
- Intimate partners committed at least 47% of murders of women in 2021, underscoring the lethal risk of IPV.
- THUSO (2026) reports that 50% of transgender respondents experienced GBV in the previous 12 months.



"When we first met, everything seemed normal. He was kind, attentive, and affectionate. He spoke about building a future together. I believed him. But slowly, without me realising it, things began to change. The physical abuse began with small incidents. After each incident, he would cry and apologise. I forgave him every time. But forgiveness did not stop the violence. It fed it.

In January 2026, after a severe beating and sexual assault, I gathered the little strength I had and went to my neighbour for help. She saw my injuries immediately. Instead of judging me, she supported me. She accompanied me everywhere: to the hospital, the police station, and the court. Eventually, he was sentenced to 15 years in prison. When I heard the judg-ment, I felt something I had not felt in a long time, relief. It was not happiness, but it was justice."

Retha, 28, Mafeteng

While there has been considerable progress towards reducing gender violence in Lesotho over the last 13 years, the battle is far from won. This is the key finding of the GBV Indicators Follow-up Study conducted by GL Lesotho in 2025, in partnership with the Lesotho Bureau of Statistics (LBOS) and the Ministry of Gender, Youth and Social Development (MGYSD). Key findings include:

- ***Lowered rates of GBV:*** Two in three women (66.7%) compared to 86% in 2013 experienced GBV in their lifetime, according to the latest GBV Indicators Study conducted by Gender Links Lesotho. Nearly half of women (45.7%), compared to 62% in 2013, experienced intimate partner violence. All forms of IPV declined since 2013, emotional IPV saw the largest drop (-18.4 pp).

- ***But these begin at an early age:*** IPV is already prevalent among adolescents aged 15-17, with 21.3% of girls and 18.9% of boys reporting experience of partner violence. Physical abuse before age 15 is the most common childhood adversity, reported by 63.6% of women and 68.7% of men.

- ***And are linked to depression:*** Each additional adverse childhood experience increases depression risk by 19-24%. Two-thirds of women survivors (65.8%) meet the clinical threshold for depression.

- ***Women with disabilities are at greater risk:*** Among ever-partnered women, those with any disability report an IPV prevalence of 50.9%, compared to 44.6% among women without disabilities.

- ***The study documents major LGBTQI+ inclusion gaps.*** No shelters currently accommodate LGBTQI+ or transgender survivors, and CGPU systems record only binary gender categories.

- ***A new dimension of GBV is Technology Facilitated GBV (TFGBV).*** One in five internet users experienced technology-facilitated GBV.

- ***Men also experience GBV:*** A new feature of the study is that it measures violence against men, as well as violence against women. The study finds that over one in four ever-partnered men (28.2%, compared to 66.7% of women) experienced IPV, as survivors only (11.0%) or alongside perpetration (17.2%). While this is lower than the rate among women, it establishes that GBV is not exclusively a women's issue and that men's experience, particularly the overlap between victimisation and perpetration, requires targeted intervention.

- ***GBV is a silent killer:*** Nine in ten women survivors never reported violence to the police. Men's silence mirrors women's - 92.5%

of male IPV survivors did not report to the police, and 90.7% never told anyone. Men who drink alcohol are nearly 3x more likely to perpetrate IPV.

- ***Laws alone are not enough:*** The Counter Domestic Violence Act (2022) has yet to be implemented. Only 12.1% of the population has heard of the CDV Act, reflecting the absence of a structured public awareness campaign following enactment, compounded by ongoing discussions around a proposed amendment.

Context

The Kingdom of Lesotho has made considerable strides in its effort to attain gender equity and equality. It is a signatory to and has ratified the Southern African Development Community (SADC) Protocol on Gender and Development, adopted by Heads of State in August 2008, and has incorporated its provisions into the National Gender and Development Policy 2018-2030.

Lesotho enacted the Sexual Offences Act in 2003, which for the first time set strict penalties for rape and incest and recognised marital rape as a criminal offence. The Legal Capacity of Married Persons Act of 2006 removed the minority status of married women in law. The 2013 GBV Indicators Study identified the absence of domestic violence legislation as a major gap, addressed with the enactment of the Counter Domestic Violence (CDV) Act of 2022, which provides for the protection of victims and the prevention of domestic violence, including economic, physical, sexual, technological, emotional, verbal, and psychological abuse. However, at the time of the 2025 survey, the CDV Act had not yet been implemented.

The 2013 study revealed alarmingly high levels of GBV, with 86% of women reporting lifetime experience of some form of violence against women and 40% of men admitting to perpetration of at least one form of violence.[15]

Building on the methodological foundation of the 2013 study, the 2025 Lesotho GBV Prevalence Study is a nationally representative, cross-sectional household survey conducted among 4,254 respondents (2,565 women and 1,689 men aged 15 and older) across all ten districts of Lesotho.

Conducted in collaboration with the Lesotho Bureau of Statistics and the then Ministry of Gender, Youth, Sports and Recreation, the study employs a multi-stage (three-stage) stratified cluster sampling design with probability-proportional-to-size selection. It applies survey weights to produce nationally representative estimates. The sampling frame covers urban, peri-urban, and rural settlement types as well as the country's four ecological zones (Lowlands, Foothills, Mountains, and Senqu River Valley). Data disaggregation follows this classification throughout the report, and the sample further permits sub-population analysis at the council level, allowing for localised profiling of GBV prevalence.[16] However, a small population (N) in some councils may result in wide confidence intervals.

A fundamental methodological advance in the 2025 study is the inclusion of men's experience of GBV. The 2013 study focused on women's experience and men's perpetration of GBV. The 2025 study captures the experience of, and perpetration by, women and men alike.

[15] Gender Links & Ministry of Gender, Youth, Sports and Recreation (2014). The Gender Based Violence Indicators Study: Lesotho. Johannesburg: Gender Links.
[16] The 2025 study expanded the sampling frame to include respondents aged 15-17 and 55+, whereas the 2013 study was limited to ages 18-49. All comparisons should be interpreted with this methodological difference in mind.

This contributes to a more nuanced understanding of the dynamics of intimate partner violence, including mutual violence and women's use of violence within relationships.

The 2025 study also expands the scope of measurement to include new forms of violence not captured in 2013, namely technology-facilitated GBV (TFGBV) and reproductive coercion (a distinct new indicator, not a sub-category of TFGBV), reflecting the evolving landscape of gender-based violence in an increasingly digital society. For the first time, the study incorporates the Washington Group Short Set on Functioning to assess the intersection of disability and GBV.[17]

This executive summary presents the key findings across five thematic areas: extent of GBV, patterns and drivers, effects, response and support, and prevention.

Extent of GBV

The 2025 study finds that GBV remains pervasive in Lesotho, although certain headline indicators suggest notable shifts since 2013. Table I presents the comparative lifetime prevalence figures across both surveys.[18]

Table I: Extent of Lifetime GBV in Lesotho (2013 and 2025)

Indicator	Women's experience 2013 (%)	Men's perpetration 2013 (%)	Women's experience 2025 (%)	Men's perpetration 2025 (%)
Overall				
Any GBV (lifetime)	86	40	66.7	27.6
Intimate Partner Violence				
Any IPV (lifetime)	62	37	45.7	27.6
Emotional/psychological IPV	52	27	32.5	19.2
Physical IPV	40	26	27.6	15.0
Economic IPV	30	13	22.6	6.2
Sexual IPV	24	10	11.1	4.1
IPV during pregnancy	14	-	6.5	N/A
Past 12 months IPV				
Any IPV (past 12 months)	28	12	14.8	5.4
Non-Partner Violence				
Any NPSV	8	16*	9.2	17.4
Attempted rape	7.9	4.4	5.0	13.1
Sexual harassment (lifetime)	63	-	21.2	10.6
New indicators (2025 only)				
Technology-facilitated GBV	-	-	18.2	20.6
Reproductive coercion	-	-	9.2	5.3

Note: * Men's perpetration figure for 2013 non-partner rape. GBV (2025) = IPV + NPSV + RC + Sexual Harassment + TFGBV + Child Marriage. TFGBV figures are among internet users only (N = 1,232 women; 681 men). IPV and RC figures are among the ever-partnered respondents. Figures may not be directly comparable due to changes in age range (2013: 18-49; 2025: 15+) and expanded definitions.

Source: Lesotho GBV 2013 & 2025 Prevalence Surveys, Gender Links

[17] The Washington Group Short Set on Functioning (WG-SS) is a globally standardised tool developed by the Washington Group on Disability Statistics for use in censuses and surveys. It identifies persons with functional limitations across six domains: seeing, hearing, walking/climbing, remembering/concentrating, self-care, and communicating. Respondents reporting 'a lot of difficulty' or 'cannot do at all' in any domain are classified as having a disability.

[18] GBV (2025) = Any IPV + Non-Partner Sexual Violence + Reproductive Coercion + Sexual Harassment + Technology-Facilitated GBV + Child Marriage. The 2013 measure included IPV, NPSV, and sexual harassment.

Table I (lifetime prevalence) shows that:

- Overall, GBV prevalence among women has decreased from 86% in 2013 to 66.7% in 2025, while perpetration by men has declined from 40% to 27.6%. While methodological differences in age range and an expanded GBV definition preclude direct comparison, the trend suggests a meaningful reduction in GBV prevalence.
- Lifetime IPV remains the most prevalent form of violence, with 45.7% of ever-partnered women experiencing any form of IPV, down from 62% in 2013. Men's self-reported IPV perpetration decreased from 37% to 27.6%.[19]
- Emotional and psychological IPV remains the most common form of violence within intimate relationships (32.5% of women experienced; 19.2% of men perpetrated), followed by physical IPV (27.6% of women; 15.0% of men), economic IPV (22.6% of women; 6.2% of men), and sexual IPV (11.1% of women; 4.1% of men).
- All forms of IPV show declines from 2013 levels, with sexual IPV showing the steepest relative reduction among women (from 24% to 11.1%).
- Any non-partner sexual violence (NPSV) among women was 9.2%, compared to forced non-partner rape at 8% in 2013. The expanded 2025 measure includes forced sex, attempted rape, pressured sex, incapacitated assault, and gang rape. Sexual harassment decreased markedly from 63% to 21.2%, a change that warrants further investigation as it may partly reflect differences in measurement approach.
- IPV during pregnancy affected 6.5% of women who had ever been pregnant, down from 14% in 2013.

2 in 3 Basotho women have experienced gender-based violence in their lifetime, yet 9 in 10 survivors never tell anyone

Changes in IPV prevalence 2013-2025

Tables II and III present a direct comparison of IPV prevalence between 2013 and 2025, restricted to ever-partnered respondents aged 18 and above to ensure comparability with the 2013 study's age range.

Table II: Changes in women's IPV experience 2013-2025 (18 and above)

IPV Type	2013 (%)	2025 (%)	Change (pp)	N (2025)
Any IPV	62	47.0	-15.0	2,159
Physical IPV	40	28.8	-11.2	2,159
Sexual IPV	24	11.4	-12.6	2,159
Emotional IPV	52	33.6	-18.4	2,159
Economic IPV	30	23.6	-6.4	2,159

Note: Denominator: Ever-partnered women aged 18+. 2013 figures from GBV Indicators Study (Gender Links, 2014). 2025 weighted prevalence. Change = 2025 - 2013 in percentage points.
Source: Lesotho GBV 2013 & 2025 Prevalence Surveys, Gender Links

[19] Ever-partnered respondents only. IPV and RC figures are among those who have ever been in an intimate relationship.

Table III: Changes in men's IPV perpetration 2013-2025 (18 and above)

IPV Type	2013 (%)	2025 (%)	Change (pp)	N (2025)
Any IPV	37	28.1	-8.9	1,386
Physical IPV	26	15.2	-10.8	1,386
Sexual IPV	10	4.2	-5.8	1,386
Emotional IPV	27	19.8	-7.2	1,386
Economic IPV	13	6.4	-6.6	1,386

Note: Denominator: Ever-partnered men aged 18+. 2013 figures from GBV Indicators Study (Gender Links, 2014). 2025 weighted prevalence. Change = 2025 - 2013 in percentage points.
Source: Lesotho GBV 2013 & 2025 Prevalence Surveys, Gender Links

Tables II and III confirm statistically significant declines across all forms of IPV for both women's experience and men's perpetration. Among women, emotional IPV showed the largest absolute decline (-18.4 pp), followed by any IPV (-15.0 pp) and sexual IPV (-12.6 pp). Among men, physical IPV perpetration declined most (-10.8 pp), followed by any IPV (-8.9 pp). The consistency of declines across all sub-types strengthens confidence in the overall trend.

Past 12 months prevalence

Women registered 14.8% and men 6.4% of past-year IPV prevalence, compared to 28% and 12%, respectively, in 2013. This halving of past-year IPV suggests that current violence may be declining faster than lifetime measures indicate.

New indicators in 2025

The study introduced a new measure, Technology-facilitated GBV (TFGBV), which affected 18.2% of women and 21.0% of men who use the Internet. Table IV presents the breakdown by type of online violence.[20]

Table IV: Technology-facilitated GBV among internet users

Type of Online Violence	Women (%)	Men (%)	N Women	N Men
Online abuse/threatening messages	9.2	13.5	1,217	681
Online stalking	11.5	10.6	1,217	681
Online sextortion	1.8	1.3	1,217	681
Non-consensual image sharing	0.6	0.7	1,217	681
Fake profile/identity theft	4.2	5.9	1,217	681
Any TFGBV	**18.2**	**21.0**	**1,217**	**681**

Note: Denominator: Internet users only. Respondents could experience multiple forms; categories are not mutually exclusive.
Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

Technology-facilitated GBV affects 18.2% of women and 21.0% of men. Online stalking is the most prevalent form among women (11.5%), while abusive or threatening messages are the most common among men (13.5%). Sextortion and non-consensual image sharing, though less prevalent, were reported by 1.8% and 0.6% of women internet users, respectively. Fake profiles or identity theft affected 4.2% of women and 5.9% of men. Yet among the 364

[20] Technology-facilitated GBV was not measured in the 2013 study. The 2025 figures are among internet users only (N = 1,232 women; N = 681 men).

respondents who experienced online abuse and were asked whether they reported the incident, only 69 (19.0%) did so, while 295 (81.0%) did not. Thematic analysis of their reasons (Section 6.7.2) reveals that the dominant barriers are normalisation (32%), digital self-resolution such as blocking perpetrators (16%), and not knowing where to report (11%), with men five times more likely than women to cite this last barrier.

Reproductive coercion[21], measured for the first time in 2025, was experienced by 9.4% of ever-partnered women and perpetrated by 5.9% of men. The three sub-categories measured are pregnancy coercion, contraceptive sabotage, and control of pregnancy outcomes, following the internationally recognised frameworks.[22]

Forms of violence ranked by prevalence

Table V: Forms of violence ranked by prevalence (2025)

Form of Violence	Women Experience (%)	Men Perpetration (%)
Any GBV (lifetime)	66.7	46.2
Any IPV (lifetime)	45.7	27.6
Emotional IPV	32.5	19.2
Physical IPV	27.6	15.0
Economic IPV	22.6	6.2
Sexual harassment	21.3	10.6
TFGBV (internet users)	18.2	21.0
Any IPV (past 12 months)	14.8	5.4
Sexual IPV	11.3	4.1
Reproductive coercion	9.4	5.9
NPSV	9.4	-
IPV during pregnancy	6.5	-

Note: Sorted by women's experience prevalence (highest to lowest). Denominator varies: GBV lifetime and sexual harassment = all respondents; IPV and reproductive coercion = ever-partnered; TFGBV = internet users. NPSV and IPV during pregnancy do not have male perpetration estimates.

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

Table V reveals a clear severity hierarchy. Emotional IPV is the most prevalent form of partner violence for both sexes (32.5% women, 19.2% men), followed by physical IPV (27.6% women, 15.0% men) and economic IPV (22.6% women, 6.2% men). The gender gap is widest for economic IPV, where women's experience exceeds men's perpetration by a factor of 3.6, suggesting that economic abuse remains particularly under-recognised by male perpetrators.

Technology-facilitated GBV is the only form where men report higher rates than women (21.0% vs. 18.2%), consistent with patterns of online harassment directed at men in digital spaces. The ranking also confirms that recent violence (past 12 months: 14.8% of women) is substantially lower than lifetime prevalence (45.7%), indicating that while many women have experienced IPV at some point, the majority are not currently in violent relationships.

[21] Reproductive coercion was not measured in the 2013 study and is a new addition to the 2025 instrument.
[22] Grace, K.T. & Anderson, J.C. (2018). Reproductive coercion: A systematic review. Trauma, Violence, & Abuse, 19(4), 371-390; Miller, E. et al. (2010). Reproductive coercion: Connecting the dots between partner violence and unintended pregnancy. Contraception, 81(6), 457-459.

Violence involvement typology

A key innovation of the 2025 study is the introduction of a four-group typology of violence involvement among ever-partnered respondents, enabled by the directional measurement approach that captures both experience and perpetration for all respondents. Table VI presents the distribution across the four groups by sex.

Table VI: Typology of violence involvement among ever-partnered respondents

Typology	Women (%)	Men (%)
Neither experienced nor perpetrated	50.4	61.4
Survivor/experienced only	28.8	11.0
Perpetrator only	3.9	10.5
Both experienced and perpetrated	16.8	17.2

Note: Denominator: Ever-partnered respondents. Gender difference is significant ($p < 0.001$). This typology was not available in the 2013 study, which measured only women's experience and men's perpetration. *Source: Lesotho GBV 2025 Prevalence Survey, Gender Links*

Table VI reveals important gender asymmetries in violence involvement. Women are far more likely to be survivors only (28.8%) than perpetrators only (3.9%), while among men, the pattern is more evenly split between experiencing (11.0%) and perpetrating (10.5%) IPV. Notably, similar proportions of women (16.8%) and men (17.2%) report both experiencing and perpetrating violence, highlighting the bi-directional nature of IPV in a substantial minority of relationships

Patterns and drivers of GBV

To answer the question of what is driving violence in Lesotho, the 2025 study employs the ecological framework (Heise, 1998) to examine risk factors for the experience and perpetration of IPV at individual, relationship, community, and societal levels. The study identifies **five key drivers** of GBV in Lesotho, ranked by strength of association and evidence base. These drivers operate at the individual, relationship, and societal levels and often interact to elevate risk.

1) ***Childhood adversity*** emerges as the strongest predictor of adult violence. The dose-response relationship[23] is pronounced. Women with four or more Adverse Childhood Experiences (ACEs) have an IPV prevalence of 66.7%, compared with 23.4% among those with no ACEs, a nearly threefold increase. Men follow an identical gradient, with 46.4% perpetration prevalence among those with 4+ ACEs versus 13.8% among those with none. This intergenerational pathway is among the most consistent findings in the global GBV literature[24] and warrants early intervention.

[23] A dose-response relationship in epidemiology means that as the level of exposure increases, so does the magnitude of the outcome. The concept was established in ACE research by Felitti, V.J. et al. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. American Journal of Preventive Medicine, 14(4), 245-258. See also Fulu, E. et al. (2017). Pathways between childhood trauma, intimate partner violence, and harsh parenting. The Lancet Global Health, 5(5), e512-e522; Hughes, K. et al. (2017). The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis. The Lancet Public Health, 2(8), e356-e366.

[24] See e.g. Fulu, E. et al. (2017). Pathways between childhood trauma, intimate partner violence, and harsh parenting: findings from the UN Multi-country Study on Men and Violence in Asia and the Pacific. The Lancet Global Health, 5(5), e512-e522; Hughes, K. et al. (2017). The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis. The Lancet Public Health, 2(8), e356-e366.



LMPS launched a Men's Forum Movement against GBV at SOS Children's Home. *Photo: LMPS*

2) ***Alcohol and substance use:*** Men who drink are nearly three times more likely to perpetrate IPV (87.0% of perpetrators are drinkers versus 66.6% of non-perpetrators). Drug use shows similar associations: 35.6% of male perpetrators have used drugs compared to 19.8% of non-perpetrators. The dose-response pattern[25] suggests that substance use is not merely associated with violence but actively increases risk, likely through disinhibition, impaired judgment, and aggression amplification.
3) ***Gender attitudes and rape myths:*** A quarter of men (27.7%) score high on the gender attitudes scale (endorsing multiple patriarchal beliefs), and 19.8% hold high acceptance of rape myths. These attitudes directly correlate with higher IPV prevalence. Encouragingly, gender attitudes have shifted dramatically since 2013. The agreement that a wife should obey her husband fell from 97% to 33,9%, suggesting that attitude change is possible at a population scale.
4) ***The community norms gap:*** Individuals consistently perceive their communities as more conservative than they themselves are, with a gap of -1.60 for women and -0.66 for men. This misperception sustains harmful behaviours by making individuals believe violence is normative when community attitudes may have shifted.
5) ***Relationship and structural factors:*** Separated women report the highest IPV prevalence (68.9%), followed by never-married women (57.5%). Counter-intuitively, employment is associated with higher IPV prevalence (51.3% for employed women versus 43.5% for unemployed), suggesting that economic independence within relationships may trigger controlling or violent responses[26] (the male backlash hypothesis).

Individual factors

Table VII presents the socio-demographic factors associated with IPV in 2025. In 2013, women aged 30-44 had the highest IPV experience rate (65.4%, p = 0.001); lower education was significantly associated with IPV (64.5% vs 50.3%, p <0.001), whereas employment status was not significantly associated with IPV.[27]

[25] ibid
[26] This is consistent with the 'male backlash hypothesis', which posits that women's economic empowerment may provoke controlling or violent responses from partners who perceive their traditional breadwinner role as threatened. See Vyas, S. & Watts, C. (2009). How does economic empowerment affect women's risk of intimate partner violence in low and middle-income countries? A systematic review of published evidence. Journal of International Development, 21(5), 577-602; Heise, L. & Kotsadam, A. (2015). Cross-national and multilevel correlates of partner violence: An analysis of data from population-based surveys. The Lancet Global Health, 3(6), e332-e340.
[27] Weighted prevalence estimates computed from the 2025 dataset (N = 4,190 complete observations). Survey weights applied, but confidence intervals not shown; see Chapter 4 for the full table with CIs.

Table VII: Socio-demographic factors associated with IPV (2025)

Factor	Women Experience (%)	Men Perpetration (%)	Men Experience (%)	Women Perpetration (%)
Age group				
15-17	21.3	13.7	18.9	17.0
18-24	38.9	22.0	23.2	16.4
25-34	49.1	23.3	26.4	26.5
35-44	47.5	37.2	35.3	22.2
45-54	50.7	29.4	32.8	22.9
55+	47.7	27.4	25.1	17.2
Marital status				
Never married	57.5	38.9	44.2	24.6
Married	46.8	31.2	28.4	22.7
Living together	31.7	21.6	24.3	15.1
Separated	68.9	29.9	38.4	38.9
Divorced	52.2	26.1	28.6	17.9
Wealth quintile				
Poorest	42.5	23.2	29.4	22.8
Poorer	42.6	26.8	30.8	22.2
Middle	48.6	29.5	25.0	20.5
Richer	55.5	30.2	30.3	22.6
Richest	40.9	29.8	24.1	14.9
Employment				
Not employed	43.5	24.2	23.8	19.1
Employed	51.3	32.3	34.1	24.8
Disability				
No disability	44.6	27.7	28.3	21.0
Any disability	50.9	27.0	27.3	20.2

Note: Weighted prevalence among ever-partnered respondents. Exp. = experience of IPV; Perp. = perpetration. See Chapter 4.
Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

Table VII shows that:

- ***Age:*** IPV experience among women peaks at ages 45-54 (50.7%) and 25-34 (49.1%), while among men, experience peaks at 35-44 (35.3%) and perpetration also peaks at 35-44 (37.2%). Notably, even adolescents aged 15-17 report significant IPV experience (21.3% of girls; 18.9% of boys), underscoring the early onset of violence in intimate relationships.
- ***Marital status:*** Separated women have the highest IPV experience rate (68.9%), followed by never-married women (57.5%). Among men, never-married respondents report the highest rates of both experience (44.2%) and perpetration (38.9%). Cohabiting couples report the lowest IPV rates for both genders.
- ***Wealth:*** The relationship between wealth and IPV is not linear. Among women, the richer quintile shows the highest experience rate (55.5%), while the richest quintile has the lowest (40.9%). Among men, perpetration is relatively uniform across quintiles (23.2%-30.2%), suggesting that economic status alone is not a strong determinant of violence.
- ***Employment:*** Employed women are more likely to experience IPV (51.3%) than unemployed women (43.5%), and employed men are more likely to both experience

(34.1%) and perpetrate (32.3%) IPV. This pattern may reflect the dynamics of economic independence within relationships.

- ***Disability:*** Women with any disability report slightly higher IPV experience (50.9% vs 44.6%), while disability shows minimal difference for men. This finding warrants further investigation, given the global evidence of heightened vulnerability among persons with disabilities.[28]

Geographic patterns

IPV prevalence varies substantially across Lesotho's ten districts, underscoring the need for geographically targeted interventions[29]. Table VIII presents the district-level breakdown for women's experience and men's perpetration of any IPV.

Table VIII: Lifetime IPV prevalence by district

District	Women Experience (%)	Men Experience (%)	Men Perpetration (%)	Women Perpetration (%)	N Women	N Men
Mohale's Hoek	65.0	24.5	14.1	33.3	219	112
Quthing	51.2	38.8	43.3	19.3	177	118
Mokhotlong	49.5	35.8	39.1	22.9	169	102
Berea	47.8	23.8	16.3	21.9	267	174
Leribe	46.8	33.9	31.9	16.5	321	199
Maseru	44.5	21.0	22.1	21.6	401	286
Botha-Bothe	44.2	38.9	47.6	20.6	203	124
Qacha's Nek	40.4	26.0	19.1	7.0	157	102
Thaba-Tseka	33.8	24.1	37.1	12.9	171	86
Mafeteng	27.5	42.7	43.3	17.4	225	132
National	**45.7**	**28.2**	**27.6**	**20.7**	**2,310**	**1,435**

Note: Sorted by women's experience prevalence (highest to lowest). Denominator: ever-partnered respondents. Some district estimates have wide confidence intervals due to small sample sizes; interpret with caution. *Source: Lesotho GBV 2025 Prevalence Survey, Gender Links*

Table VIII reveals a nearly 2.4-fold gap between the highest and lowest districts for women's IPV experience. Mohale's Hoek (65.0%) and Mafeteng (27.5%). The capital, Maseru, is near the national average (44.5%). Notably, the gender dynamics differ markedly across districts. For instance, in Mafeteng and Butha-Buthe, men's perpetration rates exceed women's experience rates, suggesting distinct patterns of violence reporting or relationship dynamics. Settlement type analysis shows minimal variation (urban 47.2%, rural 44.6%, peri-urban 45.3%), while the Senqu River Valley ecological zone records the highest prevalence (49.7%).

These geographic differences reflect district-specific social and institutional conditions rather than a simple rural-urban divide. Mohale's Hoek's elevated prevalence is associated with high male labour migration, traditional cattle-based economies, and limited formal GBV

[28] Disability measured using the Washington Group Short Set (WG-SS): reporting 'a lot of difficulty' or 'cannot do at all' in one or more functional domains (seeing, hearing, walking, concentrating, self-care, communicating).

[29] Where district-level prevalence figures are presented in this report, readers should note that some districts have small sample sizes that produce wide confidence intervals. Mokhotlong, Qacha's Nek, and Thaba-Tseka districts have the smallest samples, and prevalence figures for these districts should be treated as indicative rather than precise estimates. Where district-level differences are discussed, only those that are statistically significant are characterised as such; all other district comparisons are described as observed differences that may reflect sampling variability.

response services, a finding corroborated by the 2025 WFP national service mapping. Quthing and Mokhotlong, the second and third highest districts, are geographically remote with mountain populations, limited road access, and constrained access to health and legal services. In Mafeteng, the paradox of low women's experience (27.5%) alongside high men's perpetration (43.3%) points to suppressed female disclosure rather than genuinely lower prevalence, a pattern warranting targeted qualitative investigation. The analysis indicates that programme targeting should shift from a rural-urban frame to a district-specific approach that addresses local economic conditions, the availability of services, and community-level norms.

Childhood Adversity

The 2025 study measures childhood adversity using the Adverse Childhood Experiences (ACE) framework, expanding on the 2013 analysis of child physical abuse, sexual abuse, and neglect.[30]

Table IX: Childhood adversity by gender

ACE Domain (before age 15)	Women (%)	Men (%)	p-value
Physical abuse	63.6	68.7	0.062
Emotional abuse	32.9	33.5	0.761
Neglect	31.6	30.2	0.485
Household dysfunction	26.2	24.0	0.322
Witnessed domestic violence	21.9	14.1	< 0.001
Sexual abuse	14.4	14.5	0.970
Mean ACE score (0-6)	**1.91**	**1.85**	**0.465**

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

Childhood physical abuse remains the most prevalent form of adversity, reported by 63.6% of women and 68.7% of men. The only significant gender difference was in witnessing domestic violence before age 15, which was more commonly reported by women (21.9%) than men (14.1%, $p < 0.001$). The mean ACE score was comparable across genders (1.91 for women; 1.85 for men).

In the 2013 study, child physical abuse, sexual abuse, and neglect were all significantly associated with men's perpetration of IPV. Men who experienced child sexual abuse were particularly likely to perpetrate IPV (54%) and non-partner rape (35%), compared to 32% and 10%, respectively, among non-survivors. The 2025 analysis confirms these intergenerational pathways through the dose-response relationship between ACE scores and both IPV experience and perpetration.



Thandiwe Hlelesi and Ntsekiseng Thetsane enjoy a light moment with CGPU police officers in Quthing. *Photo: LMPS*

[30] Childhood adversity measured using the Adverse Childhood Experiences (ACE) framework with six domains: emotional abuse, physical abuse, sexual abuse, neglect, household dysfunction, and witnessing domestic violence, all before age 15.

Gender Attitudes

The 2013 study documented deeply entrenched patriarchal attitudes across a range of gender-related statements. Table X presents the 2013 and 2025 findings side by side for each attitude item, revealing the extent of attitudinal change over the twelve years.

Table X: Gender attitudes - percentage agreeing (2013 and 2025)

Statement	Women 2013	Women 2025	Men 2013	Men 2025
Gender relations				
A woman should obey her husband	97	33.9	96	49.2
A woman should give her money to her husband	-	58.0	-	67.6
A man should have the final say in family matters	73	39.4	67	60.9
A woman and a man should share household work equally.	-	76.3	-	77.8
A woman needs her husband's permission to do paid work	81	66.0	83	74.3
A woman cannot refuse sex with her husband	55	38.6	58	39.7
Children belong to a man and his family.	-	36.2	-	50.2
Nothing wrong with a married man having girlfriends	15	24.5	18	17.2
A man has the right to punish his wife	26	10.6	41	16.5
If a man pays bohali, he owns his wife	42	32.4	45	40.5
If a man pays bohali, he is entitled to sex	39	22.5	45	30.1
If a man beats you, it means he loves you.	-	4.8	-	9.9
Women and men should be treated equally.	-	74.2	-	64.6
Rape myths				
A rape survivor is to blame for the rape.	-	11.1	-	18.2
Women who are raped ask for it.	-	17.4	-	23.9
If she doesn't fight back, it is not rape	25	19.5	23	19.5
A husband can rape his wife	45	48.0	44	44.4
Rape victim must be promiscuous	40	26.1	39	37.5
Summary scores				
High gender attitudes score (% accepting)	-	19.4	-	27.7
High rape myths score (% accepting)	-	14.9	-	19.8

Note: 2013 figures represent the percentage of respondents who agreed or strongly agreed, based on the GBV Indicators Study (Gender Links, 2014). 2025 figures represent the weighted % who agreed or strongly agreed. Items without 2013 comparisons (-) are new or differently worded in 2025.

Source: Lesotho GBV 2013 & 2025 Prevalence Surveys, Gender Links

Table X shows:

- There have been substantial reductions in patriarchal attitudes across most metrics since 2013. The view that a woman should obey her husband fell from 97% to 33.9% among women and from 96% to 49.2% among men. The view that a man has the right to punish his wife fell from 26% to 10.6% among women and from 41% to 16.5% among men. The belief that a woman cannot refuse sex with her husband declined from 55% to 38.6% (women) and from 58% to 39.7% (men).
- Bohali-related attitudes also shifted. The proportion agreeing that bohali entitles a man to sex dropped from 39% to 22.5% among women and from 45% to 30.1% among men. However, agreement that bohali means ownership declined more

modestly (42% to 32.4% among women; 45% to 40.5% among men).
- Rape myths show mixed trends. Recognition that a husband can rape his wife remained stable (45% to 48.0% of women; 44% to 44.4% of men). The view that a rape victim must be promiscuous declined among women (40% to 26.1%) but remained relatively unchanged among men (39% to 37.5%).
- 14.9% of women and 19.8% of men held high acceptance of rape myths, indicating that a significant minority continue to endorse attitudes that normalise violence.
- Overall, 19.4% of women and 27.7% of men still scored high on the gender attitudes scale.

Substance use and IPV

Table XI examines the association between substance use and IPV, highlighting the role of alcohol and drug use as risk factors for both experiencing and perpetrating violence.[31]

Table XI: Substance use and association with IPV

Indicator	Women (%)	Men (%)
Substance use prevalence		
Ever drank alcohol	59.1	68.9
Drank alcohol in the past 12 months (among drinkers)	66.1	81.7
Ever used drugs	5.5	23.5
IPV by alcohol use		
Women's IPV experience - non-drinker	38.9	-
Women's IPV experience - drinker	50.3	-
Men's IPV perpetration - non-drinker	-	12.9
Men's IPV perpetration - drinker	-	33.3

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

Alcohol use is widespread in Lesotho. The association between alcohol and IPV is substantial

Alcohol use is widespread in Lesotho, with 59.1% of women and 68.9% of men reporting ever having consumed alcohol. Among those who drink, the majority consumed alcohol within the past year (66.1% of women; 81.7% of men). Drug use is markedly gendered, with 23.5% of men versus only 5.5% of women reporting ever using drugs.

The association between alcohol and IPV is substantial. Among women who are drinkers, IPV experience is 50.3% compared to 38.9% among non-drinkers, an 11 percentage-point gap. The difference is even more pronounced for men's perpetration: 33.3% of men who drink have perpetrated IPV compared to only 12.9% of non-drinkers, nearly a threefold increase. These findings point to alcohol use as a significant modifiable risk factor for IPV prevention.

[31] Alcohol use refers to lifetime use. Drinkers are respondents who reported ever consuming alcohol.

Effects of GBV

GBV has profound and far-reaching effects on survivors' physical health, mental well-being, and socio-economic outcomes. The 2025 study employs standardised instruments for mental health assessment, allowing precise quantification of the psychological toll of violence.[32]

Table XII: Effects of GBV - physical and mental health

Indicator	Women	Men	Total
Physical injury (among IPV survivors)			
Sustained physical injuries (%)	13.2	-	-
Had to stay in bed (%)	56.4	56.1	56.3
Took time off work/activities (%)	23.9	45.1	28.0
Mental health: GBV survivors vs non-survivors			
Mean CES-D score - survivors	21.36	-	-
Mean CES-D score - non-survivors	15.61	-	-
Depression risk (CES-D ≥16) - survivors (%)	65.8	-	-
Depression risk (CES-D ≥16) - non-survivors (%)	41.5	-	-
Mean PCL-5 score - survivors	20.79	-	-
Mean PCL-5 score - non-survivors	14.34	-	-
PTSD (PCL-5 ≥33) - survivors (%)	25.8	-	-
PTSD (PCL-5 ≥33) - non-survivors (%)	14.0	-	-
Risk factors (odds ratios)			
Depression: IPV survivor	OR 1.65	OR 1.87	-
Depression: per 1 ACE	OR 1.19	OR 1.24	-
PTSD: IPV survivor	OR 1.43	OR 2.34	-

Note: CES-D = Centre for Epidemiologic Studies Depression Scale (cutoff ≥16). PCL-5 = PTSD Checklist for DSM-5 (cutoff ≥33). OR = odds ratio from multivariate logistic regression. Survivors = experienced Any GBV lifetime; non-survivors = neither experienced nor perpetrated.

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

Table XII shows:

- ***Physical injury:*** Among women who experienced physical IPV, 13.2% sustained injuries. More than half of injured survivors (56.4% of women; 56.1% of men) had to stay in bed due to their injuries, and a quarter of women (23.9%) took time off work or daily activities. In 2013, 18% of physically abused women sustained injuries, and 68% of injured women spent days in bed.
- ***Depression:*** GBV survivors have significantly elevated depression risk. The mean CES-D score among women survivors is 21.36 (above the clinical threshold of 16), compared to 15.61 among non-survivors. Two-thirds of women GBV survivors (65.8%) meet the threshold for depression risk, compared to 41.5% of non-survivors. In 2013, 48% of women abused by partners suffered depression.
- ***PTSD:*** One in four women GBV survivors (25.8%) meets the clinical threshold for PTSD, compared to 14.0% of non-survivors. IPV survivorship is associated with 1.43 times the odds of PTSD among women and 2.34 times among men, after adjusting for other factors.
- ***Intergenerational effects:*** Each additional adverse childhood experience (ACE) increases depression risk by 19-24% (OR 1.19 for women; 1.24 for men), confirming the cumulative impact of childhood adversity on adult mental health.

[32] Depression risk assessed using CES-D (Centre for Epidemiologic Studies Depression Scale, cutoff ≥16). PTSD assessed using PCL-5 (PTSD Checklist for DSM-5, cutoff ≥33).

Response and Support

The pervasive underreporting of GBV to formal institutions arose as a major concern in the 2013 study. The 2025 study confirms that underreporting remains a systemic challenge.[33]

Table XIII: Underreporting of IPV among survivors

Indicator	Women (%)	Men (%)	p-value
Did not report to the police	90.1	92.5	0.268
Never told anyone	89.2	90.7	0.551
Perpetrator not arrested (among reported)	84.3	84.6	0.974
No protection order sought (among reported)	90.0	95.8	0.260

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

Table XIII shows:

- Nine out of ten women (90.1%) and men (92.5%) who experienced IPV did not report the violence to the police. Similarly, 89.2% of women and 90.7% of men never disclosed their experience to anyone. These rates of silence and non-reporting are consistent across genders with no statistically significant differences. *Culture of silence confirmed by interviews with the National University of Lesotho - Department of Sociology, the religious sector, and traditional leaders.
- Among the small proportion who did report to the police, the vast majority (84.3% of women; 84.6% of men) stated that the perpetrator was not arrested. Nine in ten women (90.0%) and nearly all men (95.8%) who reported did not seek a protection order.

Many survivors perceived the violence as 'not serious enough' to report, a finding that reveals the deep normalisation of GBV in Lesotho

Table XIV: Disclosure and support sources among GBV survivors

Indicator	Women (%)	Men (%)	Total (%)
Disclosure (told someone)			
Told family member	57.7	46.0	54.8
Told partner's family	1.1	0.9	1.0
Told a religious leader	0.1	0.0	0.1
Told an NGO worker	0.3	0.2	0.3
Support sources accessed			
Support from family	56.6	37.8	50.7
Support from spouse/partner	17.2	28.5	20.7
Support from friends	25.8	39.9	30.2
Support from a religious leader	3.3	3.6	3.3
Legal awareness			
Heard of protection orders	25.6	24.8	25.3
Know laws to protect women exist	57.5	57.1	57.3
Heard of the CDV Act	11.9	12.3	12.1

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

[33] Among ever-partnered respondents who experienced any IPV in their lifetime.

Among those who do disclose, family members are by far the most common confidants (57.7% of women; 46.0% of men), whereas formal institutions, such as religious leaders, NGOs, and health workers, are rarely approached. Family is also the primary source of support (56.6% of women), followed by friends (25.8% of women; 39.9% of men). Only 25.3% of the population has heard of protection orders, and 12.1% has heard of the Counter Domestic Violence (CDV) Act, a figure that reflects the absence of a structured public awareness campaign following enactment, compounded by ongoing technical discussions around a proposed amendment to the Act. In 2013, 41% of women and 64% of men were aware of laws protecting women. In 2025, awareness of such laws stands at 57.5% (women) and 57.1% (men).[24]

Service gap analysis

Taken together, the reporting, disclosure, justice, and health data reveal a stark service cascade in which the vast majority of GBV survivors fall through gaps at every stage. Table 10 traces this cascade from experience to outcome.

Table XV: GBV service cascade - from experience to outcome

Stage of the cascade	Women (%)	Men (%)
Experienced any IPV (lifetime)	45.7	28.2
Reporting		
Reported to police	9.9	7.5
Reported to other authority	10.8	9.3
Disclosure		
Told own family	57.9	46.7
Told friend	13.9	26.5
Told religious/community leader	0.7	0.0
Told NGO or shelter	3.3	4.4
Justice outcomes (among those who reported)		
Perpetrator arrested	15.7	15.4
Sought protection order	10.0	4.2
Health consequences (among injured survivors)		
Sought medical care	47.0	48.4
Had to stay in bed	56.4	56.1
Took time off work/activities	23.9	45.1
Mental health (GBV survivors)		
Depression risk (CES-D ≥16)	65.8	60.2
PTSD risk (PCL-5 ≥33)	25.8	23.2
Legal awareness (all respondents)		
Heard of protection orders	25.6	24.8
Heard of the CDV Act	11.9	12.3
Satisfied with police response	1.2	1.9

Note: Each row uses the appropriate denominator: IPV prevalence = ever-partnered respondents; reporting and disclosure = IPV survivors; justice outcomes = those who reported to police; health consequences = those who sustained injuries; mental health = any GBV survivors vs. non-survivors; legal awareness = all respondents. Figures are not directly cumulative.

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

[34] In the 2013 study, 41% of women and 64% of men were aware of laws protecting women from violence.

The cascade reveals a system in severe distress. Of the 45.7% of women who experience IPV, only 9.9% report to the police. Of those who report, only 15.7% see the perpetrator arrested. Just 1.2% of all women survivors are satisfied with the police response. Meanwhile, two-thirds of women and men survivors carry the burden of clinical depression risk, and one in four meets the threshold for PTSD, yet fewer than half of those who sustain physical injuries seek medical care. Only 11.9% of women have even heard of the CDV Act, the very legislation designed to protect them. This service gap represents a critical policy priority. That is, without accessible, trusted, and effective services, legislative reform alone cannot reduce the burden of GBV.

Prevention

Prevention efforts in Lesotho have historically centred on public awareness campaigns, community mobilisation, and legislative reform. Table XVI presents the 2025 prevention indicators.[35] The full chapter eight examines other GBV sector players' efforts on prevention.

Table XVI: Prevention indicators

Indicator	Women (%)	Men (%)	Total (%)
GBV campaign awareness (past 12 months)			
Heard of GBV campaign via radio	11.2	14.3	12.4
Heard of GBV campaign via television	6.4	5.8	6.2
Heard of GBV campaign via online/internet	6.7	7.2	6.9
Heard of GBV campaign via a community event	8.0	10.0	8.8
CDV Act knowledge			
Heard of the CDV Act	11.9	12.3	12.1
CDV Act source: radio	5.2	6.0	5.5
CDV Act source: community	-	-	-

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

Campaign awareness in 2025 is markedly lower than in 2013, when 64% of women and 44% of men had heard of the 16 Days of Activism campaign. In 2025, radio remains the primary channel for GBV campaign messaging (12.4% of the total population reached), followed by community events (8.8%), online/internet (6.9%), and television (6.2%). Only 12.1% of the population has heard of the Counter Domestic Violence Act. The low levels of campaign awareness suggest that sustained investment in multi-platform prevention messaging is needed, particularly leveraging digital and social media channels to reach younger populations.

Disability and GBV

For the first time, the 2025 study incorporates the Washington Group Short Set on Functioning to assess the intersection of disability and GBV. This represents a significant advancement in the evidence base, as persons with disabilities are recognised globally as being at heightened risk of violence.

[35] The 2013 study found that 64% of women and 44% of men had heard of the 16 Days of Activism campaign.

Among ever-partnered women, those with any disability report an IPV prevalence of 50.9%, compared to 44.6% among women without disabilities. For men, the pattern is less pronounced (27.3% vs 28.3% for experience; 27.0% vs 27.7% for perpetration). The full Chapter 4 analysis examines disability as a risk factor within the multivariate regression framework.

Persons with disabilities are recognised globally as being at heightened risk of violence

Conclusions and recommendations

This study identifies cross-cutting findings that underscore the urgency of sustained, multi-sectoral investment in GBV prevention, response, and survivor support across Lesotho. Key areas for policy attention include the following;

- GBV has declined but remains endemic. Lifetime IPV among women fell from 62% to 45.7%, independently corroborated by the DHS 2023-24, but progress is uneven across districts and violence types.
- Adverse childhood experiences are the architecture of future violence. Each additional ACE increases adult depression risk by 19-24%. More than 80% of adults carry at least one ACE, and women with four or more ACEs face six times the odds of adult IPV.
- Gender norms have shifted dramatically. Agreement that a woman should obey her husband collapsed from 97% to 33,9% among women.
- GBV generates a mental health crisis invisible to the health system. Two-thirds of women survivors meet the clinical depression threshold, against a mental health workforce of 0.05 psychiatrists per 100,000.
- The justice system reaches fewer than 2% of survivors. Police reporting is unchanged at 10%.
- The CDV Act 2022 is Lesotho's most significant GBV legislative advance. The next priority is operationalisation: the Family Court designation has not yet been activated, family court rules have not yet been promulgated, and public awareness stands at 12.1%, reflecting the absence of a structured dissemination campaign and ongoing discussions around a proposed amendment to the Act.
- LGBTQI+ persons experience targeted violence at rates far exceeding the general population; 50% of transgender respondents experienced GBV in the past year, with no institutional pathway for reporting or support.
- Women with disabilities experience significantly higher rates of GBV (73.3% versus 65.1% for women without disabilities), with the disparity most pronounced for economic IPV. LNFOD documents that 74% of respondents identify women and girls with disabilities as the most affected population. No CGPU office has sign language capacity, and the Disability Equity Act 2021's court accommodation provisions are not yet implemented. The ICJ's 2025 report on access to justice confirms systemic exclusion of persons with disabilities from the justice system.
- Expanding GBV prevention to reach adolescents aged 15-17, among whom IPV is already prevalent (21.3% of girls).
- Addressing alcohol as a modifiable risk factor. Men who drink are nearly three times more likely to perpetrate IPV than non-drinkers.
- Leveraging digital platforms for GBV campaigns to complement traditional radio messaging and reach younger populations.
- New prevention strategies are needed to address technology-facilitated GBV and reproductive coercion as significant concerns.

- Targeting prevention efforts toward separated and never-married populations, who report the highest IPV rates.
- Matela's (2020) evaluation of six IPV-response organisations in Lesotho provides an important organisational perspective on prevention programming. Her study documents that effective IPV prevention requires simultaneous deployment of primary prevention (awareness-raising, gender-transformative programming, engaging men), secondary prevention (counselling, shelters, economic empowerment), and tertiary prevention (law enforcement, batterer treatment, community-coordinated strategies). The finding that single-level interventions are insufficient aligns with the multi-sectoral approach recommended in the present study's Chapter 10 recommendations.

The 2025 recommendations are structured for accountability. Each recommendation names a responsible institution, specifies a priority tier (Immediate, Short-term, Medium-term, or Long-term), and sets a measurable milestone. A government performance scorecard rates progress across seven domains. An implementation roadmap sets milestone reviews at 12 months (2026), 24 months (2027), and a full study after every five years.



Help at hand: A Mokhotlong researcher is assisted to cross a river on horseback for GBV data collection, Mokhotlong, November 2025.
Photo: Palesa Mabea

CHAPTER 1
INTRODUCTION AND COUNTRY PROFILE



Getting the data by any means: Enumerators in Thaba Tseka, November 2025. *Photo: Teboho Setai*

Key findings

- Lesotho's GBV legal framework has expanded substantially since 2013: the Counter Domestic Violence Act (2022), the Labour Act 2024 with ILO C190 ratification, and the country's first national legal aid guidelines (December 2025). The Disability Equity Act 2021 marks legislative progress, but service-level inclusion remains a gap.
- Lesotho now has four nationally representative GBV datasets - the 2013 GL baseline, the 2021 LDS GBV module, the 2023-24 LDHS GBV module, and the 2025 GL follow-up study- a significant improvement over the single study available in 2013.
- A growing body of academic and operational research now documents GBV drivers, barriers, and service gaps in Lesotho, including the first Lesotho-focused analysis of technology-facilitated violence (Mokapane, 2022) and the first LGBTQI+ GBV baseline (Khutlo Project, 2024). LGBTQI+ persons experience targeted violence that existing systems do not yet record.
- HIV prevalence remains among the highest globally at 18.5% among adults aged 15-49, and adolescent girls face HIV incidence 2.5 times that of male peers - reinforcing the case for integrated GBV-HIV programming.
- GBV costs Lesotho between 1.3% and 5.5% of GDP annually (M462.9 million to M1,926 million), and 49.7% of the population lives below the national poverty line, compounding women's inability to leave abusive situations.

I wish I had gone to the police immediately



"He forced me to quit my job as a cook at one of the nearby schools. He said I could not continue working there because there were men around. One day, he took a spade and hit me with it. I was badly injured. Looking back at my life, I wish I had gone to the police immediately and not waited."

*Mary**

Mary's story captures the structural dimensions this study measures. Economic control that isolates women, physical violence that escalates unchecked, and institutional pathways that survivors deserve but too often cannot access. Her experience is not exceptional, yet since 2013, Lesotho has strengthened legal protections, expanded services, and increased community support for women more than at any previous point in the country's history.

Overview

This chapter provides the context for Lesotho's second national Gender-Based Violence Indicators Study. It sets out the rationale for the study, describes the country's demographic, economic, and social landscape as it relates to GBV, and reviews the legal and policy framework that has evolved since the 2013 baseline. The chapter then surveys previous research on GBV in Lesotho, including the growing body of academic literature and administrative data, before concluding with the case for why updated national evidence is needed now. Together, these sections establish the foundation on which the methodology (Chapter 2) and the prevalence, risk factor, response, and prevention findings (Chapters 3-9) build.

1.1 Background and rationale

Lesotho has reached an important moment in its response to gender-based violence. In 2013, the first Gender-Based Violence (GBV) Indicators Study found that 86% of women experienced some form of violence in their lifetime. It also found that 40% of men perpetrated violence against women at least once in their lifetime. Since then, the country has enacted landmark legislation, established new survivor services, and built political will across government and civil society. This study documents that progress, measures change and identifies where the next generation of investment can achieve the greatest impact.

Between the two studies, Lesotho enacted the Counter Domestic Violence Act (2022), increased women's political representation, and expanded the Child and Gender Protection Unit across all ten districts. A multi-purpose centre offering integrated GBV services also opened in Maseru. These achievements reflect genuine political commitment. At the same time, the government and its partners must sustain investment and continue reform efforts to translate legislative gains into consistently improved outcomes for survivors.

In 2021, the SADC Secretariat, in collaboration with the Ford Foundation and the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ), convened a virtual workshop on GBV prevention and coordination. Participants raised concerns about the lack of up-to-date GBV data, low reporting rates, insufficient disaggregation, and the absence of common regional surveillance systems. This study responds to that call. It provides the most comprehensive up-to-date evidence base on GBV in Lesotho since 2013 and equips the government, donors, and civil society to make evidence-led decisions.

New evidence assembled for this report underscores both the scale of the challenge and the importance of continued investment. The World Health Organisation's Country Cooperation Strategy 2024-2027 identifies interpersonal violence as a leading cause of mortality in Lesotho between 2009 and 2019, reinforcing the case for a health-sector GBV response. The World Food Programme's 2025 national mapping of GBV service providers confirms that Lesotho still ranks third globally in reported rape cases per capita. This figure shows how much further the country's strong legislative framework must go to reach survivors on the ground.

Gender Links has worked in the gender justice arena since 2001.[36] The first Lesotho GBV Indicators Study in 2013 established the baseline. The updated SADC Protocol on Gender and Development calls on state parties to halve current levels of GBV by 2030.[37] This study provides the benchmarks against which Lesotho can measure its progress towards that goal.

1.2 Unique features of the study

This study goes beyond measuring prevalence alone. It tests indicators across five inter-connected dimensions, building the evidence base for planning, funding, and evaluating the GBV response:

- Extent: What are the prevalence and patterns of GBV in Lesotho today, and how have they changed since 2013?
- Effect: What are the economic, social, physical, and psychological costs of GBV, and what does investment in prevention save?
- Response: How do police, courts, health services, and social services perform from the survivor's perspective, and where can they improve?
- Support: Which services are available to survivors, and how can their reach, accessibility (including disability-friendly services), and quality be strengthened?
- Prevention: Which campaigns and programmes are shifting knowledge, attitudes, and behaviour, and how can Lesotho accelerate that change?

The study uses a mixed-methods approach. It combines a nationally representative household survey, qualitative 'I'-Stories that capture lived experiences, administrative data analysis from criminal justice, health, and social welfare sectors, desktop research, and a political discourse analysis of statements by key public figures on GBV.

For the first time, the 2025 study explicitly measures technology-facilitated GBV (TFGBV). The 2023-24 Lesotho Demographic and Health Survey found that 5% of women aged 15-49 experienced TFGBV in the past 12 months, rising to 8% in Maseru and Quthing.[38] By capturing this emerging form of harm, which the 2013 study largely omitted, the study ensures that the response framework keeps pace with the evolving nature of GBV.

[36] Gender Links (2025). 16 Days: Lesotho - Journey of a Thousand Stories. Available at: http://genderlinks.org.za
[37] SADC (2008, updated 2016). Protocol on Gender and Development. Gaborone: Southern African Development Community.
[38] Ministry of Health, Lesotho, and ICF (2024). Lesotho Demographic and Health Survey 2023-24: Final Report. Technology-facilitated GBV past 12 months: 5% (10% aged 20-24), DHS 2023-24, Table 19.14.

1.3 Country context

1.3.1 Geography and population



Lesotho is a small, landlocked, mountainous kingdom entirely enclosed within the Republic of South Africa, covering approximately 30,350 square kilometres. Its ten administrative districts, Maseru, Berea, Leribe, Butha-Buthe, Mohale's Hoek, Mafeteng, Qacha's Nek, Quthing, Thaba-Tseka, and Mokhotlong, span four geographical regions: the mountains, the foothills, the lowlands, and the Senqu River Valley. Maseru serves as the national capital and largest urban centre.

The population stands at approximately 2.4 million as of 2025,[39] up from 2.007 million in the 2016 Census.[40] The country is young. The median age is 22.1 years, and approximately 37.8% of the population is under 15. This youth demographic presents an important opportunity for prevention programmes that reach young Basotho before harmful norms become entrenched. Organisations such as Kick4Life demonstrate the scale at which youth-focused programming can operate: over two decades, Kick4Life has delivered sport-based GBV prevention to more than 260,000 young people.[41]

1.3.2 Economy and poverty

Lesotho's lower-middle-income economy[42] relies heavily on the Lesotho Highlands Water Project (LHWP), textiles, mining, and remittances from migrant workers (who are also at risk of GBV offshore.[43]) in South Africa. The economy grew by an estimated 2.3% in 2024.[44] Unemployment stands at approximately 16 to 24%,[45] and 49.7% of the population lived below the national poverty line as of 2017[46]. Poverty intersects directly with GBV: financial dependence limits women's ability to leave abusive situations, and economic abuse through controlling money and blocking employment operates as a tool of coercion alongside physical and sexual violence.

The economic case for investing in GBV prevention and response is clear. The Commonwealth Secretariat's 2020 costing study calculated that GBV costs Lesotho at least M462.9 million per year (1.3% of 2017 GDP). In severe cases, costs rise to M1,926 million (5.5% of GDP).[47] Every loti invested in effective prevention saves many times its value in

[39] UN Department of Economic and Social Affairs - Population Division (2024). World Population Prospects: The 2024 Revision. New York: United Nations.
[40] Bureau of Statistics, Lesotho (2016). 2016 Population and Housing Census: Summary Key Findings. Maseru: BOS. Available at: https://www.bos.gov.ls
[41] UNFPA Lesotho (2025). Lesotho Successfully Concludes Pilot Census Ahead of 2026 National Count. Maseru: UNFPA.
[42] https://data.worldbank.org/country/LS
[43] See Migrant Workers Lesotho case study
[44] World Bank (2025). Lesotho Overview: Development News, Research, Data. Washington DC: World Bank.
[45] BTI Project (2024). BTI 2024 Country Report - Lesotho. Gütersloh: Bertelsmann Stiftung.
[46] https://data.worldbank.org/country/LS
[47] Commonwealth Secretariat (2020). The Economic Cost of Violence Against Women and Girls: A Study of Lesotho. London: Commonwealth Secretariat.

avoided costs to health services, law enforcement, and social welfare. Research by the Lesotho National Federation of Organisations of the Disabled (LNFOD) in 2024 highlights the economic vulnerability of women and girls with disabilities. LNFOD identifies 74% of this population as most affected by GBV, with economic dependence on caregivers constituting a distinct pathway to abuse.[48]

1.3.3 HIV, health, and gender

Lesotho maintains one of the highest HIV prevalence rates in the world: 18.5% among adults aged 15-49 as of 2023,[49] a decline from 25% in the mid-2000s. Lesotho's HIV response has built real, tangible capacity in its health system, including widespread nurse-led services and community health workers. Where that infrastructure has been deliberately adapted to provide integrated GBV clinical inquiry, basic support, and referral, initial results show improved disclosure and linkage to care. However, sustaining those gains requires strengthening GBV-specific adolescent girls and young women aged 15-24 continue to face an HIV incidence approximately 2.5 times that of their male peers,[50] reinforcing the case for gender-transformative health programming that addresses GBV and HIV together.

The integrated nature of the HIV and GBV response means that funding shocks to one system affect the other. The withdrawal of USAID funding, effective January 2025, removed approximately $1billion in HIV assistance. This disrupted elements of the GBV response infrastructure, including health facilities providing integrated services and community health worker networks.[51] Sustaining and diversifying the funding base for integrated HIV and GBV services is among the most important policy actions the government and its partners can take in the short term.

The 2023-24 Lesotho Demographic and Health Survey included, for the first time, a dedicated GBV module.[52] Published in November 2024, it found that 44% of women aged 15-49 have experienced physical or sexual violence from any perpetrator, establishing a new national benchmark. The government's decision to commission the DHS GBV module represents an important institutional commitment to evidence-based policymaking that this study builds on. A new multi-purpose centre offering integrated GBV services opened in Maseru in November 2025, with UNFPA support,[53] marking a tangible expansion of the service landscape since 2013.

1.3.4 Gender, culture, and social norms

Lesotho's patriarchal social structure has historically limited women's rights in marriage, property, inheritance, and decision-making. Important legal reforms have shifted this landscape: The harmonisation of the Rights of

53% of Basotho believe domestic violence is a private family matter rather than a criminal one

48 LANFOD [Lesotho National Federation of Organisations of the Disabled] (2024). 2024 Gender Gap Analysis and Baseline Study for the Strategic Partnership Gender and Disability in Practice - Phase II. Maseru: LANFOD.
49 National AIDS Commission, Lesotho (2024). 2024 Annual State of the AIDS Response. Maseru: NAC.
50 UN Women (2024). Beijing+30 Lesotho Report: Thirtieth Anniversary of the Beijing Declaration and Platform for Action. New York: UN Women.
51 Britoo, R. (2025). Trump's aid cuts reverse decades of HIV progress in tiny African nation: associated Press, October 2025.
52 Ministry of Health [Lesotho] and ICF (2024). Lesotho Demographic and Health Survey 2023-24: Final Report. Maseru and Rockville, MD: Ministry of Health and ICF.
53 UNFPA Lesotho (2024). A Sanctuary of Hope: Addressing Gender-Based Violence in Lesotho. Maseru: UNFPA.

Customary Widows with the Legal Capacity of Married Persons Act (2022) removes all legal restrictions imposed on women regarding the full exercise of their economic rights. These changes reflect genuine legislative progress.

Attitudes are also shifting in measurable ways. The 2023-24 Demographic and Health Survey found that 25% of men and 19% of women believe wife-beating is justified under at least one specified circumstance.[54] This represents a dramatic improvement from 2004, when 51% of men and 48% of women held such views, a halving of permissive attitudes over twenty years. This trend is among the most encouraging findings in the desktop literature reviewed for this report. It demonstrates that sustained investment in awareness, education, and norm change produces results.

Significant work remains. The 2022 Afrobarometer survey[55] found that 53% of Basotho believe domestic violence is a private family matter rather than a criminal one. Enumerators in the 2025 field study observed that 'violence in some rural areas is so normalised that it is not recognised as such. These gaps between formal legislative progress and community-level norms represent the frontier where the next generation of prevention investment needs to work.

While cultural practices in Lesotho, such as bohali, initiation rites, and norms of male household authority, hold positive social meaning and are not inherently violent, they are frequently invoked to justify, normalise, or obscure gender-based violence. Therefore, effective GBV prevention must go beyond external legal reforms and instead support community-led processes that critically reinterpret these traditions, affirming their beneficial roles while explicitly rejecting patriarchal interpretations that enable control, coercion, or abuse.

Women's political representation in local government remains substantial but below parity: women held about 39% of local council seats in 2022[56], providing an important foun dation for community-level accountability.

1.3.5 GBV against LGBTQI+ persons: an important new area of measurement

The study found that no GBV shelters in Lesotho currently accommodate LGBTQI+ or transgender survivors

The 2025 study explicitly addresses GBV experienced by LGBTQI+ persons, a population that the 2013 study did not measure and that standard administrative data systems continue to exclude. Primary evidence assembled for this report reveals the scale of unmet need. The THUSO Project Baseline Study (2026) found that 50% of transgender respondents experienced GBV in the twelve months before the survey, compared with 27.9% of non-transgender LGBTQI+ respondents. Of incidents experienced by transgender persons, 93.8%

54 Ministry of Health [Lesotho] and ICF (2024). Lesotho Demographic and Health Survey 2023-24: Final Report. Chapter 13, Figure 13.4 and trend paragraph. Maseru: Ministry of Health and ICF.
55 AD546: In Lesotho, gender-based violence tops the list of women's rights issues to be addressed. Available at: https://www.afrobarometer.org/publication/ad546-in-lesotho-gender-based-violence-tops-the-list-of-womens-rights-issues-to-be-addressed/ (Accessed: September 24, 2025).
56 Independent Electoral Commission (IEC), Lesotho (2023). 2023 Local Government Results (final results by district, council, and electoral division). Maseru: IEC Lesotho.
57 THUSO Project (2026). Baseline Study Report: Promoting Dignity, Safety, and Inclusion of LGBTIQ+ Persons in Lesotho. February 2026. Maseru: Human Rights Lab. Calculated from LGBTQI+ Community Survey dataset (n=261).
58 International Commission of Jurists (2025). Lesotho: ICJ initiates project to combat sexual and gender-based violence. 22 September 2025. Available at: https://www.icj.org

were directly linked to their gender identity or expression.[57] The International Commission of Jurists documents specific forms of targeted violence against LGBTQI+ persons in Lesotho, including 'corrective rape'.[58]

The study's desktop review also found that no GBV shelters in Lesotho currently accommodate LGBTQI+ or transgender survivors, that the CGPU's data systems record only binary gender categories, and that no LGBTQI+ inclusive standard operating procedures exist at the institutional level.[59] These findings do not reflect a failure of intent; CGPU officials interviewed for the THUSO study expressed openness to inclusive service provision, but rather a gap in guidance, training, and infrastructure that targeted investment can address. This study is the first national GBV study in Lesotho to document and measure these exclusions (though not statistically significant, as only 11 respondents were gender non-conforming), creating the baseline against which future progress can be tracked.

1.4 Legal and policy framework



GL Lesotho Country Director Thakane Sello at the launch of the Men's Forum Movement against GBV at SOS Children's Home in May 2026. *Photo: LMPS*

Lesotho has built a substantially stronger GBV legal and policy framework since 2013, and this study assesses how effectively that framework is working in practice. The landmark development is the Counter Domestic Violence Act (2022),[60] which provides comprehensive legal protection against domestic violence in all its forms, physical, sexual, emotional, verbal, psychological, economic, and technology-facilitated, for the first time in Lesotho's history. The Act empowers magistrates to issue protection orders and criminalises coercive and controlling behaviours previously outside the law's reach.

Two further legal advances deserve attention. The Labour Act 2024[61] extends anti-discrimination protections into the workplace, and Lesotho has ratified ILO Convention C190 (2019),[62] the first international instrument to explicitly affirm the right of everyone to a world of work free from violence and harassment. Together, these instruments give Lesotho a workplace GBV legal framework it did not have in 2013, one that the study assesses for implementation for the first time.

On legal aid, a 2025 national mapping exercise identified 56 legal aid service providers operating across Lesotho. In December 2025, the Legal Aid Unit published the country's first national guidelines for legal aid clinics. This is the first Lesotho legal aid framework to name sexual and gender minorities explicitly as a marginalised group eligible for legal aid.[63] While implementation gaps remain,[64] the direction of travel is clear, and this study documents both the progress achieved and the gaps that continued investment can close.

[59] THUSO Project (2026). Baseline Study Report, section 6. See also: KIIs_GBV SHELTER and CGPU_FINAL.xlsx; GBV SHELTER ASSESSMENT_FINAL.xlsx. Maseru: Human Rights Lab.
[60] Government of Lesotho (2022). Counter Domestic Violence Act 2022. Maseru: Government Printer.
[61] Government of Lesotho (2024). Labour Act 2024 (Act No. 3 of 2024). Government Gazette Extraordinary, Vol. 69, No. 22, 2 April 2024.
[62] International Labour Organisation (2019). Violence and Harassment Convention, 2019 (No. 190). Geneva: ILO.
[63] Legal Aid Unit, Ministry of Law and Justice, Lesotho (2025). Draft Guidelines for Legal Aid Clinics. December 2025. Maseru: Government of Lesotho. (EU-funded).
[64] Equality Now (2025). Laws and Protections on Ending Violence Against Women and Girls in Lesotho. Available at: https://equalitynow.org

Table 1.1: Lesotho's key GBV legal and policy instruments, progress and next steps

Instrument	Key state obligations	Progress achieved and next steps (2025)
CEDAW	Provide survivor services; prevent, prosecute, and punish perpetrators; collect disaggregated data.	CGPU is operational in all ten districts. DHS 2023/24 GBV module published the first systematic national GBV data. 56 legal aid providers mapped; national standardisation guidelines adopted December 2025. Next step: extend SOGIE-inclusive data collection and rural service reach.
Beijing Declaration and Platform for Action (1995)	Enact legislation; establish strategies for survivors; ensure women's participation.	Counter Domestic Violence Act (2022) and Administration of Estates and Inheritance Act (2024) enacted. Women hold 39% of local government seats. Next step: enforce new legislation; address LGBTQI+ gaps.
SADC Protocol on Gender and Development (2008, updated 2016)	Halve GBV by 2030; adopt integrated, multi-sectoral approaches; ensure monitoring and evaluation.	National Action Plan developed. Gender and Anti-GBV Forum inaugural meeting held (2025). The GIZ multi-sector prevention programme is active. This study restores the 12-year evidence gap. Next step: institutionalise annual GBV monitoring.
Sustainable Development Goals (2015-2030)	SDG 5.2: Eliminate violence against women and girls. SDG 16.1: Reduce all forms of violence.	The government has integrated GBV into the National Strategic Development Plan II (2023-2028) and the Gender and Development Policy 2018-2030. Next step: increase domestic budget allocation to GBV response and prevention.
ILO Convention C190 (2019) - ratified	Right to a world of work free from violence and harassment, including GBV.	Labour Act 2024 enacted; workplace GBV legal framework now in place. Next step: implementation monitoring and employer compliance guidance, particularly in the informal sector.

1.5 Previous research on GBV in Lesotho

1.5.1 The GL GBV indicators study (2013-2014)

The 2013 Gender-Based Violence Indicators Study established Lesotho's GBV baseline

The 2013 Gender-Based Violence Indicators Study established Lesotho's GBV baseline, 86% of women experienced some form of violence in their lifetime, and 40% of men perpetrated VAW at least once.[65] IPV affected 62% of women, with emotional violence most prevalent (52%), followed by physical (40%), economic (30%), and sexual (24%) IPV. In the twelve months before the survey, 28% of women experienced IPV. The 2025 study measures change against this baseline across all five dimensions.

[65] Gender Links (2015). The Gender-Based Violence Indicators Study - Lesotho. Op. cit.

1.5.2 The Lesotho Violence Against Children and Youth Survey (VACS) 2018

The 2018 VACS focused on violence among young people aged 13 to 24, finding sexual violence from classmates and, in a small proportion of cases, from teachers.[66] It highlighted the importance of addressing school-related GBV as part of the national response and underscored the need for peer-to-peer prevention approaches alongside adult-led programmes.

1.5.3 The Afrobarometer Round 9 GBV Survey (2022)

The Afrobarometer Round 9 survey found that 64% of Basotho identify GBV as the most important women's rights issue requiring government action,[67] and that 53% believe violence against women is common in their community. This strong public recognition of GBV as a priority, shared across gender, age, and geography, provides a solid foundation for the sustained political and financial investment required by the next phase of the response.

1.5.4 The 2021 Lesotho Demographic Survey (LDS 2021)

The Bureau of Statistics (BOS) included a dedicated GBV module in the 2021 Lesotho Demographic Survey (LDS 2021), the national inter-census survey. The resulting Volume IV: GBV Analytical Report[68] found that 37.6% of women aged 12-50 and 21.3% of men aged 12-50 have experienced any form of violence, physical, sexual, marital, or emotional, since age 12. While the age range (12-50) and violence definitions differ from those used in the present study (ever-partnered respondents aged 18 and older) and in the 2023/24 LDHS (women aged 15-49), the LDS 2021 findings broadly confirm that GBV affects a substantial proportion of both women and men in Lesotho.

1.5.5 The Lesotho Demographic and Health Survey (2023/24 LDHS)

The government published the 2023/24 LDHS in November 2024. The survey represents a landmark investment in national GBV data, as it is the first DHS in Lesotho to include a dedicated GBV module.[69] The findings provide the most current nationally representative GBV prevalence data available. The survey found that 44% of women aged 15-49 have experienced physical or sexual violence from any perpetrator; 36% have experienced IPV from their current or most recent partner, and 25% experienced some form of IPV in the past twelve months. These data complement this study's findings and confirm that Lesotho now has two robust national data sources for measuring GBV, a significant improvement over the single study available in 2013.

2023/24 LDHS - a landmark investment in national GBV data - the first DHS in Lesotho to include a dedicated GBV module

[66] Government of Lesotho / CDC (2020). Lesotho Violence Against Children and Youth Survey (VACS) 2018. Maseru: Ministry of Social Development.
[67] AD546: In Lesotho, gender-based violence tops the list of women's rights issues to be addressed. Available at: https://www.afrobarometer.org/publication/ad546-in-lesotho-gender-based-violence-tops-the-list-of-womens-rights-issues-to-be-addressed/ (Accessed: September 24, 2025).
[68] Bureau of Statistics. (2023). Lesotho Demographic Survey 2021, Volume IV: GBV Analytical Report. Maseru: Ministry of Finance and Development Planning, as cited in Government of Lesotho. (2024). Beijing +30 Lesotho Report. Submitted to UN Women, September 2024, p. 31.
[69] Lesotho - Demographic and Health Survey 2023-2024 . Available at: https://microdata.worldbank.org/index.php/catalog/6411 (Accessed: April 22, 2026).

1.5.6 Academic research on GBV in Lesotho

The academic literature on GBV in Lesotho has grown considerably since 2013. National University of Lesotho researcher Dr Josphine Hapazari has published peer-reviewed studies on GBV in Maseru,[70] regional masculinities as drivers of sexual violence,[71] women as perpetrators,[72] prevention narratives through the ecological model,[73] and the implementation of the Gender and Development Policy.[74] Her 2025 co-authored Palgrave Macmillan book chapter on genders, inequalities, and sexual violence in Lesotho provides the most current peer-reviewed academic synthesis.[75] Notably, Dr Hapazari also served as the consultant for the WFP's 2025 national GBV mapping, linking the academic literature directly to operational service data.

The International Commission of Jurists (ICJ) published a report titled From Exclusion to Equality: Advancing Access to Justice for Persons with Disabilities in Lesotho (September 2025), a comprehensive study examining Lesotho's compliance with the Convention on the Rights of Persons with Disabilities (CRPD) in the justice sector. The report documents how the landmark Koali Moshoeshoe judgment (Constitutional Case/14/2017) declared Section 219 of the Criminal Procedure and Evidence Act unconstitutional, removing the bar on testimony by persons with intellectual disabilities and catalysing the Disability Equity Act 2021 and the Procedure Rules 2023. The ICJ report is directly relevant to the GBV evidence base, as the Koali case itself concerned a male sexual assault victim denied justice, illustrating how legal barriers compound vulnerability for persons with disabilities who experience gender-based violence.

The most recent peer-reviewed study draws directly on Lesotho national data. Nakie et al[76]. (2025), writing in the Journal of Interpersonal Violence, applied multilevel logistic regression to the DHS 2023-24 domestic violence module (N=1,687 ever-married women aged 15-49) and reported an overall IPV prevalence of 41.68% (95% CI 39.35-44.05). Their analysis identifies five statistically significant predictors, that is, having a jealous partner (AOR 4.10), having an alcoholic partner (AOR 2.07), current tobacco smoking (AOR 1.71), women justifying wife-beating (AOR 1.57), and depressive symptoms (AOR 1.55). These findings, derived from an independent nationally representative dataset by researchers based at the University of Gondar (Ethiopia), provide important external validation of the risk factor architecture documented in the present study.

An emerging area of GBV scholarship in Lesotho concerns technology-facilitated violence. Mokapane[77] (2022), in a Master of Laws dissertation at the National University of Lesotho, provides the first Lesotho-focused analysis of digital violence against women and girls. Through a comparative legal study of Lesotho, South Africa, and the United Kingdom, the study documents forms of online violence including image-based sexual abuse, cyber-stalking, sextortion, and non-consensual intimate image distribution. The study finds that Basotho women who use the internet are similarly vulnerable to online violence as women

70 Hapazari, J. (2023). An investigation of dominant forms of gender-based violence in Maseru district, Lesotho. Journal of Social Development in Africa, 38(1): 115-135.
71 Hapazari, J. (2023). The construction of regional masculinities as drivers of sexual violence against women in Lesotho. South African Review of Sociology, 53(3): 297-312.
72 Hapazari, J. (2023). An investigation of forms and drivers of violence perpetrated by women in Lesotho. In Banwell et al. (eds), The Emerald International Handbook of Feminist Perspectives on Women's Acts of Violence. Bingley: Emerald, pp. 77-91.
73 Hapazari, J. (2024). Narratives and patterns of narratives on how to prevent violence against women. Corvinus Journal of Sociology and Social Policy, 15(2): 139-160.
74 Hapazari, J. and Letooane, M. (2024). On the frontline: Perspectives on Lesotho gender and development policy in combating gender-based violence. TUDARCo Journal of Humanities and Education, 3(1): 4-16.
75 Hapazari, J. and Mkhize, G. (2025). Genders, inequalities and sexual violence against women in Lesotho. In Mkhize, G., Ehiane, S.O. and Mphande, L. (eds), Genders, Sexualities, and Complexities in Africa. Singapore: Palgrave Macmillan, pp. 297-314.
76 Nakie, G., Tadesse, G., Fentahun, S., Rtbey, G., Andualem, F., Kibralew, G., Kelebie, M., Melkam, M., Kassa, M.A., Mengistie, B.A., Alemayehu, T.T., Yigezu, M., Segon, T., Wassie, Y.A. and Tinsae, T. (2025) 'Multilevel Analysis of Intimate Partner Violence and Associated Factors Among Reproductive-Age Women: Lesotho Demographic and Health Survey 2023 to 2024 Data', Journal of Interpersonal Violence, p. 08862605251368842. Available at: https://doi.org/10.1177/08862605251368842.
77 Mokapane, S. and Kulehile, D.M. (2022) 'Digital violence: an insight study on violence against women and girls online and the legal and institutional frameworks in Lesotho.'

elsewhere, but that Lesotho's legal framework, including the Computer Crimes and Cyber-crimes Bill, 2022, lacks adequate provisions to address these forms of gender-based violence. This gap is particularly relevant given the present study's finding that technology-facilitated GBV affects 18,2% of women and 21% of men, underscoring the need for the legislative reforms Mokapane recommends.

Matela[78] (2020), in a PhD thesis at the University of KwaZulu-Natal, investigates the role and effectiveness of intervention strategies employed by six organisations dealing with intimate partner violence in Lesotho, including FIDA, WLSA, the CGPU, the Department of Gender, UNFPA, and She Hive. Using qualitative methods informed by post-structural feminism and the social-ecological model, the study documents how socio-cultural determinants, including bohali practices, gendered Sesotho proverbs, male economic disempowerment following mine retrenchments, and high alcohol consumption, drive IPV in Lesotho. The study finds that only 3% of partnered women report violence to police or health providers and proposes a 'Confrontation Theory' advocating simultaneous primary, secondary, and tertiary prevention strategies. These qualitative findings on drivers and help-seeking barriers complement the quantitative evidence documented in the present study.

The USAID-funded Khutlo Project, implemented by Pact and Sonke Gender Justice, produced formative research (2024) that represents the first systematic study of GBV targeting LGBTQI+ communities in Lesotho, across the three districts of Maseru, Leribe, and Mokhotlong. The research establishes baseline data on the magnitude and drivers of violence against LGBTQI+ persons, maps community-based GBV resources, and identifies barriers to inclusive service provision. This study is particularly relevant to the present research, which documents TFGBV prevalence of 18,2% among women and 21% among men, and which includes gender identity as a demographic variable in the prevalence analysis. The Khutlo findings underscore the need for GBV prevention, mitigation, and response services that are explicitly inclusive of diverse sexual orientations and gender identities, a gap that the present study's recommendations in Chapter 10 also address.

1.5.7 Administrative data and other reporting

Administrative data between 2013 and 2025 provide partial but important snapshots of GBV trends. The CGPU recorded 184 sexual offences and 45 assault cases against women in just the first seven months of 2022. In 2023, 919 women and 77 men reported GBV cases to authorities. In the first nine months of 2024, the CGPU recorded 454 adult GBV cases, including 266 sexual offences and 126 cases of intimate partner violence, and 364 child GBV cases, of which 284 were sexual offences. The Police also noted a new and concerning trend: an increasing proportion of boys report sexual assault, which signals the need for dedicated programming and improved data collection. Increasing case volumes in administrative data reflect both the continuing prevalence of GBV and, importantly, growing willingness among survivors to report and access formal channels. This dual signal reinforces the need to strengthen rather than divert resources from the reporting and response infrastructure. In 2021, intimate partners committed at least 47% of murders of women, against a global average of 38%.[79] Approximately 44% of male prisoners in Lesotho are incarcerated for sexually related offences.[80] These figures speak to the severity of the problem and the importance of strong prevention investment upstream, before violence escalates.

[78] Matela, L. and Muthuki, J. (2020) 'Investigating the role and effectiveness of intervention strategies employed by six organisations dealing with intimate partner violence in Lesotho'.

Why this study, and why now

This study builds on a substantially expanded evidence base compared to the 2013 baseline. Since 2013, several important developments have enriched the landscape of GBV research and policy in Lesotho: the enactment of the Counter Domestic Violence Act 2022, the ratification of ILO Convention 190 on violence and harassment in the world of work, the Disability Equity Act 2021 following the Koali Moshoeshoe judgment, the MCA-commissioned GBV service mapping across all ten districts, the ICJ's access to justice assessment for persons with disabilities, the DHS 2023-24 which includes TFGBV and violence modules, and the development of a National GBV Strategic Plan. These developments mean that the 2025 study operates in a significantly richer policy and programmatic environment than the 2013 baseline, enabling more nuanced analysis and more specific, actionable recommendations. Notably, the DHS 2023-24 attitude data show that permissive attitudes towards wife-beating have halved since 2004, reflecting twenty years of prevention investment producing measurable normative change. At the same time, evidence-based policymaking requires current data. Without updated national prevalence and response data, policymakers cannot identify which interventions are working and where to direct resources next. The Ministry of Gender has itself acknowledged that information on GBV remains scattered across institutions without a coordinated national system, a gap this study directly addresses, generating the evidence base for the next phase of Lesotho's GBV response.

Conclusion

Lesotho has made real progress on gender-based violence through stronger laws, better institutions, expanded services, and shifting social norms. The country now needs recognition, sustained investment, and rigorous evidence to extend that progress. This study provides the evidence base through the most comprehensive assessment of GBV in Lesotho since 2013, and measures change across five dimensions: extent, effect, response, support, and prevention. It identifies where progress is happening and where gaps remain. Two populations require particular attention: persons with disabilities, who face elevated GBV prevalence compounded by inaccessible services and justice system barriers, and LGBTQI+ persons, who experience targeted violence that existing systems do not record, refer, or redress. Government, civil society, and development partners can now make the next decisions with confidence. The following chapters present the study's methodology and findings in full. Together, they call on Lesotho's stakeholders to continue, deepen, and scale the response that communities need and that international commitments require.

[78] Matela, L. and Muthuki, J. (2020) 'Investigating the role and effectiveness of intervention strategies employed by six organisations dealing with intimate partner violence in Lesotho'.
[79] WHO (2021). Cited in WFP Lesotho (2025). GBV Mapping Report. Op. cit.
[80] Afrobarometer (2022). AD546. Op. cit.
[81] Ministry of Gender, Youth, Sports, Arts, Culture and Social Development, Lesotho (2025). Internal GBV policy briefing. Maseru: Government of Lesotho.

CHAPTER 2
METHODOLOGY



Enumerators practise the questionnaire during fieldworker training, Maseru, 3 to 7 November 2025. *Photo : Ntolo Lekau*

Key findings

- The 2025 GBV Indicators Follow-up Study replicates and extends the 2013 baseline methodology, enabling, in some instances, a rigorous trend analysis across 12 years.
- A nationally representative sample of 4500 interviews (2700 women and 1800 men) was targeted across 225 Enumeration Areas (EAs) in all ten districts of Lesotho, using a three-stage proportionate stratified cluster design based on the 2022 Census frame.
- A total of 4254 interviews were completed, 2565 with women (60.3%) and 1689 with men (39,7%), representing an overall completion rate of 95%.
- All 225 clusters were visited and completed. Data collection ran from 8 November 2025 to 23 November 2025.
- The study uses five complementary research tools: a prevalence and attitudes household survey, 'I' Stories qualitative narratives, administrative data analysis, media monitoring, and political discourse analysis to triangulate findings across the extent, effects, response, support, and prevention dimensions of GBV.
- Interviewers were trained for 5 days, and data were collected electronically using tablet-based KoBoCollect software, with real-time quality monitoring by supervisors.

Overview

This chapter sets out the research design underpinning Lesotho's second national GBV Indicators Study. It defines the working concept of gender-based violence used throughout the report, states the study aim and research questions, and describes the five complementary study components: a nationally representative household survey, qualitative 'I' Stories, administrative data analysis, desktop research, and political discourse analysis. The chapter details sampling design, fieldwork procedures, ethical safeguards, data management, and the analytical framework, and documents key methodological continuities and differences with the 2013 baseline to support the trend comparisons presented in subsequent chapters.

2.1 Introduction

The study is conducted by Gender Links Lesotho (GLL) in partnership with the Lesotho Bureau of Statistics (BOS) and builds directly on the 2013 baseline study.[82] The primary aim of the follow-up study is to measure change in the prevalence, nature, and dimensions of GBV in Lesotho over the 12 years since the baseline, and to assess the effectiveness of policy and programmatic responses during that time. Guided by the SADC Protocol on Gender and Development,[83] the study provides a comprehensive, nationally representative evidence base to inform the government of Lesotho, civil society, and development partners in strengthening prevention and response to GBV.

The mixed-methods approach employed in this study reflects the complexity of GBV as a social phenomenon. No single instrument can capture the full spectrum of violence experienced by women and men, its forms, causes, consequences, and institutional responses. The study therefore uses five complementary research tools: a household prevalence and attitudes survey; qualitative 'I' Stories narratives; administrative data analysis from the criminal justice, health, and social services sectors; media monitoring; and political discourse analysis. Together, these tools triangulate findings and address the study's five core thematic dimensions: the extent, effects, response, support, and prevention of violence.

This chapter documents each methodological change relative to the 2013 baseline with a clear rationale, so comparisons between the two rounds are well-grounded, and any caveats are explicit. The main changes include the shift from Personal Digital Assistants (PDAs) to tablet-based data-collection software, additional modules, and an updated sampling frame based on the 2022 Census.



The primary aim of the follow-up study is to measure change in the prevalence, nature, and dimensions of GBV over the 12 years since the baseline

[82] Gender Links (2013). Lesotho Gender Based Violence Indicators Study: Baseline Report. Johannesburg: Gender Links.
[83] Revised SADC Protocol on Gender and Development (2016) - SADC - EU," 8 June. Available at: https://sadc-eu.sardc.net/revised-sadc-protocol-on-gender-and-development-2016/ (Accessed: April 24, 2026).

2.2 Working definition of Gender-Based Violence

For this study, GBV is understood in accordance with the 1993 UN Declaration on the Elimination of Violence Against Women, which defined violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or in private life."[84]

This definition encompassed, but was not limited to, physical, sexual, and psychological violence in the family, violence occurring within the wider community, including rape, sexual abuse, sexual harassment and intimidation; and violence perpetrated or condoned by the state. Consistent with the 2013 baseline, and recognising that GBV affects people of all genders while falling disproportionately on women and girls, the operational scope of this study covers:

- Physical, sexual, psychological, and economic intimate partner violence (IPV);
- Rape and sexual assault by a partner, stranger, acquaintance, or family member, experienced both in adulthood and in childhood;
- Sexual harassment in public, work, and educational spaces;
- Technology facilitated violence;
- Child marriages; and
- Male experience of IPV, as a dimension of intersecting vulnerabilities and gender dynamics.

The study further examines the underlying gender attitudes that enable and normalise GBV, as well as the social, psychological, and economic consequences of violence for survivors and their communities.

2.3 Study aim and objectives

The overarching aim of the 2025 follow-up study is to measure changes in GBV prevalence and its dimensions since the 2013 baseline and to assess the state of the national response. More specifically, the study seeks to:

- Quantify the current prevalence of GBV in its different forms and determine the extent of under-reporting, tracking changes over the 12 years;
- Measure the economic, social, and psychological costs of GBV;
- Assess the effectiveness of the response by police, courts, health, and social services;
- Examine GBV coverage and framing in the Lesotho media, and the extent to which coverage helps to challenge or perpetuate violence;
- Assess the level of political commitment to address GBV, as reflected in public pronouncements and legislation;
- Map the gender attitudes that underlie and perpetuate GBV;
- Evaluate the effectiveness of GBV prevention campaigns; and
- Provide evidence-based recommendations to strengthen GBV prevention and response strategies in Lesotho.

[84] United Nations General Assembly (1993). Declaration on the Elimination of Violence Against Women. A/RES/48/104. Geneva: United Nations

2.4 Key research questions

The study is organised around the following core research questions:

- What is the current scope and extent of GBV perpetration and survivor experiences in Lesotho, and how have these changed since 2013?
- What are the physical, psychological, and economic impacts of GBV on survivors, their households, and society?
- What is the response of public institutions, including the justice system, health services, and social welfare, to GBV?
- What level of political commitment to addressing GBV is demonstrated by the national government?
- To what extent do the media help to end or to perpetuate GBV in Lesotho?
- What is the impact of prevention interventions and public awareness campaigns on GBV attitudes and behaviour?

2.5 Study design and components

The study employs a mixed-methods design that combines a large-scale quantitative household survey with several qualitative and institutional data-collection components. The use of multiple tools is consistent with best practice in GBV research[85] and with the approach used in the 2013 baseline, enabling meaningful comparison.

Table 2.1 summarises the five study components and their contribution to the five thematic areas of inquiry.

Table 2.1: Study components and contribution to thematic areas

Research Component	Extent	Effects	Response	Support	Prevention
Prevalence & Attitudes Survey	❑	❑	❑	❑	❑
'I' Stories (Qualitative Narratives)	❑	❑	❑	❑	❑
Administrative Data	❑		❑	❑	
Media Monitoring			❑	❑	❑
Political Discourse Analysis			❑		❑

2.6 Prevalence and attitudes household survey

The prevalence and attitudes household survey is the flagship component of the study. It provides nationally representative data on the extent of GBV, both experienced and perpetrated, across all ten districts of Lesotho, as well as data on gender attitudes, health consequences, help-seeking behaviour, and exposure to prevention campaigns.

[85] WHO (2005). WHO Multi-country Study on Women's Health and Domestic Violence against Women. Geneva: World Health Organization.

2.6.1 Survey instruments

The 2025 study employed two separate interview schedules, one for women respondents and one for men, consistent with the 2013 baseline design. However, the 2025 instruments represent a fundamental methodological departure from the unidirectional measurement approach used in 2013. The 2013 study measured women's experience of violence (Section 10, women's questionnaire) and men's perpetration against women (Section 10, men's questionnaire). The 2025 instruments adopt a bi-directional framework: both questionnaires now capture experience and perpetration of intimate partner violence.

The men's questionnaire now includes a full Section 11 on men's experience of Intimate Partner Violence (IPV) from a partner, covering emotional, economic, physical, sexual, and reproductive coercion. In contrast, the women's questionnaire includes a parallel Section 13 on women's perpetration of IPV across the same sub-types. This bi-directional design enables the study to measure the full spectrum of violence within intimate relationships, including mutual violence, and to analyse the relationship between experiencing and perpetrating violence for both genders.

The team developed the 2025 instruments from the 2013 questionnaires, modifying them substantially to reflect emerging global and regional evidence, lessons from the baseline data collection, and changes in Lesotho's legal landscape. These changes include the Counter Domestic Violence Act (2022), the Labour Act (2024), and Lesotho's ratification of ILO Convention C190. The team translated both instruments into Sesotho and piloted them in a non-sampled area before fieldwork. Gender Links originally designed the 2013 questionnaires for its multi-country GBV Indicators Study, and some items reflected the South African context in which the instruments were first developed. The 2025 revision localised all content to Lesotho.



16 Days Campaign event in Lesotho in 2013. *Photo: Ntolo Lekau*

Beyond the bi-directional shift, the 2025 instruments introduced several entirely new measurement domains absent from the 2013 study, that is, Technology-facilitated GBV (TFGBV, Section 16), disability screening using the Washington Group Short Set on Functioning (Section 3), self-reported gender identity alongside biological sex (Q2.3), and reproductive coercion as a distinct sub-domain. The non-partner sexual violence module was expanded with additional act types (attempted rape, incapacitated assault), and sexual harassment measurement was extended to men and broadened beyond the workplace/school quid pro quo[86] to cover public spaces. The 2025 study also expanded the age range from 18 years and older to 15 years and older, with no upper age limit, enabling measurement of GBV among adolescents and elder abuse for older adults.

[86] Quid pro quo sexual harassment refers to situations where sexual favours are demanded in exchange for workplace or educational benefits, such as employment, promotion, or academic advancement. The 2025 study expands this definition to also capture sexual harassment occurring in public spaces, online environments, and other settings outside formal institutional power structures.

At the same time, the 2013 instruments already contained validated mental health instruments, the CES-D depression scale, a PTSD checklist, and an Experiences of Trauma module, which the 2025 instruments retained, updating the PTSD measure to the DSM-5-aligned PCL-5.

Both instruments covered the following core domains (see **Annex 3**) for detailed differences between the 2013 and 2025 instruments):

- Gender attitudes, including attitudes towards intimate partner violence, sexual coercion, relationship control, and perceived community norms;
- Adverse childhood experiences, including physical, emotional, and sexual abuse, neglect, household dysfunction, and witnessing domestic violence;
- Prevalence and patterns of intimate partner violence, both experience and perpetration, across emotional, physical, sexual, economic, and reproductive coercion sub-types;
- Non-partner sexual violence: experience (women) and perpetration (men), with expanded act-type detail in 2025;
- Sexual harassment in public spaces, schools, and workplaces (both genders in 2025; women only in 2013);
- Technology-facilitated GBV among internet users (2025 only);
- Health consequences of GBV, including injury, mental health (CES-D, PCL-5), substance use, and reproductive health;
- Help-seeking behaviour and access to justice after experiences of GBV, including formal and informal sources of support;
- Economic dimensions of violence, including economic abuse and its relationship to other forms of GBV;
- Awareness of relevant legislation and exposure to and assessment of prevention campaigns; and
- Functioning and disability (2025 only, via Washington Group Short Set[87]).

2.6.2 Sampling design

The sampling design for the 2025 follow-up study is a three-stage proportionate stratified cluster design, using the 2022 Lesotho Population and Housing Census as the primary frame. The Bureau of Statistics (BOS) provided the updated frame. From this frame, the team selected 225 Enumeration Areas (EAs) as primary sampling units using probability-proportional-to-size (PPS) sampling, stratified by district, ecological zone, and settlement type. The team distributed the target sample of 4,500 interviews (2,700 women and 1,800 men) across all ten districts, with 20 interviews per cluster, that is, 12 women and 8 men in separate households. Within each selected household, enumerators randomly selected one eligible respondent aged 15 or older using the Kish Grid method. While retaining the core architecture of the 2013 baseline (PPS, census-based frame, 225 EAs, one respondent per household), the 2025 design introduces refinements informed by advances in GBV survey methodology and lessons from the earlier round.

Annex 3 compares both sampling designs across 22 dimensions, with district-level allocation tables and a discussion of key differences and their implications for cross-round comparability. Both rounds used proportionate stratified cluster designs with PPS sampling, census frames, and 225 EAs across all ten districts. However, the 2025 design introduces a three-category settlement classification (urban, peri-urban, rural), an explicit three-stage selection procedure with the Kish Grid, a lower age threshold, and modernised data and analysis infrastructure.

[87] WG Short Set on Functioning (WG-SS) - The Washington Group on Disability Statistics. Available at: https://www.washingtongroup-disability.com/question-sets/wg-short-set-on-functioning-wg-ss/ (Accessed: April 24, 2026).

Table 2.2: District-level EA allocation by settlement type, 2013 and 2025

District	2013 EAs	Urban	Rural	2025 EAs	Urban	Peri-Urban	Rural
Butha-Buthe	20	8	12	18	5	0	13
Leribe	32	13	19	31	12	5	14
Berea	21	7	14	27	10	5	12
Maseru	46	26	20	40	21	6	13
Mafeteng	22	9	13	22	7	4	11
Mohale's Hoek	26	7	19	21	7	2	12
Quthing	18	6	12	17	6	2	9
Qacha's Nek	13	5	8	14	4	1	9
Mokhotlong	12	4	8	16	4	1	11
Thaba-Tseka	15	4	11	19	4	2	13
Total	**225**	**89**	**136**	**225**	**80**	**28**	**117**

Source: 2013 data from published report; 2025 data from BOS sampling frame

Table 2.3: 2025 EA distribution by district and ecological zone

District	Lowlands	Foothills	Mountains	Senqu River Valley	Total
Butha-Buthe	10	5	3	0	**18**
Leribe	23	3	5	0	**31**
Berea	22	4	1	0	**27**
Maseru	28	5	7	0	**40**
Mafeteng	17	5	0	0	**22**
Mohale's Hoek	10	3	3	5	**21**
Quthing	0	0	5	12	**17**
Qacha's Nek	0	0	8	6	**14**
Mokhotlong	0	0	16	0	**16**
Thaba-Tseka	0	0	14	5	**19**
Total	**110**	**25**	**62**	**28**	**225**

Source: BOS sampling frame. Gender Links

Table 2.4: 2025 Response rates by district

District	No. of EAs	Target Women	Target Men	Actual Women (% complete)	Actual Men (% complete)	Total (% complete)
Qacha's Nek	14	168	112	169 (101%)	114 (102%)	283 (101%)
Butha-Buthe	18	216	144	216 (100%)	143 (99%)	359 (100%)
Maseru	40	480	320	457 (95%)	318 (99%)	775 (97%)
Mokhotlong	16	192	128	187 (97%)	122 (95%)	309 (97%)
Quthing	17	204	136	195 (96%)	130 (96%)	325 (96%)
Mafeteng	22	264	176	249 (94%)	168 (95%)	418 (95%)
Berea	27	324	216	301 (93%)	206 (95%)	507 (94%)
Mohale's Hoek	21	252	168	237 (94%)	152 (90%)	389 (93%)
Leribe	31	372	248	345 (93%)	229 (92%)	574 (93%)
Thaba-Tseka	19	228	152	209 (92%)	107 (70%)	316 (83%)
TOTAL	**225**	**2700**	**1800**	**2565 (95%)**	**1689 (94%)**	**4254 (95%)**

Source: Lesotho GBV 2025, Sampling Gender Links, BOS

The overall completion rate of 95% (95% for women, 94% for men) reflects strong fieldwork execution across all 225 clusters. However, the district-level pattern reveals important variation. Qacha's Nek and Butha-Buthe achieved completion rates of 100% or higher, replacement households yielded slightly more interviews than the original target, while Maseru, Mokhotlong, and Quthing performed close to the national average at 96-97%. The more densely populated and dispersed districts of Leribe and Berea recorded slightly lower rates (93-94%), reflecting the challenge of covering more clusters across mixed settlement types. Mohale's Hoek shows a gender gap: 94% for women but only 90% for men, suggesting differential availability among male respondents. The most notable outlier is Thaba-Tseka, where the overall rate fell to 83%, driven almost entirely by the male sub-sample at 70%, the lowest of any district-gender combination. This pattern is consistent with the district's mountainous terrain, dispersed settlement, and seasonal male labour migration, which reduces the likelihood of reaching eligible male respondents within the three-visit follow-up protocol. The Thaba-Tseka male completion rate warrants interpretive caution at the district level. At the national level, however, its impact is moderated by the district's small share of the total sample (19 of 225 clusters) and by design weights that adjust for differential non-response.



Data collection through mountainous terrain in Thaba Tseka by enumerators, November, 2025. *Photo: GL Lesotho*

2.6.3 Continuities between the 2013 and 2025 designs

The 2025 design deliberately replicates the core architecture of the 2013 baseline to enable meaningful trend comparison. Both rounds employ a proportionate stratified cluster design based on PPS sampling, ensuring that clusters are selected with probabilities proportional to their population sizes.[88] Both rounds use census-based sampling frames, stratified by ecological zone (Lowlands, Foothills, Mountains, and Senqu River Valley) to ensure geographic representativeness, and maintain 225 Enumeration Areas as primary sampling units across all ten districts.

The 2025 design retains four 2013 protocols: one eligible respondent per household, the residency requirement of at least four nights per week, no respondent substitution, and three follow-up visits for non-contact. In both rounds, EA boundaries are defined from census base maps, and field teams conducted household listing exercises to produce a comprehensive sampling frame within each selected EA before household selection began. The ethical framework, voluntary informed consent, anonymity through study IDs, trauma counselling training for interviewers, and the use of neutral project descriptions to protect respondent safety are substantively unchanged.

[88] The 2013 report references Hansen, Hurwitz, and Madow (1953), Cochran (1977), and Kish (1965) as the methodological foundations for the PPS sampling approach.

2.6.4 Key methodological differences

The 2025 study expanded the settlement classification from a binary scheme to a three-category system. The 2013 design classified all 225 EAs as either Urban (89) or Rural (136). The 2025 design introduces a Peri-Urban category, producing a three-way classification: Urban (80 EAs), Peri-Urban (28 EAs), and Rural (117 EAs).[89] This refinement enables disaggregation of GBV estimates by settlement type and more nuanced analysis of the relationship between urbanisation and violence.

The most consequential procedural change is the shift from a two-stage to a three-stage sampling design. In the 2013 design, the two stages comprised EA selection (via PPS) and household selection (from a listing form). The 2025 design adds an explicit third stage: within-household respondent selection using the Kish Grid method.[90] In the 2025 procedure, enumerators compiled a household roster of all members aged 15 and above, listing each by name, sex, and age, and then ranked eligible members from oldest (rank 1) to youngest. They then cross-referenced the last digit of the household ID against the number of eligible persons in the Kish Grid table to produce a selection number. The member whose age-rank matched that number became the designated respondent. This formalised randomisation eliminates interviewer discretion in respondent selection.

The stratification variables differ between the two rounds. The 2013 design stratified by urban/rural residence and ecological zone. The 2025 design stratifies by district, ecological zone, and settlement type (urban/peri-urban/rural), allocating EAs proportionately to each district's share of the national household population. Both approaches ensure geographic representativeness, but the 2025 approach provides more explicit district-level coverage, supporting the production of district-level estimates.

The 2025 design revises the gender allocation method. In 2013, researchers interviewed only one gender per EA, allocating each EA to either male or female respondents. The 2025 design interviews both genders within the same EAs, selecting men and women from separate households to protect privacy. This permits within-cluster gender comparisons and eliminates the potential confound of gender-specific geographic selection.

The 2025 design lowers the age eligibility threshold from 18 to 15 years, with no upper age limit.[91] This substantially expands the study population, allowing the 2025 study to capture GBV among adolescents, including child marriage and early experiences of intimate partner violence, and to measure elder abuse among older adults.

The 2025 design makes the household membership criteria more explicit. It specifies inclusion rules for domestic servants (included if sleeping 5 or more nights and eating with the family), visitors (included if sleeping in the household for the past 4 weeks), and students or workers residing with the household. Members absent from institutions are excluded. While the 2013 study applied a similar residency requirement (four nights per week), it did not publish these granular inclusion/exclusion rules.

The household-level replacement protocol introduces a controlled flexibility absent from the 2013 approach. While both rounds prohibit respondent substitution within a household

[89] The peri-urban category captures transitional settlement areas - typically located on the fringes of urban centres - that share characteristics of both urban and rural settings. These areas were classified as either urban or rural in the 2013 binary scheme, potentially masking distinct GBV patterns associated with rapid urbanisation and informal settlement growth.

[90] The Kish Grid is a pre-assigned table of random numbers used to select one respondent from all eligible household members. In the 2025 study, the grid cross-references the last digit of the household ID against the number of eligible members (aged 15+) to produce a selection number. Household members are ranked by age (oldest = 1), and the member whose rank matches the selection number is interviewed. This eliminates interviewer discretion and ensures each eligible person has an equal probability of selection.

[91] The lowering of the age threshold from 18 to 15 years was informed by growing evidence of GBV among adolescents and the need to capture early experiences of violence, including child marriage, that the 2013 design could not measure.

(proxy response not permitted), the 2013 study did not permit any household replacement. The 2025 design permits up to five replacement households per cluster where the originally selected dwelling is unavailable or ineligible, reducing non-response bias while maintaining the integrity of the sampling frame.

The 2025 design updates the sampling frame from the 2013 Census to the 2022 Population and Housing Census.[92] The 2013 design was explicitly self-weighting. The PPS scheme ensured constant overall selection probabilities, reducing variance from weight variation. The 2025 design calculates and applies design weights to account for differential selection probabilities and derives normalised household weights for nationally representative estimates.

The transition from PDAs to tablet-based KoBoCollect software represents a modernisation of the data collection infrastructure. While both platforms enable electronic questionnaire administration, KoBoCollect allows real-time server synchronisation and quality monitoring. The 2025 study implemented a structured supervisor daily field reporting system (Form H01) tracking household-level progress (households visited, occupied, eligible, refused), individual respondent progress (Kish Grid selections, completed/partial interviews, refusals, by gender), quality control metrics (spot-checks, back-checks, data quality issues), and incident/safety reporting. The 2013 study required daily data downloads and merging from PDAs.

The data analysis software was upgraded from Stata Version 11 (used in 2013, with Taylor linearisation for confidence intervals from complex multistage surveys and Pearson's chi-squared test for categorical associations) to Stata/MP Version 19.5, the multiprocessor edition, which provides substantially expanded analytical capabilities, including updated survey estimation commands, enhanced multiple imputation procedures, and modern panel data methods.

The data collection period was compressed from approximately one month (16 March to 15 April 2013) to 16 days (8 to 23 November 2025), reflecting improvements in fieldwork logistics, electronic data capture, real-time quality monitoring, and supervisor coordination. Both rounds achieved complete cluster coverage.

2.6.5 Implications for comparability

The high degree of methodological continuity between the two rounds, the same number of clusters (225), PPS selection, census-based frames, ecological zone stratification, one respondent per household, and comparable ethical frameworks, supports the validity of national-level trend comparisons. The principal comparability considerations are: (i) the change in census frame, which may reflect population redistribution between Census rounds; (ii) the different stratification variables (urban/rural in 2013 versus district and settlement type in 2025), which affect cluster allocation but not the overall representativeness of the national sample; (iii) the introduction of the peri-urban category, which re-classifies some EAs that were coded as urban or rural in 2013; (iv) the gender allocation shift from EA-segregated to within-EA sampling, which improves the 2025 design but means male and female sub-samples are not drawn from identical geographic configurations across rounds; and (v) the lowered age threshold, which means the 2025 study captures a broader population (15+) than 2013 (18+). For direct trend comparisons, age-specific tabulations restricted to respondents aged 18 years and older should be used.

[92] The 2013 study used dwelling counts from the most recent Population Census as its measure of size for PPS selection. The 2025 study similarly draws from the 2022 Population and Housing Census. Both frames are nationally authoritative, but the 12-year gap between census frames means that population shifts may affect the strict comparability of cluster-level estimates.

2.6.6 Limitations of the sampling design

The following limitations are noted:

- The cross-sectional design does not allow for causal inference. While the study can compare prevalence estimates across 2013 and 2025, it cannot attribute observed changes to specific interventions or policies
- As with all surveys measuring GBV, social desirability bias and recall limitations affect self-reported data on sensitive behaviours, particularly perpetration. The study instruments are designed to minimise but not eliminate these effects.

2.6.7 Fieldworker recruitment and training

Where possible, the team recruited field staff from within each district to ensure linguistic competence in Sesotho and familiarity with local communities. Female interviewers conducted all women's interviews, and male interviewers conducted all men's interviews. Gender-matching interviewers and respondents is recognised as best practice in VAW surveys, and the study applied it consistently.

The team ran a centralised training programme from 3 to 7 November 2025, before fieldwork began. The training covered study rationale and objectives; ethical guidelines and gender sensitivity; methodology and sampling procedures; survey instrument administration; tablet-based data collection software (KoBoCollect); interviewer safety protocols; and trauma-informed interviewing techniques. Field supervisors are also trained on quality assurance, including real-time monitoring of data submissions, back-checking of completed interviews, and managing deviations from protocol.

2.6.8 Data collection

Before starting interviews in each community, field teams ran sensitisation exercises. They engaged the local councillor, chief, or other traditional authority to explain the purpose, scope, and voluntary nature of the research. The teams consistently described the study to communities as a "relationship study", a framing shown to reduce gatekeeping and refusal at the household level.

The team collected data between 8 and 23 November 2025. Interviewers administered questionnaires on Android tablets running KoBoCollect software, replacing the Personal Digital Assistants (PDAs) used in 2013. The transition improved data quality monitoring enabled real-time data transmission to supervisors, and reduced data entry errors. As in 2013, respondents chose their preferred language (Sesotho or English) for the interview. The questionnaire used intelligent skip logic that directed enumerators to only the questions relevant to each respondent. The KoBoCollect software enabled offline data collection, with enumerators uploading completed interviews whenever an internet connection was restored.

Within each selected household, the interviewer approached the eligible resident (female or male, depending on EA allocation) and interviewed them in private, away from other household members. If the sampled respondent was not at home on the first visit, the interviewer made up to three further attempts at different times of day, following the contact and replacement protocol.

2.6.9 Data management and analysis

KoBoCollect uploaded the data to a secure central server daily, allowing survey coordinators to monitor completion and data quality in real time. Field teams investigated inconsistencies and outliers flagged during daily quality checks and resolved them on the spot where possible. After fieldwork, the team ran the data through a twelve-step preparation pipeline.

The pipeline included import and cleaning, recoding, council and occupation merges, wealth index construction, qualitative theme coding, weight merging, dataset appending, and composite variable construction. It produced a single Stata analysis dataset of 4,254 respondents, 2,565 women and 1,689 men. The analysis used Stata/MP 19.5 with the survey estimation suite, specifying the EA as the primary sampling unit and the district-settlement-type stratum as the stratification variable. The Bureau of Statistics supplied the sampling weights, which the analysis applied to all estimates to account for unequal selection probabilities and non-response.

The analysis presents results as survey-weighted proportions or means, with 95% confidence intervals estimated by Taylor linearisation. Sample sizes (N) report unweighted counts. The design-adjusted Pearson chi-square statistic tests associations between categorical variables, and survey-adjusted t-tests test differences in means. Survey logistic regression (svy: logistic) identifies independent risk factors for binary outcomes, with results reported as adjusted odds ratios and 95% confidence intervals. Z-tests for proportions compare trends between the 2013 baseline and the 2025 follow-up. For these comparisons, the analysis restricts the 2025 sample to respondents aged 18 and older to match the 2013 age frame.

The analysis did not impute missing data. Survey estimation commands excluded missing observations on a per-estimate basis.

2.7 Ethical considerations

The study was conducted in accordance with ethical standards for research involving human participants, and with specific reference to WHO ethical and safety guidelines for research on violence against women.

The study was conducted in accordance with ethical standards for research involving human participants

All participation was entirely voluntary. Before each interview, the interviewer explained the purpose of the study, the voluntary nature of participation, the right to refuse any question or to withdraw at any time without consequence, and the measures in place to protect confidentiality. The interviewer delivered this information verbally and in writing in the respondent's preferred language. Each respondent then provided written informed consent before the interview began. To ensure anonymity, the team assigned non-consecutive study identification numbers to all questionnaires. The questionnaires recorded no personally identifying information, and the study has no capacity to link individuals to their responses.

Because the questions cover sensitive topics such as sexual violence, childhood abuse, and

mental health, interviewers trained in trauma-informed interviewing techniques, each woman interviewed received a referral sheet with contact details for organisations providing counselling, legal aid, and other support services. Interviewers had instructions to pause the interview and offer immediate support if a respondent showed signs of acute distress. For respondent safety and dignity, the team never interviewed men and women in the same household and never interviewed in the presence of another adult household member. Female interviewers conducted all interviews with women.

2.8 'I' Stories: Qualitative personal hand experiences of violence

The 'I' Stories methodology[93] was developed by Gender Links as part of the 16 Days of Activism against Gender Violence campaign, first implemented in 2004. It provides a structured qualitative approach to gathering first-hand accounts of GBV from survivors. The methodology gives a human face to the quantitative data, surfacing the lived experiences of violence, its causes, and its consequences in ways that statistics alone cannot convey.



Trained Gender Links staff conducted 'I' Stories interviews across all ten districts. Supporting organisations such as the CGPU and local councils helped identify and refer potential participants. Participation was entirely voluntary. Facilitators explained the purpose of the research, what participation would entail, how the team would use the stories, and the option to use a pseudonym. Each participant signed a consent form specifying how the team could use their story and whether it could publish photographs.

The 'I' Stories address the following key research questions. Can survivors identify and name the different forms of GBV they have experienced? What are the causes and consequences of violence in their lives? How has violence affected their ability to leave abusive relationships? What support, formal and informal, has been available and accessed?

Editors work collaboratively with participants on 'I' Stories, and participants approve the final version of their accounts and any changes. Where literacy is a barrier, facilitators help participants articulate their stories verbally and transcribe them with the participant's consent. Every story in this report appears with the participant's approval, identified by a pseudonym the participant chose and marked with an asterisk (*) at the end of the name.

2.8.1 'I' Stories insertion framework

The stories cover the full range of GBV forms, that is, IPV (physical, economic, emotional, sexual), non-partner rape, child sexual abuse, male victimisation, TFGBV, intergenerational violence, and institutional failure. Three archetypes structure the insertions. A chapter

[93] Gender Links (2024). I-Stories Methodology Guide. Johannesburg: Gender Links.

opening story anchors the chapter's central problem in lived experience. This is followed by an editor's note that grounds it in the chapter's analysis. Where possible, a transition story bridges the problem and the solution. A closing story shows what becomes possible when the system functions, or what is lost when it fails. Several in-text insertions qualify the quantitative data or argument being presented. The guiding principle for in-text insertions is fit for purpose. That is, each 'I' Story must illustrate the argument of the surrounding text, not simply add a compelling narrative.

2.9 Administrative data and key informant case studies

2.9.1 Rationale and objectives

The household prevalence survey provides population-level estimates of GBV experiences and perpetration, but it cannot, on its own, capture the institutional dimensions of the national response. These dimensions include the volume of cases entering formal systems, the capacity of service providers, the coordination mechanisms that connect them, and the systemic gaps that leave survivors without adequate support. To address this, the 2025 study added a complementary qualitative and administrative component to document Lesotho's institutional landscape for GBV.

As Walby (2005) observes, administrative data on GBV should not be treated as a direct measure of prevalence, since it reflects only those cases that enter formal reporting channels and is shaped by the accessibility, capacity, and recording practices of each institution.[94] Notwithstanding this limitation, administrative data provides a critical window into the functioning of the response system itself, the gap between the violence that occurs and the violence that is recorded, reported, and addressed. When triangulated with household survey data, it enables analysis of underreporting patterns, service utilisation rates, and the adequacy of institutional responses. The administrative data and case study component had three interrelated objectives. First, to document the extent of GBV as recorded in key public services, the criminal justice system (police, courts), health services, social services, and shelters. Second, to map the reach, capacity, and effectiveness of organisations working across the GBV prevention and response continuum in Lesotho and third, to identify systemic constraints, coordination gaps, and policy priorities from the perspective of practitioners and institutional actors.[95]

2.9.2 Scope and design

The component combined two complementary data collection strategies, that is, formal requests for administrative records from government institutions and semi-structured key informant interviews with representatives of organisations working in the GBV sector.

[94] Walby, S. (2005) "Improving the statistics on violence against women," Statistical Journal of the United Nations Economic Commission for Europe, 22(3-4), pp. 193-216. Available at: https://doi.org/10.3233/SJU-2005-223-402.
[95] The 2013 baseline study similarly collected administrative data from police, courts, and health services. The 2025 methodology retained this approach while expanding its scope to include additional government ministries, civil society organisations, and private-sector actors.

2.9.3 Data collection procedures

The team sent formal request letters to all government institutions and selected civil society and private sector organisations, explaining the study's objectives and specifying the administrative data indicators sought. For government institutions, the team provided data capture templates, including a court template with standardised fields for case type, status, and outcome to support consistent reporting. The team also conducted follow-up visits and meetings to address initial requests that needed clarification or data systems that did not align with the requested indicators.

Where possible, the team requested data for the period 2023-2025 and, as far back as 2014, to enable trend analysis and comparison with the 2013 baseline administrative records.

Key informant interviews were conducted face-to-face by the lead researcher and others by trained research assistants. Each interview lasted approximately 45-60 minutes and was audio-recorded with the informant's consent. Sector-specific interview guides were developed for each organisational type, tailored to the informant's mandate and operational context while maintaining the four core analytical questions that structured the analysis (see Analytical framework on page 64).[96] Interviews were conversational in tone, allowing informants to elaborate on institutional experiences, case examples, and systemic observations beyond the structured prompts. The team conducted 40 key informant interviews between February and April 2026, covering the organisations in Table 2.5.

Table 2.5: Key informant interviews by sector

Sector	Organisation(s) / Informant(s)	N
Government - Law Enforcement	Child and Gender Protection Unit (CGPU), Lesotho Mounted Police Service	1
Government - Judiciary	Children's Court, Magistrates Court, Department of Public Prosecutions (DPP)	3
Government - Ministries and Regulatory	Ministry of Gender, Youth, Sports and Development (MGYSD), MGYSD - Shelters Unit, Ministry of Health, Lesotho Communications Authority	4
Government - Development Partners	European Union Delegation, Millennium Challenge Account Lesotho, GIZ PFP Programme	3
UN Agencies	UNFPA Lesotho	1
CSOs - Legal and Rights	FIDA Lesotho (Federation of Women Lawyers), Legal Aid Clinic, Women and Law in Southern Africa (WLSA), Human Rights Lab	4
CSOs - Service Delivery and Advocacy	Care for Basotho, LANFOD (disability), Kick4Life, LPPA, SHE Hive, Mosepele Foundation, Migrant Workers Association of Lesotho, Peoples Matrix, Skillshare Lesotho, Solidarity Centre	10
Academia	Dr Rakolobe (NUL, Faculty of Education), Dr Hapazari (NUL, Gender and Sociology), Lesotho College of Education (LCE)	3
Faith and Traditional Leaders	Right Reverend Dr Makhata (Catholic Diocese), Pastor Rajaani (LHCC Church), Traditional Leaders (Mazenod)	3
Private Sector	Standard Bank Lesotho, Vodacom Foundation Lesotho	2
Media	Public Eye Newspaper, Media Influencer (Mme Dintle), MISA Lesotho, Harvest FM, LNBS (Lesotho National Broadcasting Service), Sesotho Media	6
Total		**40**

Source: Lesotho GBV 2025 Administrative Data and Case Study Records, Gender Links

[96] Interview guides were tailored to each organisation's mandate and sector. A master set of guides, organised by sector (legal/rights CSOs, service delivery CSOs, youth/health CSOs, UN agencies, government ministries, judiciary, faith and traditional leaders, private sector, media, and academia), was developed and refined iteratively.

2.9.4 Analytical framework

The team transcribed and summarised all interviews using a standardised analytical framework built around four core dimensions, and extracted verbatim quotations organised by theme. Table 2.6 overleaf presents the analytical dimensions and their guiding questions.

Table 2.6: Analytical framework for key informant case studies

Analytical dimension	Guiding question
Reach	Who is served, in which districts, and at what scale?
Evidence of impact	What outcome data, participant feedback, or observable changes exist?
Constraints	What are the funding, staffing, geographic, referral, and institutional barriers?
Systemic prevention landscape	What does this organisation's experience reveal about broader gaps, effective models, or policy needs?
Illustrative quotations	What verbatim statements illuminate the findings, organised by theme (law gaps, service gaps, survivor experiences)?

Source: Lesotho GBV 2025 Administrative Data Analysis Framework, Gender Links

For each interview, the team applied the analytical framework systematically to produce a structured summary, an overview of the organisation's mandate and operations, followed by detailed findings under each of the four dimensions. The team extracted verbatim quotations, organising them by theme, law and policy gaps, service delivery constraints, survivor experiences, data and coordination challenges, and cultural and social barriers, to support the narrative analysis in subsequent chapters. The team then consolidated individual summaries into a single integrated document, enabling cross-organisational comparison and identification of recurring themes.

The team compiled, cleaned, and tabulated administrative data from government institutions to produce descriptive statistics on reported case volumes, case outcomes, and service utilisation. The thematic chapters present these statistics alongside the household survey findings to illustrate the gap between population-level prevalence and formal recording, and to contextualise the qualitative findings on institutional capacity and coordination.

2.9.5 Limitations

Several limitations should be noted. First, the 2025 study expanded the sampling frame to include men and respondents aged 15 and above, whereas the 2013 baseline was restricted to women aged 18 and above. All trend comparisons are therefore restricted to ever-partnered respondents aged 18 and above to ensure like-for-like comparison, and a 22-dimension methodological comparison table (**Annex 3**) documents every change and its implications for comparability. However, the inclusion of younger and older respondents in 2025-specific analyses means that some headline figures are not directly comparable with 2013 without this restriction. Second, the shift from Personal Digital Assistants in 2013 to Android tablets using KoBoCollect software in 2025 represents a technology upgrade rather than a methodological change, both rounds used interviewer-administered, face-to-face

interviews with electronic skip logic, but minor differences in data entry interfaces cannot be entirely ruled out as a source of measurement variation.

Third, certain analytical constructs introduced in 2025, including the community norms index, the pluralistic ignorance measurement, and the Norms gap analysis, were not computed in the 2013 baseline and therefore represent cross-sectional findings that establish a new baseline for future measurement rather than trend comparisons. Fourth, district-level estimates for some indicators have small within-district cell sizes, particularly in districts such as Qacha's Nek and Mokhotlong, which produce wide confidence intervals and limit the reliability of sub-national inferences. District-level figures should be interpreted as indicative rather than definitive. Fifth, the study design is cross-sectional, which precludes causal attribution; observed associations between, for example, declining prevalence and legislative or programmatic investment should be interpreted as co-occurring trends consistent with a protective effect, not as evidence of direct causation. Sixth, administrative data availability and quality varied across institutions. Court records were not always disaggregated to the requested level of detail, and police case categories do not align with survey-measured violence sub-types, producing a structural survey-administrative data mismatch that limits direct triangulation. Seventh, not all targeted organisations responded to interview requests within the data collection window. For instance, several UN agencies (UN Women, UNICEF, WHO) were not interviewed, though their programming is discussed where secondary documentation was available. Health facility-level GBV data, including clinical inquiry and case management records, were not systematically accessible, which may understate the health sector's role in GBV identification and response. Eighth, the 40 key informant interviews conducted represent a purposive rather than exhaustive sample of the GBV sector, and the qualitative findings should be interpreted as illustrative of institutional experiences rather than statistically representative.

The disability analysis relies on the Washington Group Short Set on Functioning, which, while internationally recommended, may over- or under-classify some functional limitations depending on respondent interpretation. These findings should be triangulated with other disability data sources. Finally, the case study summaries rely on informants' self-reports of organisational reach and impact, which could not, in all cases, be independently verified against programme monitoring data.

2.10 Political discourse analysis and media monitoring

Public statements, speeches, and pronouncements by senior government officials and political leaders constitute a critical dimension of the policy environment in which GBV occurs and is addressed. The political discourse analysis component examines the prevalence, consistency, and substantive content of government commitment to addressing GBV, as reflected in official communications.

GL Lesotho contracted an external consultant who conducted desktop research to identify relevant speeches, policy statements, parliamentary debates, and media statements by key government functionaries, including the Prime Minister, Ministers responsible for gender, justice, and health, and members of relevant parliamentary committees, during 2020-2025. Official government websites, Hansard records, and the archives of major Lesotho newspapers were reviewed.

Collected materials were analysed for the frequency and prominence of GBV as a stated concern, the conceptual framing of GBV (whether as a human rights issue, a criminal

justice matter, a public health concern, or otherwise), the specificity of commitments made, and evidence of alignment between stated commitments and legislative, budgetary, or programmatic action. These findings are used to triangulate the quantitative and qualitative evidence on response and prevention throughout the report.

2.10.1 Media monitoring

The media monitoring component assesses the extent and quality of GBV coverage in the Lesotho print and broadcast media. Media coverage of GBV both reflects and shapes public attitudes: responsible, survivor-centred coverage can challenge norms that enable violence, while sensationalised or victim-blaming coverage can reinforce them. Monitoring the media, therefore, provides insights into both the information environment in which the public understands GBV and the extent to which media institutions are fulfilling their potential role in ending violence.[97]

Media monitoring was conducted over one month using both quantitative and qualitative methods. Quantitative monitoring involved systematic coding of GBV-related content across selected print, online, radio, and television outlets, capturing: the proportion of total coverage relating to GBV; topics covered; the sex of sources cited; the framing of survivors and perpetrators; and the geographic origin of stories. Qualitative analysis involved an in-depth examination of selected items to assess framing, language, and representation.

The following key questions guided the analysis:

- What proportion of total media coverage addresses GBV?
- What aspects of GBV receive the most and least attention?
- How are survivors of GBV depicted in media coverage?
- What is the balance of women and men as sources in GBV stories?
- Does coverage focus on prevention, response, or effects, and in what proportions?
- How does coverage in 2025 compare with findings from the 2013 baseline?



Sesotho Media and Development at Mohale FM addressing issues surrounding GBV, HIV & AIDS, and SRHR in 2025. *Photo: SM&D*

2.11 Triangulation and integration of findings

The five study components generate complementary data that are designed to be read together. Throughout this report, findings from each component are brought into conversation with one another: the quantitative prevalence estimates from the household survey are contextualised by the lived experiences documented in 'I' Stories; administrative data shed light on gaps between population-level need and service uptake identified in the survey; media monitoring and political discourse analysis illuminate the information and policy environments within which GBV occurs and is responded to.

[97] Lesotho Communications Authority (2024). Annual Report 2023/24. Maseru: LCA.

This triangulation approach strengthens the validity of findings and provides a more complete basis for policy recommendations than any single tool could offer. Where data from different components converge, confidence in the conclusions is heightened. Where data diverge, the divergence itself is informative and is examined as part of the analysis. The five thematic dimensions of the study, extent, effects, response, support, and prevention, each draw on multiple components, as illustrated in Table 2.1 above.

2.12 Methodological changes since the 2013 baseline

The 2025 follow-up study replicates the 2013 methodology as closely as possible to enable valid trend analysis. The following changes were made, and their implications for comparability are noted:

- **Updated sampling frame.** The 2013 baseline used the 2006 Census sampling frame. The 2025 follow-up uses the 2022 Census frame, reflecting significant population growth and redistribution, particularly urbanisation over the intervening period. The PSUs selected in 2025 are not the same as the EAs in 2013. National and district-level estimates are comparable, but cluster-level comparisons should not be drawn.
- **Electronic data collection platform.** The 2013 study used Personal Digital Assistants (PDAs) for electronic data capture. The 2025 study uses tablet-based KoBoCollect software, which offers enhanced data quality monitoring, skip-logic management, and real-time data transmission. The transition does not affect the content of the questionnaire or the substance of responses.
- **Updated questionnaire modules.** Minor additions to the questionnaire reflect the updated legislative context (including the Domestic Violence Act 2022) and emerging evidence on GBV and technology-facilitated abuse. Core questions on prevalence, attitudes, and help-seeking are retained from the 2013 instrument, ensuring direct comparability on the primary indicators of change.
- **Expanded administrative data scope.** The 2025 study extends the administrative data collection to cover the period 2020-2025 (where possible), providing a longer-run view of institutional trends than was possible at baseline.

The following chapters draw on all five study components to present findings on the extent, effects, response, support, and prevention dimensions of GBV in Lesotho in 2025 and to track change since the 2013 baseline.

A methodological note on the chapters that follow: The 2025 study is a cross-sectional survey and cannot establish causal relationships between interventions and prevalence changes. Where declines in GBV prevalence are observed between 2013 and 2025, these are associations that may reflect multiple contributing factors, including legislative reforms, awareness campaigns, economic changes, and broader social norm shifts. The language in this report has been carefully framed to reflect association rather than causation: phrases such as "associated with," "corresponds with," and "aligns with" are used in place of causal claims. Readers should interpret trend findings within this methodological constraint.

CHAPTER 3
EXTENT OF GENDER-BASED VIOLENCE



GL's Thandiwe Hlelesi and Ntsekiseng Thetsane engage with CGPU officer in Mohale's Hoek before collecting 'I' Stories in February, 2026.
Photo: Thakane Sello

Key findings

- Two in every three ever-partnered women (66.7%) report lifetime experience of at least one form of GBV. Nearly half of ever-partnered men (46.2%) report GBV experience.
- IPV has declined significantly across all forms since 2013.
- Past 12-month IPV prevalence stands at 14.8% for women, indicating that one in seven ever-partnered women experienced active, ongoing violence in the year preceding the survey.
- Non-partner sexual violence affects 9.4% of all women; sexual harassment, 21.3%; technology-facilitated GBV, 18.2% of internet-using women.
- Adverse childhood experiences (ACEs) are pervasive: 80.3% of women and 77.7% of men report at least one form of childhood adversity.
- Only 9.9% of women survivors report to the police, while 89.2% never told anyone about their experience.
- Women with disabilities experience higher rates of GBV than women without disabilities (73.3% versus 65.1%), with the disparity most pronounced for economic IPV (28.1% versus 21.2%) and physical IPV (33.3% versus 26.2%).
- LGBTQI+ persons face substantially elevated GBV risk.

Trapped in fear and abuse



"I have been in a relationship with my partner for years, but things have become unbearable. My partner often spends time with his friends, drinking and neglecting me, and when I try to leave, he threatens me. One night, after ignoring his calls, he came looking for me, and when he found me, he beat me with a stick and took my phone. That night, I was walking with my neighbour/friend, who disappeared upon realising my partner was coming our way, since this man tends to abuse or beat anyone I am with, even my friends and colleagues sometimes. Even if he finds me in a public bar with people, those close to me leave immediately as he causes drama or even assaults them. When I see him coming, I prefer to leave because I am tired of him embarrassing me in public and his insults. That phone he took is important because it connects me to my work, hence I went to report to the police what he did to me, including the phone issue. He has done this before, locking me inside the house, beating me, and taking my money to spend on alcohol. Even when I try to report him, the police ask me what I want them to do, as if my suffering is not serious. He continues to harass me, even attacking people I am with, and then later apologises only to repeat the same behaviour. For nearly five years, I have endured this abuse, threats, and humiliation. He tells me that if I leave him, he will kill me, and I live in constant fear. I feel trapped, exhausted, and deeply hurt, wondering if reporting him again will ever change anything. Despite everything, he insists that he is not abusive, but my reality is filled with pain, violence, and intimidation. I am tired of living this way, and I don't know how much longer I can endure it."

Masello, Butha-Buthe*

Masello's account captures every form of GBV the chapter quantifies, that is, physical violence, economic abuse, technology-facilitated harm, and the barriers survivors face when reaching for help.

Overview

This chapter presents the prevalence findings from the 2025 household survey. It documents the extent of intimate partner violence, non-partner sexual violence, sexual harassment, and technology-facilitated GBV experienced by women and perpetrated by men, disaggregated by demographic characteristics including age, district, settlement type, education, wealth, disability status, and gender identity. Where comparable measures exist, it reports change since the 2013 baseline. The chapter also presents the first national measurement of adverse childhood experiences in Lesotho. Together, these findings establish the scale and distribution of GBV that the subsequent chapters on drivers (Chapter 4), effects (Chapter 5), response (Chapter 6), support (Chapter 7), and prevention (Chapter 8) seek to explain and address.

This chapter presents the first national measurement of adverse childhood experiences in Lesotho

3.1 Introduction

Gender-based violence constitutes one of the most structurally entrenched human rights challenges in Lesotho. The 2025 GBV Indicators Follow-up Study presents the most comprehensive national measurement of GBV ever conducted in Lesotho. This chapter presents the extent of GBV across both a lifetime horizon and the twelve months immediately preceding the survey. A total of 4,254 interviews were completed, that is, 2,565 with women (60.3%) and 1,689 with men (39.7%), representing an overall completion rate of 95% (**see Statistical Appendix Table A1**). All 225 clusters were visited across all ten districts.

Statistical Appendix Table A1 includes disability prevalence figures measured using the Washington Group Short Set on Functioning (WG-SS), which classifies respondents as having a disability if they report 'a lot of difficulty' or 'cannot do at all' on at least one of the six functional domains. The overall disability prevalence in the sample is presented alongside the demographic breakdown, providing essential context for the disability-stratified GBV analysis presented later in Section 3.17.

3.2 Conceptual and measurement framework

This study uses a single aggregate GBV measure, Any GBV (lifetime), which captures any experience of gender-based violence across all domains measured in the survey, that is, intimate partner violence (physical, emotional, sexual, or economic), non-partner sexual violence, reproductive coercion, sexual harassment, technology-facilitated GBV, and child marriage as a harmful practice. This comprehensive measure structures the analysis throughout this chapter, providing the fullest picture of the GBV landscape in Lesotho. Where the chapter presents comparisons with the 2013 baseline study, these are restricted to the violence types measured in both rounds and use the 18-plus age threshold applied in the baseline; this is noted at the relevant tables and figures.

Unless otherwise stated, lifetime prevalence figures refer to the proportion of respondents who report having experienced (or perpetrated) the specified act at least once in their lifetime, with the denominator being ever-partnered women and men aged 15 and above for IPV-related measures, and all respondents aged 15 and above for NPSV, sexual harassment, and other non-partner forms of GBV. Past 12-month prevalence figures capture active or recent exposure to violence within the year preceding the survey interview. Where longitudinal comparisons with the 2013 study are presented, the analysis applies an 18-plus age restriction to maintain comparability with the baseline sampling frame.

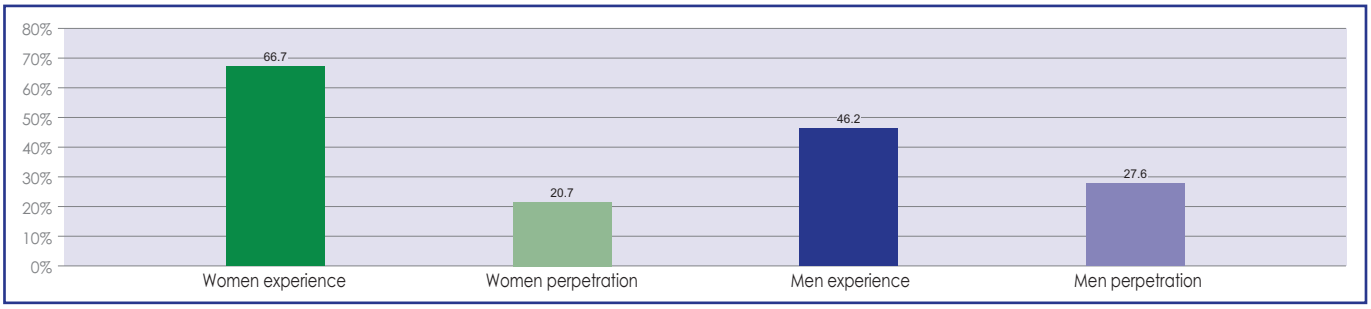
In interpreting experience-perpetration gaps throughout this chapter, two considerations are paramount. First, survey methodology cannot fully resolve the structural conditions that shape disclosure of patriarchal gender norms that minimise or normalise men's use of violence, social stigma attached to victimhood, fear of reprisal, and self-incrimination risks that may dampen men's acknowledgement of perpetration. These factors produce a systematic downward bias in men's reported perpetration relative to women's reported experience, a pattern documented in South Africa, Zimbabwe, Zambia, Botswana, and Tanzania in comparable studies. Second, consistent with GL's methodological approach,

the 2025 survey was designed to maximise disclosure through trained same-gender interviewers, dedicated interview spaces ensuring privacy, informed consent procedures, and a question sequencing that moves from less sensitive to more sensitive items within each module.

3.3 Overall prevalence of GBV in Lesotho

The 2025 study confirms that GBV remains pervasive in Lesotho, while also signalling significant progress since the 2013 baseline. Figure 3.1 presents the headline lifetime experience and perpetration figures.

Figure 3.1: Lifetime experience and perpetration of any GBV (%)



Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

Two in every three women (66.7%) report having experienced at least one form of GBV in their lifetime, placing Lesotho among the highest-burden countries in the sub-region. Nearly half of men (46.2%) also report GBV experience, a figure that reflects the bidirectionality of violence examined through the IPV typology analysis in Section 3.8.

On the perpetration side, more than one in four men (27.6%) acknowledge having perpetrated some form of violence, while one in five women (20.7%) report the same. The 39-percentage-point gap between women's experience (66.7%) and men's acknowledged perpetration (27.6%) is among the widest recorded in the GL multi-country study series, echoing and exceeding the gap observed in the 2013 baseline.[98] This gap cannot be explained by underreporting alone. Three reinforcing factors drive it. First, men systematically understate[99] their use of violence, whether through denial, minimisation, or fear of self-incrimination. Second, victimisation is not evenly distributed. That is, a smaller number of men may each victimise multiple women,[100] meaning fewer perpetrators can generate a larger pool of survivors. Third, patriarchal norms normalise certain behaviours, such as controlling a partner's movements or using physical force to "discipline", so that men do not recognise[101] or label their actions as violence, even when women experience them as such. The experience-perpetration gap is examined form-by-form throughout this chapter and constitutes a key analytical thread in the Effects, Response, and Prevention chapters.

[98] The experience-perpetration gap is a consistent finding across the GL multi-country study series. Structural factors, including patriarchal norms that minimise men's use of violence, stigma attached to male victimhood, and self-incrimination risks, systematically depress men's reported perpetration relative to women's reported experience. See Section 3.2 for a full discussion of the methodological considerations.

[99] Halim N, Ghanekar N, Mzilangwe ES, Reich N, Badi L, Agarwal N, Messersmith L. Can men's violence reporting behaviour be improved? Evidence from a couples-based cluster randomised controlled trial in Tanzania. Front Public Health. 2025 Nov 12;13:1460333. doi: 10.3389/fpubh.2025.1460333. PMID: 41312251; PMCID: PMC12646940.

[100] Robinson, A. L. (2017). Serial Domestic Abuse in Wales: An Exploratory Study Into its Definition, Prevalence, Correlates, and Management. Victims & Offenders, 12(5), 643-662. https://doi.org/10.1080/15564886.2016.1187691

[101] Hunt, X. et al. (2024) "It is in the Nature of Men": The Normalisation of Non-Consensual Sex and Intimate Partner Violence Against Women with Acquired Physical Disabilities in South Africa', Violence Against Women, 30(11), pp. 2789-2807. Available at: https://doi.org/10.1177/10778012231172710.

3.4 Forms of GBV experienced or perpetrated in a lifetime

Statistical Appendix Table A2 disaggregates the aggregate prevalence figures by violence type and subtype, revealing the relative weight of each domain in the overall GBV burden.

Intimate partner violence

Statistical Appendix Table A2 shows that IPV is the dominant contributor to the aggregate GBV figure. Among ever-partnered respondents, 45.7% of women and 28.2% of men report lifetime IPV experience. Emotional IPV is the most prevalent form for both sexes, reported by 32.5% of women and 20.8% of men, followed by physical IPV (27.6% women; 7.4% men), economic IPV (22.6% women; 11.5% men), and sexual IPV (11.3% women; 3.0% men). The dominance of emotional violence over physical forms is consistent with patterns observed across the GL multi-country framework, where coercive control through emotional manipulation and economic restriction often persists even as overt physical violence declines.

The severity of physical IPV in Lesotho warrants attention. Of the 27.6% of women who report physical IPV, nearly two-thirds (17.6%) experienced the severe form (while being hit, kicked, dragged, beaten, or having weapons used), indicating that physical violence, when it occurs, tends not to be minor. Men's reported physical IPV experience (7.4%) is markedly lower than their acknowledged perpetration (15.0%), one of the few domains where men's perpetration exceeds their reported experience, likely reflecting both greater social licence to disclose perpetration of physical acts and the framing effects of the perpetration module.

Sexual IPV remains the least reported form among women (11.3%) and men (3.0%). However, this is almost certainly a floor estimate given the well-documented barriers to disclosure of sexual violence within intimate partnerships. Women's perpetration of sexual IPV is reported at 1.4%, while men's is 4.1%. IPV during pregnancy affects 6.5% of women who have been pregnant (N=1,990), underscoring the vulnerability of pregnant women to continued or escalated violence.

Non-partner sexual violence

Any NPSV is reported by 9.4% of women, with forced sex (6.4%) and attempted rape (5.0%) the most prevalent acts. Gang rape, while reported at a lower prevalence (1.0%), represents one of the most severe forms of sexual violence and affects an estimated 23 women in the sample.

On the perpetration side, 17.6% of men report having perpetrated at least one form of NPSV. This figure is driven substantially by attempted rape (13.1%), followed by incapacitated assault (4.9%), forced sex (3.3%), and forced sex through threats (2.8%). The fact that men's NPSV perpetration (17.6%) is nearly double women's reported experience (9.4%) is striking. It may reflect that perpetrators victimise multiple women, that some perpetration occurs against women outside the survey sample, or that the perpetration module's framing elicits higher disclosure than the experience module.



Sesotho Media and police officers discussing GBV issues, HIV and AIDS and SRHR issues at Holy Cross, Mohale's Hoek in 2024. *Photo: SM&D*

Sexual harassment

Just over one in five women (21.3%) and one in ten men (10.6%) report having experienced sexual harassment in their lifetime. Among those who experienced harassment, public spaces are overwhelmingly the primary location, cited by 85.5% of women and 66.5% of men.[102] School is the second most common setting (12.3% of women; 16.4% of men), while the workplace accounts for 6.4% of women's and 13.3% of men's harassment experiences. The higher proportion of men reporting workplace and school harassment may reflect different occupational and educational exposure patterns or differing thresholds for what is recognised and reported as harassment across settings.

Technology-facilitated GBV

Among internet users, 18.2% of women and 21.0% of men report having experienced at least one form of TFGBV.[103] This is one of the few domains where men's reported experience exceeds women's, driven primarily by online abuse and unwanted messages (13.5% of men vs 9.2% of women). Online stalking affects both sexes at similar rates (11.5% women; 10.6% men). The more severe forms of online sextortion (1.8% women; 1.3% men) and non-consensual image sharing (0.6% women; 0.7% men) are reported at low but non-trivial levels that are likely underestimates given the stigma and shame associated with these experiences.

The emergence of TFGBV as a measurable domain, not captured in the 2013 baseline, reflects the rapid expansion of internet access in Lesotho and the migration of harassment and abuse into digital spaces. These findings point to the need for policy responses that extend beyond physical settings to address online safety.

Reproductive coercion

Reproductive coercion affects 9.4% of women and 6.3% of men as a form of experience, while 5.3% of women and 5.9% of men report perpetration. The relatively narrow experience-perpetration gap in this domain, compared with the wide gaps observed for IPV, suggests that reproductive coercion may be more readily acknowledged, perhaps because it is less stigmatised or less clearly identified as violence by respondents.

Among women, the most prevalent form of reproductive coercion is being told not to use birth control (5.4%), followed by forced pregnancy (2.8%) and having a condom removed during sex (2.2%). Forced miscarriage (1.8%) and forced abortion (1.3%) represent the most severe manifestations, directly endangering women's physical health and reproductive autonomy. On the perpetration side, men most commonly report refusing to use a condom (3.6%), followed by forced pregnancy (1.9%), threatening to leave if the partner did not have a child (1.3%), and hiding or destroying birth control (1.3%). Women's reported perpetration includes continuing a pregnancy against a partner's wishes (2.4%) and lying about using birth control (2.3%), forms of reproductive control that highlight the bi-directional nature of coercion in this domain.

[102] Among those who reported any sexual harassment. The denominator is N=572 for women and N=200 for men, representing the subset of respondents who experienced at least one incident of sexual harassment.
[103] TFGBV figures are restricted to respondents who reported using the internet (N=1,232 women; N=681 men).

Child marriage

A third of women (33.6%) and 28.2% of men were married or in a cohabiting union before the age of 18.[104] These are among the highest child marriage figures in the SADC region and signal a structural vulnerability that precedes and compounds adult GBV exposure. Child marriage curtails educational attainment, economic independence, and social networks, the very protective factors that reduce GBV risk in adulthood. The gender gap (5.4 percentage points higher for women) is consistent with the cultural practice of early marriage for girls. However, the substantial male figure indicates that boys are also affected, often through early cohabitation arrangements.

Childhood adversity

The childhood adversity findings are among the most striking in the entire dataset. Four in five women (80.3%) and men (77.7%) report having experienced at least one form of abuse or adversity before the age of 18.[105] Physical abuse is by far the most prevalent form, reported by 63.6% of women and 68.7% of men, reflecting deeply embedded norms around physical discipline of children. Emotional abuse (32.9% women; 33.5% men) and neglect (31.6% women; 30.2% men) affect roughly a third of both sexes. Household dysfunction, which includes parental substance abuse, incarceration, and mental illness, is reported by approximately a quarter of respondents (26.2% women; 24.0% men).

Witnessing intimate partner violence in the childhood home is reported by 21.9% of women and 14.1% of men, a gendered difference that may reflect girls' greater proximity to domestic spaces where IPV occurs, or differential recall and recognition. Childhood sexual abuse affects 14.4% of women and 14.5% of men at almost identical rates, a finding that challenges the common assumption that sexual abuse is primarily a female experience.

These figures point to a powerful intergenerational transmission cycle. The overwhelming majority of adults in the sample grew up in environments characterised by violence, abuse, or adversity, creating the normative and psychological conditions in which adult GBV is reproduced. The prevention implications are discussed in Chapter 8.

4 in 5 adults grew up in environments characterised by violence, abuse, or adversity, the intergenerational pipeline that produces the next generation of GBV

Overall, **Statistical Appendix Table A2** reveals a GBV landscape in Lesotho characterised by high aggregate prevalence, the dominance of IPV and emotional violence, significant non-partner sexual violence perpetration by men, emerging digital dimensions of abuse, widespread reproductive coercion, and an almost universal childhood adversity burden. The experience-perpetration gaps vary considerably by violence type, that is, widest for IPV (where structural under-disclosure by men is most pronounced), narrower for reproductive coercion, and reversed for TFGBV and men's physical IPV perpetration. These patterns are disaggregated by demographic characteristics, district, and other factors in the sections that follow.

[104] Child marriage is defined as marriage or cohabitation before age 18, consistent with the SADC Protocol on Gender and Development definition. The denominator excludes respondents under 18 at the time of survey (N=2,057 women; N=1,174 men).

[105] Childhood adversity items are based on adapted ACE (Adverse Childhood Experiences) questions covering physical abuse, emotional abuse, neglect, household dysfunction, witnessing IPV, and sexual abuse before age 18.

3.5 Past 12-month prevalence of GBV

While lifetime prevalence establishes the cumulative burden of GBV, past 12-month prevalence provides a measure of active, ongoing violence, the proportion of respondents who experienced GBV in the year immediately preceding the survey. This is the more policy-relevant indicator for service demand planning, and the stronger test of whether intervention programmes have had an impact in the near term.

Table 3.1: Past 12-month prevalence of GBV

Violence Type	Women Exp %	N	Men Exp %	N	Men Perp %	N	Women Perp %	N
Any GBV	22.4	2565	10.2	1689	5.4	1435	4.5	2310
Any IPV	14.8	2310	6.4	1435	5.4	1435	4.5	2310
Physical IPV	5.0	2310	1.5	1435	1.9	1435	1.3	2310
Emotional IPV	9.5	2310	4.5	1435	3.0	1435	3.1	2310
Sexual IPV	3.2	2310	0.9	1435	0.9	1435	0.1	2310
Economic IPV	8.7	2310	2.6	1435	1.7	1435	1.4	2310
Any NPSV (experience)	1.6	2565						
Any sexual harassment	12.1	2565	5.2	1689				
Any Technology-Facilitated GBV (TFGBV) - Internet Users	0.0	1232	0.0	681				

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

Table 3.1 shows that 22.4% of ever-partnered women experienced at least one form of GBV in the 12 months before the survey, reflecting the predominance of IPV in driving recent GBV experience. For men, 10.2% report recent GBV experience. Among ever-partnered women, 14.8% report past-year IPV experience, compared to 4.5% of women acknowledging IPV perpetration and 6.4% of men reporting IPV experience. This represents a marked decline from the 2013 baseline figure of 28% of women reporting IPV experience in the 12 months before that survey, suggesting a reduction of approximately 13 percentage points in recent IPV victimisation among women over the twelve years. This comparison uses the age 18 and older threshold and the violence types common to both rounds.



Sesotho Media at Mafeteng, Ha-Maoela community in 2025 to support individuals affected by GBV. *Photo: SM&D*

Within the past year, IPV experience among women, emotional IPV is the most prevalent recent form (9.5%), followed by economic IPV (8.7%), physical IPV (5.0%), and sexual IPV (3.2%). The ordering of emotional and economic IPV as the leading recent forms ahead of physical IPV is analytically significant. It is consistent with a pattern observed in other countries in the GL framework whereby coercive control, manifest in emotional manipulation and economic restriction, remains more pervasive and continuous even as overt physical violence may have reduced in frequency. Non-partner sexual violence in the past 12 months was reported by 1.6% of women.

3.6 GBV and gender identity

The study questionnaire included a self-reported gender identity question, enabling disaggregation beyond the male/female binary. While LGBTQI+ persons were not purposively sampled in this household survey, a small number of respondents (N=21) identified as gender non-conforming or other.[106] Their responses are presented descriptively in Table 3.2 for transparency. However, the small subgroup sizes mean these figures carry wide uncertainty and should not be interpreted as population-level estimates for gender-diverse persons in Lesotho.

Table 3.2: Any experience or perpetration of GBV by gender identity

Gender identity	Experience %	N	Perpetration %	N
Woman	66.5	2533	20.7	2290
Man	46.7	1700	27.9	1441
Gender non-conforming	43.7	11	16.1	8
Other / Prefer not to say	55.9	10	0.0	6

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

Gender non-conforming respondents report GBV experience at 43.7% and perpetration at 16.1%, while those selecting "other/prefer not to say" report experience at 55.9% with none reported perpetration. Given the very small denominators (N=8-11), the point estimates are indicative rather than conclusive. The full disaggregation by violence type is provided in the statistical appendix.[107]

3.6.1 Contextual evidence from dedicated LGBTQI+ research

While the household survey's probability sampling design was not structured to reach LGBTQI+ populations specifically, dedicated research conducted under the THUSO project provides more robust evidence on GBV prevalence among these communities. The THUSO Project Baseline Study (February 2026) surveyed 261 LGBTQI+ respondents across Maseru, Berea, and Leribe using purposive and snowball sampling methods appropriate for hard-to-reach populations.[108] That study found that 50% of transgender respondents experienced GBV in the twelve months preceding the survey, compared with 27.9% of non-transgender respondents, a rate considerably higher than the general population 12-month IPV figure of 14.8% recorded in the present study. Among transgender GBV incidents, 93.8% were directly linked to the survivor's gender identity or expression.

The International Human Rights Lab's research, also conducted under the THUSO project, found that 69% of LGBTQI+ persons reported experiencing GBV, with 62% reporting physical violence.[109] The research documents specific forms of targeted violence, including "corrective rape" and forced initiation prac-

[106] While LGBTQI+ persons were not purposively sampled, the study questionnaire included a gender identity question allowing respondents to self-identify beyond the binary. The resulting subgroups (N=11 gender non-conforming; N=10 other/prefer not to say) are too small for reliable statistical inference or generalisation to the broader LGBTQI+ population in Lesotho.
[107] See Appendix 3 for the full disaggregation of lifetime GBV prevalence by violence type and gender identity.
[108] THUSO Project (2026). Baseline Study Report: Promoting Dignity, Safety, and Inclusion of LGBTIQ+ Persons in Lesotho. February 2026. Maseru: Human Rights Lab. LGBTQI+ Community Survey dataset (n=261).
[109] Human Rights Lab / International Human Rights Club (2025). Interview with Gender Links, 2025. Data from TUSA project baseline study.

tices aimed at altering gender identity or sexual orientation. These forms of violence are largely invisible in standard administrative data systems and fall outside the measurement scope of household probability surveys.

These forms of violence are largely invisible in standard administrative data systems: the THUSO project's key informant interviews with CGPU offices in Maseru, Berea, and Leribe confirmed that none had standard operating procedures that explicitly included LGBTQI+ or transgender persons, and data systems recorded only binary male/female gender categories. Similarly, the THUSO project's November 2025 shelter assessment found that Lapeng Care Centre, Lesotho's sole dedicated GBV shelter, failed to meet four of twelve international criteria for safe accommodation, including the absence of staff trained in SOGIE-inclusive competencies. These institutional gaps mean that LGBTQI+ GBV falls outside the measurement scope of both household probability surveys and existing administrative recording systems.

Taken together, the survey's gender identity disaggregation and the THUSO qualitative research point to elevated GBV risk among gender-diverse and LGBTQI+ persons in Lesotho. The present study's contribution is limited to the descriptive disaggregation above (N=21 for both non-binary respondents, a sample too small for multivariate analysis), while the THUSO findings, based on a purpose-designed sampling strategy, offer the more reliable prevalence estimates for these populations.

A note on 2013-2025 comparability

The 2013 study used the term Violence Against Women (VAW) and presented findings primarily from the women's questionnaire, with the men's questionnaire serving as a perpetration comparator. The 2025 study adopts the broader term Gender-Based Violence (GBV). It expands the conceptual frame to capture violence experienced by men, mutual or bidirectional IPV, and new domains not measured in 2013 (technology-facilitated GBV, child marriage as a harmful practice).

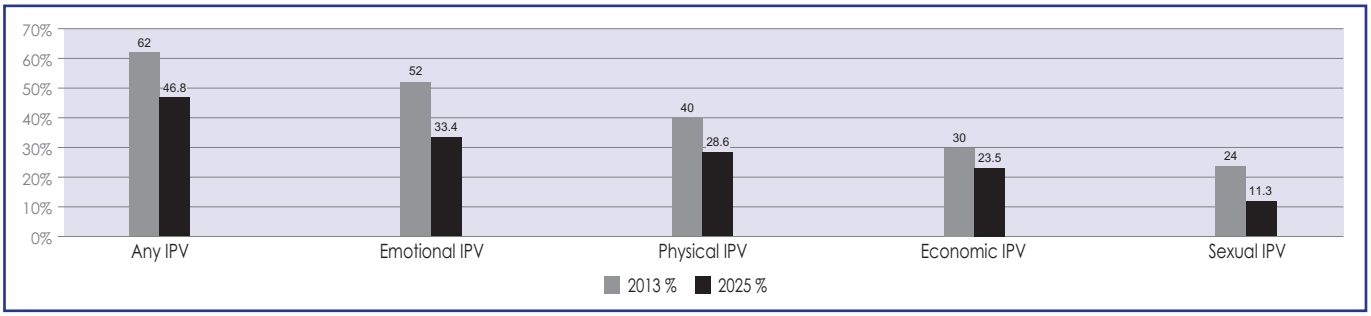
The 2013 baseline figure of 86% of women having experienced some form of VAW in their lifetime incorporated sexual harassment as the dominant contributor and was measured against all women aged 18 and above. The 2025 Any GBV lifetime figure of 66.7% is measured against respondents aged 15 and older (ever partnered for IPV and reproductive coercion; all respondents for non-partner forms). These differences in age threshold, denominator composition, and domain coverage must be borne in mind when interpreting change over time.

Where this chapter presents direct 2013-2025 comparisons, the analysis is restricted to the violence types measured in both rounds (IPV, non-partner sexual violence, and reproductive coercion), applies a common 18 and above age threshold to match the baseline sampling frame, and states denominators explicitly at each table or figure.

3.7 Changes in IPV prevalence: 2013-2025

The comparison of 2013 and 2025 data reveals statistically significant declines in every measured form of IPV. The denominator is restricted to ever-partnered women and men aged 18 and older for comparability.

Figure 3.2: Changes in women's IPV experience 2013-2025

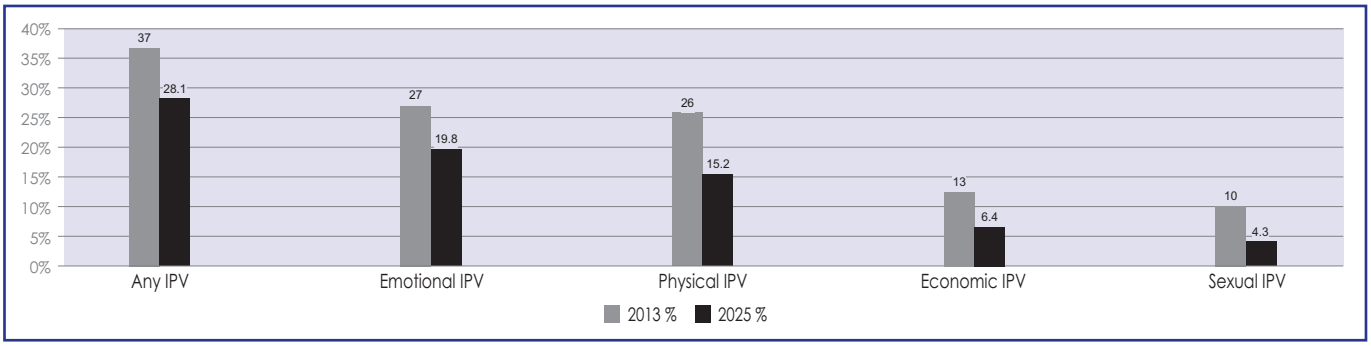


Source: Lesotho GBV 2025 Prevalence Survey, Gender Links (Denominator: Ever-partnered women aged 18 and older)

Among women aged 18 and older, any IPV declined from 62.0% to 46.8% (-15.2 pp.[110], p<0.001). Emotional IPV showed the largest absolute decline (-18.6 pp), followed by sexual IPV (-12.7 pp) and physical IPV (-11.4 pp).

Economic IPV declined by 6.5 pp, the smallest reduction, suggesting economic control remains more resistant to change. Figure 3.3 presents the corresponding changes in men's perpetration over the same period.

Figure 3.3: Changes in men's IPV perpetration 2013-2025



Source: Lesotho GBV 2025 Prevalence Survey, Gender Links (Denominator: Ever-partnered men aged 18 and older)

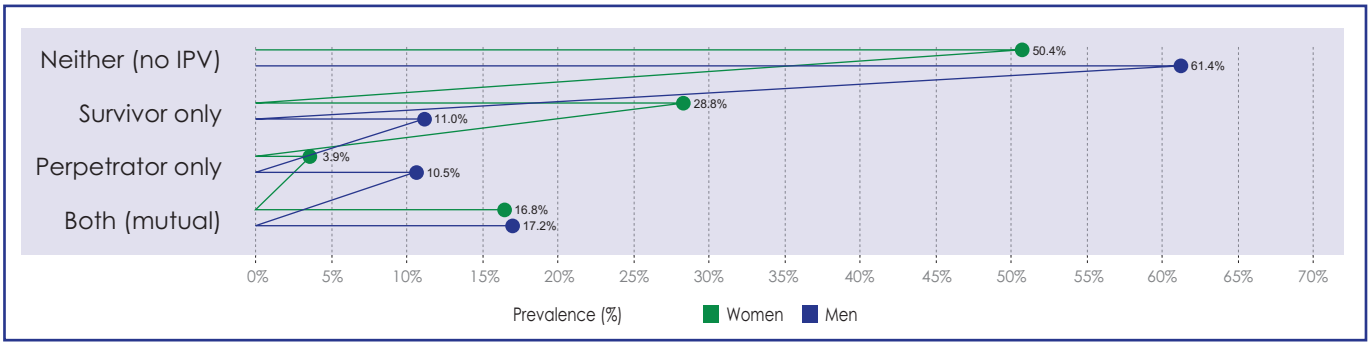
Men's acknowledged perpetration declined across all forms, with physical IPV showing the largest drop (-10.8 pp). However, this decline should be interpreted cautiously. As discussed in Section 3.3, men's reported perpetration is subject to systematic downward bias through denial, minimisation, and social desirability. It is plausible that increased public awareness of GBV, itself a product of the legislative and prevention investments made since 2013, has simultaneously reduced some men's use of violence and increased other men's reluctance to disclose it. The parallel decline in women's reported IPV experience (Section 3.3) provides corroborating evidence that some real reduction has occurred. Still, the magnitude of change in men's perpetration figures should not be taken at face value.

3.8 IPV typology: survivors, perpetrators, and mutual violence

One of the most significant additions to the 2025 study is the IPV typology analysis, which classifies ever-partnered respondents into four mutually exclusive categories based on lifetime IPV experience and perpetration profiles.[111] The four categories are: (1) Neither - no lifetime IPV experience or perpetration; (2) Survivor only - experienced IPV but did not perpetrate; (3) Perpetrator only - perpetrated IPV but did not report experiencing it; and (4) Both - reported both experiencing and perpetrating IPV, indicating bidirectional or mutual violence.

[110] pp = percentage points
[111] Johnson, M.P. (2008). A Typology of Domestic Violence: Intimate Terrorism, Violent Resistance, and Situational Couple Violence. Boston: Northeastern University Press. Straus, M.A. (2010). Thirty years of denying the evidence on gender symmetry in partner violence. Partner Abuse, 1(3), 332-362.

Figure 3.4: Intimate partner violence typology by gender (% within gender)



Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

Half of women (50.4%) report neither experience nor perpetration. Among those with IPV involvement, 28.8% are survivors only, 3.9% perpetrators only, and 16.8% report both. The pattern differs markedly for men: 17.2% report both, 11.0% survivor only, and 10.5% perpetrator only.

Three findings from Figure 3.4 carry major policy significance. First, approximately half of ever-partnered women (50.4%) and nearly two-thirds of ever-partnered men (61.4%) report no lifetime involvement in IPV as either survivor or perpetrator. This establishes that while IPV is endemic, it is not universal, and that substantial segments of the population have navigated intimate relationships without violence, a finding directly relevant to prevention programming, which can build on and amplify these healthy relationship norms.

Second, 28.8% of women are 'survivor only', the largest non-neutral category among women, and the population for whom legal response, shelter, and protection services are most directly designed. By contrast, 10.5% of men are 'perpetrator only', acknowledging perpetration without reporting victimisation, more than double the equivalent proportion among women (3.9%), consistent with men's greater role as initiators of unidirectional violence.

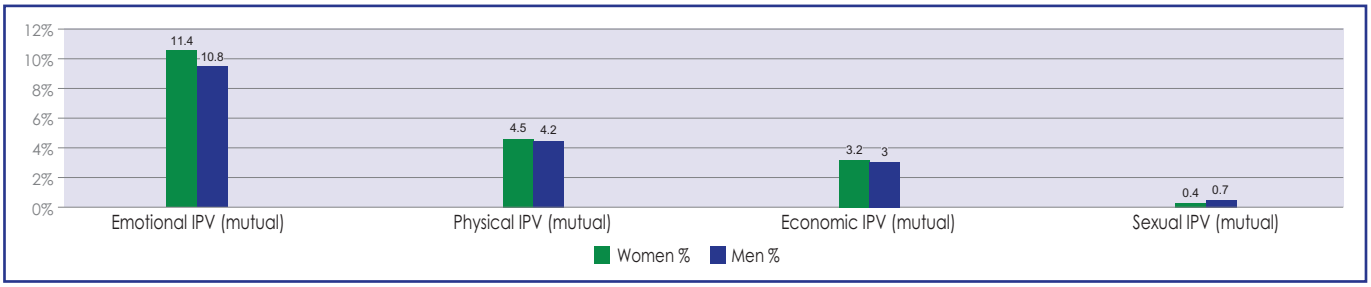


Commemoration of 16 Days of Activism Against Gender Based Violence at Mphaki, Quthing. *Photo: GL Lesotho*

Third, 16.8% of women and 17.2% of men report both experiencing and perpetrating IPV. These near-identical proportions might initially suggest symmetry, but research consistently demonstrates that women who both experience and perpetrate IPV do so predominantly in the context of reactive or defensive violence, that is, fighting back against an abusive partner, with the severity, frequency, and impact of violence they experience substantially greater than what they perpetrate.[112] It should be noted that this survey does not capture initiation, frequency, severity, or injury within mutual-violence dyads.[113] These limitations must be stated prominently when communicating this finding to policy audiences. Blanket 'mutual violence' framings risk misrepresenting the nature of women's IPV involvement and undermining survivor-centred approaches. Figure 3.5 examines mutual violence by IPV type.

[112] Swan, S.C. et al. (2008). A review of research on women's use of violence with male intimate partners. Violence and Victims, 23(3), 301-314. Hamberger, L.K. & Larsen, S.E. (2015). Men's and women's experience of intimate partner violence. Journal of Family Violence, 30(6), 699-717.
[113] Couples where both partners use violence against each other.

Figure 3.5: Mutual violence by IPV type (%)



Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

Figure 3.5 disaggregates mutual violence by IPV type. Consistent with global research findings,[114] emotional IPV is by far the most prevalent form of mutual violence, with 11.4% of women and 10.8% of men reporting having both experienced and perpetrated emotional abuse in their relationships. Physical IPV shows mutual involvement among 4.5% of women and 4.2% of men, proportions that are strikingly similar across genders for this type. Economic and sexual IPV show lower levels of mutual involvement (3.2%/3.0% and 0.4%/0.7%, respectively).

It is not surprising that mutual violence is most common in the emotional domain. Acts such as insults, humiliation, threats, and controlling behaviour are more likely to be exchanged by both partners than physical violence. However, even when both partners engage in the same behaviours, the impact is rarely equal.[115] One partner typically holds more power (unequal power dynamics), and the same act carries different weight depending on who performs it and under what circumstances. In contrast, the near-negligible level of mutual sexual IPV (less than 1% for both women and men) is consistent with the understanding that forced or coerced sex is overwhelmingly unidirectional and is exercised by men against women in the context of patriarchal marital norms.

These typology findings have direct implications for programming. Blanket 'mutual violence' framings risk misrepresenting the nature of women's IPV involvement and undermining victim-centred approaches. The data are more appropriately read as: a majority of IPV in Lesotho involves clear victim-perpetrator asymmetry; a substantial minority (approximately one in six ever-partnered adults) occurs within relationships where both partners report both experiencing and perpetrating violence, and within that minority, emotional abuse is the predominant form. Intervention approaches that engage with relational dynamics, including couples counselling and community-level norm change programmes, may be most relevant for the mutual-violence group, while legal, shelter, and protection services remain paramount for the survivor-only group.



Blanket 'mutual violence' framings risk misrepresenting the nature of women's IPV involvement and undermining victim-centred approaches

[114] Langhinrichsen-Rohling, Jennifer & Selwyn, Candice & Rohling, Martin. (2012). Rates of Bidirectional Versus Unidirectional Intimate Partner Violence Across Samples, Sexual Orientations, and Race/Ethnicities: A Comprehensive Review. Partner Abuse. 3. 199-230. 10.1891/1946-6560.3.2.199.
[115] Johnson, M. P. (2006). Conflict and Control: Gender Symmetry and Asymmetry in Domestic Violence: Gender Symmetry and Asymmetry in Domestic Violence. Violence Against Women, 12(11), 1003-1018.

3.9 Geographic disaggregation of IPV

Lesotho comprises ten administrative districts, each with distinct demographic, economic, and geographic characteristics. Disaggregating IPV prevalence to the district level provides essential information for targeted resource allocation and reveals whether the burden of violence is geographically uniform or spatially patterned. The 2025 study finds that it is strongly patterned and that a small number of districts consistently carry disproportionate burdens, pointing to where service investment should be concentrated next.

Table 3.3: IPV prevalence by district

District	Women Experience %	Men Perpetration %	Men Experience %	Women Perpetration %
Mohale's Hoek	65.0	14.1	24.5	33.3
Quthing	51.2	43.3	38.8	19.3
Mokhotlong	49.5	39.1	35.8	22.9
Berea	47.8	16.3	23.8	21.9
Leribe	46.8	31.9	33.9	16.5
Maseru	44.5	22.1	21.0	21.6
Butha-Buthe	44.2	47.6	38.9	20.6
Qacha's Nek	40.4	19.1	26.0	7.0
Thaba-Tseka	33.8	37.1	24.1	12.9
Mafeteng	27.5	43.3	42.7	17.4

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

Table 3.3 shows that Mohale's Hoek emerges as the district with the highest lifetime IPV experience prevalence among women in 2025, with 65.0% of ever-partnered women reporting at least one form of IPV, 19 percentage points above the national average. In 2013, Mohale's Hoek was the second-highest district for past-year IPV experience. The 2025 data confirm a persistently elevated burden in the predominantly rural southern lowlands district. The mechanisms underlying Mohale's Hoek's position warrant specific investigation, including male labour migration patterns, cattle ownership, norms, and the limited presence of formal GBV response services in the district, an investment opportunity the WFP's 2025 national service mapping confirms.[116]

Quthing (51.2%) and Mokhotlong (49.5%) rank second and third for women's lifetime IPV experience. Both are geographically remote districts with mountain populations, limited road access, and constrained access to health and legal services. The WFP mapping found that these highland districts are among the most severely underserved nationally for GBV response infrastructure, confirming that women's elevated exposure in these areas is compounded by limited access to support when violence occurs. These districts represent a clear and addressable investment priority. Mafeteng records the lowest women's IPV experience at 27.5% but presents a paradox demanding analytical attention. Men's experience (42.7%) and perpetration (43.3%) are among the highest in the country, approximately 16 percentage points above national figures. This inversion, where men's self-reported involvement in IPV is high while women's reported victimisation is low, is more likely to

[116] World Food Programme (2025). Service Mapping Exercise of GBV Service Providers, Referral Pathways and Services for Children in Lesotho. April 2025. Maseru: WFP Lesotho.

reflect stronger inhibitions on women's disclosure in Mafeteng than a genuinely lower prevalence. This paradox is replicated across all IPV forms and across NPSV and harassment domains, and points strongly to a district-specific barrier to disclosure that qualitative research and targeted survivor outreach should address.

Across districts, the pattern of men's perpetration exceeding their reported experience is particularly notable in Butha-Buthe (47.6% perp vs 38.9% exp), Quthing (43.3% vs 38.8%), and Thaba-Tseka (37.1% vs 24.1%). This reverse gap, that is, more men acknowledging perpetration than experience, is unusual and may reflect the typology finding that many men occupy the 'perpetrator only' cell. It may also reflect a greater willingness to disclose perpetration than experience of victimisation in specific local cultural contexts. Maseru and Berea show the closest convergence between men's experience and perpetration rates, consistent with relatively more disclosure-permissive urban contexts.

Table 3.4: Prevalence of IPV in the 12 months before the survey by district

District	Women Exp %	N	Men Perp %	N	Men Exp %	N	Women Perp %	N
Any past year IPV (National)	14.8	2310	5.4	1435	6.4	1435	4.5	2310
Maseru	19.5	401	1.9	286	5.0	286	5.7	401
Butha-Buthe	16.9	203	7.4	124	7.7	124	3.2	203
Mohale's Hoek	16.6	219	5.5	112	11.9	112	5.0	219
Mokhotlong	16.5	169	4.1	102	3.8	102	3.4	169
Leribe	14.8	321	9.6	199	5.7	199	5.7	321
Berea	12.1	267	1.8	174	4.0	174	3.2	267
Quthing	11.9	177	10.7	118	11.3	118	2.9	177
Thaba-Tseka	9.4	171	5.0	86	0.9	86	4.3	171
Mafeteng	8.4	225	15.8	132	12.8	132	4.6	225
Qacha's Nek	7.6	157	3.4	102	5.1	102	2.0	157

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

For past-year IPV experience, Maseru records the highest prevalence among women (19.5%), followed closely by Butha-Buthe (16.9%), and Mohale's Hoek (16.6%). The capital's high recent IPV rate is notable. Despite Maseru being the country's urban centre with the greatest access to GBV services, help-seeking agencies, and media-based awareness campaigns, Maseru women experience recent IPV at rates above the national average. This suggests that urbanisation does not straightforwardly protect against IPV, and that the structural drivers of violence, including economic inequality, housing stress, alcohol availability, and changing gender role expectations in urban settings, may generate different but no less prevalent forms of violence.

Mafeteng again presents its paradox. Women's past-year experience (8.4%) is the second lowest nationally, while men's past-year perpetration (15.8%) is the highest of any district, nearly three times the national figure of 5.4%. The absolute magnitude of this gap is striking and, as with the lifetime figures, points strongly to suppressed female disclosure in this district rather than a genuinely lower prevalence. This represents a priority area for qualitative research and targeted service outreach.

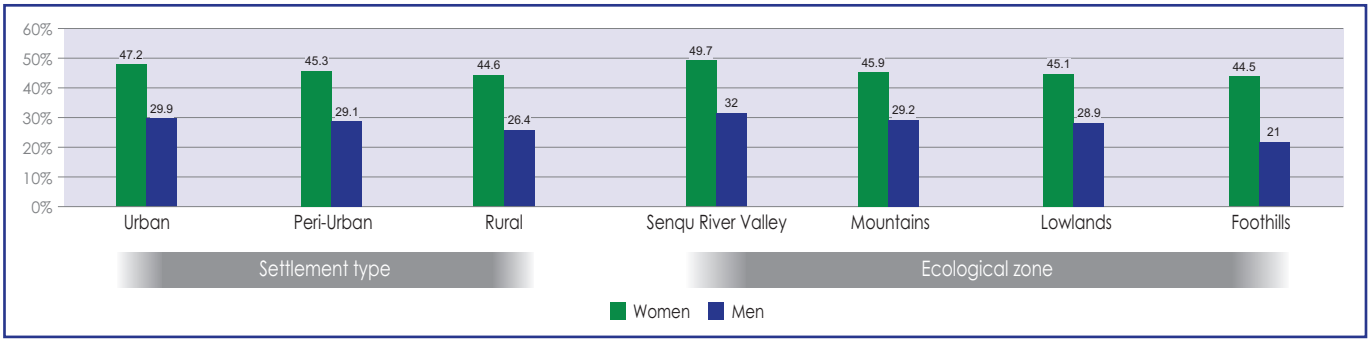
Quthing shows an unusual pattern in the past-year data: men's past-year experience (11.3%) and perpetration (10.7%) are nearly equal, and both are close to double their female counterparts' experience (11.9% and 2.9% perpetration). This aligns with the district's high

mutual-violence profile in the lifetime data and suggests that bidirectional dynamics particularly characterise violence in Quthing partnerships. This also appeared in the 2013 baseline, which found Quthing had the highest perpetration prevalence in the past-year data (22%), and contextualises that earlier finding within a clearer mutual-violence frame.

3.9.1 IPV by settlement type and ecological zone

A new feature of the 2025 study is the disaggregation of IPV prevalence by settlement type (urban, peri-urban, rural) and ecological zone (Lowlands, Foothills, Mountains, Senqu River Valley). These cross-cutting dimensions allow the study to move beyond administrative boundaries and examine how the physical geography and urbanisation characteristics of women's and men's living environments relate to IPV exposure. Figure 3.6 shows IPV prevalence by settlement type and ecological zone.

Figure 3.6: IPV prevalence by settlement type and ecological zone



Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

One of the most important findings from the settlement-type analysis is the near-absence of a rural-urban differential in women's IPV experience. Urban women report a lifetime IPV experience rate of 47.2%, peri-urban women 45.3%, and rural women 44.6%. This finding directly challenges policy assumptions that rural women are systematically more exposed to IPV than urban women in Lesotho. It suggests that the structural determinants of IPV, gender inequality, economic dependence, patriarchal norms, and alcohol consumption are pervasive across the settlement continuum. Prevention and response programming must reach urban and peri-urban women with the same intensity as applied to rural communities.

For men, urban residents report slightly higher IPV experience (29.9%) than their rural counterparts (26.4%), with peri-urban men falling between the two at 29.1%. The marginally higher urban figure may reflect the erosion of traditional masculine provider roles in urban settings, where unemployment, housing pressure, and shifting gender expectations create friction within partnerships, or it may indicate that urban men are more willing to recognise and disclose experiences that rural men normalise as part of relationship dynamics. The differences are modest, however, and should not be overinterpreted.

The ecological zone disaggregation reveals a more differentiated picture. The Senqu River Valley records the highest IPV experience for both women 49.7% and men, 32.0%. The Valley encompasses parts of Quthing and Mohale's Hoek districts, both of which appear in the high-prevalence district data, and its combination of geographic isolation, high male labour migration, and socioeconomic vulnerability compounds IPV risk. The Mountains (45.9%)

and Lowlands (45.1%) are close to the national average.[117]

The absence of strong settlement-type and ecological differentials, combined with the district-level variability documented above, points to a key strategic insight. IPV in Lesotho is driven less by urbanisation or geographic context *per se*, and more by district-specific social and institutional conditions, the strength of traditional authority, the availability of GBV services, local economic conditions, and community-level norms. Programme targeting must shift from a rural-urban frame to a district-specific and community council frame.

3.9.2 Community council level

The 2025 study is the first in the GL-Lesotho series to present IPV data at the community council (CC) level, a sub-district administrative unit that corresponds closely to local governance structures through which GBV services, community policing, and child protection programmes are delivered. Statistical Appendix Tables A6-A11 present lifetime IPV experience and perpetration for all 77 community councils sampled, representing a significant advance in the granularity of GBV data available to district administrators and local planners. However, a critical methodological caveat applies. Unweighted sample sizes at the council level are small. Many councils have between 6 and 35 respondents, producing wide confidence intervals. The community council data should be used as an indicative planning tool and field-validated before informing resource allocation decisions.



The 2025 study is the first in the GL-Lesotho series to present IPV data at the community council (CC) level

Notwithstanding these limitations, several council-level patterns are analytically noteworthy. Among councils with larger samples ($N \geq 30$), the highest women's lifetime IPV experience rates are recorded in Mohale's Hoek CC (65.3%, N=67), Qhoasing CC (65.7%, N=42), and Maputsoe CC (56.5%, N=87). Councils with smaller samples also record striking rates, Senqunyane CC (82.9%, N=23) and Menkhoaneng CC (55.9%, N=24), though these estimates carry wide confidence intervals and should be interpreted with caution. At the other end, councils such as Tsoilitsoili CC (0.0%, N=8), Ts'ana-Talana CC (11.1%, N=20), and Lehlakaneng CC (12.6%, N=29) record very low women's experience; however, these are also based on small samples and should not be treated as evidence of low prevalence without confirmation.

Several councils show perpetration rates among men that markedly exceed both women's experience in the same council and national perpetration norms, for example, Khutlo-se-Metsi CC (80.1%, N=5), Ngoajane CC (78.6%, N=15), and Metsi-Maholo CC (71.4%, N=7). While these figures are based on very small male sub-samples and cannot be relied upon as population estimates, they may indicate localities where male perpetration of IPV is concentrated and where focused community-level intervention is warranted.

The full council-level dataset (Appendix Tables A6-A11) is provided in the statistical appendix and serves as programme-facing reference tables for district administrators and local planners.

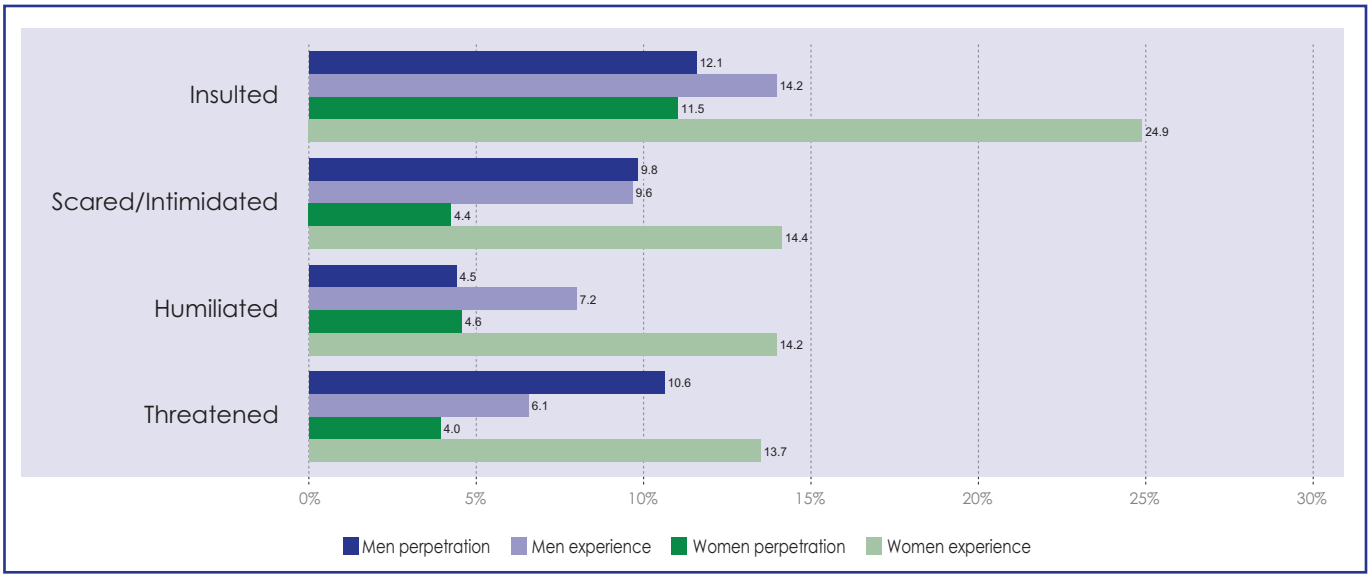
[117] Gender Links (2015). The War @ Home: Revised Edition - Southern Africa GBV Indicators Study. Johannesburg: GL. See Chapter 3 analysis of geographic remoteness and IPV burden.

3.10 Intimate partner violence by type

3.10.1 Emotional intimate partner violence

Emotional IPV, that is, verbal abuse, humiliation, intimidation, threats, and controlling behaviour, is both the most prevalent and the most measurement-challenging form of intimate partner violence recorded in 2013 and 2025. Unlike physical or sexual IPV, emotional abuse leaves no visible injury, is more likely to be normalised within patriarchal relational norms and often operates as the mechanism through which sustained coercive control is maintained.[118] The 2025 survey assessed emotional IPV through four behavioural items. That is, being insulted or made to feel bad; being humiliated in front of others; being threatened with harm; and being subjected to acts designed to intimidate or scare.

Figure 3.7: Acts of emotional abuse in lifetime



Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

Nationally, 32.5% of ever-partnered women report experiencing at least one form of emotional IPV in their lifetime, down from 52% in 2013, a decline of approximately 18.6 percentage points. This is the steepest absolute reduction recorded for any single IPV form and represents a particularly encouraging finding that emotional abuse is the most pervasive form, and its reduction signals that the cultural shift underway in Lesotho reaches into the relational and psychological dimensions of violence, not only its physical manifestations.

Being insulted or made to feel bad is the most common individual act (24.9%), consistent with the 2013 finding where this ranked first at 33%. The district picture mirrors the national: Mohale's Hoek leads with 49.9% of women reporting emotional IPV experience (nearly 17 pp above the national figure), while Mafeteng again records the lowest women's experience (20.8%) alongside the highest men's emotional IPV experience (33.6%), extending the disclosure paradox to the emotional domain.

[118] Stark, E. (2007). Coercive Control: The Entrapment of Women in Personal Life. New York: Oxford University Press. Johnson, M.P. (1995). Patriarchal terrorism and common couple violence. Journal of Marriage and the Family, 57(2), 283-294.

Emotional abuse acts: 2013-2025 comparison

The 2013 baseline measured six individual emotional abuse acts among ever-partnered women aged 18 and older. Comparing these with the 2025 figures reveals consistent declines across every act, though the magnitude varies. Being insulted or made to feel bad remains the most prevalent act in both rounds, declining from 32.9% in 2013 to 24.9% in 2025 (-8.0 pp). Threatening to hurt a partner, the second most common act in 2013 at 29.6%, shows one of the steepest absolute reductions. Being scared or intimidated on purpose declined from 21.4%, while being belittled or humiliated in front of others fell from 17.5%.

Two acts displayed broadly similar 2013 prevalence but differed in their dynamics. Being stopped from seeing friends or family (17.9% in 2013) is a controlling behaviour that isolates the victim from support networks, while boasting about or bringing home girlfriends (10.8%) is a form of humiliation specific to the Lesotho context and reflects patriarchal entitlement norms around male infidelity. Both acts show meaningful reductions in 2025.

The overall pattern is encouraging: the steepest declines occurred in the more overtly threatening acts (threats to hurt, intimidation), while the more normalised forms of emotional abuse (insults, belittling) declined less steeply. This is consistent with the hypothesis that legislative and awareness interventions first reduce behaviours that are most visibly recognised as violence. At the same time, subtler forms of emotional control prove more resistant to change.

Table 3.5: Lifetime prevalence of emotional IPV by district - 2025

District	Women Exp %	N	Men Perp %	N	Men Exp %	N	Women Perp %	N
Mohale's Hoek	49.9	219	7.5	112	16.9	112	22.5	219
Berea	36.4	267	10.2	174	15.7	174	17.2	267
Quthing	36.2	177	34.3	118	31.9	118	16.0	177
Butha-Buthe	34.9	203	32.2	124	30.8	124	14.3	203
Maseru	32.0	401	18.7	286	17.1	286	17.6	401
Leribe	30.3	321	20.6	199	21.3	199	13.0	321
Mokhotlong	29.2	169	15.1	102	20.1	102	16.3	169
Qacha's Nek	27.1	157	8.5	102	17.2	102	3.3	157
Thaba-Tseka	21.6	171	30.4	86	24.1	86	2.5	171
Mafeteng	20.8	225	29.9	132	33.6	132	6.7	225

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

Mohale's Hoek again leads for women's emotional IPV experience (49.9%), nearly 17 percentage points above the national figure of 32.5%. Quthing (36.2%) and Berea (36.4%) are joint second. Mafeteng records the lowest women's emotional IPV experience (20.8%) yet the highest men's emotional IPV experience (33.6%) and second-highest men's perpetration (29.9%), extending the now-established Mafeteng disclosure paradox to the emotional domain. Quthing and Butha-Buthe stand out for near-equal men's experience and perpetration of emotional IPV (Quthing: 31.9% experience, 34.3% perpetration; Butha-Buthe: 30.8% experience, 32.2% perpetration), consistent with high mutual-violence dynamics in both districts.

The typology analysis shows that emotional, physical and sexual IPV rarely occur in isolation. One survivor's account captures the concurrent pattern:

Bua! Speak out!

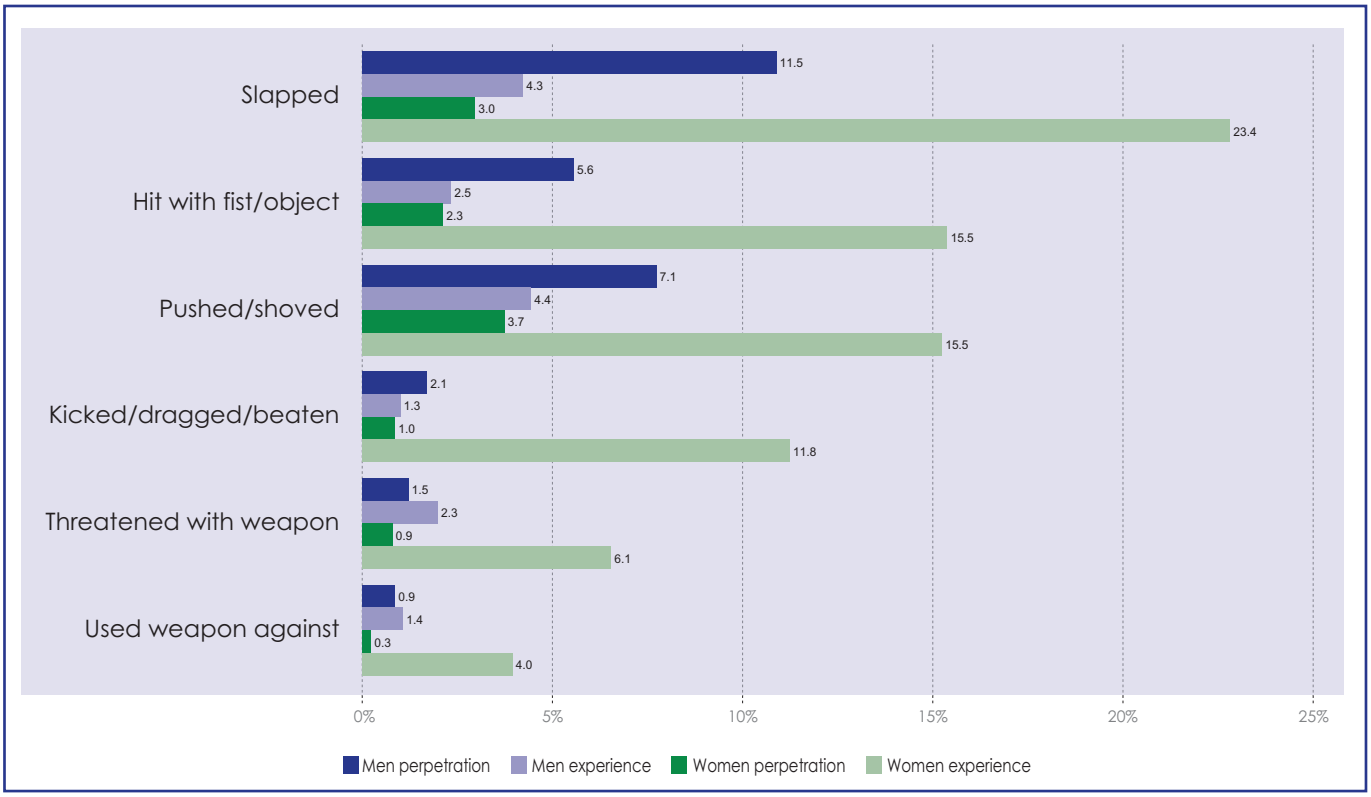
"He would wait until we were at his family's home to beat me, and later he began attacking me even in our own house. He often took my phone, deleted messages, and accused me of infidelity. My child, only nine years old, witnessed many of these incidents and was deeply traumatised."

Mokhotlong Participant 2

3.10.2 Physical intimate partner violence

Physical IPV is reported by 27.6% of ever-partnered women in their lifetime, down from 40% in 2013, a reduction of approximately 11.4 percentage points. Men's perpetration of physical IPV has declined from 26% to 15%, one of the steepest reductions in any form of perpetration across the study. The decline in physical perpetration is particularly notable as physical IPV is the form most likely to be legally actionable, suggesting a potential deterrence or accountability effect of the strengthened legislative framework introduced since 2003.

Figure 3.8: Acts of physical IPV in lifetime



Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

The analysis of the physical IPV table reveals significant patterns and disparities in the experiences of men and women regarding this issue. Among the acts reported by women, slapping emerged as the most common, with 23.4% of women experiencing this form of violence, followed by being pushed or shoved and hit with a fist or harmful object, each at 15.5%, and being kicked, dragged, or beaten at 11.8%. Conversely, the least frequently reported acts included being threatened with a weapon at 6.1% and having a weapon used against them at 4.0%. Notably, women's experiences of physical IPV significantly sur-

passed those of men across all acts, with 23.4% of women slapped compared to only 4.3% of men.

Furthermore, when comparing perpetration rates, men exhibited higher rates than women for every listed act, with 11.5% of men reporting slapping compared to 3.0% of women, and for being pushed or shoved, 7.1% of men versus 3.7% of women. This data underscores a pronounced asymmetry where women are disproportionately affected by physical IPV, while men are more likely to admit to perpetrating such violence. The disparity is notably pronounced in more severe forms of IPV, such as being hit, kicked, dragged, or threatened with weapons, indicating that women bear a greater burden of victimisation in the context of physical IPV. The DHS 2023-24 independently confirms this severity picture, where 38% of women who experienced IPV sustained injuries, and 10% reported serious injuries, including broken bones and deep wounds.[119]

Physical IPV acts: 2013-2025 comparison

The 2013 baseline documented five physical IPV acts among ever-partnered women. Every act shows a substantial decline by 2025. Slapping, the most prevalent act in both rounds, declined from 34.4% to 23.4% (-11.0 pp), a reduction of nearly one-third. Being pushed or shoved fell from 23.3% to 13.7% (-9.6 pp), while being hit with a fist or something harmful declined from 16.7% to 13.7% (-3.0 pp), the smallest absolute reduction among the five acts.



Sesotho Media at Mafeteng, Ha-Maoela community in 2025 to support individuals affected by GBV. *Photo: SM&D*

Kicking or dragging declined from 12.2% to 9.0% (-3.2 pp), and threatening with a weapon, already the least common act in 2013 at 6.4%, declined further by 2025. The pattern of decline is noteworthy: the most common acts (slapping, pushing) recorded the largest absolute reductions, while the more severe acts (hitting with objects, kicking, weapon threats) declined less steeply in absolute terms. This may reflect a floor effect, where more severe acts were already less common and thus had less room to decline. Still, it also suggests that the most extreme forms of physical violence are more resistant to change than moderate-severity acts.

The persistence of hitting with a fist or harmful object at 13.7%, nearly identical to pushing/shoving, is analytically significant. In the 2013 data, hitting was 6.6 pp less common than pushing; by 2025, they had converged. This convergence suggests that while moderate physical violence (slaps, pushes) has declined fastest, the relative share of severe physical violence within the overall physical IPV category has increased. For programming, this means that although fewer women experience physical IPV overall, those who do are more likely to experience its severe forms.

[119] Ministry of Health [Lesotho] and ICF (2024). Lesotho Demographic and Health Survey 2023-24: Final Report Maseru and Rockville, MD: Ministry of Health and ICF.

Table 3.6: Lifetime prevalence of physical IPV by district

District	Women Exp %	N	Men Perp %	N	Men Exp %	N	Women Perp %	N
Mohale's Hoek	36.3	219	7.7	112	13.3	112	8.9	219
Quthing	34.3	177	26.7	118	7.9	118	4.1	177
Berea	31.9	267	6.4	174	4.6	174	10.2	267
Butha-Buthe	29.6	203	21.2	124	11.3	124	5.0	203
Maseru	28.9	401	14.0	286	7.5	286	6.3	401
Leribe	26.7	321	13.5	199	4.6	199	5.3	321
Qacha's Nek	24.8	157	14.8	102	8.0	102	1.7	157
Mokhotlong	23.1	169	28.9	102	10.7	102	6.4	169
Thaba-Tseka	19.0	171	20.0	86	0.7	86	7.2	171
Mafeteng	14.3	225	17.7	132	8.6	132	2.8	225

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

Table 3.6 shows that Mohale's Hoek leads women's lifetime physical IPV experience (36.3%), followed by Quthing (34.3%) and Berea (31.9%). Mafeteng is lowest (14.3%), half the national average of 27.6%. The Mafeteng paradox continues, with the lowest women's experience (14.3%) yet high men's perpetration (17.7%), suggesting men in Mafeteng are more willing to disclose perpetration than women are to report experience, or that perpetration is directed at partners outside the district sample. Mokhotlong has the highest men's perpetration (28.9%), followed by Quthing (26.7%) and Butha-Buthe (21.2%). These highland/southern districts consistently show elevated male-reported perpetration across violence types. Experience-perpetration gaps vary enormously by district: In Mohale's Hoek, women's experience (36.3%) dwarfs men's perpetration (7.7%), a 29-point gap. In Thaba-Tseka, the reverse pattern: women's experience (19.0%) is close to men's perpetration (20.0%), suggesting relatively honest male disclosure there.

3.10.3 Sexual intimate partner violence

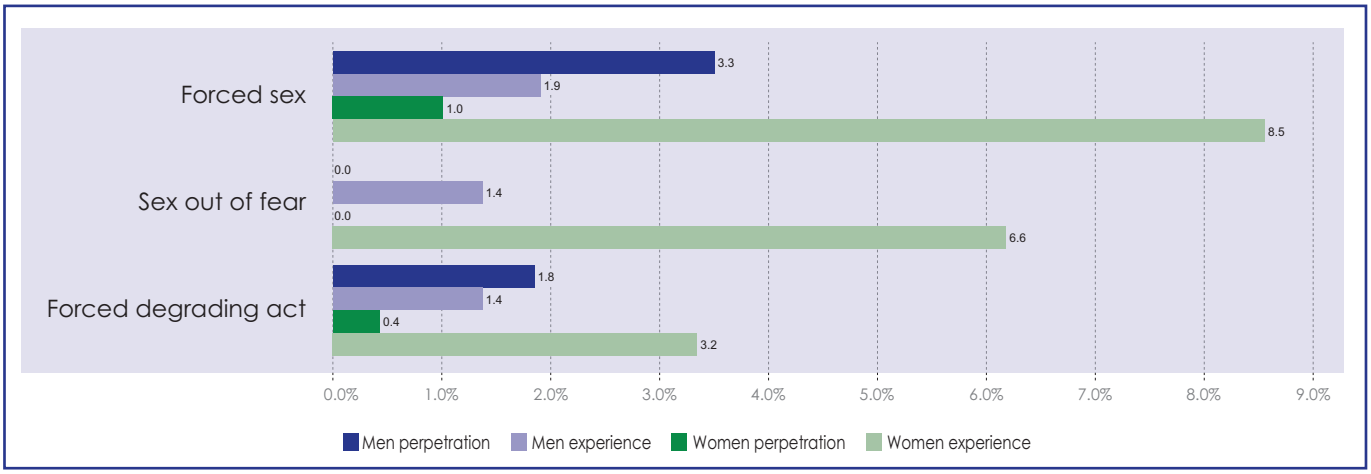


Sexual IPV shows the widest experience-perpetration gap in the study

Sexual IPV shows the widest experience-perpetration gap in the study. One in nine ever-partnered women (11.3%) report lifetime experience versus 1.4% of men acknowledging perpetration, a gap of nearly 10 percentage points.[120] This gap is attributable primarily to severe male under-disclosure of sexual coercion within partnerships, a pattern consistently observed in comparable research contexts where forced marital sex is culturally normalised and stigma against disclosure is intense. The decline from 24% (2013) to 11.3% (2025) in women's experience is the second-largest absolute reduction after emotional IPV. However, the extremely low men's perpetration figure counsels caution about attributing this to a genuine prevalence decline alone.

[120] Jewkes, R. et al. (2002). Prevalence of emotional, physical, and sexual abuse of women in three South African provinces. South African Medical Journal, 91(5), 421-428. Government of Lesotho (2003). Sexual Offences Act No. 3 of 2003, Section 3.

Figure 3.9: Acts of sexual IPV in lifetime



Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

Figure 3.9 presents the specific acts that constitute sexual IPV. Three behaviours were measured: forced sex, sex carried out because the respondent was afraid of what their partner might do if they refused, and being forced into a degrading sexual act.

Forced sex is the most reported act, experienced by 8.5% of ever-partnered women and 1.9% of men. Women's perpetration of forced sex is reported at 1.0%. In comparison, men's is 3.3%, a pattern consistent with the wider sexual IPV picture in which men acknowledge perpetration at higher rates than their own reported experience. The gap between women's experience (8.5%) and men's acknowledged perpetration (3.3%) is more than five percentage points, reflecting the severe under-disclosure of sexual coercion by male perpetrators documented across the GL study series.

Sex out of fear or consenting to sex not because the act itself was physically forced, but because of the anticipated consequences of refusal, is reported by 6.6% of women. No men report experiencing this act, and no women or men report perpetrating it. This is the most gendered item in the sexual IPV module: it captures a form of coercion that operates through implicit threat rather than physical force, and its exclusive concentration among women reflects the power asymmetry within partnerships where women anticipate violence, economic punishment, or abandonment if they refuse sex. The zero-perpetration figure is telling. It is important to note that neither sex recognises this dynamic as something they "do" to a partner, even when women clearly experience it as coercive.

Being forced into a degrading sexual act is reported by 3.2% of women and 1.4% of men, with men's perpetration (1.8%) slightly exceeding their experience. Women's perpetration is 0.4%. This is the least prevalent act but also the most likely to carry lasting psychological harm, given the humiliation and dehumanisation involved.

Taken together, the three acts reveal that sexual IPV operates along a spectrum from implicit coercion (sex out of fear) through direct force (forced sex) to degradation (forced degrading acts). Women's experience is concentrated at the coercive end of this spectrum. Forced sex and sex out of fear account for the vast majority of their sexual IPV, while the near-total absence of perpetration disclosure for sex out of fear suggests that this form of violence remains invisible even to those who benefit from it.

Table 3.7: Lifetime prevalence of sexual IPV by district

District	Women Exp %	N	Men Perp %	N	Men Exp %	N	Women Perp %	N
Berea	9.6	267	3.6	174	1.4	174	0.0	267
Butha-Buthe	12.4	203	11.0	124	10.2	124	1.7	203
Leribe	10.4	321	4.5	199	0.5	199	0.7	321
Mafeteng	4.9	225	7.0	132	3.4	132	1.4	225
Maseru	14.7	401	2.9	286	2.3	286	2.0	401
Mohale's Hoek	12.8	219	2.8	112	9.9	112	1.1	219
Mokhotlong	11.0	169	5.8	102	4.3	102	0.3	169
Qacha's Nek	7.7	157	2.7	102	2.0	102	1.3	157
Quthing	16.2	177	5.4	118	2.4	118	2.4	177
Thaba-Tseka	4.6	171	2.1	86	1.7	86	3.1	171

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

Sexual IPV is the least commonly reported form of intimate partner violence nationally, at 11.3% for women and 3.0% for men. However, the district-level variation is wider than for any other IPV form, with a threefold difference between the highest and lowest districts for women's experience. This suggests that sexual violence within partnerships is particularly sensitive to local social norms and disclosure environments.

Quthing records the highest women's sexual IPV experience at 16.2%, followed by Maseru (14.7%), Mohale's Hoek (12.8%), and Butha-Buthe (12.4%). At the other end, Thaba-Tseka (4.6%) and Mafeteng (4.9%) record rates less than a third of Quthing's. Women's reported perpetration of sexual IPV is very low across all districts, ranging from 0.0% in Berea to 3.1% in Thaba-Tseka, consistent with the national figure of 1.4%. These near-zero figures likely reflect floor effects in disclosure rather than a genuine absence; sexual perpetration by women remains heavily stigmatised and under-measured.

Two districts stand out for men's experience of sexual IPV. Butha-Buthe (10.2%) and Mohale's Hoek (9.9%) report rates more than three times the national average of 3.0%. Both districts also show elevated men's experience across other IPV forms, suggesting either genuinely higher bidirectional violence or a local disclosure culture in which men are more willing to report victimisation. In Butha-Buthe, men's experience (10.2%) and men's perpetration (11.0%) are nearly identical, pointing to a pattern of mutual sexual coercion within partnerships that warrants further qualitative investigation.

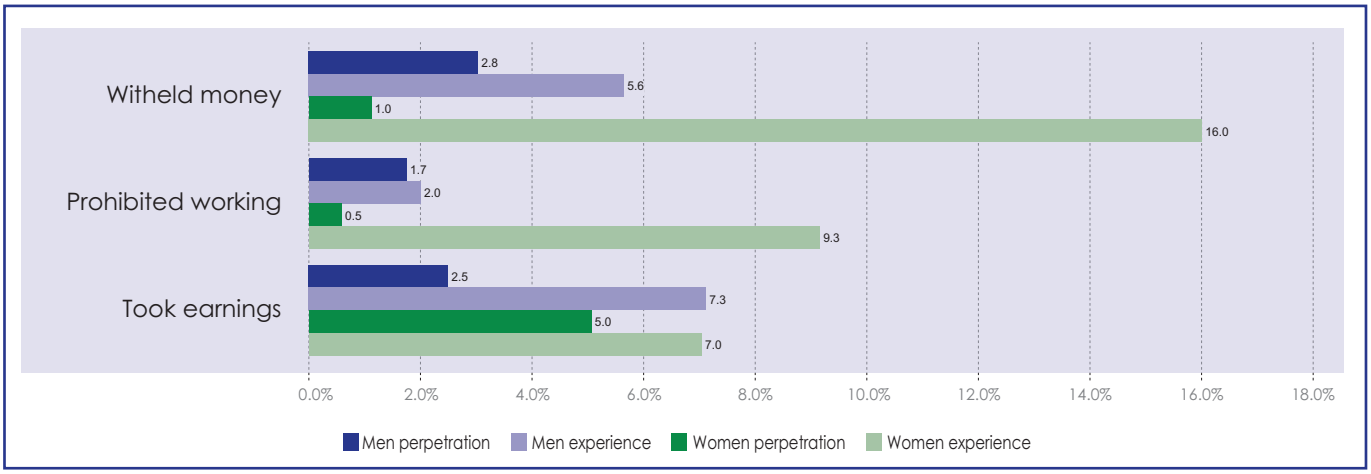
The Mafeteng disclosure paradox observed in earlier sections holds for sexual IPV as well. Mafeteng records the second-lowest women's experience (4.9%) yet the second-highest men's perpetration (7.0%), a gap in the opposite direction to what would be expected. This consistent cross-domain pattern strengthens the interpretation that something specific about the Mafeteng context suppresses women's reporting or facilitates men's disclosure of perpetration, rather than reflecting genuinely low violence against women in the district.

[120] Jewkes, R. et al. (2002). Prevalence of emotional, physical, and sexual abuse of women in three South African provinces. South African Medical Journal, 91(5), 421-428. Government of Lesotho (2003). Sexual Offences Act No. 3 of 2003, Section 3.

3.10.4 Economic intimate partner violence

Economic IPV is experienced by 22.6% of ever-partnered women in their lifetime, down from 30% in 2013 (approximately -6.5 pp). Economic abuse encompasses being denied money for household needs, having earnings taken, being prevented from working, and having property destroyed. This form of violence is particularly significant in the Lesotho context, given the country's poverty levels and women's frequent financial dependence on male partners, conditions that make economic coercion simultaneously a driver of GBV vulnerability and a consequence of GBV victimisation.

Figure 3.10: Acts of economic abuse in lifetime



Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

Figure 3.10 presents three acts that constitute economic IPV in this study. These are withholding money needed for household expenses, prohibiting a partner from working or earning income, and taking a partner's earnings.

Withholding money is the most prevalent form of economic violence against women, reported by 16.0% of ever-partnered women, accounting for the majority of the 22.6% aggregate economic IPV figure. This act captures a specific dynamic of financial gatekeeping in which one partner controls the household's economic resources, leaving the other dependent and unable to meet basic needs. Women's perpetration of withholding money is 1.0%, creating a 15-percentage-point experience-perpetration gap that mirrors the broader pattern of male under-disclosure. Men's experience of having money withheld (5.6%) and men's perpetration (2.8%) are both considerably lower than the women's figures. However, the men's experience rate suggests that roughly one in eighteen men has had household money withheld by a partner.

Prohibiting a partner from working is the second most common act against women at 9.3%, and the most overtly controlling. Unlike the other economic IPV acts, which involve the distribution of existing resources, this act directly curtails a partner's capacity to generate independent income, thus attacking economic autonomy at its source. It is almost exclusively directed at women, as men's experience of being prohibited from working is 2.0%, and women's perpetration is just 0.5%. Men's perpetration (1.7%) is also low, creating a wide gap with women's experience (9.3%) that suggests male perpetrators substantially underreport this act. Prohibiting a partner from working has cascading effects beyond the immediate financial harm. It limits social

networks, reduces access to information and services, and deepens the dependence that makes it harder to leave a violent relationship.[121]

Taking a partner's earnings is the most gender-symmetrical act in the economic IPV module. Women's experience (7.0%) and men's experience (7.3%) are nearly identical, suggesting that confiscation of earnings operates bidirectionally in Lesotho's partnerships. Women's perpetration (5.0%) is the highest of any economic IPV act for women, further supporting the bidirectional pattern. Men's perpetration (2.5%) is lower, though this likely reflects under-disclosure rather than genuinely lower rates, given that women report experience at 7.0%. The near parity in experience rates may reflect the economic realities of Lesotho's households, where both partners often contribute earnings through formal or informal work, and where control over those earnings is contested from both sides.

Taken together, the three acts reveal a hierarchy of economic control. Withholding money is the most common and the most gendered, overwhelmingly directed at women. Prohibiting work is the most structurally damaging, cutting off the pathway to economic independence entirely. Taking earnings is the most bidirectional, suggesting that economic coercion in this specific form is not exclusively a tool of patriarchal control but operates as a feature of resource contestation within partnerships. The policy implication is that interventions addressing economic IPV need to go beyond income-generation programmes for women. They must also address the norms that permit partners to claim control over another's earnings and labour.

Economic abuse acts: 2013-2025 comparison

The 2013 study measured four economic abuse acts. The 2025 study measures three of these using broadly comparable wording, while 'forced to leave employment' (8.0% in 2013) was dropped as a standalone item. Comparison across the matched acts reveals a mixed picture.

Prohibiting a partner from working declined from 19.3% to 9.3% (-10.0 pp), the largest reduction among all economic IPV acts and one of the most striking act-level declines in the entire study. This halving likely reflects the expansion of women's labour-force participation and increasing social recognition that preventing a partner from working constitutes abuse. Not being given money for household expenses remained stable at 16.0% in both 2013 and 2025, indicating that financial gatekeeping within relationships has proven resistant to the changes that reduced other economic abuse acts. Taking a partner's earnings was measured at 2.7% in 2013; the 2025 figure of 7.0% is higher, though the different item wording (the 2013 study asked specifically about 'earnings taken away' while 2025 broadened the item) limits direct comparability.

The stability of withholding money at 16.0% across 12 years is among the most policy-relevant findings in the economic IPV domain. While overt acts of economic control, such as prohibiting work, have halved, the subtler form of financial gatekeeping has remained constant. This pattern mirrors the emotional IPV finding where normalised behaviours prove more resistant to change than overtly recognised forms of abuse. It suggests that programming targeting economic IPV needs to move beyond employment rights messaging toward addressing the distribution of financial resources within households.

[121] Stylianou, Amanda. (2018). Economic Abuse Within Intimate Partner Violence: A Review of the Literature. Violence and Victims. 33. 3-22. 10.1891/0886-6708.33.1.3.

Table 3.8: Lifetime prevalence of economic IPV by district

District	Women Exp %	N	Men Perp %	N	Men Exp %	N	Women Perp %	N
Leribe	28.6	321	11.0	199	16.1	199	4.8	321
Butha-Buthe	26.5	203	10.8	124	5.7	124	6.6	203
Berea	24.6	267	3.7	174	9.2	174	10.9	267
Mokhotlong	24.3	169	3.8	102	14.9	102	5.7	169
Maseru	22.9	401	2.5	286	8.2	286	3.4	401
Quthing	22.9	177	8.7	118	15.2	118	1.7	177
Mohale's Hoek	20.5	219	6.2	112	18.5	112	11.9	219
Thaba-Tseka	16.7	171	4.9	86	3.7	86	3.4	171
Mafeteng	16.3	225	17.9	132	17.4	132	9.8	225
Qacha's Nek	15.3	157	2.3	102	8.9	102	1.5	157

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

Economic IPV is the third most prevalent form of intimate partner violence nationally, reported by 22.6% of women and 11.5% of men. District-level patterns reveal a distinctive dynamic. The districts with the highest women's experience are not the poorest, challenging the assumption that economic violence is primarily a product of material deprivation.

Leribe leads women's economic IPV experience at 28.6%, followed by Butha-Buthe (26.5%), Berea (24.6%), and Mokhotlong (24.3%), all above the national figure. These districts include some of Lesotho's more economically active areas, where formal employment and access to financial resources might be expected to protect women. The paradox suggests the opposite: in settings where women earn independent income, control over those earnings becomes a more contested site of intimate partner power. Economic IPV in these districts may manifest less as deprivation and more as financial gatekeeping, withholding money, prohibiting work, or confiscating wages. Qacha's Nek (15.3%), Mafeteng (16.3%), and Thaba-Tseka (16.7%) record the lowest women's experience, though even these figures indicate that roughly one in six ever-partnered women in these districts has experienced economic violence.

Women's perpetration of economic IPV shows an unusual pattern. Mohale's Hoek (11.9%), Berea (10.9%), and Mafeteng (9.8%) record the highest rates, well above the national figure of 6.2%. These figures suggest that economic control operates bidirectionally in some partnerships, with women also restricting men's access to household resources. The relatively narrow national experience-perpetration gap in economic IPV (22.6% women's experience vs 6.2% men's perpetration) is the smallest of any IPV form, consistent with economic acts being more readily acknowledged than physical or sexual ones.

Men's experience of economic IPV is notably high in several districts. Mohale's Hoek leads at 18.5%, followed by Mafeteng (17.4%), Leribe (16.1%), and Quthing (15.2%). The Mafeteng pattern is particularly striking: women's experience is among the lowest (16.3%) while men's experience (17.4%) and men's perpetration (17.9%) are both among the highest, extending the Mafeteng disclosure paradox into the economic domain and suggesting genuinely high bidirectional economic control in that district. Mafeteng is the only district where men's perpetration of economic IPV (17.9%) exceeds women's experience (16.3%), reinforcing the pattern of unusually open male disclosure there.

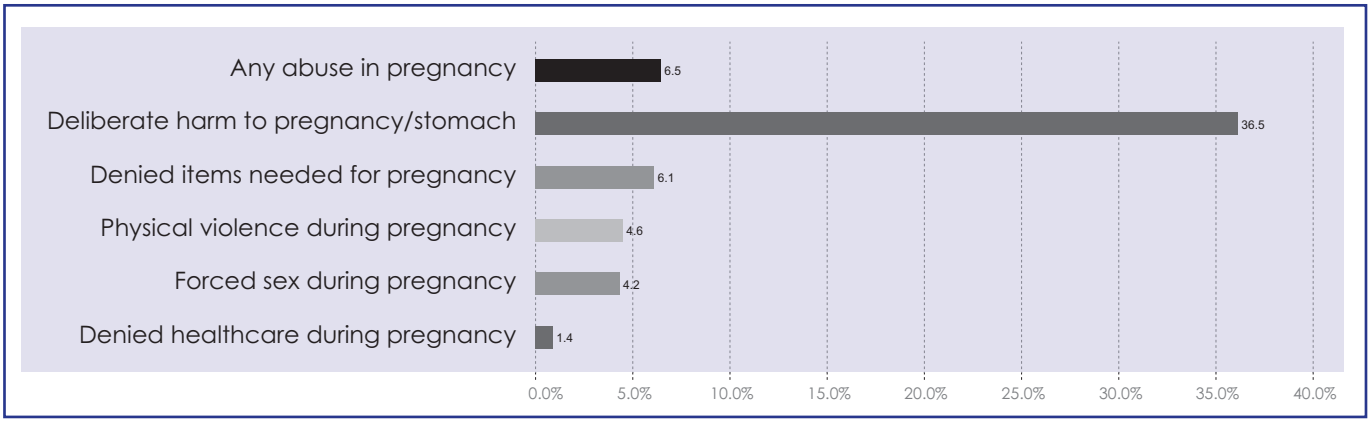
Thaba-Tseka presents the most contained profile overall, with the lowest or near-lowest figures across all four columns (16.7% women's

experience, 3.4% women's perpetration, 3.7% men's experience, 4.9% men's perpetration). Whether this reflects genuinely lower economic IPV in this remote highland district or reduced disclosure in a setting where subsistence livelihoods offer fewer visible financial control points remains an open question.

3.10.5 Violence during pregnancy

Violence during pregnancy is one of the most severe forms of intimate partner violence, with direct physical risks to both mother and fetus. The 2025 survey finds that 6.5% (N=1,990) of ever-pregnant women experienced some form of physical violence from a partner during at least one pregnancy, down from 14% recorded in the 2013 baseline, a reduction of approximately 7.5 percentage points.[122] The DHS 2023-24 corroborates this finding, reporting 6% of ever-pregnant women experiencing pregnancy violence.[123] The convergence of two independent national surveys on a similar figure significantly strengthens confidence in this estimate.

Figure 3.11: Acts of abuse in pregnancy in lifetime



Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

The study asked women who had ever been pregnant (N=1,990) about five specific acts of abuse during pregnancy. Overall, 6.5% of ever-pregnant women report experiencing at least one form of abuse during pregnancy. Denial of items needed for pregnancy is the most reported act at 6.1%, affecting roughly one in sixteen pregnant women. This encompasses the withholding of food, medication, transport to antenatal appointments, or other essentials required for a healthy pregnancy. It is a form of economic violence that operates through neglect rather than direct aggression, and its position as the leading act suggests that pregnancy abuse in Lesotho is more commonly expressed through deprivation and control than through overt physical or sexual force.

Physical violence during pregnancy is reported by 4.6% of women, indicating that nearly one in twenty pregnancies was marked by physical assault. This figure is lower than the lifetime physical IPV rate of 27.6%, suggesting that pregnancy offers some, but far from complete, protection against physical violence. Forced sex during pregnancy is reported at a similar rate of 4.2%, underscoring that sexual coercion does not cease when a partner is pregnant. Both acts carry serious risks for maternal and foetal health, including miscarriage, premature

[122] Chambliss, L.R. (2008). Intimate partner violence and its implication for pregnancy. Clinical Obstetrics and Gynecology, 51(2), 385-397. Hedin, L.W. & Janson, P.O. (2000). Domestic violence during pregnancy. Acta Obstetricia et Gynecologica Scandinavica, 79(8), 625-630.
[123] Ministry of Health [Lesotho] and ICF (2024). Lesotho Demographic and Health Survey 2023-24: Final Report. Maseru and Rockville MD: Ministry of Health and ICF. Table 19.1 and Chapter 19 key findings.

labour, low birth weight, and placental abruption.

Denial of healthcare during pregnancy affects 1.4% of women. While the lowest of the individual acts, this is arguably the most dangerous in a context where maternal mortality remains a significant public health concern in Lesotho. Preventing a pregnant woman from accessing antenatal care directly jeopardises both her life and the life of the unborn child. It represents an extreme form of partner control over reproductive health.

The figure for deliberate harm to the pregnancy or stomach (36.3%) requires careful interpretation. The denominator for this item is only N=85, that is, women who reported that a partner had specifically tried to cause harm to the pregnancy, not the full sample of ever-pregnant women. This means that among the small group of women who experienced targeted pregnancy harm, over a third reported that a partner had deliberately struck or harmed the stomach area. The very small N means this estimate carries wide uncertainty and should not be generalised. Still, the existence of this subgroup points to a severe and intentional form of violence that specifically targets the pregnancy itself, going beyond incidental physical IPV to constitute a deliberate attack on reproductive outcomes.

Taken together, these findings show that pregnancy does not provide a shield against intimate partner violence. The combination of denial of essentials (6.1%), physical violence (4.6%), and forced sex (4.2%) paints a picture in which a significant minority of pregnant women in Lesotho face multiple, overlapping forms of abuse at a time when they are physiologically vulnerable and most in need of partner support. The implications for antenatal care programming are direct. Indicator-based clinical inquiry for IPV during pregnancy visits should be standard practice, and health workers need the training and referral pathways to respond when abuse is disclosed.

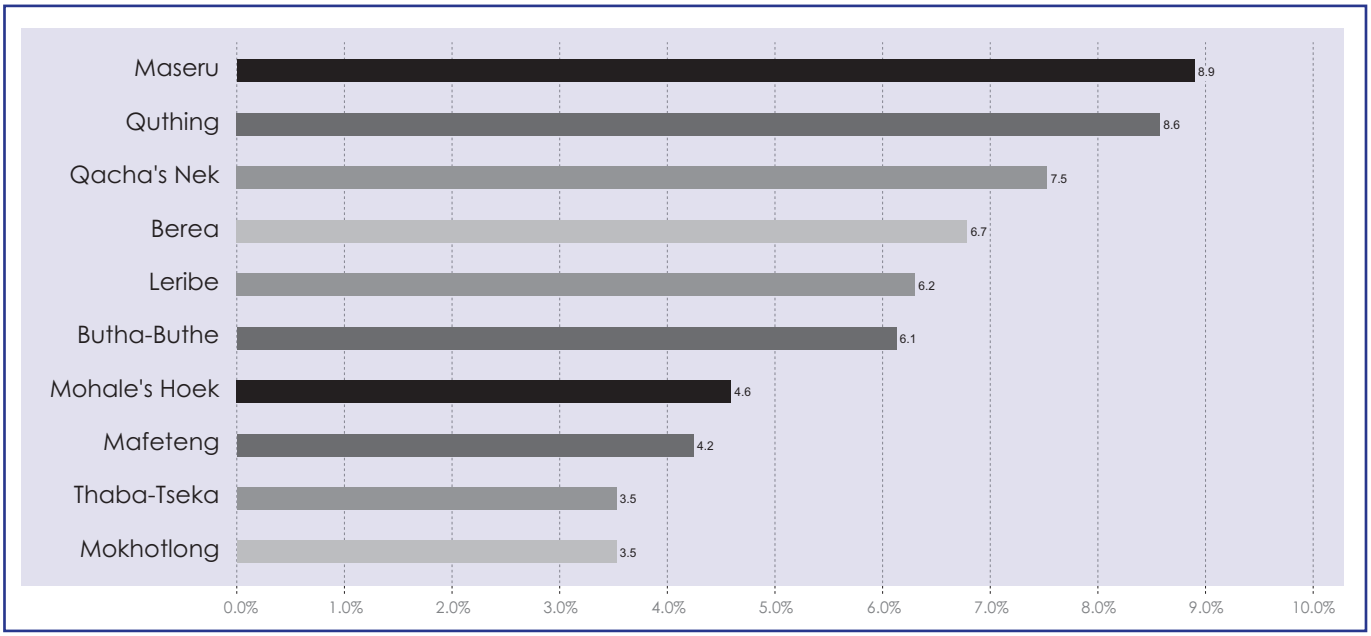
Pregnancy abuse acts: 2013-2025 comparison

The 2013 study found that 13.8% of ever-pregnant women experienced some form of abuse during pregnancy. The 2025 figure of 6.5% represents a halving of pregnancy abuse (-7.3 pp), one of the most encouraging trend findings in the study. This decline aligns with the expansion of antenatal care coverage and the increased integration of GBV clinical inquiry into maternal health services since the first study.

At the act level, being refused clothes or food needed for pregnancy was reported by 15.0% in 2013, making it the most common pregnancy abuse act; the 2025 equivalent (denial of items needed for pregnancy) stands at 6.1%, a decline of approximately 9 pp. Being kicked or hit in the stomach fell from 4.2% to 4.6%, the only act showing a marginal increase, though the small absolute difference (0.4 pp) is within sampling variability and should not be interpreted as a statistically significant rise. Being prevented from going to the clinic, already the rarest act in 2013 at 0.5%, declined further to 1.4% in 2025 as a denial-of-healthcare item; however, the 2025 item wording broadened to 'denied healthcare' rather than specifically clinic attendance, which may partly account for the apparent rise.

The overall halving of pregnancy abuse is consistent with the broader pattern of IPV decline documented throughout this chapter. Importantly, the decline is driven primarily by the reduction in denial of material support (food, clothing), suggesting that economic empowerment interventions and maternal health programmes have been effective. The persistence of physical violence during pregnancy at approximately 4-5% across both rounds, however, indicates that the most dangerous form of pregnancy abuse has not meaningfully declined and continues to place pregnant women at risk of obstetric complications.

Figure 3.12: Lifetime prevalence of abuse in pregnancy by district



Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

The district data show Maseru (8.9%), Quthing (8.6%), and Qachas Nek (7.5%), recording the highest rates of any abuse in pregnancy among ever-pregnant women, a finding relevant to the design and strengthening of antenatal care services in those districts.

3.11 Non-partner sexual violence

Non-partner sexual violence (NPSV) refers to sexual violence perpetrated by someone outside an intimate partnership, such as strangers, acquaintances, colleagues, authority figures, or family members. The 2025 survey finds that 9.4% of women aged 15 and older report experiencing at least one form of NPSV in their lifetime. On the perpetration side, 17.6% of men report having perpetrated at least one form of NPSV, nearly double women's reported experience, a gap explored below.

Table 3.9: Non-partner sexual violence experience and perpetration - 2025

NPSV type	Women Exp %	N	Men Perp %	N	Women Perp %	N
Any NPSV	**9.4**	**2565**	**17.6**	**1689**	**1.4**	**2310**
Forced sex (non-partner)	6.4	2308	3.3	1402	1.0	2310
Attempted forced sex	5.0	2293	13.1	1689		
Pressured/coerced sex	3.0	2314	2.8	1499		
Sex while incapacitated	1.5	2297	4.9	1474		
Gang rape / other sexual violence	1.0	2312	1.9	1402		

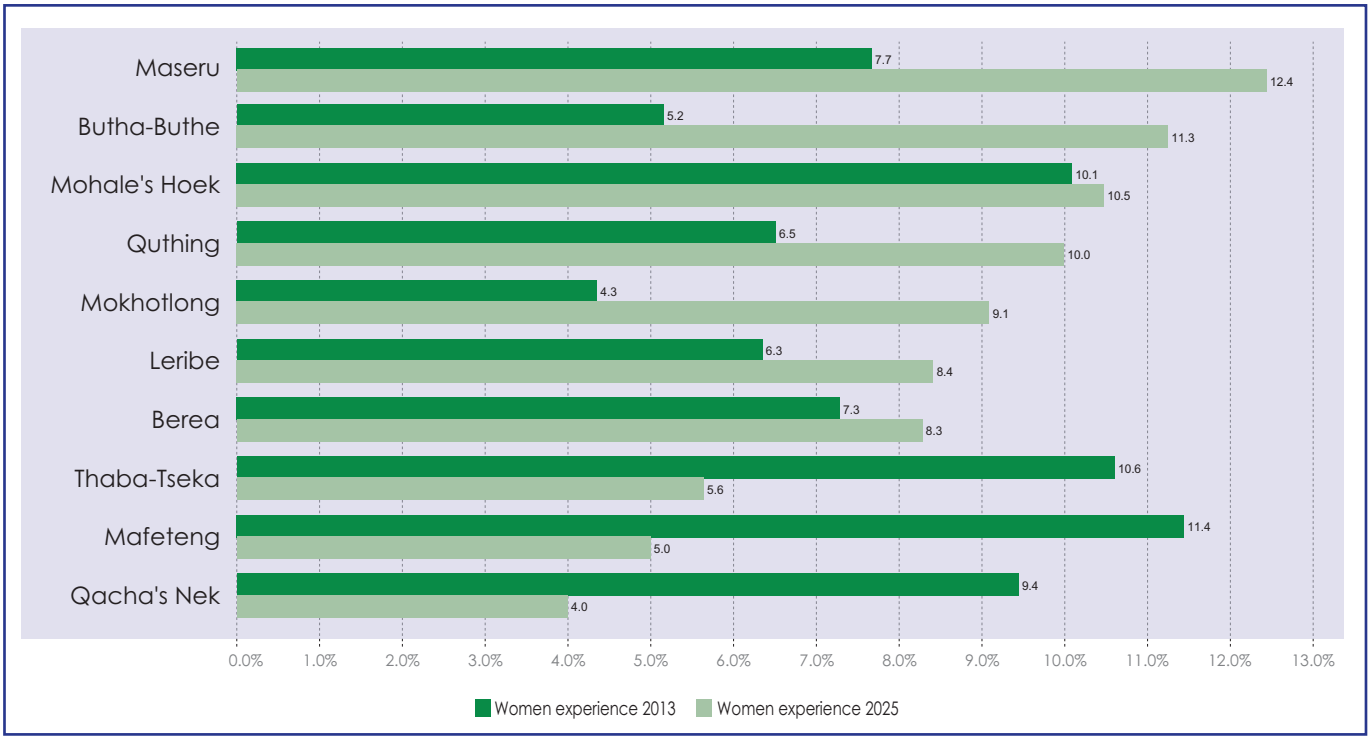
Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

Forced sex by a non-partner is the most prevalent act experienced by women (6.4%), followed by attempted rape (5.0%), pressured or coerced sex (3.0%), incapacitated assault (1.5%), and gang rape (1.0%).[124] The relatively high rate of attempted rape relative to completed forced sex suggests that women's resistance and social proximity to others interrupt perpetration in some cases, a finding relevant to community safety design.

Women's perpetration of NPSV is reported at 1.4%, comprising forced sex (1.0%) and gang rape or other sexual violence (0.4%). Men's perpetration is substantially higher across all act types: attempted rape leads at 13.1%, followed by incapacitated assault (4.9%), forced sex (3.3%), pressured sex (2.8%), and gang rape (1.9%).

The most analytically striking finding in the NPSV domain is the gap between men's reported perpetration and women's reported experience. Men's aggregate NPSV perpetration (17.6%) is nearly double the 9.4% of women who report experiencing it. Three factors likely contribute to this disparity. First, serial perpetration means a smaller number of men can generate a larger pool of victims. Second, cultural shame discourages women from identifying non-partner sexual encounters as violence, even in anonymous research settings.[125] Third, the perpetration module's behavioural framing, asking men whether they "made someone have sex" rather than whether they "committed rape", may elicit higher disclosure than the experience module, which requires women to self-identify as victims.[126]

Figure 3.13: Lifetime prevalence of abuse in pregnancy by district



Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

[124] In this study, forced sex refers to completed sexual intercourse compelled through physical force by a non-partner. Attempted rape refers to an attempted but uncompleted act of forced sex, where the assault was interrupted through the woman's resistance, bystander intervention, or situational factors before penetration occurred. Pressured or coerced sex refers to sexual intercourse obtained not through physical force but through threats, intimidation, blackmail, or persistent pressure, the woman consented under duress rather than freely. These three acts represent a continuum from direct physical force through attempted force to non-physical coercion.
[125] Gender Links & LBOS (2013). Op. cit., p. 55: 'In Lesotho just like in many settings in Africa, rape victims are treated with shame and contempt.'
[126] Campbell, R. et al. (2009). The psychological impact of rape victims' experiences with the legal, medical, and mental health systems. American Psychologist, 64(8), 702-717.

At the district level, Maseru records the highest NPSV rate for women (12.4%), consistent with the concentration of risk in urban environments where women's public mobility is higher. An important contextual finding from the WFP's 2025 service mapping is that Maseru, despite its urban resources, concentrates all of Lesotho's formal shelter capacity in a single facility, meaning that even in the highest-burden urban district, immediate safety options for NPSV survivors are severely limited.

Non-partner sexual violence: Comparison with 2013 data

The 2013 baseline reported that 9% of women had experienced non-partner sexual violence, broadly comparable to the 9.4% recorded in 2025. Unlike all four IPV forms, which showed substantial declines, NPSV has remained essentially stable over the 12 years. This stability warrants careful interpretation.

Three hypotheses may explain why NPSV has not followed the declining IPV trajectory. First, the drivers of non-partner sexual violence, including stranger violence, authority abuse, and community-level norms around male sexual entitlement, operate through different structural pathways than those driving IPV. IPV-focused interventions (couples counselling, economic empowerment, relationship skills programmes) do not reach non-partner perpetrators. Second, increased awareness and reduced stigma around sexual violence disclosure may have produced a counter-vailing effect: more women now report NPSV than in 2013, offsetting any true decline. Third, the expansion of the 2025 sample to include women aged 15-17 captures a high-risk group not included in the 2013 baseline, potentially inflating the 2025 estimate.

The stability of NPSV alongside declining IPV shifts the relative composition of women's GBV burden. In 2013, NPSV accounted for a smaller share of total GBV (9% against an overall VAW figure of 86%). In 2025, with the overall GBV figure at 66.7% and IPV substantially reduced, NPSV's proportional contribution has increased. This compositional shift has direct programming implications: as IPV-specific programmes continue to bear fruit, resources need to be rebalanced toward community safety, public-space interventions, and institutional account-ability mechanisms that address non-partner perpetration.

3.12 Sexual harassment

Sexual harassment across public spaces, workplaces, and educational settings is reported by 21.3% of women and 10.6% of men in the 2025 survey. These figures represent a different measurement framework from the 2013 headline of 63% and are not directly comparable. The 2013 figure incorporated sexual harassment as the dominant component of the 'any VAW' measure using a broader denominator. The 2025 figure, measuring standalone harassment against all women aged 15 and above, establishes a new baseline for this domain.



Table 3.10: Sexual harassment by location

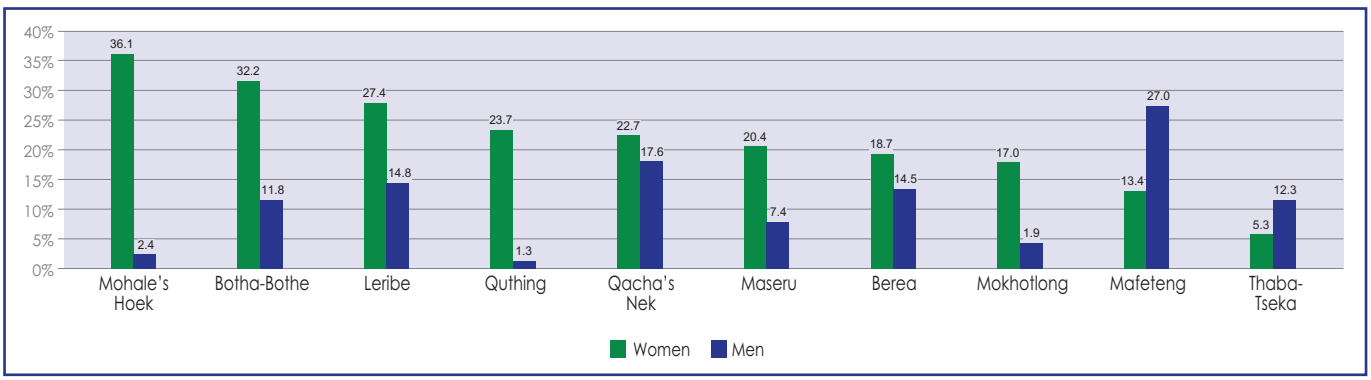
Panel A: Prevalence among all respondents				
Harassment Item	**Women %**	**N**	**Men %**	**N**
Any sexual harassment	**21.3**	**2565**	**10.6**	1689
Harassed in public spaces	18.2	2565	7.1	1689
Harassed in school	2.6	2565	1.8	1689
Harassed at work	1.4	2565	1.4	1689
Panel B: Location among those who experienced harassment				
Harassment Location	**Women %**	**N**	**Men %**	**N**
In public spaces	85.5	572	66.5	200
In school	12.3	572	16.4	200
At work	6.4	572	13.3	200

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

Public streets and transport are the most common locations for sexual harassment. Panel A shows the prevalence of harassment at each location as a proportion of all women or all men. For example, 'Harassed in public spaces' in 1) Panel A = % of all women who were both harassed and experienced it in a public space. 2) Panel B restricts the denominator to harassment reporters only, answering: 'Of those who experienced harassment, where did it occur?' Panel B figures will be substantially higher than Panel A because the denominator is much smaller (e.g. 572 women reporters vs 2,565 total women). 3) Respondents could report harassment in multiple locations; categories are not mutually exclusive. 4) 'Public spaces' combine street, public transport, and market locations.

Public spaces are the dominant setting, with 85.5% of women who reported harassment having experienced it in a public place, with workplace harassment reported by a considerably smaller proportion and school harassment at the lowest levels in population terms. The high concentration of NPSV and harassment in Maseru, which simultaneously has the highest service concentration nationally, reinforces the case for urban-targeted prevention programming, including safer public space design, transport safety measures, and workplace harassment policies. GIZ's programme with Help Lesotho on public transport safety represents an important pilot in this area that warrants evaluation and potential scaling.

Figure 3.14: Lifetime sexual harassment experience by district



Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

Sexual harassment is reported by 21.3% of women and 10.6% of men nationally, but the district-level distribution reveals striking geographic variation and some unexpected gender reversals.

Mohale's Hoek records the highest women's sexual harassment experience at 36.1%, more than six times the rate in Thaba-Tseka (5.3%), the lowest. Butha-Buthe (32.2%) and Leribe (27.4%) follow, both well above the national average. At the lower end, Mafeteng (13.4%), Mokhotlong (17.0%), and Berea (18.7%) cluster below the national figure. The widespread sevenfold difference between the highest and lowest districts is larger than for any form of IPV. It suggests that sexual harassment is highly sensitive to local contextual factors such as urbanisation, public transport density, market activity, and the visibility of women in public spaces.

Men's experience presents a markedly different geographic pattern. Mafeteng leads at 27.0%, more than double the national men's figure and, unusually, twice the women's rate in the same district (13.4%). This is the most dramatic gender reversal in the entire dataset. It may reflect the specific nature of men's harassment experience in Mafeteng (potentially in workplace or institutional settings) or a disclosure environment in which men are more forthcoming about harassment while women are not. Qacha's Nek (17.6%), Leribe (14.8%), and Berea (14.5%) also record elevated men's experience, while Quthing (1.3%), Mokhotlong (1.9%), and Mohale's Hoek (2.4%) report near-zero rates for men, even as Mohale's Hoek leads for women.

The inverse relationship between women's and men's experience in several districts is analytically noteworthy. Mohale's Hoek has the highest women's rate and among the lowest men's rates. Mafeteng has the highest men's rate and among the lowest women's rates. Thaba-Tseka has the lowest women's rate yet moderate men's experience (12.3%). These patterns suggest that the drivers of sexual harassment differ fundamentally by gender and location. Women's harassment is concentrated in districts with larger public-facing economies and urban centres. In contrast, men's harassment may be driven by different institutional or social dynamics that do not map onto the same geographic pattern.

The Thaba-Tseka profile deserves specific attention. At 5.3%, women's sexual harassment experience is exceptionally low, less than a quarter of the national average. This remote highland district has limited public infrastructure, fewer market spaces, and lower population density, all of which reduce women's exposure to the public-space harassment that dominates the national picture (85.5% of women's harassment occurs in public spaces). The finding reinforces that sexual harassment is fundamentally a spatial phenomenon, shaped by the built environment and the conditions under which women move through public life.

3.13 Reproductive coercion

Reproductive coercion refers to behaviours by an intimate partner that interfere with a person's autonomous decisions about whether, when, and how to become pregnant or to continue a pregnancy.[127] Tarzia and Hegarty (2021) identify three sub-domains: pregnancy coercion (pressuring a partner to conceive), contraceptive sabotage (tampering with or withholding birth control), and control over pregnancy outcomes (forcing abortion or miscarriage).[128] The Lesotho 2025 survey measured reproductive coercion using items

[127] Grace, K.T. & Anderson, J.C. (2018). Reproductive coercion: A systematic review. Trauma, Violence & Abuse, 19(4), 371-390; Miller, E. et al. (2010). Pregnancy coercion, intimate partner violence, and unintended pregnancy. Contraception, 81(4), 316-322.
[128] Tarzia, L. & Hegarty, K. (2021). A conceptual re-evaluation of reproductive coercion: Centring intent, fear and control. Reproductive Health, 18, 87.

spanning all three sub-domains. Because reproductive control is exercised differently by women and men, some items were asked only of women and others only of men. For men, all experience items refer to coercive behaviours directed at them by a female partner. For example, "forced pregnancy" means a partner pressured or deceived a man into fathering a child against his wishes, not that the man himself became pregnant.

Table 3.11: Acts of Reproductive Coercion

Violence Type	Women Exp %	N	Men Perp %	N	Men Exp %	N	Women Perp %	N
Any Reproductive coercion (RC)	9.4	2310	5.9	1689	6.3	1689	5.9	2565
Pregnancy coercion								
Forced pregnancy	2.8	2310	1.9	1499	2.1	1463	1.9	2310
Threatened to leave if there was no child			1.3	1499			1.3	2310
Contraceptive sabotage								
Told not to use birth control	5.4	2310			2.8	1463		
Damaged birth control	0.8	2310	1.0	1499	0.8	1463	1.0	2310
Condom removed during sex	2.2	2310			3.3	1499		2310
Hidden/destroyed birth control			1.3	1499			1.3	
Blocked partner from the clinic			1.1	1499			1.1	
Refused to use a condom			3.6	1499			3.6	
Lied about using birth control								2310
Stopped birth control without telling								2310
Control of pregnancy outcomes								
Forced abortion	1.3	2310						
Forced miscarriage	1.8	2310						
Continued pregnancy against the partner's wishes								2310
Lied about paternity								2310

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

Overall, 9.4% of ever-partnered women and 6.3% of men report experiencing at least one act of reproductive coercion in their lifetime. On the perpetration side, 5.3% of women and 5.9% of men acknowledge perpetrating at least one act. The narrow gap between women's and men's reports, both for experience and perpetration, makes reproductive coercion the most gender-symmetric GBV domain in the study. This relative symmetry suggests that reproductive coercion operates through relationship-level dynamics, such as disagreements about family planning, rather than the one-directional power imbalance that characterises physical or sexual IPV.

Abuse escalates during periods of physical vulnerability, illness, pregnancy, and caregiving, when the survivor is least able to protect herself or leave:



"When I fell ill, he refused to help me, even when I needed medical care. He mocked me and left me to fend for myself. He physically assaulted our children during Christmas. Even after being convicted, he showed no remorse, and the cycle of abuse continued."

Mokhotlong Participant 4

Pregnancy coercion

Among women, 2.8% report that a partner forced or pressured them to become pregnant. Among men, 2.1% report that a partner pressured or deceived them into fathering a child against their wishes. Perpetration rates are 0.6% for women and 1.9% for men.

A second item, threatening to leave if the partner does not have a child, is reported as perpetrated by 0.2% of women and 1.3% of men, indicating that men more commonly exercise pregnancy pressure through relationship threats.

Contraceptive sabotage

Contraceptive sabotage is the most varied sub-domain, with several items reflecting the gendered nature of reproductive control. Among women, the most reported experience is being told by a partner not to use birth control (5.4%), followed by having a condom removed during sex (2.2%) and having birth control damaged by a partner (0.8%). Among men, the most common experience is a partner refusing to use a condom (3.3%), followed by a partner telling them not to use contraception (2.8%) and a partner damaging their birth control (0.8%).

On the perpetration side, the data reveal distinctly gendered tactics. Women's perpetration includes lying about using birth control (2.3%), stopping birth control without telling their partner (1.1%), removing a condom during sex (0.4%), and damaging birth control (0.3%). Men's perpetration includes refusing to use a condom (3.6%), hiding or destroying a partner's birth control (1.3%), blocking a partner from attending the clinic (1.1%), and damaging birth control (1.0%). These patterns show that women's tactics tend to involve deception around their own contraceptive use. In contrast, men's tactics more often involve direct interference with a partner's access to reproductive health services and supplies.

The finding that condom removal during sex (2.2% of women) and refusal to use a condom (3.6% of men's perpetration) are among the most reported acts carries direct implications for HIV prevention. In Lesotho's high-prevalence context,[129] forced or coerced condomless sex constitutes a GBV-HIV transmission pathway. Integrated programming across the health and gender sectors is needed to address reproductive coercion as both a rights violation and a driver of HIV risk.

Control over pregnancy outcomes

The most severe acts of reproductive coercion fall within the control of pregnancy outcomes sub-domain. Among women, 1.8% report that a partner forced them to have a miscarriage and 1.3% report that a partner forced them to have an abortion. While these figures are lower than other forms of reproductive coercion, they represent extreme violations of bodily

[129] UNAIDS (2023). Country Factsheet: Lesotho. Geneva: UNAIDS.

autonomy in which a partner overrides a woman's decision to carry a pregnancy to term.

Women's perpetration items in this sub-domain take a different form: 2.4% of women report continuing a pregnancy against their partner's wishes, and 0.3% report lying about paternity. These acts reflect a different dimension of reproductive control, one in which decisions about a pregnancy's continuation or a child's parentage are made unilaterally, without the partner's knowledge or consent.

3.14 Technology-facilitated gender-based violence

Technology-facilitated GBV (TFGBV), measured for the first time in the 2025 study, affects 18.2% of internet-using women and 21.0% of internet-using men. These figures, taken among the approximately 40-48% of the sample who use the internet,[130] establish Lesotho's first baseline for digital GBV monitoring. Items measured cover online abuse, cyberstalking, sextortion, non-consensual image sharing, and identity theft or impersonation through digital platforms.



"Another deeply traumatic experience was seeing the man's case posted on social media. The police posted information suggesting that I had been drunk and blacked out, without my consent. Instead of supporting the victim, people mocked and blamed me. This significantly hindered my healing process."

Thaba-Tseka Participant 5

Table 3.12: Technology-facilitated GBV

Type of Online Violence	Women %	N	Men %	N
Online stalking	11.5	1232	10.6	681
Online abuse/messages	9.2	1232	13.5	681
Fake profile/identity theft	4.2	1232	5.9	681
Online sextortion	1.8	1232	1.3	681
Image sharing without consent	0.6	1232	0.7	681
Any TFGBV	**18.2**	**1232**	**21.0**	**681**

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

Women report higher rates of online stalking (11.5% vs 10.6% for men), a form consistent with intimate partner surveillance and the digital extension of coercive control.[131] Men report higher rates of threatening online messages (13.5% vs 9.2% for women), which may partly reflect non-gendered peer or political conflict in online spaces that requires more contextual analysis. Near-equal rates of sextortion (women 1.8%, men 1.3%) and non-consensual image sharing (women 0.6%, men 0.7%) suggest these severe forms are not strongly gendered in incidence. However, their reputational and psychological consequences may be distributed unequally. Men's higher TFGBV experience rate (21.0% vs 18.2%) suggests that online spaces present distinct risk profiles across genders. Yet these distinct profiles converge on a shared outcome: 81% of online abuse survivors did not report the experience, with

[129] UNAIDS (2023). Country Factsheet: Lesotho. Geneva: UNAIDS.
[130] International Telecommunication Union (2023). Measuring Digital Development: Facts and Figures 2023. Geneva: ITU.
[131] Woodlock, D. (2017). The abuse of technology in domestic violence and stalking. Violence Against Women, 23(5), 584-602. Henry, N. & Powell, A. (2016). Sexual violence in the digital age. Social & Legal Studies, 25(4), 397-418.

normalisation (32%) and not knowing where to report (11%), the latter affecting men at five times the rate of women, emerging as the dominant barriers (see Chapter 6 Section 6.7.2).

The DHS 2023-24 independently records 5% of women aged 15-49 experiencing TFGBV in the past 12 months, with rates reaching 8% in Maseru and Quthing, converging with the 2025 GL study findings and strengthening confidence in the scale of the problem. As Lesotho's digital infrastructure expands, this domain will grow in importance. Establishing legal provisions for TFGBV under the Counter Domestic Violence Act 2022, which includes technology-facilitated violence in its scope, and building CGPU capacity to receive and respond to digital GBV reports are among the most important near-term investments in this area.

Qualitative evidence from service providers corroborates the legal vacuum around TFGBV. In a 2026 interview, **Women and Law in Southern Africa (WLSA)** confirmed that Lesotho does not yet have a dedicated law addressing technology-facilitated GBV, such as cyber-stalking and revenge pornography, although the Ministry of Communications has discussed the need for such measures. WLSA reported that it has not yet encountered TFGBV cases among its clients.

Similarly, the **Mosepele Foundation** noted that while its radio programmes through Mohale FM have discussed online harms, including non-consensual sharing of images, these topics have not yet been integrated into community group curricula. These accounts suggest that TFGBV remains largely invisible to the formal service system, not because it does not occur, but because legal frameworks, reporting channels, and community awareness have not yet caught up with the digital reality captured in the prevalence data above.

The **Lesotho Communications Authority (LCA)** confirmed that its regulatory mandate covers only FM broadcasting frequencies and does not extend to online platforms, social media, or internet-based content. This regulatory vacuum means that technology-facilitated GBV occurring through Facebook, WhatsApp, and other digital platforms falls entirely outside the Authority's jurisdiction. LCA reported developing Child Online Protection Guidelines in partnership with UNICEF, but these are preventive and educational rather than punitive - they cannot compel platform compliance or mandate content removal. A critical structural barrier is that Meta's artificial intelligence content moderation systems perform poorly for Sesotho-language content. The LCA noted that Lesotho's small user base gives it minimal commercial priority for platform investment in language-specific moderation, meaning harmful content in Sesotho is less likely to be detected and removed than equivalent content in globally dominant languages. The Communications Act is currently under review, but its scope expansion to cover online harms remains uncertain.

The **Khutlo Project** formative research[132] (Sonke Gender Justice and Pact, 2024) provides additional context for these TFGBV findings. Conducted across Maseru, Leribe, and Mokhotlong, the Khutlo study is the first in Lesotho to systematically document GBV, including online and technology-facilitated forms, experienced by LGBTQI+ communities. While the present study measures TFGBV prevalence in the general population, the Khutlo findings highlight that LGBTQI+ persons face additional and compounded forms of technology-facilitated violence linked to stigma and discrimination, reinforcing the need for inclusive GBV prevention programming.

[132] 'USAID/Lesotho Khutlo Project Formative Research Report' (2024) Sonke Gender Justice, 21 June. Available at: https://genderjustice.org.za/publication/usaid-lesotho-khutlo-project-formative-research-report/ (Accessed: 8 July 2026).

3.15 Adverse childhood experiences

Adverse Childhood Experiences (ACEs) refer to potentially traumatic events occurring before age 18. ACE domains, including physical, emotional, or sexual abuse; neglect; household dysfunction; and witnessing IPV before age 18, are among the most robust predictors of adult GBV as both survivor and perpetrator.[133] The 2025 Lesotho study measured ACEs in all respondents aged 15 and older using a standardised six-domain checklist.

Table 3.13: Childhood adversity and adverse childhood experiences

ACE Domain/Type	Women % 2013	Women % 2025	N	Men % 2013	Men % 2025	N
Physical abuse	80	63.6	2565	90	68.7	1689
Emotional abuse	n/a	32.9	2565	n/a	33.5	1689
Neglect	60	31.6	2565	71	30.2	1689
Household dysfunction	n/a	26.2	2565	n/a	24.0	1689
Witnessed intimate partner violence	n/a	21.9	2565	n/a	14.1	1689
Sexual abuse	18	14.4	2565	25	14.5	1689
Any childhood adversity[134]	**n/a**	**80.3**	**2565**	**n/a**	**77.7**	**1689**
Mean ACE Score[135]	**n/a**	**1.91**		**n/a**	**1.85**	

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

The ACE findings for Lesotho are among the most striking in this chapter, with 80.3% of women and 77.7% of men reporting at least one form of childhood adversity. These figures place Lesotho at the upper end of ACE prevalence globally. They are consistent with broader southern African patterns where childhood physical discipline is normalised, and household dysfunction is widespread.[136] The mean ACE score of 1.91 for women and 1.85 for men indicates that the average Lesotho adult experienced nearly two distinct categories of adversity before the age of 18. This underscores the deep intergenerational roots of violence in Lesotho and the importance of upstream, early childhood prevention alongside adult-focused responses.

The most prevalent individual ACE domain is childhood physical abuse, reported by 63.6% of women and notably an even higher 68.7% of men. This is one of the few ACE domains where men's experience exceeds women's and is consistent with cultural norms around corporal punishment of boys in Lesotho's educational and household settings. Emotional abuse (women 32.9%, men 33.5%) and neglect (women 31.6%, men 30.2%) rank second and third, with near-identical prevalences across genders, again consistent with undifferentiated exposure to household-level adversity in early life.

The most important gender divergence in the ACE data is in witnessing intimate partner violence during childhood: 21.9% of women compared with 14.1% of men. This 7.8-percentage-point gap is consistent with research demonstrating that girls are more frequently present in household spaces where IPV occurs, and that they are more likely to be caregivers for victimised mothers. These roles

[133] Felitti, V.J. et al. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. American Journal of Preventive Medicine, 14(4), 245-258.
[134] 'Any childhood adversity' is a binary indicator: 1 if at least one ACE domain was reported
[135] Mean ACE Score is the average number of ACE domains reported.
[136] Jewkes, R. et al. (2011). Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa. The Lancet, 376(9734), 41-48.

expose them to direct observation of violence.[137] [138] Crucially, witnessing IPV in childhood is one of the strongest intergenerational predictors of both experiencing and perpetrating IPV in adulthood in their own adult relationships,[139] [140] suggesting that today's elevated GBV prevalence in Lesotho is in part being reproduced through childhood exposure pathways that require explicit intergenerational prevention strategies. This finding points to a prevention dividend in programmes that reduce IPV among parents and caregivers. Every relationship in which violence is reduced or prevented simultaneously reduces the ACE exposure of the children within that household.

Childhood sexual abuse shows near-identical prevalence for women, 14.4%, and men, 14.5%. This symmetry is unusual in global ACE literature (which shows that 7.9% of men and 19.7% of women had suffered some form of sexual abuse prior to the age of eighteen), where childhood sexual abuse typically shows higher rates for girls and women.[141] The finding warrants careful interpretation. It may reflect genuine symmetry in childhood sexual abuse experiences in Lesotho, differential willingness to disclose sexual abuse across genders or other factors. A dedicated qualitative follow-up study focused on childhood sexual abuse experiences, particularly among men, would be needed to illuminate these patterns. Some excerpts from the 'I' Stories below show how child sexual abuse occurs and how it is hidden. Child sexual violence frequently involves premeditation by the perpetrator and deliberate isolation of the child:



"He sent my friends to fetch something while telling me to wait. He told me to hide, claiming he would hide elsewhere, but instead, he followed me. He threatened me with violence if I ever spoke out. My father reported the matter to the perpetrator's parents, but the boy continued attending school as if nothing had happened."

Lisebo, 11, Leribe*

Threats that accompany child sexual violence shape what the child reports and to whom, compounding the harm with forced complicity:



"When my stomach began to show, my school principal noticed and called my mother. Out of fear, I lied. I accused my neighbour, just as I had been instructed. I felt terrible, but I was terrified for my life. I believed his threats."

Railey, 14, Thaba-Tseka*

[137] Koenen, K.C. et al. (2003). Domestic violence is associated with environmental suppression of IQ in young children. Development and Psychopathology, 15(2), 297-311.
[138] McCloskey, L.A. (2004), 'The effects of childhood exposure to marital violence on adolescent gender-role beliefs and dating violence,' Psychology of Women Quarterly, 28(4), 344-357.
[139] Jewkes, R. et al. (2011). Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa. The Lancet, 376(9734), 41-48.
[140] Koenen, K.C. et al. (2003). Domestic violence is associated with environmental suppression of IQ in young children. Development and Psychopathology, 15(2), 297-311.
[141] Pereda, N. et al. (2009), 'The prevalence of child sexual abuse in community and student samples: A meta-analysis,' Clinical Psychology Review, 29(4), 328-338.

Comparison with 2013 ACE data

Table 3.13 presents both the 2025 and 2013 ACE prevalence figures side by side, enabling direct trend assessment across the six domains. The comparison reveals a mixed picture. Physical abuse remains the dominant ACE domain in both rounds. However, the 2025 figures (63.6% of women, 68.7% of men) suggest a continuation of deeply entrenched norms around corporal punishment rather than any meaningful decline. Emotional abuse prevalence is broadly stable (32.9% of women in 2025 compared with the 2013 baseline), while neglect (31.6% of women, 30.2% of men) and household dysfunction (26.2% of women, 24.0% of men) remain at levels that affect roughly one in four to one in three adults.

The stability of ACE prevalence across the two rounds stands in stark contrast to the substantial declines recorded for adult IPV. It carries profound implications for GBV prevention design in Lesotho. The divergence suggests that while interventions targeting adult relationship violence have gained traction, the upstream childhood conditions that feed the intergenerational cycle of violence remain largely unchanged. A very large proportion of Lesotho's adult population carries a childhood burden of adversity. The mean ACE score of 1.91 for women and 1.85 for men indicates nearly two distinct adverse experiences per person, which is known to elevate GBV risk through neurobiological, psychological, and social-behavioural pathways. Prevention strategies that do not address childhood adversity, particularly the normalisation of physical punishment and children's exposure to household violence, risk treating symptoms while leaving the root causes intact. The Effects chapter (Chapter 5) develops the causal pathway analysis, including dose-response modelling between ACEs and adult GBV outcomes, in detail.

3.16 GBV among persons with disabilities

The intersection of disability and gender-based violence is a global public health and human rights concern. Persons with disabilities face systematically elevated risks of GBV,[142] due to dependency relationships, communication barriers, social exclusion, limited access to services, and heightened vulnerability to coercion and exploitation. The 2025 study measures disability using the Washington Group Short Set on Functioning (WG-SS).[143] The internationally recommended instrument for disability identification in population surveys. Respondents are classified as disabled if they report 'a lot of difficulty' or 'cannot do at all' in at least one of six functional domains, which are seeing, hearing, walking, concentrating, self-care, and communicating. Using this measure, 19.5% of women and 10.7% of men in the sample report at least one functional difficulty, and 7.3% of women and 3.3% of men report difficulties in two or more domains, figures that are broadly consistent with WHO estimates for low- and middle-income countries.

While this section focuses on men's and women's GBV experience disaggregated by disability status, a comparable analysis for mental health effects by disability is presented

133 Felitti, V.J. et al. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. American Journal of Preventive Medicine, 14(4), 245-258.
134 'Any childhood adversity' is a binary indicator: 1 if at least one ACE domain was reported
135 Mean ACE Score is the average number of ACE domains reported.
136 Jewkes, R. et al. (2011). Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa. The Lancet, 376(9734), 41-48.
142 Hughes, K. et al. (2012). Prevalence and risk of violence against adults with disabilities: A systematic review and meta-analysis of observational studies. The Lancet, 379(9826), 1621-1629.
143 Washington Group on Disability Statistics (2020), The Washington Group Short Set on Functioning (WG-SS). Hyattsville, MD: NCHS. Available at: https://www.washingtongroup-disability.com.

in Chapter 5. Both analyses use the Washington Group Short Set on Functioning (WG-SS) to identify respondents with disabilities. The small number of male respondents with disabilities in the sample means that some disaggregated prevalence figures for men with disabilities have wide confidence intervals. Where confidence intervals overlap with those of men without disabilities, the apparent prevalence difference should be interpreted with caution.

Table 3.14: GBV prevalence by disability status (WG-SS)

Violence Type	Disabled women %	N	Not Disabled women %	N	Disabled men %	N	Not Disabled men %	N
Any GBV (lifetime)	73.3	527	65.1	2038	41.4	180	46.7	1509
Any IPV (experience)	50.8	483	44.4	1827	27.3	157	28.3	1278
Any IPV (perpetration)	20.1	483	20.9	1827	27.0	157	28	1278
Emotional IPV	35.0	483	26.2	1827	17.7	157	21.2	1278
Physical IPV	33.3	483	31.9	1827	9.4	157	7.1	1278
Economic IPV	28.1	483	11.0	1827	13.8	157	11.2	1278
Sexual IPV	12.5	483	21.2	1827	1.3	157	3.3	1278
Any NPSV (experience)	11.8	527	8.8	2038				
Any NPSV (perpetration)	1.6	483	1.3	1827	12.6	180	18.2	1509
Any sexual harassment	20.6	527	21.5	2038	9.9	180	10.7	1509
Any TFGBV	20.7	167	17.9	1065	31.9	38	20.3	643
Any Reproductive coercion (experience)	11.2	483	8.9	1827	3.6	180	6.6	1509
Any Reproductive coercion (perpetration)	4.1	527	5.6	2038	6.4	180	5.9	1509
Any child abuse/adversity	80.8	527	80.2	2038	76.0	180	77.9	1509
IPV experience by disability domain (WG-SS)								
Seeing difficulty	52.8	234	44.9	2076	22.6	63	28.4	1372
Hearing difficulty	50.7	62	45.5	2248	22.9	26	28.3	1409
Walking difficulty	50.0	182	45.3	2128	22.5	63	28.4	1372
Concentrating difficulty	55.5	247	44.5	2063	29.5	57	28.1	1378
Self-care difficulty	40.1	16	45.7	2294	16.2	21	28.4	1414
Communication difficulty	56.2	13	45.6	2297	8.2	9	28.3	1426
Multiple disabilities (2+)	55.6	185	44.9	2125	24.5	46	28.3	1389
Disability prevalence (WG-SS)								
Any disability	19.5	2565			10.7	1689		
Multiple disabilities (2+)	7.3	2565			3.3	1689		
Seeing	9.4	2565			4.6	1689		
Hearing	2.4	2565			2.1	1689		
Walking	7.2	2565			4.3	1689		
Concentrating	9.9	2565			3.6	1689		
Self-care	0.9	2565			1.5	1689		
Communicating	0.8	2565			1.0	1689		

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

GBV prevalence by disability status

Women with disabilities report higher lifetime GBV prevalence than women without disabilities (73.3% vs 65.1%). For men, the pattern reverses slightly: 41.4% of disabled men report any GBV compared with 46.7% of non-disabled men. This reversal for men is driven largely by lower reporting of sexual IPV and sexual harassment among disabled men. It may reflect differences in social exposure or partner dynamics rather than lower actual risk.

For intimate partner violence specifically, 50.8% of disabled women report lifetime experience compared with 44.4% of non-disabled women. The gap is widest for economic IPV, where disabled women report more than double the rate of non-disabled women (28.1% vs 11.0%). Emotional IPV also shows a notable gap (35.0% vs 26.2%), while physical IPV rates are closer (33.3% vs 31.9%). Sexual IPV is an exception: disabled women report a lower rate (12.5%) than non-disabled women (21.2%), a pattern that warrants further investigation in qualitative research.

IPV perpetration rates show no meaningful difference by disability status for either women (20.1% disabled vs 20.9% non-disabled) or men (27.0% vs 28.0%). This suggests that disability increases vulnerability to experiencing violence but does not affect the likelihood of perpetrating it.

Among non-partner domains, disabled women report slightly higher rates of NPSV experience (11.8% vs 8.8%) and reproductive coercion experience (11.2% vs 8.9%). Sexual harassment rates are similar regardless of disability status for both women (20.6% vs 21.5%) and men (9.9% vs 10.7%). Technology-facilitated GBV shows an elevated rate among disabled men (31.9%) compared with non-disabled men (20.3%). However, this estimate is based on only 38 disabled men who use technology and should be interpreted with caution. Childhood adversity rates are similarly high for both groups, at around 80% for women and 77% for men, regardless of disability status.

IPV experience by disability domain

A methodological consideration is warranted when interpreting disability-domain-specific findings. The Washington Group Short Set measures functional difficulty rather than diagnosed disability. In a context such as Lesotho, where the burden of non-communicable diseases (including diabetes-related vision impairment and mobility-limiting conditions) is substantial, the WG-SS seeing and mobility domains may capture NCD-related functional limitation as well as disability per se. This may partially explain the elevated violence prevalence among respondents reporting vision and mobility difficulties. The more analytically significant finding is that concentrating difficulty, which is more closely associated with cognitive or intellectual disability, shows the strongest IPV gradient (55.5% for women). This pattern is consistent with the ICJ's documentation that persons with intellectual disabilities face the most severe access-to-justice barriers, and suggests that cognitive disability, rather than physical functional limitation, is the domain where the disability-violence intersection is most pronounced.

Breaking down the IPV experience by the six WG-SS domains reveals that not all disabilities carry the same risk. Among women, those with concentration difficulty report the highest IPV rate (55.5%), followed by seeing difficulty (52.8%), hearing difficulty (50.7%), and walking difficulty (50.0%). Women with multiple disabilities (two or more domains) report 55.6% IPV experience. All these rates exceed the 44.5-45.3% reported by women without each respective difficulty.

Among men, the pattern is less consistent. Men with concentration difficulty report a slightly elevated IPV rate (29.5% vs 28.1%), while those with seeing or walking difficulty report lower rates (22.6% and 22.5%, respectively) than men without these difficulties (28.4%). Men with multiple disabilities report 24.5% IPV experience compared with 28.3% among those without. Estimates for self-care difficulty (N=16 women, N=21 men) and communication difficulty (N=13 women, N=9 men) are based on very small samples and should not be used for policy conclusions. The low prevalence of these functional limitations in the sample means that larger, disability-focused studies would be needed to assess GBV risk in these specific groups reliably.

The LNFOD gender analysis (2024) complements and contextualises the 2025 survey finding: 74% of LNFOD respondents identify women and girls with disabilities as the population most affected by GBV, with economic dependence on caregivers documented as a specific and distinct pathway to abuse. Sign language capacity is absent across all ten CGPU offices nationally, which means that deaf survivors of GBV face a structural barrier to reporting that no survey can quantify. Addressing this gap through interpreter training, accessible reporting channels, and disability-inclusive service standards is among the most achievable service improvements available to government within existing institutional frameworks.

The overall pattern for women is clear. Disability increases vulnerability to GBV, with economic IPV showing the starkest disparity. Among the disability domains, concentrating difficulty consistently emerges as the strongest risk marker for both women and men. These findings reinforce the need for GBV prevention and response services, including shelter services, legal aid, and psychosocial support, that are accessible to and inclusive of persons with disabilities in terms of physical access, communication formats, and service provider capacity. The Counter Domestic Violence Act 2022 provides protections that, in principle, cover persons with disabilities, but implementation must be monitored with disability-disaggregated data going forward. Economic empowerment programming for disabled women deserves particular attention, given the 28.1% economic IPV rate, more than double that of non-disabled women.

The ICJ's September 2025[146] report provides important triangulation for these survey findings. The report documents that, prior to the 2019 Koali Moshoeshoe judgment[147] Section 219 of the Criminal Procedure and Evidence Act categorically barred persons with intellectual disabilities from giving testimony, rendering them, in the court's words, "vulnerable to all kinds of vulnerable treatment, the worst kinds being sexual." The Disability Equity Act 2021 and Procedure Rules 2023 have since established a rights-based framework, including Rule 13(3), which specifically protects GBV survivors with disabilities. However, the ICJ documents that implementation remains severely constrained. No intermediaries or sign language interpreters have been formally appointed by the judiciary. Only one court-appointed intermediary serves all five district children's courts, and most court buildings remain physically inaccessible. These implementation gaps directly affect the ability of persons with disabilities who experience GBV to access justice and help explain the low formal reporting rates observed in the survey data.

[144] Estimates based on fewer than 25 unweighted observations should be interpreted with caution due to low statistical precision.
[145] LANFOD [Lesotho National Federation of Organisations of the Disabled] (2024). 2024 Gender Gap Analysis and Baseline Study for the Strategic Partnership Gender and Disability in Practice - Phase II. Maseru: LANFOD.
[146] 'From Exclusion to Equality: Advancing Access to Justice for Persons with Disabilities in Lesotho - Executive Summary | ICJ' (2025) International Commission of Jurists. Available at: https://www.icj.org/resource/from-exclusion-to-equality-advancing-access-to-justice-for-persons-with-disabilities-in-lesotho-executive-summary/ (Accessed: 7 July 2026).
[147] 'Lesotho: Koali v. Director of Public Prosecutions | ICJ' (2019) International Commission of Jurists. Available at: https://www.icj.org/resource/lesotho-koali-v-director-of-public-prosecutions/ (Accessed: 7 July 2026).

3.17 Underreporting, extent and structural causes

The formal reporting, disclosure, and help-seeking behaviour of GBV survivors is a critical dimension of any prevalence study, as it bridges the gap between the true burden of violence and the caseload visible to service systems. In Lesotho, as across sub-Saharan Africa, GBV is characterised by severe underreporting to police and health systems, limited disclosure even within informal social networks, and significant barriers to accessing justice. The 2025 study captures reporting, disclosure, and help-seeking behaviour among lifetime IPV survivors, women and men, as well as justice outcomes among the subset who reported to police.

These patterns of low formal reporting are extensively documented in Matela's (2020) qualitative study[148] of six IPV-response organisations in Lesotho. Her research identifies specific strategies women use to navigate IPV before, and often instead of accessing formal services: rationalising and tolerating abuse, self-blaming, keeping quiet, fighting back, reporting to family members, withholding sex as a reprimand, drawing on network circles for social support, meditating on Sesotho proverbs, and prayer. Her finding that only 3% of partnered women reported violence to police or medical providers corroborates the low formal help-seeking rates documented in the present survey and underscores the dominance of informal coping mechanisms in Lesotho's GBV response landscape.

Table 3.15: Underreporting and help-seeking

Outcome	Women %	N	Men %	N
Reporting to the Police				
Reported to the police	9.9	1033	7.5	411
Reported to another authority/organisation	10.8	1033	9.3	411
Disclosure (told someone about the violence)				
Told my own family	57.9	114	46.7	38
Told partner's family	16.6	114	19.4	38
Told friend	13.9	114	26.5	38
Told the religious leader	0.7	114	0.0	38
Told the community leader	7.3	114	13.7	38
Told NGO/service provider	3.3	114	4.4	38
Told shelter	0.4	114	0.0	38
Help-Seeking				
Sought help for physical violence	2.0	1035	3.5	405
Sought help for emotional violence	9.8	270	12.0	181
Sought professional help	13.3	1035	11.3	416
Sought medical attention	47.0	134	48.4	36
Justice outcomes (among those who reported to police)				
The perpetrator was arrested	15.7	115	15.4	30
The perpetrator was convicted[149]	63.7	18	90.7[150]	5
Protection Orders				
Sought a protection order	10.0	107	4.2	30

Note: All figures are among lifetime IPV survivors (those who experienced any form of IPV), unless otherwise stated. Justice outcomes are among the subset who reported to the police. Disclosure and help-seeking items were asked only of IPV survivors (skip pattern).

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

[148] Matela, L. and Muthuki, J. (2020) 'Investigating the role and effectiveness of intervention strategies employed by six organisations dealing with intimate partner violence in Lesotho'.
[149] Small cell sizes for justice outcomes (especially convictions) may produce unstable estimates
[150] Small cell sizes for justice outcomes (especially convictions) may produce unstable estimates

The underreported data tells a sobering story. Among lifetime IPV survivors, only 9.9% of women and 7.5% of men reported their experience to the police, meaning that more than nine in ten survivors never engage the formal justice system. Reporting to other authorities or organisations is marginally higher (10.8% for women and 9.3% for men), but the overall formal reporting rate remains critically low. These figures are consistent with the 2013 baseline's finding that 'despite such high levels (of VAW) there is serious underreporting to both the police and the hospitals', a structural feature of Lesotho's GBV landscape that has not materially changed over twelve years, despite significant legislative reform.

Among the subset of survivors who disclosed their experience, informal networks are the primary channel. That is, 57.9% of women and 46.7% of men told their own family about the violence (N=114 women, 38 men who disclosed). Friends were the second most common confidant for men (26.5%) and the third for women (13.9%), while the partner's family was told by 16.6% of women and 19.4% of men. Community leaders were consulted by 7.3% of women and 13.7% of men, suggesting that traditional authority structures remain a more accessible pathway for men. Disclosure to religious leaders is near-zero for women (0.7%) and absent for men. NGO and service provider disclosure remains very low (3.3% women, 4.4% men), and shelter disclosure is effectively non-existent (0.4% women). These patterns indicate that GBV disclosure in Lesotho flows overwhelmingly through kinship and peer networks rather than formal service systems, a finding with direct implications for community-based intervention design. The contrast with formal reporting rates (9.9% to police) underscores that survivors are far more likely to tell a relative or friend than to engage any institutional pathway. These figures reflect the profound silence that surrounds GBV victimisation in Lesotho, a silence rooted in fear of stigma, shame, disbelief, normalisation of violence, and the expectation that domestic matters remain private. The 2013 'I' stories illustrated these dynamics powerfully at the individual level. The 2025 quantitative data and the 'I' Stories reconfirm them at the population and individual level, respectively.

Help-seeking is slightly higher overall. For instance, 13.3% of women and 11.3% of men sought some form of professional help, a category that includes medical, legal, and psychosocial services. However, this figure is inflated by the conditional item on medical attention among those who were injured, 47.0% of injured women and 48.4% of injured men sought medical care. When this is removed from the denominator, the proportion seeking proactive, non-emergency professional support for GBV is considerably smaller, reflecting poor awareness of available services, geographic inaccessibility in rural and mountain districts, and financial constraints on access to services.

The justice outcome data, while based on very small sub-samples that limit statistical confidence, reveal a concerning pipeline. Of the small proportion who reported to police, only 15.7% of women's cases resulted in a perpetrator arrest, and of those arrested, an estimated 63.7%[151] resulted in conviction, conditional on very small N (18 women, 5 men reporting convictions). Even accepting these figures at face value, they suggest that the end-to-end justice pathway from reporting through to conviction is functional in only a small fraction of cases. Additionally, among those who reported violence, only 10.0% of women, with a wide CI reflecting small sample size, sought a protection order. These findings underscore the persistent justice gap in Lesotho's GBV response and will be explored further in the Response chapter (Chapter 6).

[151] Caution when interpreting this, as it is based on a very small N (18 women, 5 men reporting convictions)

Conclusion

The 2025 Lesotho GBV Indicators Follow-up Study confirms that gender-based violence remains pervasive, with two in three women (66.7%) and nearly half of men (46.2%) reporting lifetime GBV experience. At the same time, the data documents significant progress since the 2013 baseline. Among ever-partnered women aged 18 and older, any IPV declined from 62.0% to 46.8%, a reduction of 15.2 percentage points driven by substantial declines in emotional IPV (-18.6 pp), sexual IPV (-12.7 pp), and physical IPV (-11.4 pp). Pregnancy abuse halved from 13.8% to 6.5%. These reductions represent real gains that reflect more than a decade of legislative reform, awareness programming, and service expansion.

Yet the progress is uneven, and several findings demand sustained attention. Economic IPV declined the least (-6.5 pp), with financial gatekeeping and withholding money for household needs remaining unchanged at 16.0% across both rounds. Non-partner sexual violence held steady at approximately 9%, suggesting that IPV-focused interventions have not reached community-level and institutional drivers of sexual violence. The act-level analysis reveals that while moderate forms of violence have declined fastest, severe physical violence and physical violence during pregnancy have proven resistant to change. The experience-perpetration gap, particularly the finding that men's NPSV perpetration (17.6%) is nearly double women's reported experience (9.4%), points to serial perpetration and structural under-disclosure that survey methodology alone cannot resolve.

Three cross-cutting patterns shape the programming and policy agenda that emerges from this chapter. First, the near-universal prevalence of adverse childhood experiences (80.3% of women, 77.7% of men) establishes intergenerational transmission as perhaps the single most important upstream driver of GBV in Lesotho. Second, the pronounced geographic variation, with Mohale's Hoek recording women's IPV rates 19 percentage points above the national average, while Mafeteng records the lowest, confirms that district-level targeting of resources is both feasible and necessary. Third, the emergence of technology-facilitated GBV (18.2% of internet-using women) and the documentation of reproductive coercion (9.4% of women) as measurable dimensions of the GBV landscape signal that the conceptual and programmatic framework must continue to expand beyond physical and sexual violence.



Supervisors and Enumerators training. *Photo: GL Lesotho*

The 2025 study also establishes two new evidence bases that the 2013 baseline did not measure. The first-ever disability disaggregation, using the Washington Group Short Set on Func-

tioning, confirms that women with disabilities face elevated GBV prevalence (73.3% versus 65.1% for women without disabilities), with the disparity most pronounced for economic IPV (28.1% versus 21.2%). Among the WG-SS domains, concentration difficulty carries the strongest IPV gradient (55.5% for women), consistent with the ICJ's documentation that persons with intellectual disabilities face the most severe access-to-justice barriers. The gender identity disaggregation and dedicated LGBTQI+ research under the THUSO Project document that 50% of transgender respondents experienced GBV in the preceding twelve months, with 93.8% of incidents directly linked to gender identity or expression - a rate and a driver with no parallel in the general population. Together, these findings establish that disability-inclusive and SOGIE-inclusive service design are not optional additions to the GBV response but evidence-led priorities that the prevalence data now demand.

Finally, the underreporting findings underscore the scale of the hidden burden. More than nine in ten IPV survivors never report to the police, and fewer than one in seven seek any form of professional help. The justice pipeline narrows sharply at every stage: fewer than two per cent of all survivors ultimately see a perpetrator convicted. Addressing this service gap through accessible, trusted, and survivor-centred response systems is as urgent as the prevention work documented in this chapter. The chapters that follow examine the drivers, consequences, and response dimensions of the GBV landscape mapped here.

CHAPTER 4
DRIVERS AND PATTERNS OF GBV IN LESOTHO



Ministry of Gender hosting International Men's Day in Ha-Lepolesa, Mafeteng 2023. *Photo: Ministry of Gender*

Key findings

- Adverse childhood experiences (ACEs) are the dominant independent predictor of both women's IPV experience (OR 6.68 for 4+ ACEs) and men's perpetration (OR 4.75), by a wide margin the strongest driver across all measured factors.
- Women's experience of IPV increases from 23.4% (no ACEs) to 66.7% (4 or more ACEs); for men, it rises from 14.5% to 46.9%.
- Separated women (69.4%) carry the heaviest IPV burden of any demographic group.
- Agreement that a woman should obey her husband fell from 97% (women) and 96% (men) in 2013 to 33.9% and 49.2%, respectively, in 2025.
- Rape myths acceptance is the most consistent attitudinal predictor: men who perpetrate IPV are nearly twice as likely to hold high rape myths acceptance (28.9% vs 16.4%).
- Alcohol is present in 86-87% of men with any lifetime IPV involvement.
- LGBTQI+ persons face GBV driven specifically by gender identity and sexual orientation, with 93.8% of transgender GBV directly identity-linked, a driver absent from the general population model.
- Disability's elevated association with IPV (OR 1.09) is mediated by ACEs after full adjustment.

Something inside me broke, but something inside me awakened



"My name is Naledi*, aged 42. When I think about the times I felt most significant in my life, I remember the days before the abuse started, sitting with my family, laughing freely, feeling safe in my own home. Life was simple, and even though we did not have much, I had peace. The abuse began when my husband physically assaulted me because he thought I was dating the chief. Electricians had come to our village to install electricity. They were doing their job, but my husband assumed I was in love with them. After I took him to the chief's place to resolve the issue, things became worse, he started accusing me of dating the chief, too. That is when the accusations became endless.

He forced me to quit my job as a cook at one of the nearby schools because there were men around. That job was important to me because it helped me provide for my children. He hated to see men passing by our house. Sometimes I would just be responding politely to a greeting, but to him, that was enough reason to beat me. I lived in constant fear because I never knew what would trigger him next.

One day, he took a spade and hit me with it. I became unconscious. When I came to, he did not give me money for medical help. I had to move from one family to another, asking for money while I was bleeding. On that same day, he broke my phone so that I would not call for help. The injury I got that day has still not fully healed. Emotionally, the abuse destroyed me. I became quiet. I stopped laughing. I started isolating myself because if anyone visited me, he would accuse me of cheating with them. Slowly, people stopped coming. I lost friendships.

I went to the chief to report the problems. Nothing changed. I went to the police and opened a case, but I withdrew it because I felt pity for him. I kept thinking about my children. I told myself that if he went to prison, they would grow up without a father. I carried that burden alone and chose to suffer in silence for their sake.

The courage to finally walk away came from my children. I did not want them to grow up seeing violence and thinking it was normal. Looking back, I wish I had gone to the police immediately and pursued the case fully. This man married me when I was still a child, and child marriage is illegal in Lesotho. At that time, I did not understand my rights. Now I do."

Naledi, Thaba-Tseka*

This 'I' Story illustrates, in a single lived experience, the convergence of multiple drivers examined in this chapter. Naledi's account documents child marriage as a structural entry point into violence (Section 4.8.1); jealousy and controlling behaviours, restricting her movement, monitoring her interactions with men, destroying her phone, and forcing her to quit her job, as relationship-level risk factors (Section 4.8.3); economic control through the withholding of medical care and income (Section 4.2.4); and the intergenerational transmission concern that motivated her eventual decision to leave (Section 4.3). Her account also reflects the normative environment analysed in Section 4.4: a context in which male sexual proprietorship over a wife is treated as a self-evident justification for violence. The story is not selected to illustrate a single driver but to show how multiple drivers interact within one relationship, the ecological model operating not as an abstract framework but as the architecture of one woman's lived reality.

Overview

This chapter examines the factors that predict GBV in Lesotho. Using multivariate regression analysis, it identifies the independent demographic, attitudinal, behavioural, and childhood adversity predictors of women's IPV experience and men's IPV perpetration. The chapter analyses gender attitudes, rape myth acceptance, the social norms gap between personal beliefs and perceived community norms, and relationship-level factors including partner dynamics, child marriage, and bohali practices. It traces how these drivers operate across the ecological model, from individual risk factors through relationship dynamics to community and structural conditions, providing the evidence base for the targeted prevention strategies recommended in Chapters 8 and 10.

4.1 Introduction

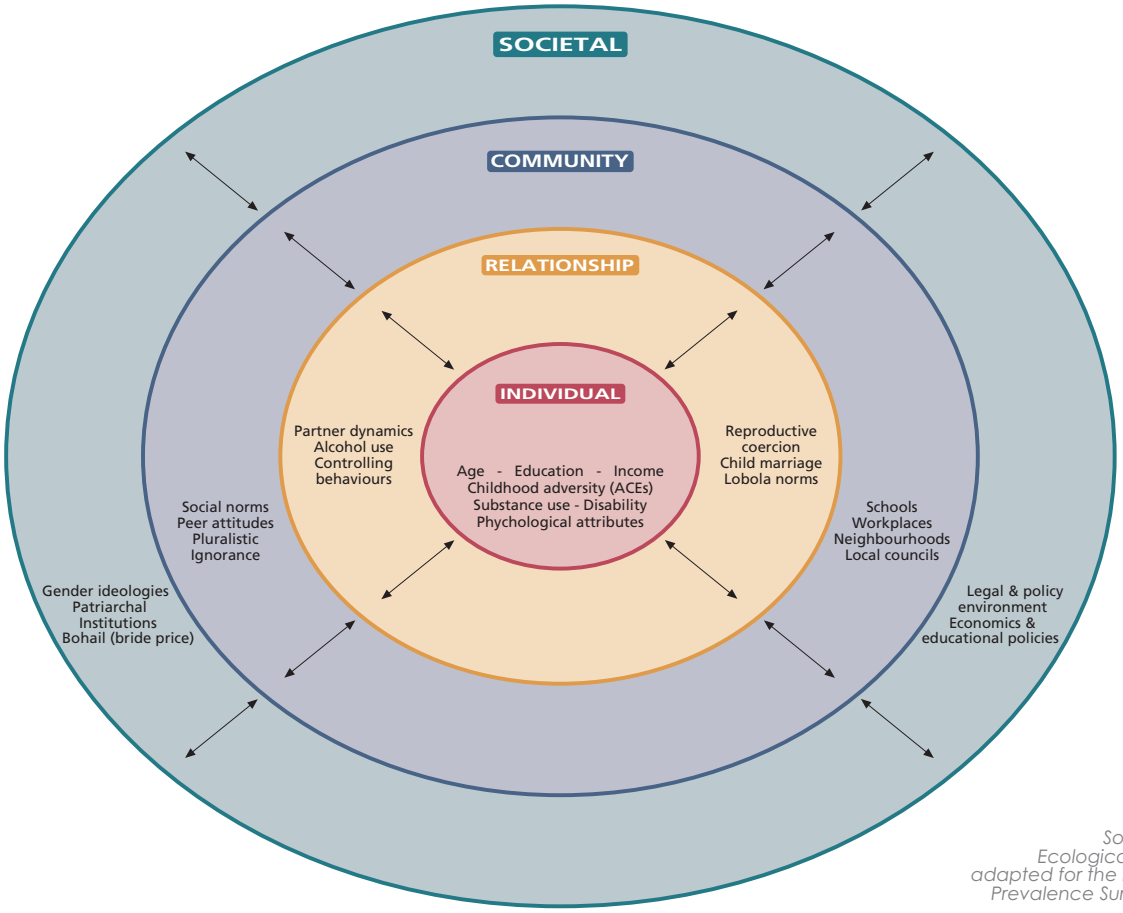
The 2025 Lesotho GBV Indicators Follow-up Study is the first in the GL-Lesotho series to apply a fully bidirectional analytical framework, examining risk factors for GBV experience and perpetration among both women and men. This generates insights about four distinct analytical groups: (i) women as survivors of IPV; (ii) women as perpetrators of IPV; (iii) men as survivors of IPV; and (iv) men as perpetrators of IPV, each with a different risk factor profile requiring different intervention approaches. The 2013 baseline documented drivers primarily for women's experience and men's perpetration. The 2025 framework makes visible the two groups that were largely invisible in 2013, that is, women who perpetrate violence and men who experience it.

Two important analytical advances distinguish the 2025 study from the 2013 baseline. First, the bidirectional framework makes visible risk patterns for men as GBV survivors that were largely invisible in 2013's unidirectional analysis. Second, the multivariate regression models (Section 4.9) allow the chapter to distinguish between factors that are independently significant drivers of GBV and those whose apparent associations are mediated by more fundamental upstream causes. All univariate associations are presented as risk correlates rather than causes. Causal interpretation is reserved for findings confirmed in the adjusted models.

The chapter also incorporates evidence from the desktop research review that directly contextualises key drivers. Peer-reviewed scholarship by Dr Josphine Hapazari of the National University of Lesotho, including her research on regional masculinities as drivers of sexual violence and her examination of prevention narratives through the ecological model, provides the academic framework for interpreting several findings. The DHS 2023-24 attitude trend data and the LNFOD gender analysis add independent corroboration at key points.

The chapter is organised around the ecological model of violence (Figure 4.1), originally proposed by Heise (1998) and adapted bidirectionally for this study following the WHO Violence Framework. The model positions GBV as the product of factors operating across four nested levels, each influencing and being influenced by the others.

Figure 4.1 The Ecological model of factors associated with GBV



Source: Heise (1998) Ecological violence model, adapted for the Lesotho GBV 2025 Prevalence Survey, Gender Links

At the **individual** level, personal history, demographic characteristics, age, education, income, disability, childhood adversity (ACEs), substance use, and psychological attributes shape vulnerability to both experiencing and perpetrating violence. At the **relationship** level, partner dynamics, including alcohol use, controlling behaviours, reproductive coercion, child marriage, and bohali[152] norms, create the immediate relational context within which violence occurs. At the **community** level, social norms, peer attitudes, and the phenomenon of pluralistic ignorance, operating through schools, workplaces, neighbourhoods, and local councils, normalise or constrain GBV. At the **societal** level, gender ideologies, patriarchal institutions, customary practices such as bohali , and the legal, economic, and educational policy environment set the structural conditions within which individual behaviour is embedded. The bidirectional arrows indicate that influence flows in both directions. Societal norms shape individual behaviour, but individual and relational experiences also reshape community and societal norms over time.

[152] In Lesotho, bride wealth, also known as "bohali," is a customary practice where the groom's family provides gifts or livestock to the bride's family as a symbol of appreciation for their daughter.

4.2 Individual-level factors: socio-demographic characteristics

The individual level of the ecological model encompasses the demographic and social characteristics that shape an individual's probability of experiencing or perpetrating GBV. **Statistical Appendix Table A3** presents lifetime IPV prevalence disaggregated by age, education, marital status, wealth quintile, employment status, disability, and settlement type for all four analytical groups. These are unadjusted associations; adjusted estimates controlling for all factors simultaneously appear in the regression models in Section 4.9.

4.2.1 Age

The relationship between age and IPV experience among women describes a rising trajectory from adolescence into mid-life, with a plateau in older age groups. Women aged 15-17 report a lifetime IPV experience of 21.2%, rising sharply to 38.9% among those aged 18-24 and peaking at 50.5% among women aged 45-54. The steep rate of increase between adolescence and young adulthood confirms that the early partnership years (18-24) constitute a critical window of heightened vulnerability and a corresponding investment opportunity for programmes targeting young adults before patterns of violence become entrenched.

The 2013 baseline found that women aged 30-44 reported the highest lifetime IPV experience (65.4%). By 2025, the comparable figure for the 35-44 group is 47.4%, a reduction of approximately 18 percentage points, entirely consistent with the overall IPV decline documented in Chapter 3 and confirming that the improvements in the national picture extend across age groups rather than being concentrated in cohorts.

The 2025 prevalence figures receive independent corroboration from the DHS 2023-24. Nakie et al.[153] (2025), analysing the DHS domestic violence module for 1,687 ever-married women aged 15-49, report an overall IPV prevalence of 41.68% (95% CI 39.35-44.05). This figure falls within the range defined by the GL 2025 lifetime estimate (45.7% for ever-partnered women 15+) and the GL 2025 past-year estimate (14.8%), confirming that the post-2013 decline in IPV is a real population-level trend rather than a methodological artefact. The slight difference between the DHS figure and the GL figure is expected given the different denominator definitions: the DHS uses ever-married women aged 15-49, while the GL study uses the broader category of ever-partnered women (including cohabiting and dating relationships) across all ages 15 and above.

For men, IPV experience and perpetration both peak in the 35-44 age group (35.3% experience; 37.2% perpetration), with both declining at age 55 and above. This mid-life concentration, when household formation, economic stress, and the consolidation of relationship power dynamics are most intense, represents a period of heightened bilateral IPV involvement consistent with the 2013 finding that men aged 30-44 had the highest perpetration rate.

[153] Nakie, G., Tadesse, G., Fentahun, S., Rtbey, G., Andualem, F., Kibralew, G., Kelebie, M., Melkam, M., Kassa, M.A., Mengistie, B.A., Alemayehu, T.T., Yigezu, M., Segon, T., Wassie, Y.A. and Tinsae, T. (2025) 'Multilevel Analysis of Intimate Partner Violence and Associated Factors Among Reproductive-Age Women: Lesotho Demographic and Health Survey 2023 to 2024 Data', Journal of Interpersonal Violence, p. 08862605251368842. Available at: https://doi.org/10.1177/08862605251368842.

4.2.2 Education and the empowerment backlash

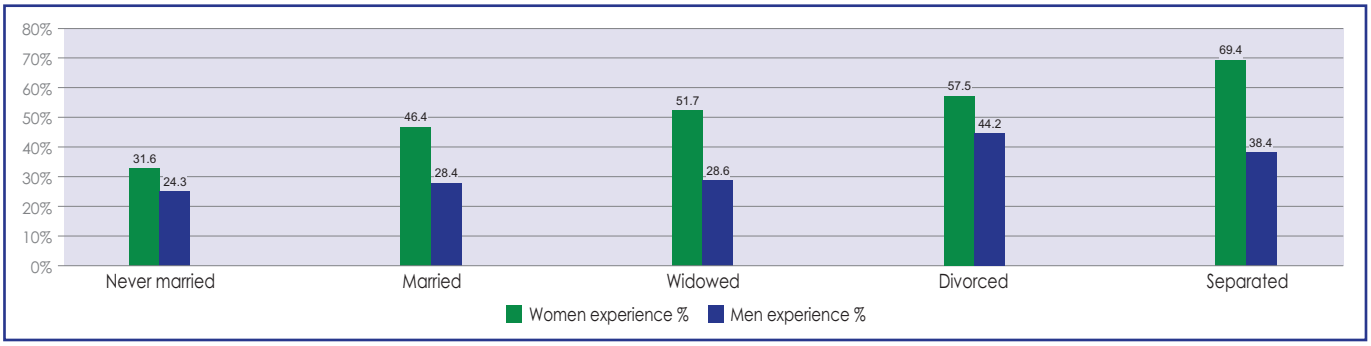
The education gradient for women's IPV experience does not follow a simple protective pattern, a finding observed in 2013 and confirmed in 2025. Women who never attended school report a lifetime IPV experience of 34.3%, while women with some high school report 50.6%. This non-linear pattern is consistent with the "empowerment backlash",[154] a hypothesis documented across sub-Saharan Africa, that as women acquire education and assert greater autonomy, some male partners respond with increased controlling behaviour and violence to re-establish dominance. The finding reinforces the argument that economic empowerment programmes for women must be accompanied by parallel work with male partners on gender norms and relationship expectations, not implemented in isolation.

This pattern is consistent with Hapazari's (2023) analysis of regional masculinities in Lesotho, which identifies the threat to male dominance as a proximate driver of sexual violence, a mechanism operating not only at the societal level of gender norms but within specific intimate relationships where women's increasing competence challenges established power hierarchies.

4.2.3 Marital status: dissolution as the highest-risk context

Marital status is the most analytically revealing socio-demographic correlate of IPV in the 2025 data.

Figure 4.2: Lifetime IPV experience by marital status



Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

Figure 4.2 shows that separated women report the highest lifetime IPV experience of any marital status group, 69.4%, nearly 23 percentage points above currently married women (46.4%). Divorced women also report elevated experience (57.5%). Two mechanisms account for this. First, past IPV may be the cause of separation or divorce rather than a correlate. Second, the dissolution process itself, contested over children, property, and customary obligations, may generate new episodes of violence. The adjusted regression (Section 4.9) confirms that never-married women have significantly lower odds of IPV experience relative to divorced women (OR 0.33, p=0.002), the strongest marital status effect in the full model.

[154] Vyas, S. & Watts, C. (2009). How does economic empowerment affect women's risk of intimate partner violence in low and middle-income countries? A systematic review of published evidence. Journal of International Development, 21(5), 577-602

The implication for service design is direct. The most targeted services for IPV survivors are designed for women currently in abusive partnerships. The data show that separated and recently divorced women carry the heaviest burden and may be the group least consistently reached by relationship-focused programmes and the group most urgently in need of legal, housing, and safety support during and after dissolution. The Legal Aid Clinic guidelines, published in December 2025, which standardise legal aid across 56 providers, represent an important step toward closing this gap.

4.2.4 Wealth quintiles

Women in the 'richer' wealth quintile report the highest lifetime IPV experience (55.1%), while women in the poorest quintile report a lower rate (42.5%), and the richest (40.2%) are comparable to the poorest. This pattern is consistent with the empowerment backlash dynamics noted for education. Women with sufficient economic resources to assert independence may face greater resistance from controlling partners. It also confirms that economic resources do not automatically translate into physical safety within marriage. For men, wealth quintile shows no consistent gradient for either experience or perpetration, and wealth quintile is not a statistically significant predictor in the adjusted regression.

4.2.5 Employment

Employed women report higher lifetime IPV experience (51.3%) than unemployed women (43.3%), consistent with the empowerment backlash pattern. However, employment loses its significance in the adjusted regression (OR 1.23, p=0.156), suggesting that its apparent effect is partly explained by its correlation with other factors, such as age and ACE burden, rather than operating as an independent driver of IPV risk. For men, employed men report substantially higher IPV experience (34.1% vs 23.8%) and perpetration (32.3% vs 24.2%), more consistent with the argument that workplace masculine norm environments or the dual-earning partnership dynamic elevate risk than with economic stress theories that predict violence among unemployed men. The adjusted model similarly finds that the employment effect for men attenuates after controlling for ACEs.

4.2.6 Disability and GBV



Women with any disability report higher lifetime IPV experience (50.8%) than non-disabled women (44.4%)

Women with any disability report higher lifetime IPV experience (50.8%) than non-disabled women (44.4%), extending the disability-GBV gradient established in Chapter 3 into the drivers analysis. The LNFOD gender analysis (2024) provides crucial contextualisation where 74% of LNFOD respondents identify women and girls with disabilities as the population most affected by GBV, with economic dependence on caregivers documented as a specific and

distinct driver pathway, one that operates independently from the intimate partner dynamics that structure most IPV. The adjusted regression confirms the direction of the disability-IPV association (OR 1.09). However, it does not reach statistical significance, suggesting disability's association with IPV is largely mediated by correlated factors such as ACEs, age, and marital status. For men, disability is not associated with differential IPV involvement in either the unadjusted or adjusted analysis.

Settlement type shows minimal differentiation, consistent with the Chapter 3 finding that urban-rural location is not a significant structural fault line for IPV in Lesotho. The adjusted regression confirms that neither peri-urban nor rural location is an independent predictor of women's IPV experience relative to urban location (both non-significant). District, rather than settlement type, remains the relevant spatial unit for service targeting.

4.3 Individual-level factors: childhood adversity and the ACE dose-response

Among all individual-level risk factors measured in the 2025 survey, adverse childhood experiences (ACEs) emerge as the most powerful predictor of adult IPV, for both women's experience and men's perpetration. The intergenerational pathway is visible not only in the statistical data but in the lived experiences of families across Lesotho:



"The abuse has had a profound impact on the children, who grow up in an environment filled with insults, conflict, and instability. They replicate abusive behaviours at school, bullying peers and using offensive language. One child expressed the pain directly, saying: 'My father does not want me'."

Mokhotlong Participant 1

Chapter 3 documented that 80.3% of women and 77.7% of men in Lesotho report at least one ACE. This section examines the dose-response[155] relationship between ACE burden and adult IPV, demonstrating that as the number of ACE categories reported increases, the probability of adult IPV involvement rises systematically and substantially.

Table 4.1: IPV prevalence by childhood adversity

ACE Category	Women Exp %	N	Women Mean ACE	Men Exp %	N	Men Mean ACE	p-value
None	23.4	454	0.00	14.5	279	0.00	0,000
1 ACE	39.7	568	1.00	21.4	332	1.00	
2-3 ACEs	51.4	933	2.44	32.0	598	2.42	
4+ ACEs	66.7	355	4.46	46.9	226	4.43	

Note: Denominator: Ever-partnered women and men. ACE categories are based on the total number of ACE domains endorsed.
Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

[155] A dose-response relationship in epidemiology means that as the level of exposure increases, so does the magnitude of the outcome. The concept was established in ACE research by Felitti, V.J. et al. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. American Journal of Preventive Medicine, 14(4), 245-258. See also Fulu, E. et al. (2017).

Table 4.1 reveals a striking and consistent dose-response relationship. Among women with no childhood adversity, the lifetime IPV experience rate is 23.4%, roughly half the national average of 45.7%. Each additional ACE category adds a meaningful increment, from 39.7% (1 ACE) to 51.4% (2-3 ACEs) to 66.7% among women with four or more ACEs. Women who experienced the highest burden of childhood adversity are almost three times as likely to have experienced IPV in their lifetime as women with no childhood adversity.

The dose-response is equally pronounced for men. Men with no ACEs report 14.5% IPV experience, rising to 46.9% among those with 4+ ACEs, a more than threefold increase. The proportion of men with 4+ ACEs reporting IPV experience exceeds the proportion without ACEs by 32 percentage points, confirming that men in Lesotho are not only perpetrators but are themselves survivors of violence at elevated rates when they carry a heavy childhood adversity burden. This is consistent with the bidirectional dynamics documented in the typology analysis in Chapter 3.

The multivariate regression models (Section 4.9) confirm that the ACE dose-response holds after adjustment for all other measured risk factors. For women, the adjusted odds of IPV experience rise from 2.19 for one ACE, to 3.64 for two to three ACEs, to 6.68 for four or more ACEs (all $p<0.001$), by far the strongest independent predictor in the entire model. For men, the same pattern emerges for perpetration: the adjusted odds rise to 2.73 for two to three ACEs and 4.75 for four or more ACEs (all $p<0.001$), again the dominant predictor after full adjustment.

These findings carry profound implications for prevention investment. A very large share of adult IPV in Lesotho, for both experience and perpetration, traces to childhood adversity roots that are, in principle, preventable. An intervention that successfully reduces the ACE burden for one generation of Lesotho's children would, based on this evidence, substantially reduce the next generation's IPV rates. The intergenerational transmission pathway operates through neurobiological mechanisms[156] (disrupted attachment and stress regulation), psychological processes[157] (normalisation of coercion as conflict resolution), and social learning[158] (witnessing IPV as a model for adult relationships). Prevention programmes focused exclusively on adult behaviour change, without addressing the ACE pipeline, operate downstream of the primary generative mechanism. The human cost of that pipeline is captured in the account of a young woman from Qacha's Nek, whose experience illustrates how childhood sexual abuse, institutional failure, and the absence of a protective adult combine to produce lasting psychological harm:



"I was 10 years old when the abuse started. My father sexually abused me over a long period. At that time, I did not fully understand what rape was, but I knew that what he was doing was wrong. My mother never believed me. At one point, she told me I should show her proof after being abused. This deeply disappointed me because I believed she was the only person who could help me. Because of the lack of peace at home, I once attempted suicide. Eventually, I left the family meeting and went directly to the police station to report the abuse. I now struggle to be around boys or men and cannot focus on school due to emotional distress."

Qacha's Nek Participant 12

[156] Teicher, M.H. & Samson, J.A. (2016). "Annual research review: Enduring neurobiological effects of childhood abuse and neglect." Journal of Child Psychology and Psychiatry, 57(3), 241-266

[157] Widom, C.S., Czaja, S. & Dutton, M.A. (2014). "Child abuse and neglect and intimate partner violence victimization and perpetration: A prospective investigation." Child Abuse & Neglect, 38(4), 650-663.

[158] Heise, L. (2011). What Works to Prevent Partner Violence? An Evidence Overview. London: STRIVE Research Consortium, London School of Hygiene and Tropical Medicine

The Chapter 4 ACE regression finds that women with over four adverse childhood experiences face an adjusted odds ratio of 6.68 for adult IPV, the single strongest predictor in the model. This account shows how an ACE is created. A trusted adult perpetrates sexual abuse; the primary protective figure (the mother) disbelieves; the child navigates the justice system alone. Three compounding adversities in one childhood, each increasing the risk that the next chapter of her life will involve violence. Lesotho's Counter Domestic Violence Act 2022 and the CGPU's survivor-centred approach exist precisely to prevent this cycle, and the evidence here is a compelling case for strengthening that prevention pipeline at its earliest point.

Key findings on individual-level drivers:

- ACEs are the dominant independent predictor of both women's IPV experience (OR 6.68 for 4+ ACEs; $p<0.001$) and men's perpetration (OR 4.75 for 4+ ACEs; $p<0.001$) - by a wide margin the strongest driver in the full model.
- The ACE dose-response is clear and consistent. Women's IPV experience rises from 23.4% (no ACEs) to 66.7% (4+ ACEs); men's experience rises from 14.5% to 46.9%.
- Separated women (69.4%) and divorced women (57.5%) carry the heaviest IPV burden of any demographic group. Relationship dissolution, not stable marriage, is the highest-risk marital status.
- Employed women (51.3%) and women in the richer wealth quintile (55.1%) report higher IPV than their less economically advantaged peers, consistent with the empowerment backlash mechanism, and a reminder that economic empowerment programmes need parallel male engagement components.
- Women with disabilities report higher IPV exposure (50.8% vs 44.4%), with economic dependence on caregivers identified by LNFOD (2024) as a specific and distinct driver pathway for this population.
- Settlement type (urban/rural) is not independently significant after adjustment. District-level targeting, not sector-level targeting, is the appropriate framework for resource allocation.

4.4 Societal-level factors: gender attitudes change from 2013 to 2025

Gender attitudes, beliefs about the roles, rights, and treatment of women and men, operate at the societal and community levels of the ecological model and are among the most extensively studied predictors of GBV. A critical contribution of the 2025 study is the availability of direct 2013-2025 trend comparisons on thirteen individual gender attitude items and five rape myth statements, the most granular longitudinal analysis of normative change in Lesotho to date. The DHS 2023-24 independently confirms the direction of attitude change. The proportion of men justifying wife-beating fell from 51% in 2004 to 25% in 2023-24, and women from 48% to 19%. The GL and DHS data, drawn from different instruments and samples, converge on the same conclusion: that Lesotho's gender norms are shifting, and that shift is evidence of what sustained investment in awareness and prevention can achieve.



Participants duirng the GBV App training in Mohale's Hoek in 2018.
Photo: Ntolo Lekau

Table 4.2: Gender attitudes - percentage agreeing, 2013 vs 2025

Statement	Women 2013	Women 2025	Men 2013	Men 2025
Gender relations				
A woman should obey her husband	97	33.9	96	49.2
A woman should give her money to her husband	-	58.0	-	67.6
A man should have the final say in family matters	73	39.4	67	60.9
A woman and a man should share household work equally	-	76.3	-	77.8
A woman needs her husband's permission to do paid work	81	66.0	83	74.3
A woman cannot refuse sex with her husband	55	38.6	58	39.7
Children belong to a man and his family	-	36.2	-	50.2
Nothing wrong with a married man having girlfriends	15	24.5	18	17.2
A man has the right to punish his wife	26	10.6	41	16.5
If a man pays lobola, he owns his wife	42	32.4	45	40.5
If a man pays lobola, he is entitled to sex	39	22.5	45	30.1
If a man beats you, it means he loves you.	-	4.8	-	9.9
Women and men should be treated equally.	-	74.2	-	64.6
Rape myths				
A rape survivor is to blame for the rape.	-	11.1	-	18.2
Women who are raped ask for it.	-	17.4	-	23.9
If she does not fight back, it is not rape	25	19.5	23	19.5
It is possible for a husband to rape his wife	45	48.0	44	44.4
Rape victim must be promiscuous	40	26.1	39	37.5
Summary scores				
High gender attitudes score (% accepting)	-	19.4	-	27.7
High rape myths score (% accepting)	-	14.9	-	19.8

Note: 2013 figures: % agreeing or strongly agreeing, GBV Indicators Study (Gender Links, 2013). 2025 figures: weighted % agreeing or strongly agreeing. Negative change (pp) = reduction in acceptance of an inequitable attitude.

Source: Lesotho GBV 2013 & 2025 Prevalence Surveys, Gender Links

4.4.1 Normative shifts

The single most dramatic normative change between 2013 and 2025 concerns the belief that a woman should obey her husband. In 2013, 97% of women and 96% of men agreed with this statement, a near-universal endorsement. By 2025, that figure has fallen to 33.9% of women and 49.2% of men, declines of 63 and 47 percentage points, respectively. These are extraordinary shifts. While some methodological caution is warranted regarding question wording and response option differences between rounds, the magnitude across both genders is consistent with genuine normative transformation in how Basotho adults perceive the marital relationship.

Women's attitudes have shifted more dramatically than men's, creating a gender gap in residual obedience attitudes (33.9% vs 49.2% in 2025) that is analytically significant. Women are leading the normative shift toward egalitarian partnerships, a pattern consistent with the education-driven attitude change documented across sub-Saharan Africa.[159] However, this divergence in expectations within couples

[159] Pierotti, R. S. (2013). Increasing Rejection of Intimate Partner Violence: Evidence of Global Cultural Diffusion. American Sociological Review, 78(2), 240-265. http://www.jstor.org/stable/23469173

may itself generate conflict and violence as women assert rights that their partners' normative frameworks do not yet accommodate, a dynamic consistent with the empowerment backlash mechanisms discussed in Section 4.2. As Hapazari's (2024)[160] Analysis of prevention narratives through the ecological model argues that normative change at the individual level must be accompanied by community-level reinforcement to sustain itself and avoid triggering backlash at the relationship level.

4.4.2 Attitudes that have changed, but not enough

Several attitude items show meaningful reductions that nonetheless leave large minorities, or majorities, holding harmful views. Men's belief that a man has the right to punish his wife fell from 41% in 2013 to 16.5% in 2025 (_24.5 pp). This is a very welcome trend: one in six adult men in Lesotho still endorses the right to punish a wife physically, but this represents a dramatically smaller proportion than in 2013. Similarly, women's acceptance that a woman cannot refuse her husband sex fell from 55% to 38.6% (-16.4 pp) and men's from 58% to 39.7% (-18.3 pp). Progress is real, and so is the distance remaining.

The **Bohali** items show the most resistant attitudes, particularly among men. The belief that paying bohali entitles a husband to sex declined from 45% to 30.1% among men (-14.9 pp), but three in ten men still hold this view. The belief that bohali means a husband owns his wife shows the smallest absolute change for men (45% - 40.5%, -4.5 pp), suggesting that the commodification dimension of the bohali institution is the most resistant to normative challenge. This is consistent with international evidence that attitudes tied to material transactions and economic interests shift more slowly than those tied to relational or moral norms.[161] It also points to the need for specific programming that addresses the legal and customary dimensions of the bohali institution rather than treating it as a monolithic cultural norm.

4.4.3 An attitude moving in the wrong direction

One attitude item shows a concerning increase. Women's endorsement of the statement "nothing wrong with a married man having girlfriends" rose from 15% in 2013 to 24.5% in 2025 (+9.5 pp), the only gender attitude item to move in the wrong direction among women over the twelve years. Men's endorsement declined marginally (18% to 17.2%), suggesting this shift is primarily a women's attitude change. The reasons are not immediately apparent from the survey data alone, but they may be partly legible through the culture's own language. The Sesotho proverb *Monna ke mokupu, oa nama,* "a man is like a pumpkin that spreads its vines," meaning a man may engage in multiple intimate relationships, encodes male infidelity as a natural rather than transgressive behaviour. In a context where this norm is deeply embedded, the increase in women's agreement may reflect pragmatic adaptation rather than genuine approval. Women accepting partner infidelity as an unavoidable feature of their relational lives rather than endorsing it as a moral position. If so, the shift signals not a weakening of women's values but a hardening of resignation, a distinction with direct implications for programme design. Interventions that challenge male infidelity norms without

[160] Hapazari, J. (2024). Narratives and patterns of narratives on how to prevent violence against women: Context of the ontogenic and microlevels of the ecological model of violence against women - Corvinus: Journal of Sociology and Social Policy, 15(2): 139-160. https://cjssp.uni-corvinus.hu/index.php/cjssp/article/view/792

[161] Jewkes, R., Flood, M. & Lang, J. (2015). "From work with men and boys to changes of social norms and reduction of inequities in gender relations: A conceptual shift in prevention of violence against women and girls." The Lancet, 385(9977), 1580-1589.

acknowledging the cultural proverbs and idioms through which those norms are transmitted and normalised risk speaking past the communities they seek to reach. Qualitative investigation of this specific attitudinal shift and its relationship to the mokupu norm would strengthen the evidence base for targeted prevention messaging.

4.4.4 New attitude items

Four new items introduced in 2025 reveal important dimensions of gender attitudes not measured in 2013. Most analytically significant, 58.0% of women and 67.6% of men agree that a woman should give her money to her husband. This majority-endorsed norm directly enables economic IPV in a context where 22.6% of women report lifetime economic IPV experience. This attitude-behaviour alignment is stark. It points to the normalisation of financial control as a feature of marriage rather than a form of abuse, and it provides a direct evidence base for the financial literacy and economic autonomy programming that GIZ and other partners are pursuing in Lesotho.

The belief that children belong to a man and his family is endorsed by 36.2% of women and a majority (50.2%) of men. This norm has direct implications for women's willingness to leave abusive relationships, particularly the fear of losing access to children. Administrative data from the children's courts confirm that custody and maintenance disputes constitute most cases heard, approximately 500-600 custody and 800 maintenance cases per year, dwarfing the criminal caseload. In a context where bohali-linked ownership norms remain prevalent among 40.5% of men, women's concern that leaving an abusive marriage will result in loss of custody is not unfounded. It may function as a structural barrier to help-seeking.

Finally, 74.2% of women and 64.6% of men agree that women and men should be treated equally, demonstrating that gender equality as an abstract principle has substantial popular support. However, the gap between this majority endorsement and the simultaneous endorsement of specific subordinating norms (giving money to husband, needing permission to work, and agreement that a woman should obey her husband) reveals the deep contradiction between stated values and the practical normative frameworks governing daily life. This contradiction is precisely where prevention programmes have room to work, not by introducing new values but by helping people align their practical behaviours with the egalitarian values they already hold in principle.

4.5 Gender attitudes, rape myths, and their association with IPV

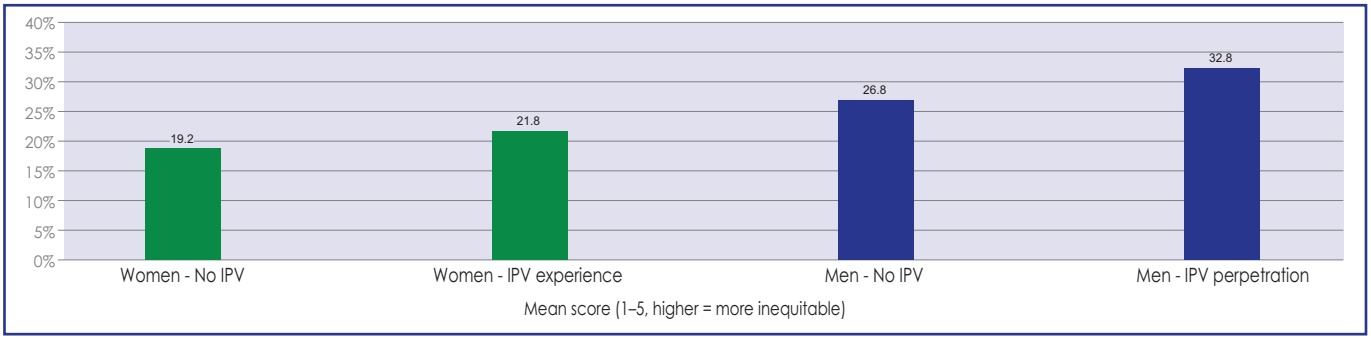
The relationship between gender attitudes and intimate partner violence is one of the most extensively theorised pathways in the GBV literature. Heise's (1998) ecological model positions patriarchal gender norms as a societal-level driver that creates the normative environment within which individual violence occurs, while Jewkes (2002)[162] identifies gender inequity as one of the two most consistent cross-cultural predictors of IPV prevalence, the other being social norms around the acceptability of violence. Rape myths, cognitive frameworks that minimise sexual violence, blame victims, and exonerate perpetrators, operate as a distinct attitudinal domain. They do not merely reflect general gender inequity

[162] Jewkes, R. (2002). "Intimate partner violence: Causes and prevention." The Lancet, 359(9315), 1423-1429.

but function as specific permission structures for sexual coercion (Bohner et al,[163] 2009; Suarez & Gadalla,[164] 2010). The 2025 study measures both domains using composite scales. The Gender Attitudes Scale (GAS), which aggregates responses across the attitude items examined in Section 4.4, and a Rape Myths Scale adapted from established instruments.

This section examines whether individuals who hold more inequitable attitudes and higher rape myth acceptance are significantly more likely to be involved in IPV, and, critically, which of these attitudinal domains retains independent predictive power after adjustment for all other measured risk factors.

Figure 4.3: Mean Gender Attitudes Score by IPV status



Note: 1. Gender attitudes score: higher values indicate more inequitable gender attitudes. 2. High inequitable attitudes are defined as scoring above the median on the Gender Attitudes Scale.

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

Table 4.3: Rape myths by IPV experience and perpetration status

Rape myth item	Women Mean	Men Mean	Women No IPV %	Women IPV %	Men No Perp %	Men Perp %	p-value (Women)	p-value (Men)
Overall Rape Myths Score	1.20	1.38						
High Rape Myths Acceptance %	14.7	19.8						
By IPV Status								
Women No IPV			11.5					
Women's IPV Experience				18.6			0.000	
Men No Perpetration					16.4			
Men Perpetration						28.9		0.000

Note: IPV status = any lifetime IPV experience (women) or perpetration (men). High inequitable attitudes = above median on the Gender Attitudes Scale. High rape myths acceptance = above median on Rape Myths Scale.

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

Men who perpetrate IPV hold significantly more inequitable gender attitudes than non-perpetrating men (p=0.041) and are nearly twice as likely to hold high rape myth acceptance (28.9% vs 16.4%; p<0.001), a gap of 12.5 percentage points. These associations are statistically significant and directionally consistent with the extensive international evidence on gender attitudes as a driver of male IPV perpetration.[165]

For women, the attitude-IPV association is in the expected direction but falls short of conventional statistical significance for the general gender attitudes scale (p=0.062). This suggests that women's endorsement of inequi-

[165] Fulu, E., Jewkes, R., Roselli, T. & Garcia-Moreno, C. (2013). "Prevalence of and factors associated with male perpetration of intimate partner violence: Findings from the UN Multi-country Cross-sectional Study on Men and Violence in Asia and the Pacific." The Lancet Global Health, 1(4), e187-e207. Available at: https://doi.org/10.1016/S2214-109X(13)70074-3.

table norms is partly a consequence of IPV exposure rather than a prior risk factor. Women in abusive relationships may internalise their partner's controlling frameworks over time. The adjusted regression confirms this interpretation. That is, highly gender inequitable attitudes are not a significant independent predictor of women's IPV experience after adjustment (OR 1.00, p=0.98), confirming that attitudes for women operate downstream of rather than upstream of their IPV experience.

Crucially, rape myth acceptance retains significance in both adjusted models (women: OR 1.48, p=0.015; men: OR 1.72, p=0.006), even when general gender attitudes do not. Rape myths, beliefs that rape victims are to blame, that women who do not fight back were not really raped, that promiscuous women are not credible complainants, operate as cognitive permission structures for sexual violence. Men who accept these myths are more likely to minimise forced sex within relationships as not constituting rape, less likely to respond empathetically to disclosures, and more likely to perceive sexual coercion as contextually justified. This finding has important implications for programme design. Targeted challenges to rape myth beliefs are more analytically justified as a GBV prevention investment than generic gender equality messaging, because rape myths, not general inequitable attitudes, retain independent predictive power in this population after full adjustment. The account below illustrates how rape myth logic manifests in practice, a partner deploying accusations of infidelity and promiscuity to justify escalating abuse:



"He accused her of infidelity, called her a prostitute, a witch, and even a Satanist, spreading these accusations to their child. This deeply hurt her, as she felt the child was being manipulated. At one point, he physically attacked their child as well, leading neighbours to intervene."

Butha-Buthe Participant 6

4.6 Community-level factors

The Norms gap analysis, including the community norms index and the pluralistic ignorance measurement, represents a new analytical lens introduced in the 2025 study. These constructs were not computed in the 2013 baseline and therefore cannot be compared across the two survey rounds. The Norms gap findings presented in this section are 2025 cross-sectional results that establish a baseline for future measurement, not trend comparisons.

An innovative feature of the 2025 study is the measurement of both personal norms (what individuals themselves believe) and perceived community norms (what they believe most people in their community think is acceptable). The gap between these two measurements is theoretically important. In communities where individuals privately hold more equitable attitudes than they perceive their community to hold, a phenomenon known as pluralistic ignorance operates.



An innovative feature of the 2025 study is the measurement of both personal norms (what individuals themselves believe) and perceived community norms

Each person assumes they are an outlier in holding equitable views, when the community is more equitable than any individual perceives. This misperception suppresses the public expression of egalitarian norms. Individuals self-censor for fear of social sanction, a sanction that would not materialise because those around them privately hold more equitable views (Prentice & Miller,[166] 1993; Cislaghi & Heise,[167] 2020).

Table 4.4: Social norms gap between personal and community attitudes

Norms Measure	Women Mean	Men Mean	No IPV %	IPV %	p-value
Personal Norms Score	24.78	24.18			
Community Norms Score	23.18	23.52			
Norms Gap (Personal-Community)	-1.60	-0.66	-1.02	-1.64	0,064

Note: A negative gap indicates that individuals perceive community norms as less equitable than their own personal norms, the pluralistic ignorance pattern. *Source: Lesotho GBV 2025 Prevalence Survey, Gender Links*

Both women and men score higher on personal norms (women: 24.78; men: 24.18) than on perceived community norms (women: 23.18; men: 23.52), where both scales use the same nine items scored 9-36, and higher scores indicate more equitable views. The norms gap is -1.60 for women and -0.66 for men, confirming that pluralistic ignorance operates across the adult population. Individuals privately hold more equitable views than they believe their communities hold. Women who have experienced IPV show a larger norms gap (-1.64) than those who have not (-1.02), consistent with evidence that sustained exposure to partner violence causes women to overestimate community tolerance of abuse, inferring from their partner's behaviour that the community condones it, when it may not.[168]

The pluralistic ignorance finding has direct and practical implications for prevention investment. Social norms change approaches, community dialogue programmes, male champions networks, and media campaigns that make visible the actual distribution of community attitudes are particularly effective in contexts of pluralistic ignorance[169], as demonstrated by the Start, Awareness, Support, Action! (SASA!) community mobilisation model, which reduced IPV by 52% in a rigorous cluster-randomised trial in Uganda[170]. If adults in Lesotho already privately hold more equitable views than they perceive, then correctly informing people about what their neighbours believe can catalyse behavioural change without requiring a fundamental shift in underlying values. Lesotho already has two strong platforms for this work: the GL Sixteen Days of Activism campaigns and the GIZ multi-sector prevention programme, whose Principal Secretaries' roundtable is driving inter-ministerial visibility of equitable norms at the highest governmental level.

Institutional evidence corroborates the persistence of norms that tolerate GBV. The **Department of Public Prosecutions (DPP)** reported in 2026 that prosecutors routinely anticipate case withdrawal in intimate partner violence matters, effectively normalising the expectation that complainants will not follow through, a pattern that both reflects and reinforces community tolerance of partner violence.

[166] Prentice, D.A. & Miller, D.T. (1993). "Pluralistic ignorance and alcohol use on campus: Some consequences of misperceiving the social norm." Journal of Personality and Social Psychology, 64(2), 243-256
[167] Cislaghi, B. & Heise, L. (2020). "Gender norms and social norms: Differences, similarities and why they matter in prevention science." Sociology of Health & Illness, 42(2), 407-422.
[168] Tankard, M.E. & Paluck, E.L. (2016). "Norm perception as a vehicle for social change." Social Issues and Policy Review, 10(1), 181-211.
[169] Cislaghi, B. & Heise, L. (2020). "Gender norms and social norms: Differences, similarities and why they matter in prevention science." Sociology of Health & Illness, 42(2), 407-422.
[170] Abramsky, T., Devries, K., Kiss, L. et al. (2014). "Findings from the SASA! study: A cluster randomised controlled trial to assess the impact of a community mobilisation intervention to prevent violence against women and HIV in Kampala, Uganda." BMC Medicine, 12, 122.

Similarly, the **Lesotho College of Education (LCE)** documented ongoing gender stereotyping among student teachers, including the persistence of "sugar daddy" culture, where older men provide financial support to female students in exchange for sexual relationships. LCE noted cases of male students pushing pregnant female students and a lecturer dismissed for sexual exploitation, illustrating how institutional environments simultaneously reproduce and challenge harmful gender norms.

Key findings on societal and community-level drivers:

- The most dramatic normative shift (2013-2025), agreement that a woman should obey her husband fell from 97% (women) and 96% (men) in 2013 to 33.9% and 49.2%, respectively, in 2025.
- Women's attitudes are shifting faster than men's, creating a divergence in normative expectations that may generate empowerment backlash within relationships.
- Persistent harmful norms show that in 2025, 39-40% of adults still believe a woman cannot refuse her husband sex; 40.5% of men believe bohali entitles a husband to sex; 58-68% agree a woman should give money to her husband, the normative foundations of sexual and economic IPV.
- The DHS 2023-24 independently confirms the direction of change: men justifying wife-beating fell from 51% (2004) to 25% (2023-24), two decades of investment in prevention producing measurable results in a completely independent national survey.
- Women's agreement that a married man having girlfriends is acceptable increased from 15% to 24.5% (+9.5 pp), the only attitude item moving in the wrong direction, likely reflecting pragmatic adaptation to male infidelity norms.
- Rape myths acceptance is the most consistent attitudinal predictor of IPV involvement, with men who perpetrate IPV being nearly twice as likely to hold high rape myths acceptance (28.9% vs 16.4%; $p < 0.001$). Targeted anti-rape-myth programming is more analytically justified than generic gender equality messaging.
- Pluralistic ignorance operates strongly (norms gap: women -1.60; men -0.66), both genders privately hold more equitable views than they perceive their communities to hold, creating a programme opportunity, that is, making visible what communities believe can catalyse change without requiring fundamental value shifts.

4.7 Relationship-level factors: alcohol, substance use, and GBV

The relationship between alcohol and substance use and GBV is one of the most extensively documented in the global literature and was a prominent finding in the 2013 Lesotho baseline. The 2013 study found that 33% of women whose partners drank alcohol reported IPV in the past 12 months compared with 26% of those whose partners did not drink ($p=0.002$), and that 16% of men who drank alcohol perpetrated IPV compared with 9% of non-drinking men ($p<0.001$). The 2025 study provides updated analysis across all four analytical groups, including, for the first time, a dose-response analysis using the Alcohol Use Disorders Identification Test - Consumption (AUDIT-C), a validated three-item screening tool that captures drinking frequency, typical quantity per session, and binge drinking frequency on a composite 0-12 scale.[171]

[171] Bush, K., Kivlahan, D.R., McDonell, M.B., Fihn, S.D. & Bradley, K.A. (1998). "The AUDIT alcohol consumption questions (AUDIT-C): An effective brief screening test for problem drinking." Archives of Internal Medicine, 158(16), 1789-1795.

The DHS 2023-24 provides an important corroborating figure from an independent national source. It finds that women whose partners drink frequently face a 60% IPV rate compared with 22% among those whose partners do not drink at all, a ratio of nearly 3:1 that independently confirms alcohol as the single strongest measurable relationship-level risk factor in Lesotho's national data. The consequences extend beyond the couple. Children who witness alcohol-fuelled violence absorb both the behaviour and the justifications that surround it, as one participant from Berea describes:



"My child has asked why his father always causes trouble when drunk, while I remain calm. This situation has affected the child, who now believes that we are the ones who provoked his bad behaviour since he sees us fighting in front of him. The child has started using vulgar language, imitating what he hears."

Berea Participant 4

Alcohol and IPV, a consistent association across all four groups

The binary indicators tell a clear story. Table 4.6 (Statistical Appendix Table A4) shows that among men who experienced IPV, 86.2% have ever drunk alcohol versus 66.7% of non-IPV men, a 19.5 percentage-point gap ($p<0.001$). Male perpetrators show a near-identical pattern: 87.0% ever drank versus 66.6% of non-perpetrators ($p<0.001$). The near symmetry of these figures across experience and perpetration groups suggests that alcohol use is a pervasive environmental feature of men's GBV involvement in Lesotho, present in both victimisation and perpetration contexts.

For women, the gap is smaller but significant for experience (66.8% vs 56.0%, $p<0.001$). On the perpetration side, past-12-month drinking shows a stronger association (76.9% vs 62.9%, $p<0.001$) than for experience (70.1% vs 62.2%, $p=0.009$), suggesting that alcohol's role in women's violence is more closely tied to perpetration than to victimisation. Men's past-12-month drinking does not differentiate by IPV status (85.3% vs 81.0%, $p=0.222$) because men's baseline drinking rate is already so high that there is limited room for differentiation.

Dose-response shows quantity per session as the critical dimension

The AUDIT-C[172] [173] analysis moves beyond binary ever-drank indicators to examine whether the pattern of alcohol consumption, not just its presence, distinguishes IPV-involved individuals. An important finding is the typical quantity consumed per drinking session. Men who experienced IPV report a higher mean quantity score (1.31 vs 1.07, $p=0.005$), and male perpetrators show an even larger gap (1.37 vs 1.04, $p<0.001$). This indicates that it is not merely whether a man drinks but how much he drinks per occasion that is associated with IPV involvement, a pattern consistent with international evidence that heavy episodic drinking, rather than moderate regular consumption, is the proximate alcohol-related risk factor for violence.[174] [175]

[172] Alcohol Use Disorders Identification Test (AUDIT). Available at: https://auditscreen.org/ (Accessed: 1 June 2026).
[173] WHO (2001). AUDIT: The Alcohol Use Disorders Identification Test - Guidelines for Use in Primary Care (2nd ed.). Geneva: World Health Organisation.
[174] Graham, K., Bernards, S., Wilsnack, S.C. & Gmel, G. (2011). "Alcohol may not cause partner violence, but it seems to make it worse: A cross-national comparison of the relationship between alcohol and severity of partner violence." Journal of Interpersonal Violence, 26(8), 1503-1523.
[175] WHO (2006). Intimate Partner Violence and Alcohol. WHO Fact Sheet. Geneva: World Health Organisation.

Matela (2020)[176] documents alcohol as a distinct socio-cultural driver of IPV in Lesotho, noting that poverty-related stress, combined with alcohol abuse, breeds IPV particularly where men have lost their breadwinner position. This qualitative finding complements the dose-response pattern documented in the AUDIT-C analysis above, confirming that the alcohol-violence nexus in Lesotho operates through both pharmacological and socio-economic pathways.

Alcohol use frequency, by contrast, shows a significant association only for women's IPV experience (1.67 vs 1.50, p=0.032) and not for men in either direction. Binge drinking frequency is not significantly associated with IPV for either gender. The composite AUDIT-C total for male perpetrators (4.68 vs 4.21) is borderline significant (p=0.051), confirming that quantity per session is the primary driver of the composite difference. This gender distinction in the alcohol-IPV pathway matters for programme design. For men, the risk is concentrated in heavy per-session consumption, while for women, it is in the regularity of drinking. Age of drinking onset shows no significant association for either gender.

Cannabis and other substances



Lesotho's substance-GBV nexus is predominantly alcohol and hard drug use (cocaine, heroin, mandrax, methamphetamine)

Cannabis shows an even steeper gradient for men. Among those who experienced IPV, 29.2% report cannabis use compared with 15.7% of non-IPV men; among perpetrators, the pattern is almost identical at 30.6% versus 15.3% (p<0.001 for both comparisons). This consistent doubling across both experience and perpetration groups suggests that cannabis use, like alcohol, is a pervasive feature of men's GBV involvement rather than specific to either side of the violence dynamic. For women, drug use is significant at the aggregate level (7.6% vs 4.3%, p=0.008) but cannabis specifically does not reach significance (1.5% vs 1.0%, p=0.466) due to very low base rates. Drug use frequency among users does not differ by IPV status for either gender, meaning the association is driven by whether someone uses drugs at all, not by how often.

Hard drug use (cocaine, heroin, mandrax, methamphetamine) approaches zero across all groups, confirming that Lesotho's substance-GBV nexus is predominantly alcohol and cannabis. Prescription drug misuse, though low in absolute terms, is significantly elevated among women with IPV experience (2.5% vs 1.4%, p=0.014) and among male perpetrators (3.2% vs 0.9%, p=0.013). The women's findings may indicate self-medication for pain or distress resulting from violence. The male perpetration finding, uniquely significant on the perpetration side but not the experience side, warrants monitoring, given the broader regional trend of increasing non-prescribed pharmaceutical use. While the statistical evidence documents the association between substance use and IPV at the population level, individual accounts reveal the lived reality behind the numbers and, occasionally, the possibility of change.

[176] Matela, L. and Muthuki, J. (2020) 'Investigating the role and effectiveness of intervention strategies employed by six organisations dealing with intimate partner violence in Lesotho'.



"My husband becomes violent when he drinks alcohol, although when he is sober, he is a peaceful man. Recently, after drinking, he threatened to kill me, forcing me to flee to the chief for safety. On one occasion, he admitted guilt and promised to stop drinking, acknowledging that alcohol fuels his anger. Since the police warned him that a third offence would lead to imprisonment, I have noticed some improvement."

Berea Participant 2

Three important analytical caveats govern the interpretation of these findings. First, the causal direction cannot be established from cross-sectional data. Survivors may increase alcohol use as a coping mechanism, making alcohol both a risk factor and a consequence of GBV. Second, alcohol is a contextual facilitator, not a sufficient cause. Most alcohol users do not perpetrate violence, and GBV occurs in the absence of alcohol. Attributing GBV to alcohol risks deflecting accountability from perpetrators and from the structural gender norms that underlie violence. Third, the dose-response finding that quantity per session rather than frequency drives the association for men has direct implications for community-based alcohol harm reduction. That is, interventions targeting heavy per-session drinking are the most evidence-based alcohol investment for GBV reduction.

Independent corroboration of these risk factor findings is provided by Nakie et al. (2025)[177], who conducted a multilevel logistic regression analysis of the Lesotho DHS 2023-24 data (N=1,687 ever-married women aged 15-49). Their analysis identifies five statistically significant predictors of IPV that closely mirror the risk architecture documented in the present study: having a jealous partner (AOR 4.10, 95% CI 3.13-5.36), having an alcoholic partner (AOR 2.07, 95% CI 1.58-2.71), current tobacco smoking (AOR 1.71, 95% CI 1.10-2.64), women justifying wife-beating (AOR 1.57, 95% CI 1.11-2.21), and depressive symptoms (AOR 1.55, 95% CI 1.04-2.30). Their overall IPV prevalence of 41.68% (95% CI 39.35-44.05) among ever-married women aged 15-49 aligns closely with the 45.7% lifetime IPV figure documented in the present study among ever-partnered women aged 15 and above, with the 4-percentage-point difference attributable to different partnership and age denominators. The convergence of findings from two independent studies using different survey instruments, different samples, and different analytical frameworks strengthens the evidence base substantially. Notably, the DHS-based analysis does not examine adverse childhood experiences, which the present study identifies as the strongest independent predictor of adult IPV (OR 6.68 for women with 4+ ACEs), representing a unique contribution of the GL study to the Lesotho evidence base.

Qualitative evidence from Matela (2020)[178] further contextualises these risk factors. Her PhD study of six IPV-response organisations in Lesotho identifies bohali as a structural driver, with some men interpreting the practice as conferring ownership rights over wives. The study also documents how the retrenchment of Basotho men from South African mines and the consequent reversal of breadwinner roles have generated male identity crises that manifest as IPV. These qualitative findings align with the present study's quantitative evidence on controlling behaviours and economic stress as IPV predictors and illustrate the socio-cultural mechanisms through which the statistically identified risk factors operate in the Lesotho context.

[177] Nakie, G., Tadesse, G., Fentahun, S., Rtbey, G., Andualem, F., Kibralew, G., Kelebie, M., Melkam, M., Kassa, M.A., Mengistie, B.A., Alemayehu, T.T., Yigezu, M., Segon, T., Wassie, Y.A. and Tinsae, T. (2025) 'Multilevel Analysis of Intimate Partner Violence and Associated Factors Among Reproductive-Age Women: Lesotho Demographic and Health Survey 2023 to 2024 Data', Journal of Interpersonal Violence, p. 08862605251368842. Available at: https://doi.org/10.1177/08862605251368842.

[178] Matela, L. and Muthuki, J. (2020) 'Investigating the role and effectiveness of intervention strategies employed by six organisations dealing with intimate partner violence in Lesotho'.

4.8 Relationship-level factors: Partner dynamics, child marriage, and bohali norms

Beyond substance use, the relational context within which violence occurs is shaped by specific partnership characteristics, the age at which the union began, the economic and cultural terms on which it was formed, and the patterns of control and coercion that define its daily dynamics.

4.8.1 Child marriage as a structural risk factor

Statistical Appendix Table A5 shows that child marriage is a significant structural risk factor for IPV in 2025. Among women who experienced IPV, 39.0% were married before age 18, compared with 33.8% of those without IPV experience (a 5.2 percentage difference). For men, the contrast is more pronounced: 38.4% of men who experienced IPV were married before 18, compared with 26.0% of non-IPV men (a gap of 12.4 percentage points). Child marriage is thus associated with elevated IPV involvement for both women's experience and men's experience, with the association particularly strong for men.



A wall graphic on Children's rights at the Maseru Children's Court, Lesotho.
Photo: Thandiwe Hlelesi

The Chapter 3 data establish that 33.6% of ever-partnered women and 28.2% of ever-partnered men report having been married before age 18, placing child marriage as a high-prevalence phenomenon with direct population-level implications for IPV burden. The Counter Domestic Violence Act 2022 and the Marriage Act's minimum age requirements address child marriage in law. But enforcement, particularly in rural and mountain districts, remains inconsistent. The connection between child marriage and adult IPV documented here provides a strong evidence base for treating the enforcement of these legal provisions as a frontline GBV prevention strategy, not merely a child protection issue.

4.8.2 Reproductive coercion as a relationship-level risk marker

Reproductive coercion within partnerships is strongly associated with overall IPV experience. Women who experienced any IPV are 3.6 times more likely to have had a partner refuse birth control use (8.9% vs 2.5%) and seven times more likely to have had a partner damage or destroy birth control (1.4% vs 0.2%). For men who experienced IPV, partner refusal of birth control (7.6% vs 0.9%) and destruction of birth control (2.5% vs 0.1%) are similarly concentrated.

These associations confirm reproductive coercion as both a form of IPV (measured as such in Chapter 3) and as a contextual marker of abusive relationship dynamics more broadly. Reproductive coercion rarely operates in isolation. It co-occurs with emotional control, physical intimidation, and sexual coercion as components of a broader pattern of intimate partner abuse. The practical implication is direct. Screening for reproductive coercion in health and family planning settings should treat

a positive finding as a proxy indicator for broader IPV risk, triggering appropriate referral pathways to GBV services. In Lesotho's HIV context, men's condom refusal simultaneously constitutes reproductive coercion and a disease transmission risk, making integrated GBV-SRHRGBV clinical inquiry at health facilities both analytically justified and practically urgent.

The DHS 2023-24 provides powerful independent corroboration of the controlling behaviour-IPV association. Among partnered women whose husbands display five controlling behaviours, 88% have experienced physical or sexual violence, compared with just 13% among those whose husbands display no controlling behaviours (DHS 2023-24, Table 19.11.2). Overall, 64% of partnered women have experienced at least one controlling behaviour (Table 19.9).

4.8.3 Partner employment, co-residence, and bohali norms

Women who experienced IPV are more likely to have a currently employed partner (50.8%) than those without IPV experience (43.1%), consistent with the employment backlash pattern discussed for respondents' own employment in Section 4.2. Men who experienced IPV are substantially more likely to have ever lived with a partner (50.2% vs 36.7%), suggesting that residential cohabitation, where daily interaction and power dynamics are most intensified, is associated with elevated GBV exposure. The account below illustrates how employment and cohabitation create the conditions for economic control, where a partner's income becomes not a source of household security but a tool of domination:



"Her husband earns money in Lesotho and South Africa, but withholds money, spends it secretly, and accuses her of stealing or misusing his earnings. Since 2012, after he returned from the mines, financial struggles worsened, and he became increasingly violent, even threatening to kill her."

Mamosele, Leribe*

The Bohali norm items confirm that men involved in IPV hold stronger pro-bohali ownership beliefs than men without IPV experience. The persistent resistance of bohali-linked ownership attitudes to normative change, identified in Section 4.4 as among the least changed items over 2013-2025, is directly reflected in their association with IPV involvement at the individual level. This convergence of normative resistance and IPV association at two levels of the ecological model strengthens the case for specific programming addressing the bohali institution's ownership dimensions. Not to eliminate bohali as a cultural practice, but to specifically challenge and renegotiate the ownership and sexual entitlement dimensions that link it to GBV perpetration.

Age at first sex is not associated with IPV experience for either women (p=0.835) or men (p=0.280). Sexual debut age, therefore, does not appear to operate as an independent risk pathway for IPV in Lesotho, differentiating Lesotho's profile from some sub-Saharan contexts where very early sexual debut correlates with coerced sex and subsequent partnership violence.

4.9 Multivariate analysis: Independent predictors of IPV experience and perpetration



Celebrating Women's Day, Mohale's Hoek, 2019. *Photo: Ntolo Lekau*

The bivariate analyses in Sections 4.2 through 4.8 identify a range of socio-demographic, psychological, attitudinal, and relational correlates of IPV across all four analytical groups. Many of these factors are inter-correlated[179]. For instance, ACE burden correlates with age; age correlates with marital status, making it impossible from unadjusted analyses alone to determine which independently predicts IPV when others are controlled. The regression models in Tables 4.5 and 4.6 address this through survey-weighted logistic regression, estimating adjusted odds ratios while holding all other factors constant.

Table 4.5: Independent risk factors for women's lifetime IPV experience, adjusted odds ratios (logistic regression), 2025

Risk Factor	Adj. OR	95% CI	p-value	Interpretation
Age (ref: 15-17)				
18-24	**2.04**	1.13-3.70	**0.018**	2 x odds vs the youngest group
25-34	**2.51**	1.34-4.71	**0.004**	Strongest age effect
35-44	**1.93**	1.00-3.72	**0.049**	Borderline significant
45-54	**2.16**	1.12-4.19	**0.022**	Significant
Education (all levels)	-	0.83-1.83	All NS	Not independently significant
Marital status (ref: divorced)				
Never married	**0.33**	0.17-0.66	**0.002**	Strong protective effect
Wealth quintile (all)	-	0.72-1.44	All NS	Not independently significant
Employment	1.23	0.92-1.65	0.156	Non-significant after adjustment
Disability	1.09	0.82-1.47	0.546	Non-significant after adjustment
ACE burden (ref: none)				
1 ACE	**2.19**	1.48-3.23	**<0.001**	Dose-response begins
2-3 ACEs	**3.64**	2.53-5.25	**<0.001**	Highly significant
4+ ACEs	**6.68**	4.47-9.97	**<0.001**	STRONGEST predictor in the model
Highly gender-inequitable attitudes	1.00	0.71-1.40	0.983	Not significant - operates via other pathways
High rape myths acceptance	**1.48**	1.08-2.03	**0.015**	Significant independent predictor

Note: Survey-weighted logistic regression. Denominator: ever-partnered women aged 15+. OR>1 = higher odds of IPV experience. All factors entered simultaneously. NS = not statistically significant at p<0.05. Green shading = significant (p<0.05).
Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

[179] A more specific and statistical term meaning the variables move together quantitatively (when one goes up, the other tends to go up or down in a measurable way), enabling the calculation of a correlation coefficient between them.

Table 4.6: Independent risk factors for men's lifetime IPV perpetration, adjusted odds ratios (logistic regression), 2025

Risk Factor	Adj. OR	95% CI	p-value	Interpretation
Age (all groups vs 15-17)	-	1.43-2.47	All NS	Not significant - small reference group
Education (all levels)	-	0.80-2.47	All NS	Not independently significant
Marital status (all vs divorced)	-	0.60-0.81	All NS	Non-significant after adjustment
Employment	1.32	0.91-1.91	0.142	Non-significant
ACE burden (ref: none)				
1 ACE	1.35	0.72-2.53	0.357	Non-significant at 1 ACE
2-3 ACEs	**2.73**	1.61-4.63	**<0.001**	Highly significant
4+ ACEs	**4.75**	2.61-8.65	**<0.001**	STRONGEST predictor in the model
Highly gender-inequitable attitudes	1.11	0.76-1.62	0.602	Not significant after adjustment
High rape myths acceptance	**1.72**	1.17-2.54	**0.006**	Significant independent predictor

Note: Survey-weighted logistic regression. Denominator: ever-partnered women aged 15+. OR>1 = higher odds of IPV experience. All factors entered simultaneously. NS = not statistically significant at p<0.05. Green shading = significant (p<0.05).

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

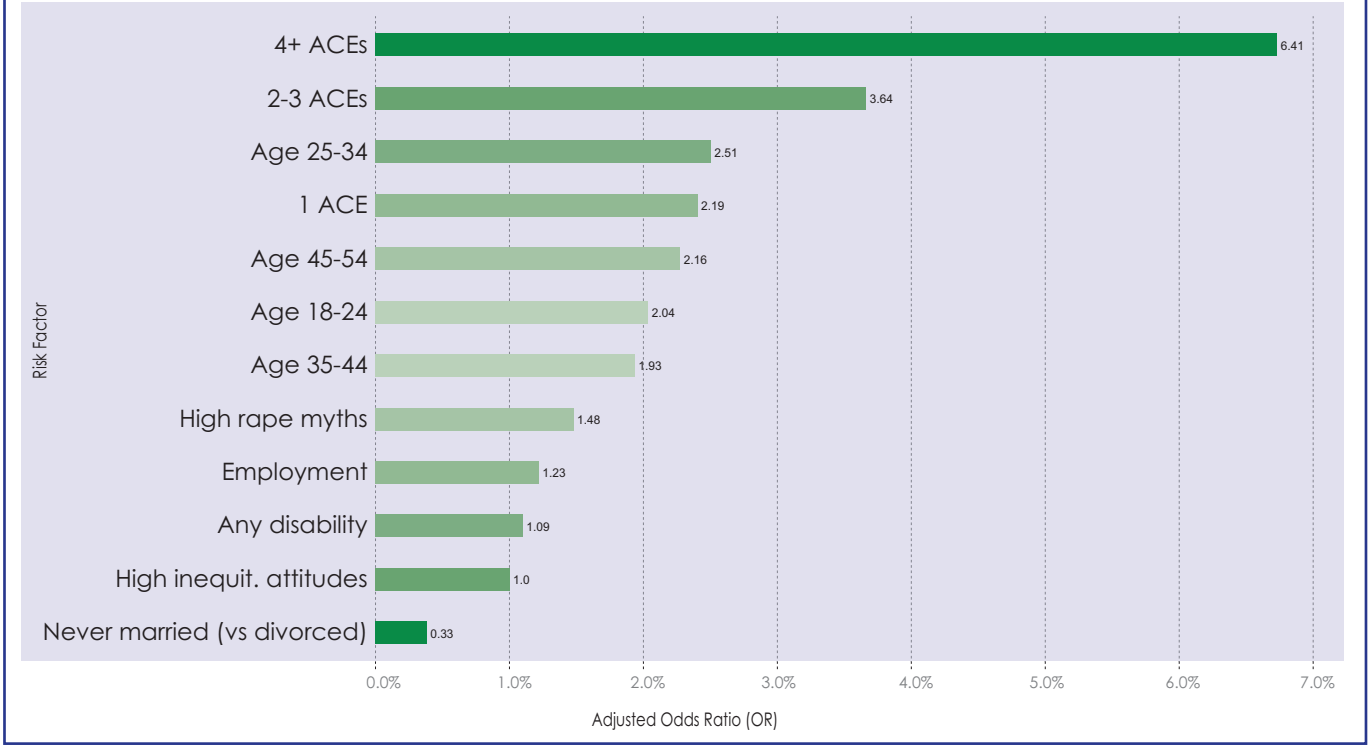
4.9.1 ACEs: the dominant independent predictor for both models

The most important finding from both regression models is the overwhelming dominance of childhood adversity as an independent risk factor. After controlling for all other measured factors, the ACE dose-response survives in both models with extraordinary statistical strength. For women's IPV experience, the adjusted odds ratios rise from OR 2.19 (1 ACE) to OR 3.64 (2-3 ACEs) to OR 6.68 (4+ ACEs), all p<0.001. For men's IPV perpetration, the gradient rises from a non-significant OR 1.35 for 1 ACE to OR 2.73 (2-3 ACEs; p<0.001) and OR 4.75 (4+ ACEs; p<0.001). These are among the largest adjusted odds ratios reported in any GBV risk factor analysis in the sub-Saharan African literature, and they confirm that childhood adversity is not merely one risk factor among many. It is the dominant upstream driver of GBV involvement in Lesotho for both genders.

For men, the ACE effect does not reach significance at 1 ACE (OR 1.35; p=0.36) but becomes highly significant at the 2-3 ACE level and beyond. This threshold pattern is consistent with the established finding that health and behavioural risks accelerate[180] non-linearly at higher ACE counts, particularly at four or more exposures[181], suggests that a single adverse experience does not substantially elevate men's perpetration risk above baseline, but that cumulative adversity crosses a threshold at which neurobiological and behavioural consequences become sufficient to significantly elevate violence risk. The direct implication for programme targeting is that ACE-informed prevention for men is most usefully directed at those with multiple rather than single adversity exposures.

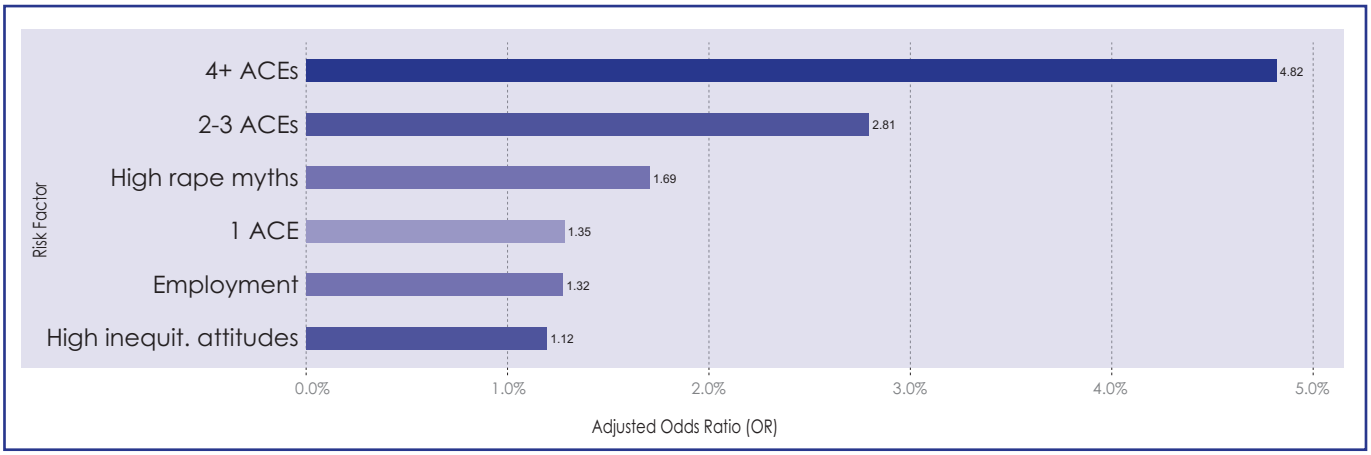
[180] Hughes, K., Bellis, M.A., Hardcastle, K.A. et al. (2017). "The effect of multiple adverse childhood experiences on health: A systematic review and meta-analysis." The Lancet Public Health, 2(8), e356-e366.
[181] Felitti, V.J., Anda, R.F., Nordenberg, D. et al. (1998). "Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study." American Journal of Preventive Medicine, 14(4), 245-258

Figure 4.4: Independent predictors of women's lifetime IPV experience (adjusted OR), 2025



Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

Figure 4.5: Independent predictors of men's lifetime IPV perpetration (adjusted OR), 2025



Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

4.9.2 What the regression models do not find

The regression results also clarify which factors, commonly assumed to predict GBV, do not retain independent significance after adjustment. Education, wealth, employment, disability, and settlement type are all non-significant in both models. This does not mean these factors are irrelevant to GBV; rather, their unadjusted associations are largely explained by their correlation with more fundamental upstream drivers, primarily ACE burden and age.

Most notably, highly gender-inequitable attitudes are not a significant independent predictor of IPV in either model (OR 1.00 for women; OR 1.11 for men). This counterintuitive finding is best understood in two ways. First, in a context where patriarchal attitudes remain widespread, there may be insufficient variance in the aggregate attitudes score to detect independent effects after other factors are controlled. Second, attitudes may operate indirectly, that is, shaping behaviour through effects on ACE accumulation, alcohol use patterns, and relationship selection, rather than directly predicting individual IPV episodes. Rape myths acceptance, by contrast, retains significance in both models (women OR 1.48, p=0.015; men OR 1.72, p=0.006), pointing to specifically sexual-violence-justifying beliefs as the more proximate attitudinal driver of GBV in this study population.

4.10 Drivers of GBV for LGBTQI+ persons

The drivers of GBV for LGBTQI+ persons in Lesotho operate through a distinct mechanism not captured in the ecological model as applied to the general population: the targeted use of violence as a means of enforcing hetero-normativity and punishing non-conformity to binary gender roles. The THUSO Project Baseline Study (2026) found that 93.8% of GBV incidents experienced by transgender respondents were directly linked to the survivor's gender identity or expression, confirming that violence against this population is not primarily driven by the individual, relational, or economic factors that structure IPV in the general population. It is driven by identity-based discrimination and the absence of legal protection.

The ICJ documents specific forms of targeted violence against LGBTQI+ persons in Lesotho, including 'corrective rape', sexual violence used to 'cure' or 'correct' gender identity or sexual orientation, and forced attendance at initiation schools aimed at changing gender identity. These forms of violence operate at the community and societal levels of the ecological model. They are sanctioned by community norms, enabled by the absence of explicit legal protections, and carried out by multiple actors, including family members, community leaders, and institutional gate-keepers.

Lesotho's Gender and Development Policy 2018-2030 and the Counter Domestic Violence Act 2022 do not explicitly address sexual orientation or gender identity as protected characteristics. The Legal Aid Clinic guidelines are the first national legal framework to explicitly name sexual and gender minorities as a marginalised group eligible for services, an important precedent that the Chapter 6 (Response) analysis builds on. The RISE project, launched by the ICJ in September 2025, has legal reform and expanded access to justice for LGBTQI+ persons as an explicit programme goal. Hapazari and Letooane's (2024) analysis[182] of Lesotho's Gender and Development Policy identifies implementation gaps across the board that are particularly acute for populations not explicitly named in the policy.

The THUSO Project Baseline Study (2026) found that 93.8% of GBV incidents experienced by transgender respondents were directly linked to the survivor's gender identity or expression

[182] Hapazari, J. and Letooane, M. (2024). On the Frontline: Perspectives on Lesotho Gender and Development Policy in Combating Gender-Based Violence, TUDARCo Journal of Humanities and Education, 3(1): 4-16. ISSN: 2820-266X https://tudarco.ac.tz/wp-content/uploads/2024/06/TJHE-Volume-3-Number-1_.pdf

Conclusion

Chapter 4 has applied the ecological model bidirectionally to examine the drivers and patterns of GBV in Lesotho across childhood adversity, gender attitudes and rape myths, social norms, alcohol and substance use, and relationship dynamics. The evidence points to where Lesotho can make the greatest gains in the next phase of its GBV response:

- ***Childhood adversity is the engine of adult GBV:*** The extraordinary dominance of ACEs as an independent predictor (OR 6.68 for women with over 4 ACEs; OR 4.75 for men) places early childhood protection at the centre of Lesotho's GBV strategy. In a country where four in five adults report at least one ACE and one in seven reports four or more, prevention strategies that do not include ACE reduction will systematically under-address the primary generative mechanism of adult GBV. The intergenerational dividend is clear: reducing the ACE burden for one generation reduces the next generation's IPV rates. Existing platforms, including the CGPU, the Children's Protection and Welfare Act (2011), and community-based child protection mechanisms, provide the institutional infrastructure to build this upstream prevention.

- ***Normative change is real, uneven, and worth accelerating:*** Agreement that a woman should obey her husband has collapsed from near-universal to a minority position. Men's endorsement of wife punishment has fallen by 24 percentage points. The DHS 2023-24 independently confirms that the justification of wife-beating has halved since 2004. This is genuine progress, and it is the product of sustained investment over two decades. The challenge now is acceleration, particularly on the more resistant norms, that is, bohali-linked sexual entitlement (30% of men), women needing permission to work (74% of men), and the new finding that 67% of men believe women should give money to husbands. Programmes that target these specific economic control norms, rather than generic gender equality, and that specifically challenge rape myths (the most consistent attitudinal predictor of IPV) will generate the greatest returns in the next phase.

- ***Relationship dissolution and specific relationship dynamics are proximate risk spaces:*** Separated women face 69.4% lifetime IPV, the highest of any demographic group. Child marriage elevates IPV for both genders. Reproductive coercion is a reliable proxy for broader abuse patterns. Alcohol and cannabis are present in 86-87% of GBV-involved men's histories.

- ***The bidirectional framework reveals new priorities for engaging men:*** The 2025 study's bidirectional approach reveals that men's own IPV experience is substantial (28.2% lifetime), driven by the same ACE architecture and alcohol use patterns as women's. Men occupy four distinct roles in the GBV landscape: as survivors, as perpetrators, as normative change agents, and as fathers whose ACE-generating behaviour shapes the next generation's risk profile. Prevention and response systems designed exclusively for female survivors miss men as survivors and fail to engage men as the primary lever for next-generation ACE reduction. Kick4Life's[183] boys' module, reaching young men with evidence-based gender norm and violence prevention content, and GIZ's male champion and religious leader engagement programmes represent the type of investment that the 2025 data most strongly justify scaling.

[183] Kick4Life. Available at: https://www.kick4life.org/ (Accessed: 2 June 2026).

CHAPTER 5
EFFECTS OF GENDER-BASED VIOLENCE



Berea, Ha-Moshati SM&D with police officers and community leaders to share their experiences and identify strategies to improve community responses in 2025. *Photo: SM&D*

Key findings

- 13.2% of women and 8.5% of men who survived IPV sustained physical injuries. The DHS 2023-24 national survey independently recorded that 38% of women who experienced IPV sustained injuries, with 10% sustaining serious injuries such as broken bones or deep wounds.
- 65.8% of women and 60.2% of men who experienced IPV suffer clinically significant depression risk: more than 20 percentage points above those unaffected.
- Men who experience IPV carry adjusted odds of depression (OR 1.87) and probable PTSD (OR 2.34) that match or exceed those of women survivors.
- IPV perpetration independently raises depression odds for both women (OR 1.36) and men (OR 2.07), a novel finding that opens a new therapeutic entry point for ending re-offending without compromising survivor-first principles.
- 6% of women experienced violence during pregnancy (DHS 2023-24), a figure that closely matches the GL survey finding and anchors the maternal and child health case for integrated GBV clinical inquiry in antenatal care.
- Persons with disabilities who experience GBV face compounding barriers to the health, mental health, and economic recovery services documented in this chapter.
- LGBTQI+ survivors face additional institutional exclusion from formal mental health support pathways.

Abuse disguised as authority, when the money exists but the child suffers



"My daughter developed a high fever and was shivering uncontrollably. I asked him for transport money to take her to the clinic, but because we had argued earlier that day, he refused. I felt helpless holding my sick child, knowing that money existed but was being used to control me. In that moment, I realised that this was not normal marital disagreement; it was abuse disguised as authority. Something inside me broke, but at the same time, something me awakened. I began secretly attending a women's savings group in the village."

Mamo Qacha's Nek*

Chapter 5 estimates that **GBV costs Lesotho between 1.33% and 5.55% of GDP in lost productivity**, healthcare expenditure, and legal costs. Mamo's sick child is the street-level face of that statistic: money existed, but economic coercion prevented a child from reaching a clinic. Her recovery, joining a savings group, connects directly to the recommendation in Chapter ten that economic empowerment is a key component of long term solutions to GBV.

Overview

This chapter documents the consequences of GBV for survivors, perpetrators, and the broader Lesotho economy. It presents the physical health effects, including injury rates and medical help-seeking, and introduces the first nationally representative mental health assessment using internationally validated clinical instruments for depression (CES-D) and post-traumatic stress disorder (PCL-5). The chapter examines sexual and reproductive health consequences, HIV intersections, economic costs at both household and national levels, and the intergenerational transmission of violence through adverse childhood experiences. These findings quantify what GBV costs Lesotho and strengthen the investment case for the response, support, and prevention interventions assessed in Chapters 6-8.

5.1 Introduction

Gender-based violence does not end with the act of violence. Its effects ripple outward across time, domains, and relationships, manifesting in physical injury, chronic health impairment, mental illness, economic loss, reduced productivity, damaged social bonds, and intergenerational trauma. Survivors often carry these consequences for years or decades after the violence ceases. Perpetrators, a dimension almost absent from the 2013 baseline analysis, also bear measurable effects: psychological distress, social sanctions, relationship breakdown, and legal consequences. Children who witness or experience GBV carry the effects into their own developmental trajectories and their adult risk profiles, completing the intergenerational cycle documented in Chapter 4.

This chapter documents the effects of GBV in Lesotho in 2025 across two primary quantitative domains: physical effects (injuries, medical help-seeking, and productivity losses) and mental health effects (depression and probable post-traumatic stress disorder, measured with internationally validated clinical instruments). The analysis examines effects

on all four groups: women as survivors, women as perpetrators, men as survivors, and men as perpetrators, a significant advance over the 2013 baseline, which documented effects on women only. The chapter closes with a contextual discussion of broader effects, including sexual and reproductive health consequences, HIV risk, economic costs, and intergenerational transmission, drawing on 2013 baseline evidence, the Demographic and Health Survey 2023-24, the Commonwealth Secretariat's economic costing for Lesotho, and the international literature.

Persons with disabilities who experience GBV face compounding barriers that amplify the health, psychological, and economic effects documented in this chapter. The ICJ September 2025 report on access to justice for persons with disabilities in Lesotho documents that physical inaccessibility of health facilities, communication barriers from the absence of sign language interpreters, attitudinal barriers including assumptions about the capacity of persons with disabilities, and economic dependence on caregivers who may themselves be perpetrators all compound the effects of violence. For women with disabilities who experience IPV, the barriers documented in this chapter to medical help-seeking, disclosure, and psychosocial support are therefore substantially greater than for women without disabilities, and the prevalence figures should be understood as likely underestimates of the true burden.

A critical methodological advance in 2025 is the use of two internationally validated psycho-metric instruments. The study measures depression using the Centre for Epidemiologic Studies Depression Scale (CES-D), a 20-item self-report instrument scored 0-60, where 16 or above indicates clinically significant depressive symptomatology.[184] The study assesses post-traumatic stress disorder using the PTSD Checklist for DSM-5 (PCL-5), a 20-item instrument scored 0-80, where 33 or above is the recommended cut-off for probable PTSD.[185] These instruments replace the 2013 study's symptom-counting approach, allowing clinical-level interpretation and internationally comparable prevalence estimates. The 2025 findings, therefore, sit alongside the global literature on GBV and mental health in ways that were not possible from the 2013 data.

The chapter follows the World Health Organisation (WHO) pathways framework, which identifies three proximate pathways through which GBV generates health harm: *physical trauma* (direct injury, bodily harm); *psychological trauma* (emotional and cognitive damage leading to mental health disorders and suicidality); and *fear and control* (restriction of autonomy, healthcare avoidance, reproductive harm). The 2025 data directly measure outcomes in the first two pathways. The third pathway draws on contextual evidence and on the DHS 2023-24 help-seeking findings.[186]

A further development in the 2025 evidence landscape is the public-health framing of GBV in Lesotho's national health architecture. The WHO's Country Cooperation Strategy (CCS4) 2024-2027 for Lesotho records that interpersonal violence rose to become one of the top causes of mortality between 2009 and 2019, thus placing GBV alongside HIV, tuberculosis, and non-communicable diseases as a core driver of premature death.[187] This trajectory elevates the effects of GBV from a gender and justice issue to an unambiguous public-health priority, strengthening the case for sustained investment in prevention, response, and survivor support systems.

[184] Radloff, L.S. (1977), 'The CES-D scale: A self-report depression scale for research in the general population,' Applied Psychological Measurement, 1(3), 385-401. The ≥16 clinical cutoff is the most widely used threshold in population survey research (Andresen et al., 1994).
[185] Weathers, F.W. et al. (2013), The PTSD Checklist for DSM-5 (PCL-5). National Center for PTSD. Cutoff of ≥33 recommended for probable PTSD diagnosis in population studies (Bovin et al., 2016, Psychological Assessment, 28(11), 1379-1391).
[186] WHO (2013), Global and Regional Estimates of Violence Against Women: Prevalence and Health Effects of Intimate Partner Violence and Non-Partner Sexual Violence. Geneva: WHO. Pathways framework, Figure 1, p. 10.
[187] WHO (2024), Country Cooperation Strategy: Lesotho 2024-2027. Brazzaville: WHO Regional Office for Africa. Mortality trend analysis, 2009-2019.

5.2 Physical effects, injuries and medical help-seeking

Physical injury is among the most immediate and measurable consequences of GBV. The 2025 survey asked IPV survivors whether they had ever been physically injured because of the violence, how frequently they were injured, and what consequences followed, including whether they sought medical attention and whether they disclosed the cause of injury to a health provider. The survey administered these questions to both female and male IPV survivors, enabling the first gender comparison of physical injury burden in the GL-Lesotho series.

Table 5.1: Physical injuries from IPV - women and men survivors, 2025

Indicator	Women %	N	Men %	N
Injury prevalence				
Ever physically injured from IPV	**13.2**	1,033	8.5	411
Injury frequency (among those injured)				
Injured once	10.4	140	12.1	36
Injured a few times	4.3	140	1.7	36
Injured many times	**12.7**	140	5.5	36
Injury consequences (among those injured)				
Sought medical attention	**47.9**	140	48.4	36
Told the health provider the cause of the injury	**82.8**	70	100.0	20

Note: Denominator: IPV survivors (any lifetime IPV, N=1,033 women; N=411 men). Injury frequency and consequences denominator: those physically injured (N=140 women; N=36 men). Wide CIs for injury frequency sub-items and men's columns reflect small sub-samples - injury frequency estimates are indicative only. Men's 'told provider' based on N=20 - extreme caution warranted.

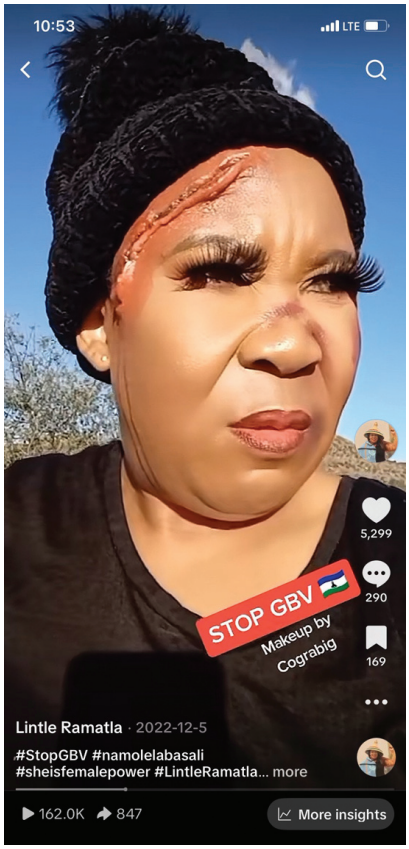
Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

Among lifetime IPV survivors, 13.2% of women and 8.5% of men report having been physically injured because of the violence they experienced. This 4.7-percentage-point gender gap, in which women are more likely to sustain physical injury than men, aligns with the broader body of evidence on IPV injury: women sustain more severe and injurious violence than men, even in relationships where both report some form of physical IPV.[188] The 2013 baseline reported 18% of physically abused women sustained injuries; the 2025 figure of 13.2%, drawn from all IPV survivors rather than only physical IPV survivors, is not directly comparable, but indicates that the overall injury rate among survivors remains substantial. The Demographic and Health Survey 2023-24 provides an important independent corroboration of the physical injury burden. The DHS reports that 38% of women who experienced IPV sustained physical injuries, with 10% sustaining serious injuries such as broken bones or deep wounds, and 8% reporting serious injuries in the past 12 months alone.[189] The two national surveys use different denominators; the GL survey reports among lifetime IPV survivors, and the DHS reports among women who experienced physical IPV specifically, but together they establish that physical injury is a common consequence of partner violence in Lesotho and that a meaningful share of injuries are severe enough to carry long-term health implications. Programme design for health-system GBV response can now proceed from a well-triangulated evidence base.

[188] Ellsberg, M. et al. (2008), 'Intimate partner violence and women's physical and mental health in the WHO multi-country study on women's health and domestic violence: An observational study,' The Lancet, 371(9619), 1165-1172.
[189] Ministry of Health [Lesotho] and ICF (2024), Lesotho Demographic and Health Survey 2023-24: Final Report. Maseru and Rockville: MoH and ICF. Chapter 19, Table 19.13.

Among women who sustained injuries, the frequency distribution is noteworthy: 12.7% were injured many times, while only 10.4% were injured once and 4.3% a few times. Repeated injury is therefore more common than single-incident injury among those who were injured at all, a pattern consistent with the understanding that injury-generating physical IPV is typically recurrent rather than isolated.[190] Men's sub-samples (N=36) are too small for reliable frequency estimates, and the men's figures should be read as indicative only.

The health-sector response to injury remains mixed, though a clear opportunity to strengthen it now exists. Among women who sustained injuries, 47.9% sought medical attention, meaning that more than half of injured women did not access formal medical care. The 2013 baseline recorded a broadly comparable 52% seeking-care rate after injury. The DHS 2023-24 help-seeking pathway data reinforce the picture that is, 45% of women who experienced violence told no one and sought no help, while 49% of those who did seek help went first to their own family rather than to a health or justice service.[191] Lesotho's expanded health infrastructure since 2013, including the MCA-documented network of hospitals and health centres offering post-sexual-violence care, crisis counselling, and mental health services across all ten districts, provides the physical platform for closing this gap. The next step is to match the infrastructure with systematic facility-level GBV clinical inquiry protocols and community-facing awareness of the care available, so that survivors who reach the health system at any entry point are routed into evidence-based support.[192]



One of Lintle Ramatla's (Social media influencer in Lesotho) posts on TikTok depicts the effects of physical violence. *Photo: Lintle Ramatla*

For men, 48.4% of injured survivors sought medical care, a strikingly similar rate, suggesting that the barriers to post-injury help-seeking operate comparably across genders in Lesotho. Addressing these barriers through integrated, de-stigmatised entry points at the primary care level holds the potential to lift help-seeking rates for women and men alike.

Among those who did seek medical care, 82.8% of women disclosed the cause of their injuries to the health provider, a figure notably higher than the general culture of silence around GBV documented in Chapter 3 might predict. This is an encouraging finding: when injured GBV survivors reach the health system, the majority are willing to disclose the cause when the clinical environment allows. The primary barrier is therefore reaching the health system, not disclosing once there, a pattern that directly supports investment in facility-level GBV clinical inquiry and enabling clinical environments

[190] Campbell, J.C. et al. (2002), 'Health consequences of intimate partner violence,' The Lancet, 359(9314), 1331-1336; Johnson, M.P. (2008), A Typology of Domestic Violence. Boston: Northeastern University Press.
[191] Ministry of Health [Lesotho] and ICF (2024), op. cit. Figure 19.3 and Table 19.19.
[192] Millennium Challenge Account Lesotho (2024), Directory of GBV Services Providers: Hospitals and Health Centres Across 10 Districts. Maseru: MCA. GPS coordinates and service listings for every facility.

5.3 Physical effects, productivity and activity loss

Physical injury from GBV generates economic costs directly through medical expenditure and indirectly through lost productivity, inability to work, and restricted mobility. The 2025 survey asked IPV survivors who had been physically injured about three forms of activity disruption. Being bedridden for at least one day, taking time off from work or usual activities, and avoiding leaving home. The survey captured the mean days lost alongside prevalence.

GBV generates functional impairment and, on some accounts, suicidal ideation. Male survivors face the additional barrier that institutional responses frequently fail to recognise their experience as abuse:



"I reached a point of despair, even thinking of ending my life, but thinking about my children kept me alive. They are the reasons I did not take such a drastic step. The police dismiss my complaints, saying men are not abused, but I know this is abuse because it affects the children most of all."

Leribe Participant 1

Table 5.2: Days lost due to violence among physically injured survivors

Impact	Women %	Mean days (women)	Men %	Mean days (men)
Stayed in bed for at least one day	**56.4**	**6.5**	56.1	**23.0**
Took time off work or usual activities	23.9	9.3	**45.1**	**22.2**
Avoided leaving home	**51.1**	8.5	30.7	7.0

Note: Denominator: Physically injured survivors (N=140 women; N=36 men). Mean days calculated among those reporting each impact. Men's figures have very wide CIs reflecting N=36.
Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

The productivity data shows both the breadth and depth of GBV's physical impact. More than half of physically injured women (56.4%) spent at least one day bedridden because of their injuries, with an average of 6.5 days, indicating that, when injury occurs, it is often severe enough to incapacitate the survivor. The 2013 baseline recorded 68% bedridden, pointing to some reduction, though the differing denominators caution against direct comparison.

More than half of injured women (51.1%) avoided leaving home for an average of 8.5 days, reflecting both physical incapacity from injury and the psychological dimension of fear-based spatial restriction. Confinement to the home, whether through injury or fear, has direct consequences for women's access to markets, health facilities, schools (for children in their care), and social support networks, compounding the harm beyond the immediate physical impact.

The gender comparison on productivity loss produces an unexpected finding for the time off work category: 45.1% of injured men took time off from work or usual activities, compared with 23.9% of women. Men's mean days off work (22.2) also substantially exceed women's (9.3 days). The very small male sub-sample (N=36) counsels caution, but the directional finding merits analytical attention. It may reflect the types of work men typically perform, manual, physically demanding labour where injury-related incapacity is more immediately disabling, or the severity gradient of men's injuries relative to their lower overall injury rate.

Men's bedridden rates (56.1%, mean 23.0 days) broadly match women's prevalence but substantially exceed it in mean duration. Again, the pattern is consistent with more severe individual injury episodes among men who are injured.

The economic implications of these productivity losses are significant. Nearly a quarter of women who sustained injuries lost close to ten working days on average. In Lesotho's informal economy, where many women are self-employed, piece-rate workers, or engaged in subsistence agriculture, each day of incapacity represents direct income loss with no sick pay, no social protection, and no substitution. The 2013 baseline found that 31 of 45 surveyed injured women incurred out-of-pocket expenses after physical abuse, covering transport and court fees. This represents a substantial macroeconomic burden, a burden the Commonwealth Secretariat has now quantified (see Section 5.8.4).

65.8% of women and 60.2% of men IPV survivors meet the CES-D threshold for clinically significant depression risk - a mental health crisis invisible to the health system

5.4 Mental health effects: Depression and PTSD across all five GBV groups

The 2025 study's most analytically significant methodological advance in the effects domain is the measurement of mental health outcomes using validated clinical instruments across all five GBV role groups: women survivors, women perpetrators, men survivors, men perpetrators, and those with no GBV involvement. This five-group design moves the analysis beyond the simple survivor-versus-non-survivor comparison of the 2013 baseline. It allows the chapter to ask a question rarely addressed in the sub-Saharan African GBV literature: **what is the mental health burden of perpetration itself?**

Table 5.3: Mental health outcomes by GBV role - CES-D and PCL-5, 2025

Mental health measure	Women survivors	Men perpetrators	Men survivors	Women perpetrators	Neither (baseline)	p-value
Depression (CES-D 0-60; cutoff ≥16)						
CES-D mean score	**21.36**	18.07	19.33	17.89	15.61	p<0.001
Depression risk % (CES-D ≥16)	**65.8**	**56.1**	**60.2**	**50.0**	**41.5**	-
PTSD (PCL-5 0-80; cutoff ≥33)						
PCL-5 mean score	**20.79**	18.19	20.26	19.13	14.34	-
Probable PTSD % (PCL-5 ≥33)	**25.8**	**13.4**	**23.2**	**24.0**	**14.0**	-
Sample sizes (unweighted N)						
N (CES-D model)	1,025	159	394	98	2,483	-
N (PCL-5 model)	1,035	173	416	98	2,532	-

Note: CES-D = Centre for Epidemiologic Studies Depression Scale (0-60; cutoff ≥16 = depression risk). PCL-5 = PTSD Checklist for DSM-5 (0-80; cutoff ≥33 = probable PTSD). Groups: survivors = any lifetime IPV experience; perpetrators = any lifetime IPV perpetration (may overlap with survivors in bidirectional cases); neither = no IPV experience or perpetration.

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

5.4.1 The depression burden among survivors

Table 5.3 reveals a mental health burden of striking proportions. Among women IPV survivors, **65.8% meet the CES-D threshold for clinically significant depression risk**, compared with 41.5% of those with no GBV involvement, a gap of 24.3 percentage points. The mean CES-D score among women survivors (21.36) sits substantially above the clinical cutoff of 16, indicating that the average survivor carries a meaningful depressive symptom burden rather than merely approaching the threshold. The 2013 baseline found 43% of all women and 46% of IPV survivors reporting depressive symptoms using a symptom checklist. The 2025 figure of 65.8% using the validated CES-D reflects both improved measurement sensitivity and a genuine high mental health burden that the system can now detect and plan around.

Among **men who experienced IPV, 60.2% meet the depression threshold** (CI: 54.6-65.8%), a figure almost as high as that of women survivors and dramatically higher than that of either group (41.5%). This is one of the most important findings in this chapter: men who survive IPV in Lesotho carry a mental health burden comparable in magnitude to women survivors, yet men are substantially less likely to disclose their victimisation, seek help, or be targeted by GBV mental health services. The 2013 baseline did not measure men's depression in relation to their IPV experience. The 2025 data make this gap visible and, therefore, addressable.

Repeated sexual violence against a child can trigger severe mental health deterioration requiring inpatient psychiatric care. This account from Berea documents the full GBV-to-psychiatric-admission pipeline:



"Lebo's condition worsened, with her mental state becoming increasingly unstable. The repeated abuse and community stigma left the family heartbroken. Some villagers blamed the child herself, saying she brought shame to the community. Her parents felt isolated and considered leaving the village altogether."

Mamokethi, Lebo's* mother*

5.4.2 The perpetrator burden, a new analytical dimension

Perhaps the most analytically novel finding in this chapter is that IPV perpetration is also associated with elevated depression risk, and the effect is larger for men perpetrators than for men survivors in some models. Among women perpetrators, 50.0% meet the depression threshold, 8.5 percentage points above the baseline. Among men perpetrators, 56.1% meet the threshold, 14.6 percentage points above baseline. The adjusted regression models (Section 5.7) confirm that this association survives full statistical control: men who perpetrate IPV have adjusted odds of depression (OR 2.07) that exceed the odds for men who are survivors (OR 1.87), a striking reversal of the expected hierarchy.

The regression model finds that male perpetrators of IPV carry an OR of 2.07 for depression, and depression is also a documented effect for male survivors. This account illustrates the emotional collapse that can follow discovering a partner's infidelity and experiencing abandonment:



"After discovering the cheating and experiencing separation, I went into depression. I am no longer as active as I used to be. There was a time when I was energetic, social, and hopeful. Now I often feel withdrawn and tired emotionally. I am surviving, but it has not been easy."

Mofokeng, Thaba-Tseka*

This finding requires careful analytical framing. It does not diminish the responsibility of perpetrators for the violence they commit, nor does it exonerate GBV perpetration. The primary moral and legal obligation remains to end the violence and protect survivors. What it does establish is that perpetration in Lesotho is associated with significant psychological distress for the perpetrators themselves, distress that likely reflects the social, relational, and psychological costs of abusive behaviour: guilt, shame, relationship breakdown, fear of legal consequence, and unresolved trauma (as established in Chapter 4, where ACEs are the dominant predictor of perpetration).

Recognising this burden has practical prevention implications: perpetrators experiencing mental health distress may be more reachable for therapeutic intervention when appropriate pathways exist, and addressing their distress without excusing their behaviour may be a more effective route to stopping re-offending than punitive approaches alone.[193]

5.4.3 PTSD burden

For probable PTSD, the patterns diverge importantly from depression. Women survivors report the highest probable PTSD prevalence (25.8%), with men survivors close behind at 23.2%, again establishing that men's PTSD burden from GBV exposure is substantial. Women perpetrators also show elevated probable PTSD (24.0%), nearly as high as women survivors, consistent with research showing that women who perpetrate IPV typically do so within relationships where they are also experiencing victimisation, a pattern variously described as violent resistance,[194] or situational couple violence.[195]

PTSD symptoms compound when justice is delayed. The conviction collapse documented in Chapter 6, from 74 convictions in 2021 to 1 in 2024, means many survivors remain in Mamotlatsi's position: still waiting, still traumatised, still living in the same community as the perpetrator:



"She explains that she still feels deeply traumatised and cries often. The case is still pending, and she is waiting for the court date. She faces hostility in the community, where some people side with the perpetrator and spread rumours that she might have been in a relationship with him."

Mamotlatsi, Leribe*

[193] Murphy, C.M. & Eckhardt, C.I. (2005), Treating the Abusive Partner: An Individualised Cognitive-Behavioural Approach. New York: Guilford Press; Smedslund, G. et al. (2011), 'Cognitive behavioural therapy for men who physically abuse their female partner,' Cochrane Database of Systematic Reviews, Issue 2.
[194] Swan, S.C., Gambone, L.J., Caldwell, J.E., Sullivan, T.P. & Snow, D.L. (2008). "A review of research on women's use of violence with male intimate partners." Violence and Victims, 23(3), 301-314.
[195] Johnson, M.P. (2008). A Typology of Domestic Violence: Intimate Terrorism, Violent Resistance, and Situational Couple Violence. Northeastern University Press.

Men perpetrators show a different PTSD profile. Their probable PTSD prevalence (13.4%) sits very close to the baseline (14.0%), suggesting that, for men, perpetrating IPV is not independently associated with elevated PTSD symptoms in the way it is with depression. This divergence between the depression and PTSD profiles for male perpetrators is analytically significant and is confirmed in the regression models (Section 5.7). Perpetration is a significant predictor of men's depression (OR 2.07) but not PTSD (OR 1.02). The survey data do not fully resolve the mechanisms underlying this pattern. Still, they are consistent with evidence that depression and PTSD have partially distinct antecedents, with PTSD being more strongly triggered by direct exposure to traumatic threats (as a survivor) than by the act of perpetrating violence.[196]



"My life has never been the same since then. I no longer feel safe going out, I fear men, and I have become antisocial. Throughout everything, my brother has been my only support system. He has been my counsellor, and I never felt comfortable talking to anyone else. I was supposed to graduate last September, but I did not attend the ceremony because I was not emotionally okay. I only went later to collect my certificate. The last time I checked, the man was still under arrest. I did not withdraw the charges, but I am not sure whether he is still in custody or has been released. My wish is for the courts to deliver justice to victims of abuse. Justice would help reduce the prevalence of abuse and restore the dignity, safety, and hope of survivors."

Thaba-Tseka Participant 5

The Chapter 5 regression finds that women survivors face an OR of 1.36 for depression and an OR of 1.78 for PTSD. This survivor names the PTSD symptoms the chapter quantifies: avoidance of public spaces, hypervigilance around men, social withdrawal, and functional impairment severe enough to prevent attending her own graduation. The graduation she missed is the most specific illustration of GBV's cost to educational attainment in the Lesotho qualitative record.

5.5 Mental health effects by type of IPV

Not all forms of IPV carry equal mental health consequences

Not all forms of IPV carry equal mental health consequences. The 2025 study examines CES-D and PCL-5 scores separately for survivors of physical, sexual, and emotional IPV, allowing an assessment of which forms of violence generate the highest psychological burden. Table 5.4 presents mean scores for survivors versus non-exposed respondents for each IPV type, for both women and men.

[196] Brewin, C.R. et al. (2000), 'Meta-analysis of risk factors for posttraumatic stress disorder in trauma-exposed adults,' Journal of Consulting and Clinical Psychology, 68(5), 748-766.

Table 5.4: Mental health outcomes by IPV type - survivors vs non-exposed

IPV type and outcome	Women survivors	Women non-exp	p-value	Men survivors	Men non-exp	p-value
Physical IPV						
CES-D mean score	**22.77**	17.69	p<0.001	**22.33**	14.92	p<0.001
PCL-5 mean score	**22.37**	16.97	p<0.001	**23.50**	13.81	p<0.001
Sexual IPV						
CES-D mean score	**25.04**	18.33	p<0.001	21.33	15.28	p=0.001
PCL-5 mean score	**23.58**	17.81	p<0.001	**23.80**	14.24	p=0.002
Emotional IPV						
CES-D mean score	21.93	17.73	p<0.001	19.14	14.49	p<0.001
PCL-5 mean score	22.12	16.70	p<0.001	21.17	12.79	p<0.001

Note: Means compared between survivors and non-exposed using survey-weighted regression (all p<0.05). All differences between survivors and non-exposed are statistically significant across all three IPV types and both genders.

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

Table 5.4 shows that every form of IPV, physical, sexual, and emotional, is associated with significantly elevated CES-D and PCL-5 scores relative to non-exposed respondents, for both women and men. This universality of mental health harm across IPV types carries an important programmatic implication. No form of IPV can be dismissed as psychologically benign, and any GBV clinical inquiry definition that focuses exclusively on physical violence will miss the mental health burden generated by sexual and emotional abuse.

For women, **sexual IPV generates the highest depression burden** (CES-D mean 25.04), notably higher than physical (22.77) or emotional (21.93) IPV. The sexual violation of bodily autonomy within an intimate partnership, particularly in a context where marital rape has historically been socially minimised, appears to generate a uniquely severe depressive burden. The 2013 baseline showed a similar pattern: 55% of lifetime rape survivors had depressive symptoms compared with lower rates for other IPV types. Strengthened recognition of marital rape and coercive sexual violence in the post-2013 legal framework offers a foundation for redress that the service system can now build on.

For men, **physical and sexual IPV produce the highest PTSD burden** (PCL-5 means 23.50 and 23.80, respectively), with a notably wide gap between survivors and non-exposed men for physical IPV: a 9.7-point difference (22.33 survivors vs 13.81 non-exposed), and a 9.6-point gap for sexual IPV (23.80 vs 14.24). The magnitude of these PTSD gaps for men is comparable to that for women, further reinforcing that men's GBV-associated mental health burden deserves equivalent clinical attention. Emotional IPV, while also significantly associated with elevated PCL-5 scores for men (21.17 vs 12.79; +8.4 points), appears to generate somewhat lower PTSD symptom burden than physical or sexual IPV, consistent with international evidence that PTSD symptom profiles respond most strongly to events involving direct physical threat.



Rethabile Liphola holding a discussion amongst youth of Good Shepard Centre for teenage mothers based at Sehlabeng sa Thuathe, 13 February 2026.

Photo by Matseliso Lepheane

5.6 Mental health and adverse childhood experiences

Chapter 4 established that adverse childhood experiences are the dominant independent predictor of adult IPV involvement in Lesotho. Chapter 5 establishes a complementary finding that ACEs are also directly associated with adult mental health outcomes, independently of and additively to their effects through adult GBV exposure. Table 5.5 presents CES-D and PCL-5 scores by ACE dose category, showing a clear dose-response relationship for both depression and PTSD across both genders.

Table 5.5: Mental health outcomes by adverse childhood experience dose

ACE category	Women	Women's CES-D mean	Women PCL-5 mean	Men N	Men's CES-D mean	Men PCL-5 mean
No ACEs (0)	523	17.31	16.99	337	14.48	9.08
1 ACE	629	17.03	16.22	383	13.77	12.51
2-3 ACEs	1,014	19.79	18.31	655	15.48	16.13
4+ ACEs	**379**	**21.65**	**21.83**	**239**	**18.86**	**20.90**
Test for trend (p-value)	-	p<0.001	p<0.001	-	-	-

Note: Denominator: All respondents with a valid ACE score. CES-D cutoff ≥16 = depression risk; PCL-5 cutoff ≥33 = probable PTSD. Test for trend: survey-weighted linear regression of score on ACE category (p<0.001 for women's CES-D and PCL-5).

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

For men, the ACE-mental health gradient is even more striking for PTSD. Men's PCL-5 scores rise from 9.08 (no ACEs) to 20.90 (4+ ACEs), more than doubling the mean PTSD symptom burden. Men with no ACEs score well below the clinical threshold (33), whereas men with 4+ ACEs approach the lower range of clinical concern. For men, therefore, childhood adversity acts as a particularly powerful amplifier of PTSD risk, consistent with the regression model (Table 5.7), which finds ACE score a significant independent predictor of men's PTSD (OR 1.34 per ACE unit, p<0.001) but not women's (OR 1.07, p=0.185).

The ACE-mental health relationship documented in Tables 5.5 and 5.6 represents a compounding, not simply additive, burden. Adults in Lesotho who experienced childhood adversity (80.3% of women, 77.7% of men) carry that psychological load into adulthood. Those who then experience adult GBV, whether as survivors or perpetrators, face a second layer of traumatisation acting on already-compromised psychological foundations. The regression models (Section 5.7) show that both ACE burden and adult GBV involvement contribute independently to mental health risk, meaning that survivors with high ACE scores face a double jeopardy of childhood and adult trauma. ACE-informed service design, now widely codified in international practice, offers the Lesotho mental health system a clear, evidence-based template for responding to this compounding burden.

adverse childhood experiences are the dominant independent predictor of adult IPV involvement in Lesotho

5.7 Multivariate analysis: independent predictors of depression and PTSD

Tables 5.6 and 5.7 present survey-weighted logistic regression models for depression risk (CES-D ≥16) and probable PTSD (PCL-5 ≥33), respectively. Each model includes IPV survivor status, IPV perpetrator status, and ACE score as simultaneous predictors, allowing the independent contribution of each to be estimated with the others controlled. The study runs the models separately for women and men.

Table 5.6: Independent risk factors for depression (CES-D ≥16) - adjusted odds ratios

Risk factor	Women OR	95% CI	p-value	Men OR	95% CI	p-value	Interpretation
IPV survivor (any lifetime IPV experience)	**1.65**	1.28-2.13	p<0.001	**1.87**	1.33-2.64	p<0.001	Significant for both genders
IPV perpetrator (any lifetime perpetration)	**1.36**	1.03-1.80	p=0.032	**2.07**	1.49-2.88	p<0.001	Men's perpetrator OR >survivor OR
ACE score (per 1-unit increase)	**1.19**	1.10-1.28	p<0.001	**1.24**	1.12-1.36	p<0.001	Each additional ACE raises odds by 19-24%

Note: Survey-weighted logistic regression. Depression = CES-D ≥16. The model includes IPV survivor, IPV perpetrator, and ACE score simultaneously (adjusted estimates). OR>1 = higher odds of depression. *Source: Lesotho GBV 2025 Prevalence Survey, Gender Links*

Table 5.7: Independent risk factors for probable PTSD (PCL-5 ≥33) - adjusted odds ratios

Risk factor	Women OR	95% CI	p-value	Men OR	95% CI	p-value	Interpretation
IPV survivor (any lifetime IPV experience)	**1.43**	1.02-2.02	p=0.039	**2.34**	1.52-3.60	p<0.001	Men's OR is much larger than women's
IPV perpetrator (any lifetime perpetration)	**1.51**	1.10-2.06	p=0.010	1.02	0.63-1.67	p<0.001	Significant women, not men
ACE score (per 1-unit increase)	1.07	0.97-1.19	p=0.185	**1.34**	1.17-1.54	p<0.001	Significant for men: each ACE +34%

Note: Survey-weighted logistic regression. Probable PTSD = PCL-5 ≥33. The model includes IPV survivor, IPV perpetrator, and ACE score simultaneously. Bold = statistically significant at p<0.05. *Source: Lesotho GBV 2025 Prevalence Survey, Gender Links*

5.7.1 Depression

For depression, both survivor status and perpetrator status are independently associated with elevated risk for both genders. Among women, being an IPV survivor is associated with 65% higher odds of depression (OR 1.65; CI: 1.28-2.13; p<0.001) and being a perpetrator with 36% higher odds (OR 1.36; CI: 1.03-1.80; p=0.032). For men, the pattern is even more pronounced: male survivors have OR 1.87 (CI: 1.33-2.64; p<0.001) for depression, and male perpetrators have OR 2.07 (p<0.001), the largest single predictor in the depression model for men. Each additional ACE domain contributes independently: OR 1.19 per unit for women and OR 1.24 for men, meaning that a person with 4 ACEs faces approximately 1.19 = 2.01 times higher odds of depression from ACEs alone[197], compounded by any adult GBV involvement.

[197] Implies that each additional ACE increases the probability of clinically significant depression by approximately 19%, meaning that a person with four ACEs faces roughly double the risk of someone with none

The finding that male perpetrators carry higher adjusted odds of depression than male survivors is clinically and theoretically significant. It aligns with evidence from related literature, including research on combat veterans, perpetrators of domestic homicide, and perpetrators in court-mandated treatment programmes, showing that the psychological consequences of perpetrating serious violence can be as severe as, or more severe than, experiencing it.[198] For men in Lesotho, where social norms restrict emotional disclosure and help-seeking, the mental health distress of perpetration is likely to remain unaddressed without deliberate service design. This creates a cycle in which unresolved psychological burden raises the probability of continued perpetration. Integrating male perpetrator-oriented mental health and behaviour-change pathways into the national GBV response is therefore a concrete next step open to the Ministry of Health, the Ministry of Gender, and civil society partners.

The association between depression and IPV is independently confirmed by the DHS 2023-24 analysis. Nakie et al[199](2025) report that depressive symptoms are significantly associated with IPV experience among women (AOR 1.55, 95% CI 1.04-2.30). While the DHS analysis measures the association cross-sectionally and cannot establish directionality, the present study's CES-D data showing 65.8% of women IPV survivors meeting the clinical depression threshold, combined with the multivariate finding that depression is independently predicted by IPV experience, suggests a bidirectional relationship in which violence and depression mutually reinforce each other. This convergence across two independent datasets underscores the urgency of integrating mental health clinical inquiry into the GBV response pathway.

5.7.2 PTSD shows diverging patterns for women and men

The PTSD regression models tell a strikingly different story from the depression models. For women, both survivor (OR 1.43; p=0.039) and perpetrator status (OR 1.51; p=0.010) significantly predict PTSD, but ACEs do not (OR 1.07; p=0.185). For men, **the survivor effect is much larger (OR 2.34; p<0.001)**, that is, men who experience IPV have more than double the odds of probable PTSD, but perpetrator status is non-significant (OR 1.02; p=0.923). ACEs, by contrast, significantly predict men's PTSD (OR 1.34; p<0.001), each additional ACE raising odds by 34%.

This divergence suggests that PTSD in men is driven primarily by their own direct victimisation and the cumulative neurological impact of childhood adversity, rather than by their perpetration of violence. Women's PTSD risk, by contrast, is elevated by both survival and perpetration, consistent with the finding that women who perpetrate IPV are predominantly doing so within abusive relationships where they are also victims[200] (the mutual violence group), and where perpetration and victimisation are jointly traumatic experiences. Women's PTSD risk from ACEs, though directionally positive, does not retain significance in the adjusted model, suggesting that for women, adult GBV experience is the more proximate PTSD trigger, with ACEs operating through their effects on adult GBV risk rather than directly on PTSD outcomes.

[198] MacManus, D. et al. (2012), 'Aggressive and violent behavior among military personnel deployed to Iraq and Afghanistan: Prevalence and link with deployment and combat exposure,' Epidemiologic Reviews, 35(1), 26-39; Currier, J.M. et al. (2019), 'Moral injury and health-related quality of life among veterans,' Psychological Trauma, 11(2), 159-168.
[199] Nakie, G., Tadesse, G., Fentahun, S., Rtbey, G., Andualem, F., Kibralew, G., Kelebie, M., Melkam, M., Kassa, M.A., Mengistie, B.A., Alemayehu, T.T., Yigezu, M., Segon, T., Wassie, Y.A. and Tinsae, T. (2025) 'Multilevel Analysis of Intimate Partner Violence and Associated Factors Among Reproductive-Age Women: Lesotho Demographic and Health Survey 2023 to 2024 Data', Journal of Interpersonal Violence, p. 08862605251368842. Available at: https://doi.org/10.1177/08862605251368842.
[200] Johnson, M.P. (2008). A Typology of Domestic Violence: Intimate Terrorism, Violent Resistance, and Situational Couple Violence. Northeastern University Press.

5.8 Broader effects: sexual and reproductive health, HIV, and economic costs

The 2025 survey administered a sexual health and behaviours module (Section 17 of both questionnaires) that included STI diagnosis and symptom history, HIV testing and self-reported status, condom use patterns, and contraception. It also captured out-of-pocket medical expenditure items (Section 12) for survivors who sought medical care following violence. This section presents the 2025 cross-tabulations of these indicators by IPV status, supplemented by contextual evidence from the 2013 baseline, the DHS 2023-24, the UNAIDS 2023 country factsheet, and the Commonwealth Secretariat 2020 economic costing.

5.8.1 Sexually transmitted infections

The biological pathways linking GBV to sexually transmitted infections are well established: forced or coerced sex increases transmission risk through genital trauma, inability to negotiate condom use, and exposure to partners with multiple concurrent relationships (WHO, 2013). The 2025 survey, for the first time in the GL-Lesotho series, enables direct cross-tabulation of STI diagnosis and symptom history against IPV status for both women and men, moving beyond the 2013 baseline's reliance on women-only data.

Table 5.8: STI diagnosis and symptoms by IPV status

Indicator	Women No IPV %	Women IPV %	p-value (W)	Men No IPV %	Men IPV %	p-value (M)	N
Ever diagnosed with an STI	9.4	16.0	<0.001	13.1	28.5	<0.001	3825
Symptom: unusual discharge	15.8	27.8	<0.001	17.4	32.8	<0.001	3825
Symptom: pain during urination	27.5	42.0	<0.001	26.4	50.3	<0.001	3825
Symptom: genital ulcer/sore	27.1	37.6	<0.001	22.4	41.2	<0.001	3825

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

STI diagnosis is significantly and substantially elevated among IPV survivors of both genders. Among women, 16.0% of those with lifetime IPV experience have been diagnosed with an STI, compared with 9.4% of women without IPV experience (p<0.001). Among men, the gap is even wider: 28.5% of IPV-experienced men report an STI diagnosis versus 13.1% of non-IPV men (p<0.001), more than double the rate. All three STI symptom indicators confirm this pattern. Pain during urination, the most prevalent symptom, is reported by 42.0% of women with IPV experience versus 27.5% without (p<0.001), and by 50.3% of IPV-experienced men versus 26.4% without (p<0.001). Genital ulcers show a similar gradient: 37.6% versus 27.1% for women, and 41.2% versus 22.4% for men (both p<0.001). These findings are consistent with the 2013 baseline, which found 23.3% of non-partner rape survivors reported an STI diagnosis compared with 10.3% of those never raped (p<0.001), and confirm the documented mechanisms linking GBV to STI risk, that is, inability to negotiate condom use, coerced unprotected sex, and physical trauma that facilitates transmission.[201]

[201] Meel, B.L. (2005), 'Incidence of HIV in relation to rape in the Transkei Region of South Africa,' Journal of Clinical Forensic Medicine, 12(1), 6-10; WHO (2013), op. cit.

5.8.2 HIV and violence

Lesotho's HIV burden remains among the highest in the world. UNAIDS (2023) estimates adult HIV prevalence at approximately 20.3% (aged 15-49), with women disproportionately affected.

Table 5.9: HIV testing and self-reported status by IPV status

Indicator	Women No IPV %	Women IPV %	p-value (W)	Men No IPV %	Men IPV %	p-value (M)	N
Ever tested for HIV	92.2	95.2	0.305	90.0	89.5	0.929	3787
Self-reported HIV positive (among those disclosing the result)	38.1	48.6	0.045	13.8	14.4	1.000	1218

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

The 2025 survey data on self-reported HIV status reveal a significant association between IPV and HIV for women. Among women who disclosed their last test result, 48.6% of those with IPV experience tested positive compared with 38.1% of those without IPV experience (p=0.045). For men, HIV status does not differ significantly by IPV experience (14.4% vs 13.8%, p=1.00).

The 2013 baseline found 16% of women in the sample HIV-positive, rising to 18% among IPV survivors and 31% among non-partner rape survivors. The 2025 data, while based on self-reported results rather than biomarker testing, confirm that the GBV-HIV nexus persists a decade later. The biological, behavioural, and social pathways linking GBV to HIV are well established: sexual violence directly facilitates transmission through genital trauma and non-use of condoms; coercive relationship power dynamics prevent women from negotiating condom use with seropositive partners; and the fear and control dimensions of IPV restrict women's access to HIV testing, treatment, and prevention services.[202] The higher absolute HIV prevalence in the 2025 self-reported data (48.6% among IPV survivors) compared with 2013 reflects both the maturation of the epidemic and possible selection effects in who discloses test results.

HIV testing rates are near-universal among women regardless of IPV status (95.2% IPV vs 92.2% no IPV, p=0.305), reflecting Lesotho's strong ANC-based testing programme. Men's testing rates are also high and do not differ by IPV status (89.5% vs 90.0%, p=0.929). The policy implication is that the bottleneck in the GBV-HIV response is not testing access, but what happens after a positive result, particularly for women in abusive relationships where the fear and control dimensions of IPV restrict access to treatment and prevention services. The 2025 data on non-disclosure (Chapter 6, Section 6.7) show that 24% of women who did not disclose the cause of their injury to a health provider cited partner-surveillance fear, confirming this pathway.

The DHS 2023-24 adds a new dimension to the GBV-HIV linkage by measuring violence during pregnancy. The DHS records that 6% of women experienced physical violence during pregnancy. This finding closely matches the GL survey's 6.5%, and that anchors the maternal-and-child-health case for integrated GBV clinical inquiry in antenatal care.[203] Violence during pregnancy increases the risk of miscarriage, stillbirth, low birth weight, and maternal depression; in Lesotho's high-HIV-prevalence context, it also raises the risk of vertical HIV transmission where the pregnant

[202] Jewkes, R. et al. (2010), 'Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa,' The Lancet, 376(9734), 41-48; UNAIDS (2023), Country Factsheet: Lesotho. Geneva: UNAIDS.
[203] Ministry of Health [Lesotho] and ICF (2024), op. cit. Table 19.3.

woman's antenatal attendance is disrupted by violence. The ante- and post-natal service platforms, already the most universally accessed health touchpoints for women of reproductive age, are the natural locus for GBV clinical inquiry, referral, and support, and the matched GL/DHS evidence now makes this integration a concrete programming target. The GBV-HIV nexus operates through direct pathways (sexual coercion, forced unprotected sex) and indirect pathways (a partner's infidelity resulting in HIV transmission to the household). This account from Maseru documents the indirect pathway:



"Medical tests revealed that he was HIV positive, and it was clear that he had contracted the infection from the deceased woman. This marked the beginning of a painful journey, as the illness spread within our household. He would frequently threaten me with violence, sometimes even pointing a gun at me. On several occasions, I had to run to neighbours for help, and once the police and military had to intervene to confiscate his weapon."

Maseru Participant 5

The integration of GBV and HIV programming, already identified as a priority in the 2013 report, remains as urgent in 2025, and the expanded national HIV platform offers a ready delivery system for combined GBV-HIV clinical inquiry and support.

The Ministry of Health identified a critical service gap affecting sexual assault survivors who become pregnant. Termination of pregnancy requires a court order, a process that introduces delays incompatible with medical timelines. By the time survivors navigate the legal requirements, they have frequently passed the permissible gestational limit, effectively forcing births resulting from sexual violence. This procedural barrier transforms a reproductive health service into an access-to-justice problem, compounding the trauma documented above.

5.8.3 Condom use and reproductive autonomy

Condom use patterns provide a direct indicator of the intersection between GBV and HIV/STI transmission risk.

Table 5.10: Condom use and contraception by IPV status

Indicator	Women No IPV %	Women IPV %	p-value (W)	Men No IPV %	Men IPV %	p-value (M)	N
Condom use: Never	63.8	66.0	0.023	34.9	33.6	0.474	3825
Condom use: Always	9.8	8.6	0.015	34.2	24.8	0.010	3825
Currently using contraception	39.9	40.0	0.778	50.2	57.1	0.113	3824
Agrees that PEP should be available	46.4	54.2	0.001	55.7	63.0	<0.001	3826

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

The integration of GBV and HIV programming, already identified as a priority in the 2013 report, remains as urgent in 2025, and the expanded national HIV platform offers a ready delivery system for combined GBV-HIV clinical inquiry and support.

The Ministry of Health identified a critical service gap affecting sexual assault survivors who become pregnant. Termination of pregnancy requires a court order, a process that introduces delays incompatible with medical timelines. By the time survivors navigate the legal require-

ments, they have frequently passed the permissible gestational limit, effectively forcing births resulting from sexual violence. This procedural barrier transforms a reproductive health service into an access-to-justice problem, compounding the trauma documented above.

5.8.4 Economic costs

The economic costs of GBV fall on individuals, households, and the national economy. At the individual level, the 2025 productivity-loss data (Table 5.2) show that physically injured survivors lose an average of 6.5 to 23 days of productivity depending on gender and activity type, losses concentrated among populations that cannot afford income interruption. At the household level, GBV generates direct out-of-pocket costs (medical care, transport to police or courts) that compete with essential expenditure on food, school fees, and household maintenance. The 2013 baseline found that 45 injured women reported out-of-pocket expenses after physical IPV, with transport and court fees as the primary cost categories.

The permanent physical and psychological effects of lifetime GBV can include permanent disability, mental breakdown, and substance use as a coping mechanism. Keresia carries all three, and the permanence of her injuries illustrates the irreversibility of GBV's corporeal costs:

GBV costs Lesotho between 1.33% and 5.55% of GDP. The fiscal case for prevention is sound macroeconomic policy, not only human rights



"The reason I do not have teeth today is because of the violence I suffered at his hands. He damaged my mouth during one of the beatings. At one point in my life, I lost my mind. The abuse, trauma, and stress became too much. I was not mentally stable. During that time, I started drinking heavily. I am still here. I have been beaten, abused, raped, judged, and abandoned, but I am still alive."

Keresia, Qacha's Nek*

At the macro level, the Commonwealth Secretariat's 2020 study[204] is the only comprehensive economic costing exercise yet completed for Lesotho. Drawing on 2017 data, the study estimates the total direct and indirect cost of VAWG at M462.9 million under the typical-case scenario (1.33% of 2017 GDP) and M1,926 million under the full-coverage scenario (5.55% of 2017 GDP).[205] Law-enforcement costs alone accounted for M100.1 million (0.29% of GDP). The High Court of Lesotho provided expert input confirming that VAWG is the major cause of divorce in the country, and the study estimated divorce costs attributable to VAWG at M15.9 million. A notable observation from the study, which reported health service costs were modest (M1.3 million) because of low health-service utilisation by survivors, reflects

[204] Commonwealth Secretariat's 2020 Economic Cost of Violence Against Women and Girls: A Study of Lesotho
[205] Commonwealth Secretariat (2020), The Economic Cost of Violence Against Women and Girls: A Study of Lesotho. London: Commonwealth Secretariat, pp. 59-61.

under-reporting rather than low incidence, and aligns directly with the 47.9% medical help-seeking rate documented in Section 5.2. The 2017 figures are conservative and are expected to be higher in the 2025 context as the population, prices, and service coverage have all expanded.

Table 5.11: Estimated annual economic cost of VAWG in Lesotho, by cost category

Cost category	Typical case (M)	% of GDP	Full coverage (M)	% of GDP
Direct cost: law enforcement	≈ 100.1	0.29%	-	-
Direct cost: health services*	≈ 1.3	<0.01%	-	-
Divorce costs are attributable to VAWG	≈ 15.9	0.05%	-	-
Other direct + indirect costs	≈ 345.6	~0.99%	-	-
Total estimated VAWG cost	**462.9**	**1.33%**	**1,926**	**5.55%**

Note: *Low health service cost reflects low utilisation (under-reporting), not low incidence. Typical-case scenario models observed service utilisation; full-coverage scenario models the cost under universal survivor contact with services. 2017 GDP baseline; 2025 figures expected to be higher.

Source: Commonwealth Secretariat (2020)

Applied to Lesotho's 2024 GDP of approximately USD 2.1 billion,[206] the 1.33%-5.55% range implies an annual GBV-related economic burden of USD 28-117 million, a cost Lesotho is already paying in the form of healthcare expenditure, criminal justice costs, lost labour productivity, divorce and household dissolution, and foregone human-capital development. Investing in GBV prevention, response, and support is therefore not a new cost to the fiscal system; it is a substitution of upstream prevention spending for existing downstream losses, with the potential to release a share of the M462.9m-M1,926m back to productive use. This macroeconomic framing transforms the investment case: expanding the GBV budget becomes a matter of sound fiscal policy alongside its human-rights and public-health justifications and gives the Ministry of Finance and Development partners a quantified argument for the coming budget cycles.

5.8.5 Out-of-pocket costs of GBV

Among the 176 IPV survivors who sought medical care following physical injury and reported expenditure data, the direct out-of-pocket costs are substantial.

Table 5.12: Out-of-pocket costs following violence-related injury (Maloti)

Cost Category	Mean (Maloti)	Median (Maloti)	N with costs	Range
Medication	M482	M100	104	M1 - M10000
Transport to the facility	M236	M90	94	M1 - M4000
Other services	M571	M200	23	M1 - M3000

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

Applied to Lesotho's 2024 GDP of approximately USD 2.1 billion,[206] the 1.33%-5.55% range implies an annual GBV-related economic burden of USD 28-117 million, a cost Lesotho is already paying in the form of healthcare expenditure, criminal justice costs, lost labour productivity, divorce and household dissolution, and foregone human-capital development. Investing

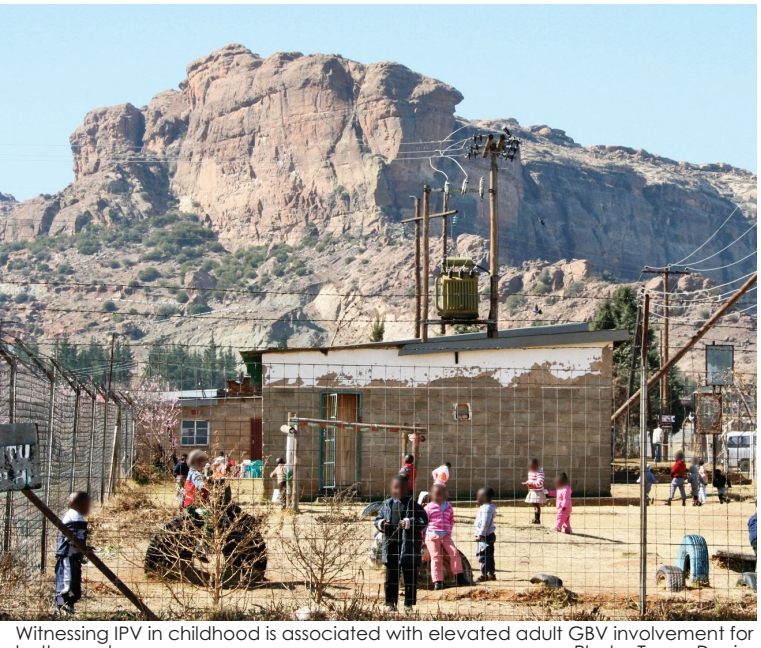
[206] World Bank (2024), Lesotho GDP Data. Washington: World Bank. GDP current USD estimate for Lesotho, 2024.

in GBV prevention, response, and support is therefore not a new cost to the fiscal system; it is a substitution of upstream prevention spending for existing downstream losses, with the potential to release a share of the M462.9m-M1,926m back to productive use. This macro-economic framing transforms the investment case: expanding the GBV budget becomes a matter of sound fiscal policy alongside its human-rights and public-health justifications and gives the Ministry of Finance and Development partners a quantified argument for the coming budget cycles.

5.8.6 Effects on women and girls with disabilities

The 2024 LNFOD Gender Analysis Study provides the first national evidence base on the differential effects of GBV on women and girls with disabilities. LNFOD reports that 74% of respondents identified women and girls with disabilities as the most affected by GBV, with sexual violence affecting 38% and emotional violence affecting 44% of people with disabilities in the sample. Economic dependence on caregivers, itself a product of accessibility gaps in education, employment, and mobility, emerges as the dominant driver pathway.[207] These findings align with the Chapter 4 regression finding that disability is an elevated independent risk factor for GBV, and they extend the picture on effects: survivors with disabilities carry the injury, mental-health, and economic burdens documented in this chapter, compounded by additional accessibility barriers to the very services that would otherwise mitigate those effects. Disability-inclusive service design, including accessible shelters, sign-language-enabled CGPU and health intake, and disability-sensitive ACE-informed mental health protocols, is an evidence-led next step that the service system, supported by LNFOD and disability-sector partners, can now take.

5.8.7 Intergenerational effects



Witnessing IPV in childhood is associated with elevated adult GBV involvement for both genders. *Photo: Trevor Davies*

Chapter 4 established that witnessing IPV in childhood is associated with elevated adult GBV involvement for both genders, and that the ACE dose-response for adult IPV is the strongest independent predictor in the Chapter 4 regression models. Table 5.5 in the present chapter establishes that ACEs also directly elevate the adult mental health burden.

Together, these findings define the intergenerational cycle of GBV in Lesotho. Adult GBV generates childhood trauma for the children who witness or experience it. That childhood trauma elevates their risk of both adult GBV involvement and adult mental health disorders. Additionally, those adults, now perpetrators or survivors, generate the next generation of traumatised children.

[207] Lesotho National Federation of Organisations of the Disabled (LANFOD) (2024), Gender Analysis Study. Maseru: LANFOD.

This intergenerational transmission pathway is not inevitable. It can be interrupted at multiple points through effective prevention and therapeutic intervention. The 2013 baseline's perpetrator narrative, the story of Tumelo, who witnessed his father's violence and became a serial rapist, illustrates the pathway qualitatively. The 2025 quantitative data documents it at the population scale. Breaking the cycle requires investing not only in adult GBV services but in early childhood development, ACE-informed parenting support, school-based counselling, and community-level programmes that specifically address the transmission of violence across generations. Lesotho's strong primary-school enrolment base and expanding early-childhood-development infrastructure place the country in a strong position to deliver these interventions at scale.

The scale of the mental health burden documented in this chapter raises a critical service capacity question. The CES-D and PCL-5 results identify a population-level need for psychosocial support that substantially exceeds Lesotho's documented service capacity. Psychiatric nurses, the primary cadre qualified to provide GBV-related mental health support, are based only at hospital level, and the psychosocial support sector mapped in Chapter 7 is small, Maseru-concentrated, and donor-dependent. The January 2025 disruption of major HIV-related donor support (including PEPFAR-funded platforms) poses an additional risk to the integrated HIV-GBV service delivery models that had begun to expand the reach of mental health support through community health worker networks. These capacity constraints mean that the depression and PTSD prevalence documented here translates into unmet need for the affected individuals.

Conclusion

Key conclusions from this chapter are that:

- **GBV has generated a measurable mental-health burden that the system can now address:** The use of validated clinical instruments (CES-D and PCL-5) in 2025 delivers a level of mental health analysis that was not possible from the 2013 symptom-counting approach. The findings are unambiguous: GBV in Lesotho is generating a substantial mental health burden. Two in three women IPV survivors and three in five men who experienced IPV meet the clinical threshold for depression risk, and approximately one in four women and men IPV survivors meet the threshold for probable PTSD. These are clinical-level disorders that, left untreated, worsen over time, impair parenting and economic functioning, and perpetuate the intergenerational cycle of trauma. These burdens are amplified for persons with disabilities, who face inaccessible services, and for LGBTQI+ persons, who face institutional exclusion from the formal support system.

  Lesotho's existing mental health infrastructure, the psychiatric service base documented in 2013 and the expanded primary-health-care platform since then give the country a foundation to build from. The 2025 findings make a concrete case for GBV-informed psychosocial support at the primary-health-care level, delivered by trained community health workers and counsellors rather than requiring specialist psychiatric referral in every case. The WHO Country Cooperation Strategy 2024-2027, which explicitly recognises interpersonal violence as a top-tier mortality driver, provides the policy frame in which this investment can move forward.
- **The bidirectional framework opens new doors for men, and provides the country with a solid foundation to build upon for perpetrator intervention:** The 2025 chapter's most significant methodological contribution is its five-group analysis of mental health outcomes, distinguishing survivors, perpetrators, and those with no GBV involvement for both

genders. Two findings demand a deliberate policy response. First, men who experience IPV carry a mental health burden that matches women survivors yet remain almost invisible in current GBV mental-health service provision, a gap the system can now close by explicitly including men in clinical inquiry, messaging, and support pathways. Second, IPV perpetration is independently associated with depression for both genders, and the effect is largest for men, establishing that perpetrators themselves carry a significant psychological burden associated with their violent behaviour. This finding opens a new therapeutic intervention space. That is, programmes that engage male perpetrators therapeutically, without compromising accountability and while centring survivor safety, may be a more effective route to ending violence than punitive approaches alone. The policy payoff is preventive, in that addressing perpetrator distress is a concrete route to reducing re-offending and therefore to reducing the next wave of survivor harm.

- **The ACE burden gives the system an evidence-based intervention template:** The connections between ACEs, adult GBV, and adult mental health outcomes form a coherent, empirically robust causal chain in the 2025 data. ACEs drive adult GBV (Chapter 4); adult GBV drives mental health disorders (Chapter 5); and childhood adversity also directly elevates adult mental health burden independently of adult GBV. Adults with 4+ ACEs face approximately 2x the depression risk from ACEs alone, compounded by the OR 1.65-2.07 from adult GBV involvement. For men with 4+ ACEs and GBV involvement, the total compounded odds of depression relative to a non-exposed, ACE-free man approach 4-fold. This compounding burden means GBV mental health services are most effective when they screen for and address childhood adversity alongside adult GBV, the internationally established ACE-informed service model, which the Ministry of Health, the Ministry of Gender, and civil society can now codify in Lesotho's own clinical and community service standards.
- **The health and economic case for GBV investment is now fully quantified:** Taken together, the physical injury data, the mental health burden, the STI and HIV transmission risk, the productivity losses, violence in pregnancy, and the intergenerational reproduction of violence constitute an unambiguous economic and public-health case for expanded GBV investment that reaches beyond its status as a human-rights obligation. The Commonwealth Secretariat's 2020 estimate of the annual macroeconomic burden of VAWG in Lesotho, to be M462.9 million (1.33% of GDP) under the typical-case scenario and M1,926 million (5.55% of GDP) under the full-coverage scenario, represents a cost the government and its development partners already pay, in healthcare expenditure, criminal justice costs, lost labour productivity, and foregone human-capital development.

Investing in GBV prevention, response, and support is therefore not a new cost to the fiscal system. It is a substitution of upstream prevention for existing downstream losses, with the potential to release a share of the M462.9m-M1,926m back to productive use. The Counter Domestic Violence Act 2022, the DHS 2023-24 national data platform, the MCA-documented national health-facility network, and the Commonwealth's macroeconomic framing together give the Lesotho government, the Ministry of Finance, and development partners evidence base strong enough to justify and direct an expanded investment. The case is made; what is now required is funding, the human resources, and the service infrastructure to implement it at scale, and in doing so, translate legal rights into lived protection.

CHAPTER 6
RESPONSE TO GBV



Gender Links, LMPS and the Ministry of Gender held a workshop to align Standard Operating Procedures for the newly launched Safe Spaces and review emerging GBV Indicators Follow-up Study evidence, January 2026, Sesotho Media and Development, Maseru. *Photo: SM&D*

Key findings

- Lesotho's GBV legal framework has expanded substantially since 2013: the Counter Domestic Violence Act 2022, ILO Convention 190 (ratified 2019), the Labour Act 2024, and the Legal Aid Clinics Guidelines (December 2025)
- Police reporting is 9.9% for women survivors and 7.5% for men, structurally unchanged from 2013.
- Medical disclosure is blocked by partner-surveillance fear (24.0% of non-disclosing women) and provider non-enquiry (10.3%).
- Disclosure patterns are consistent across two national datasets: the 2025 survey shows 6.2% of women and 4.3% of men told their family; the DHS 2023-24 shows 45% of women told no one, and 49% of help-seekers went first to their own family.
- Shelter utilisation is 1.0-1.3% of IPV survivors, driven by infrastructure scarcity rather than service quality.
- Legal awareness has improved but remains low: 57.3% know laws exist; 25.3% know protection orders exist; 22.6% know the Sexual Offences Act; 12.1% know the CDV Act.
- The Parliamentary Women's Caucus is the most active political voice on GBV in 2025, but 93% of ministerial statements contain no budget specificity.
- The Children's Court handles approximately 49 GBV criminal cases annually against ~1,400 civil cases;
- No CGPU office has sign language capacity or LGBTIQ+ inclusive standard operating procedures, structurally excluding persons with disabilities and LGBTQI+ persons from the justice system's entry point.

Silenced by the system



"The abuse began in 2011 with verbal insults and humiliation in front of my friends. At first it was not physical, but later he began to beat me. In early 2024, he assaulted me in a car and strangled me with a seatbelt. I reported the matter to the police, but the case was treated as a relationship issue rather than criminal violence. Even after seeking help from my family and the police, the abuse continued. In 2025, he threatened to kill me when I tried to collect my child. He later stabbed my hand, leaving my fingers impaired. Despite medical treatment and repeated police reports, authorities often dismissed my complaints as domestic disputes. I eventually filed for divorce, but he continued to threaten my life. I feel unsupported by the justice system."

Thandi, Butha-Buthe*

Thandi's experience spans the full arc of this chapter: laws that exist but are not enforced, police who treat domestic violence as a private matter, courts that process cases slowly while the abuse continues, and a survivor left to navigate a fragmented system alone. This chapter examines the response architecture, from international obligations and national legislation to police, medical, court, shelter, and political accountability, and measures the distance between what the law promises and what survivors receive.

Overview

This chapter assesses how Lesotho's formal institutions respond to gender-based violence from the survivor's perspective. It reviews the legal framework, examines police response through the Child and Gender Protection Unit, documents medical sector and court performance, and analyses survivor disclosure and help-seeking patterns. The chapter also covers shelter and support services, institutional GBV, legal knowledge, and the political discourse on gender-based violence. For each institution, it identifies what has improved since 2013, where gaps remain, and what investment is needed to translate legislative progress into consistently improved outcomes for survivors.

6.1 Introduction

The response to gender-based violence encompasses the full range of state and non-state actions that prevent violence before it occurs, protect survivors when it does occur, hold perpetrators accountable through the justice system, and provide recovery pathways for those affected. Effective GBV response is multi-sectoral; it spans the legal framework, law enforcement, the health system, the judiciary, social welfare services, civil society, and political leadership, and its quality is ultimately measured not in the laws enacted or institutions created, but in whether survivors can access safety, justice, and healing when they need it.

In 2013, the Lesotho GBV Indicators Study found "a consistent pattern of high policy priority and robust policy formulation, but weak patterns of implementation", a conclusion consistent

with GL's findings across the six countries in the multi-country study. Twelve years later, the 2025 study examines whether this gap between policy and practice has narrowed, widened, or transformed in character. The intervening period has seen Lesotho's most significant legislative advance on domestic violence, the enactment of the Counter Domestic Violence Act (CDV Act) No. 4 of 2022, as well as the Labour Act 2024 giving domestic legal effect to ILO Convention 190 on violence and harassment in the world of work, and the publication of the Legal Aid Clinics Guidelines of December 2025 (EU-funded) that for the first time standardise legal aid provision across Lesotho's 56 legal-aid providers and explicitly name sexual orientation and gender identity as protected grounds of non-discrimination. These advances are real, and they mark a legal architecture that is materially stronger in 2025 than at any point in the country's history.

At the same time, the 2025 prevalence data (Chapter 3) document that police reporting rates remain at approximately 10%, that shelter utilisation is near-zero, and that only one in eight Basotho adults has heard of the CDV Act. The DHS 2023-24 confirms these help-seeking barriers at the national scale: 45% of women who experienced violence told no one, and only 29% sought help from the police.[208]

The evidence reviewed in this chapter suggests that the 2013 diagnosis remains largely valid in 2025, with the important addition that the legal architecture has been significantly upgraded. That upgrade creates both new opportunities and new accountability demands: where the 2013 report could call for laws to be enacted, the 2025 report must call for the laws that now exist to be operationalised.

Effective GBV response is multi-sectoral; it spans the legal framework, law enforcement, the health system, the judiciary, social welfare services, civil society, and political leadership

The analytical framework for this chapter draws on the 2025 Political Discourse Analysis report, a systematic desk review of publicly available political statements, media coverage, and official documents on GBV from January to December 2025.

The political discourse analysis provides a critical context for understanding the gap between political commitment and operational delivery that runs throughout this chapter. It also documents the emergence of the Parliamentary Women's Caucus as the most consistent political voice on GBV in 2025. This structural shift opens a new pathway for parliamentary oversight of implementation.

6.2 The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)

Lesotho's GBV response framework is grounded in obligations arising from international human rights conventions and regional instruments to which the Kingdom is party. These obligations create binding standards for the state's treatment of GBV survivors and its accountability to them, standards against which the 2025 survey and political discourse findings can be assessed.

[208] Ministry of Health (Lesotho) and ICF (November 2024), Lesotho Demographic and Health Survey 2023-24. Maseru: MoH Lesotho; Rockville, MD: ICF. Help-seeking figures from DHS 2023-24, domestic violence module.

6.2.1 The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)

Lesotho ratified CEDAW on 22 August 1995, with a reservation to Article 2 to the extent that it conflicts with constitutional provisions on succession to the throne and chieftainship.[209]

CEDAW General Recommendation No. 19 (1992) and General Recommendation No. 35 (2017, updating GR19) both confirm that gender-based violence constitutes discrimination within the meaning of the Convention, and that State Parties bear responsibility to eliminate violence perpetrated by private actors as well as state agents.[210]

Lesotho's most recent periodic reporting to the CEDAW Committee expressed ongoing concern about the limited domestication of the Convention at the community level and the low awareness of CEDAW rights among women, particularly those in rural and mountain areas, and among the judiciary and law enforcement officials. The 2025 survey data, showing that 57.5% of respondents know that laws protecting women exist, but only 25.6% have heard of protection orders, and only 12.1% have heard of the CDV Act 2022, demonstrate that the awareness barriers documented in previous CEDAW cycles persist.

6.2.2 The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol)

The Maputo Protocol (2003), which Lesotho ratified in 2004, is the continental African human rights framework that most specifically addresses women's rights, including the right to protection from gender-based violence. Article 4 guarantees every woman's right to life, integrity, and security of person, and obliges States Parties to enact and enforce laws prohibiting all forms of violence against women, including unwanted or forced sex. Article 5 addresses the elimination of harmful practices, and Article 11 provides for the protection of women in armed conflicts. The Protocol's provisions are directly relevant to the findings of this study, particularly regarding the legal protection gaps documented in Sections 6.3-6.5.

6.2.3 The SADC Protocol on Gender and Development

Lesotho is a signatory to the SADC Protocol on Gender and Development (2008, amended 2016), which provides the most specific regional framework for GBV response among SADC member states. Article 20 of the Protocol requires that State Parties enact and enforce legislation prohibiting all forms of gender-based violence, including domestic violence and sexual harassment. Article 21 requires comprehensive testing, treatment, and care for survivors of sexual offences, including emergency contraception and PEP for HIV.[211]

The 2025 survey data on medical help-seeking (Table 6.3) shows that less than half of injured survivors sought medical care and that 10.3% of those who did not tell their doctor the cause cited that the provider did not ask, suggesting that Article 21 obligations on the health sector remain incompletely fulfilled.

[209] UN Treaty Collection (1995), CEDAW Ratification and Reservation by Lesotho, August 22 1995. Available at: https://treaties.un.org.
[210] CEDAW Committee (1992), General Recommendation No. 19: Violence Against Women; CEDAW Committee (2017), General Recommendation No. 35 on Gender-Based Violence Against Women, Updating General Recommendation No. 19. UN Doc. CEDAW/C/GC/35.
[211] SADC (2016), SADC Protocol on Gender and Development (Amended). Gaborone: SADC Secretariat, Articles 20-21.

The SADC Protocol also requires State Parties to achieve gender parity in decision-making bodies (Article 12, target 50% by 2030, extended from the original 2015 target). Lesotho's National Assembly, with 43 women members out of 120 (35.8%), remains below this target but above the sub-Saharan African average.[212]

The Parliamentary Women's Caucus, as documented in the 2025 political discourse analysis, has emerged as a significant force in GBV advocacy precisely because of the critical mass of women parliamentarians achieved since 2017.

6.2.4 The ILO Convention on Violence and Harassment (C190), workplace GBV obligations

Lesotho ratified ILO Convention 190 on Violence and Harassment in the World of Work in 2019, becoming among the earliest African State Parties to do so. C190 imposes obligations on State Parties to prohibit and prevent violence and harassment at work, including gender-based violence and harassment, and to provide effective remedies and protection for affected workers.[213]

Lesotho gave domestic legal effect to these obligations through the Labour Act 2024, which includes explicit provisions on workplace sexual harassment and gender-based violence in employment. The Labour Act 2024 is the legal anchor for workplace GBV complaint mechanisms and for employer obligations on prevention, response, and survivor protection. Together with ratified C190, it creates a workplace-specific legal framework that did not exist when the 2013 study was conducted, and that is now available. However, public awareness and institutional enforcement remain at an early stage.

6.2.5 Other binding international instruments

Beyond CEDAW, C190, and the SADC Protocol, Lesotho is party to several additional instruments with GBV-relevant obligations. The Convention on the Rights of the Child (CRC) (ratified 1992), together with the African Charter on the Rights and Welfare of the Child (ACRWC), grounds the Children's Protection and Welfare Act 2011 and the operations of the Children's Court system. The African Charter on Human and Peoples' Rights (Banjul Charter) and its Maputo Protocol (Protocol to the African Charter on the Rights of Women in Africa, to which Lesotho acceded in 2004) provide regional human rights protections, including specific articles on violence against women, harmful practices, and reproductive rights.[214]

The Sustainable Development Goals (particularly SDG 5.2 on eliminating violence against women and SDG 16.1 on reducing violence) provide the global reporting framework within which the 2025 GBV Indicators Follow-up Study is positioned.



[212] IPU Parline Data (2025), Women in National Parliaments. Available at: https://data.ipu.org; Chidhakwa (2026), op. cit., Section 1.2.
[213] International Labour Organization (2019), Convention on the Elimination of Violence and Harassment in the World of Work (C190). Geneva: ILO. Lesotho ratification 2019. See also Solidarity Center (2024), Lesotho Labour Rights Briefing: ILO C190 and the Labour Act 2024.
[214] African Union (2003), Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol). Addis Ababa: AU. Lesotho accession 2004.

6.3 National legislative framework: From the Sexual Offences Act to the CDV Act and the Labour Act 2024

Table 6.1: National legislative framework relevant to GBV response, key instruments, 2025

Legislation	Year	Key GBV-Relevant Provisions	Implementation Status (2025)
Sexual Offences Act No. 3	2003	Criminalises rape (including marital rape); establishes mandatory reporting.	Operational, primary statute for sexual violence prosecution; forensic lab gaps impede evidence processing.
Legal Capacity of Married Persons Act	2006	Removes the minority legal status of married women; enables women to enter into contracts, open bank accounts, and access courts independently	Operational and foundational for women's legal agency, awareness remains limited in rural areas.
Labour Code Amendment	2006/09	Prohibits workplace sexual harassment; provides for maternity leave.	Superseded in part by the Labour Act 2024, enforcement via the labour inspectorate is still weak.
Children's Protection and Welfare Act	2011	Prohibits child marriage (under 18); establishes the Children's Court; and domesticates CRC obligations.	Children's Court is operational but under-resourced; family court rules are not yet established under DVA.
Anti-Trafficking in Persons Act	2011	Criminalises all forms of trafficking; harsh penalties for perpetrators.	Enforcement is limited; cross-border dimensions require regional cooperation.
ILO Convention 190 (ratified)	2019	Binding international obligation to prevent and address workplace violence and harassment, including GBV.	Ratified; domestic effect via the Labour Act 2024.
Counter Domestic Violence Act No. 4	2022	Defines domestic violence broadly (physical, sexual, emotional, economic); provides for protection orders; provides that every court shall sit as a Family Court for domestic violence matters (Section 16); requires a multi-sectoral response.	**Critical gaps:** Family Court designation not yet operationalised; family court rules not promulgated; presiding officers not designated; only 12.1% public awareness; protection order mechanism not fully operational.
Labour Act	2024	Prohibits workplace violence and harassment, including GBV; codifies C190 obligations; creates an employer's duty of prevention and response.	Enacted; regulations and employer-awareness rollout at the early stage.
Legal Aid Clinics Guidelines	2025	Standardises legal aid across 56 providers; establishes non-discrimination on grounds including sexual orientation and gender identity; EU-funded.	Recently promulgated; implementation across providers is in progress.

Note: Sources: Government of Lesotho (2003, 2006, 2011, 2022, 2024), legislation as cited; Ministry of Law and Justice (December 2025), Legal Aid Clinics Guidelines Lesotho. Administrative data interviews (March 2026), Political Discourse Analysis report (Chidhakwa, 2026), Human Rights Lab interview (Thuso Project), and Thuso CGPU KIIs (2025)

Between 2013 and 2025, Lesotho's legal framework governing gender-based violence has been substantially upgraded. Three developments stand out. First, the enactment of the Counter Domestic Violence Act, Act No. 4 of 2022, was the first legislation in Lesotho specifically targeting domestic violence as a defined legal category. Second, the enactment of the Labour Act 2024, giving domestic effect to ILO C190 and creating a workplace-specific GBV legal framework. Third, the promulgation of the Legal Aid Clinics Guidelines of December 2025, which for the first time standardise legal aid across the 56 providers operating in the country and explicitly name sexual orientation and gender identity among the protected grounds of non-discrimination in legal-aid service delivery.[215]

These legislative and regulatory advances culminate more than a decade of advocacy, during which the 2013 study could document only a "draft Issues Paper" on domestic violence prepared by the Law Reform Com-mission. The enactment trajectory and its ongoing implementation challenges are the central legislative story of this chapter.

6.3.1 The Counter Domestic Violence Act 2022, architecture and implementation gap

The CDV Act 2022 represents a paradigm shift in Lesotho's legal approach to domestic violence. Prior to this Act, domestic violence was not defined as a distinct legal category in Lesotho law. It was prosecuted under the Sexual Offences Act (for sexual violence), the Penal Code (for assault), or through customary dispute resolution processes. The CDV Act for the first time provides a statutory definition of domestic violence that encompasses physical, sexual, emotional, and economic abuse, and establishes a specific protection order regime for domestic violence survivors distinct from criminal prosecution.

The Act's most significant structural provisions are: the designation of every court as a Family Court within its area of jurisdiction (Section 16(2)), with the Chief Magistrate responsible for designating presiding officers (Section 16(3)); a protection order regime enabling survivors to obtain emergency and full protection orders without requiring criminal prosecution; and a multi-sectoral response obligation requiring health, police, social welfare, and justice actors to cooperate in serving GBV survivors. These provisions represent the best international practice in domestic violence legislation and are consistent with SADC Protocol obligations. As of July 2026, the following CDV Act provisions remain unimplemented or only partially implemented: (a) the Family Court designation has not been operationalised in any district; (b) presiding officers have not been designated by the Chief Magistrate; (c) no comprehensive public awareness campaign has been conducted, partly due to ongoing technical discussions around a proposed amendment to the Act; (d) regulations required to operationalise the Act's institutional structures and funding streams have not been finalised; and (e) the Act's multi-sectoral response obligations, while legally binding, lack an enforcement mechanism with consequences for non-compliance. The low public awareness figure of 12.1% must therefore be interpreted in this implementation context: it reflects not public disengagement, but the absence of a systematic dissemination effort following enactment.

The gap between the Act's provisions and operational reality is wide. Interviews with

[215] Ministry of Law and Justice, Legal Aid Unit (December 2025), Legal Aid Clinics Guidelines Lesotho - Final Draft. Maseru: Government of Lesotho, with technical and financial support from the European Union. The Guidelines document that a national mapping exercise identified 56 legal aid service providers, and establish the Equality, Inclusion and Non-Discrimination principle: "Legal aid services should be provided without discrimination based on factors such as race, ethnicity, gender identity, religion, disability, sexual orientation, or socio-economic status."

magistrates reveal that the GBV-designated court system has not been operationalised: "designated GBV magistrates and councils" with unclear roles were established by Parliament without sufficient prior consultation with the judiciary, creating provisions that are legally present but not practically implementable. As one magistrate stated, the court continues to use existing statutes, the Sexual Offences Act and the Penal Code, because the CDV Act's operational requirements are not yet implementable in practice. The family court rules required to give operational effect to the domestic violence provisions have not been promulgated, leaving the Act without the procedural framework needed for enforcement.



The CDV Act 2022 was enacted to end the practice of classifying domestic violence as a "relationship matter" rather than a criminal offence

An independent civil society perspective corroborates these implementation challenges. The International Human Rights Lab (Thuso Project), which provides GBV legal support in Lesotho, documents substantive contradictions between the CDV Act, the Sexual Offences Act 2003, and the Penal Code, contradictions that complicate prosecution strategy and create inconsistency in how similar conduct is charged across districts.[216]

The survey data confirm the public awareness dimension of this gap: only 12.1% of all respondents (CI: 10.7-13.4%) have heard of the Counter Domestic Violence Act, a figure virtually identical for women (11.9%) and men (12.3%). Among those who have heard of it, radio (47.0%) and community meetings (30.0%) are the primary information sources, with social media (15.0%) and television (18.8%) emerging as new channels, not present in the 2013 study findings. This low awareness level means that the Act's protections, including the protection order regime, cannot be accessed by survivors who remain unaware that the mechanism exists.

The CDV Act 2022 was enacted to end the practice of classifying domestic violence as a "relationship matter" rather than a criminal offence. Three years after enactment, this misclassification continues:



"In early 2024, she was assaulted in a car, strangled with a seatbelt, and again reported the matter to the police, but the case was treated as a relationship issue rather than criminal violence. Even after seeking help from her family and the police, the abuse continued."

Butha-Buthe Participant 2

[216] International Human Rights Lab / Thuso Project (2025), Interview transcript: GBV legal support in Lesotho. Thakane (Human Rights Lab): "There are challenges in implementing these laws, particularly due to contradictions between the Counter Domestic Violence Act, the Sexual Offences Act, and the penal code."

6.3.2 The Sexual Offences Act 2003, twelve years of implementation experience

Front-line legal service providers offer additional confirmation of the CDV Act's implementation deficit. In a 2026 interview, WLSA reported that in its assessment, the Counter Domestic Violence Act is currently "not practically usable in court" because it lacks the enabling regulations and the institutional architecture the legislation presumes, particularly the family courts that have never been established. Without these structures and the resources to operate them, the Act cannot be fully applied despite being on the statute books. WLSA further noted that the Law Society has withdrawn practising certificates for NGO lawyers, forcing organisations such as WLSA and ICG to pursue strategic litigation in the Constitutional Court to restore their right of audience. This restriction directly reduces the pool of legal professionals available to GBV survivors who cannot afford private representation, compounding the access-to-justice deficit documented above.

The Department of Public Prosecutions (DPP) provided direct corroboration of this implementation deficit. The DPP reported that prosecutors regard CDV Act penalties as "ridiculously low" compared to the Sexual Offences Act, creating a disincentive to prosecute domestic violence cases under the newer legislation. No GBV-specific case classification system exists within the prosecution service; cases involving gender-based violence are handled under generic Penal Code categories (assault, rape, indecent assault), making it impossible to track GBV case volumes, outcomes, or patterns through prosecution data.

On capacity building, the Ministry of Gender took early steps following the enactment of the CDV Act. Ministry records confirm that in 2022, sensitisation meetings were held in Leribe and Maseru to train members of the prosecution service, CGPU, the magistracy, the Ministry of Health (DHMT), local courts, and the Department of Gender on the provisions of the Act. The DPP confirmed that these sessions reached key justice-chain actors in the two districts. The challenge that remains is one of scale, where comprehensive formal training is yet to be extended to all prosecutors nationwide. Expanding this training and the GBV specialisation model piloted in Maseru district to all ten districts represents a clear next step in closing the gap between the CDV Act's provisions and day-to-day prosecutorial practice.

The Sexual Offences Act 2003 remains the primary operative statute for sexual violence prosecution in 2025, more than two decades after its enactment. The 2013 study identified several implementation challenges, including ambiguity around HIV testing requirements, limited awareness among survivors, and inadequate training of police and prosecutors. The 2025 evidence suggests that while awareness has improved marginally (22.6% of all respondents have heard of the SOA in 2025, compared with 35% of women in 2013, though the 2013 figure was among those who had specifically heard about any laws, a different denominator), implementation challenges persist.

Newsday reporting in 2025 documented 91 rape cases before the courts in January-April 2025 alone, a headline figure that captures the scale of current prosecution activity under the SOA 2003 and indicates that the statute continues to be invoked actively, even as conviction rates have collapsed.[217]

[217] Newsday Lesotho (2025), "Rape Crisis: 91 Cases Before Courts January-April 2025". Maseru: Newsday. The Newsday figure captures cases filed; it does not indicate the proportion proceeding to conviction.

The most critical implementation barrier identified in the 2026 magistrate interview is the collapse of Lesotho's national forensic laboratory. The laboratory burned down, and forensic specimens, including rape kits, are now sent to Pretoria, South Africa, causing delays of months between alleged offences and evidential results. In sexual offence cases where forensic evidence is central to conviction, these delays directly undermine prosecution outcomes and may contribute to case attrition. This infrastructure failure represents an acute justice gap that requires emergency investment.

6.3.3 The Laws of Lerotholi and customary law, unresolved tensions

The tension between Lesotho's statutory law framework and the Laws of Lerotholi, the codified customary law governing most Basotho in matters of family, marriage, and property, was identified in the 2013 study as a central structural challenge. Customary law, administered through local courts, does not recognise gender-based violence as a legal category in the same terms as statutory law. The dispute resolution norms of family and community mediation, presided over predominantly by male chiefs and family elders, often prioritise reconciliation, family stability, and economic continuity over individual rights protection for female survivors.

Mental illness as a barrier to justice, where a perpetrator's mental health status closes a case rather than determining appropriate intervention, leaves survivors without protection:



"Two weeks later, I was called to the station and told that the suspect was mentally unstable, so there was little chance of him being detained. I was deeply troubled, wondering whether the investigation would end there or lead to justice. It was painful to realise that the law seemed powerless when crimes were committed by someone considered mentally ill."

Maseru Participant 1

The CDV Act 2022 does not explicitly address the jurisdictional relationship between statutory domestic violence provisions and customary law mechanisms. This is a significant omission. The 2025 survey data show that when survivors do disclose violence, the primary recipient is family (57.9% of those who disclosed to someone told a family member). That disclosure to community leaders is near-negligible (0.9% of all survivors). The near-absence of chiefs, village councils, and traditional dispute mechanisms in survivors' help-seeking pathways is analytically ambiguous; it could reflect the limited effectiveness of these mechanisms, survivors' preference for privacy within immediate family, or the absence of accessible formal alternatives. Qualitative follow-up would be needed to unpack this pattern.

6.3.4 The Legal Aid Clinics Guidelines 2025

The promulgation of the Legal Aid Clinics Guidelines in December 2025 is a material advance in Lesotho's GBV legal infrastructure. A national mapping exercise conducted as part of the Guidelines development identified 56 legal aid service providers operating across all ten districts, meaning that survivors in every part of the country can access legal support locally, reducing travel costs and removing a significant barrier to justice, a landscape that had previously remained unstructured due to a lack of coordination and limited human and

financial resources. The Guidelines, developed by the Legal Aid Unit in the Ministry of Law and Justice with technical and financial support from the European Union, aim to standardise and harmonise the provision of legal aid across this network, ensuring uniformity, quality, and accessibility in line with Sections 12, 18, and 19 of the Constitution of Lesotho, which provide for access to a fair trial.[218]

Two features of the Guidelines are particularly significant for GBV response. First, the Equality, Inclusion and Non-Discrimination principle explicitly names sexual orientation and gender identity among the grounds on which legal aid must be provided without discrimination, the first time a Lesotho legal aid instrument has recognised sexual and gender minorities in this way. Second, the Guidelines establish minimum professional qualification thresholds (paralegal status or above) for service providers and create an oversight function for the Legal Aid Unit, creating an accountability architecture that did not previously exist for the sector.

For GBV survivors, the Guidelines' potential is substantial. If implemented, they would provide a uniform minimum standard across all 56 providers, ending the current situation in which survivors' access to quality legal support depends on which provider they happen to reach. The legal-aid network's breadth (56 providers across ten districts) is already greater than that of any other GBV response institution in Lesotho, including the shelter system (one functioning shelter) and the Family Court system (not yet operationalised). The Guidelines, therefore, convert an existing civil-society asset into a potentially regulated, quality-controlled national service if implementation follows promulgation.

Civil society legal-aid actors have, in parallel, developed paralegal networks that extend the reach of the formal legal aid system. FIDA Lesotho reports training 72 paralegals across four districts and identifying 11 trafficking-in-persons cases through this community-based legal support mechanism.[219]

The FIDA paralegal model, together with the Legal Aid Guidelines, creates for the first time a plausible architecture for bridging formal legal institutions and community-level justice access, a bridge that the 2013 study identified as absent.

6.4 Police response

The Lesotho Mounted Police Service (LMPS) is the primary first-responder institution for GBV in Lesotho, the first formal point of contact for survivors who choose to access the justice system. In 2013, the LMPS was found to have a 17% female composition overall, with an established Child and Gender Protection Unit (CGPU) created in 2002. The CGPU was commended for weekly sensitisation activities, radio programming, and awareness campaigns, but criticised for uneven geographic distribution, insufficient training of its own officers, and the absence of vehicles in remote stations. This section examines what the 2025 survey data reveal about the LMPS response, drawing on survivor-reported outcomes. It triangulates them with CGPU administrative data and qualitative evidence from the Human Rights Lab and Thuso Project's CGPU key informant interviews.

[218] Ministry of Law and Justice, Legal Aid Unit (December 2025), op. cit. The mapping finding of 56 providers and the EU technical/financial support are directly recorded in the Guidelines' introduction.
[219] FIDA Lesotho (2024), Paralegal Programme Narrative Report 2023-2025. Maseru: FIDA. The 72-paralegal / four-district / 11 TIP-case figures are reported directly in FIDA's programme narrative.

Table 6.2: Police reporting, arrests, convictions, and satisfaction among IPV survivors, 2025

Indicator	Women %	95% CI	Men %	95% CI	Total %	95% CI
Reporting and formal response (denominator: IPV survivors)						
Reported abuse to the police	9.9	7.1-12.8	7.5	4.4-10.7	9.3	7.0-11.6
Justice pipeline (denominator: among those who reported to police)						
The perpetrator was arrested	15.7	6.6-24.8	15.4	0.5-30.4	15.6	7.3-24.0
The perpetrator was convicted*	62.0	35.6-88.3	90.7	70.4-110.9	68.3	50-86.7
Satisfaction (denominator: all IPV survivors)						
Satisfied with police response	**1.2**	0.3-2.1	**1.9**	-0.2-4.0	**1.4**	0.5-2.3

Note: Denominator: IPV survivors for reporting and satisfaction (N=1,033 women; N=411 men). Among those who reported (N=107 women; N=30 men) for arrest rate. *NB: Among arrested cases for conviction (N=16 women; N=5 men, extreme caution: very small base). All estimates are survey-weighted.

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

6.4.1 The reporting rate and the 90% justice gap

The headline finding from the police response data is stark and consistent with the Chapter 3 underreporting analysis: only 9.9% of women IPV survivors and 7.5% of men reported their experience to the police, meaning that more than nine in ten survivors of intimate partner violence in Lesotho never engage the formal justice system. The gender difference (9.9% vs 7.5%) is not statistically significant (p=n.s.), indicating that the barrier to police reporting operates comparably across genders.

This figure has not materially changed from 2013, when the study found similarly low rates of police reporting among survivors. The DHS 2023-24 national survey corroborates this finding independently: only 29% of women who experienced violence sought help from the police, while 49% turned to their own family first, and 45% sought no help and told no one.[220]

Twelve years of CGPU sensitisation, legislative reform, and awareness campaigning have not moved the reporting rate. This structural persistence demands examination of the reasons why survivors do not report, reasons the 2025 survey captures in Table 6.3.

Table 6.3: Reasons for not reporting to police, among non-reporting IPV survivors, 2025

Reason for not reporting	Women %	95% CI	Men %	95% CI
Fear of consequences	**19.5**	7.6-31.5	6.9	-2.4-16.2
Shame or embarrassment	15.6	5.1-26.1	3.2	-3.4-9.9
Thought it was not serious enough	10.0	1.9-18.2	1.7	-1.9-5.4
Financial barriers	0.0	-	2.4	-2.7-7.5

Note: Denominator: IPV survivors who did not report to police (N=75 women; N=45 men). Wide CIs reflect small sub-samples. Multiple reasons could be selected; percentages do not sum to 100%. Categories are not mutually exclusive.

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

The barriers to reporting are gendered in their composition. For women, fear of consequences is the leading named reason for non-reporting (19.5%), followed by shame (15.6%) and minimisation of severity (10.0%). Among men, 6.9% mention fear of consequences, and 1.7% perceive the violence as not serious enough. The gendered pattern is evident. Women cite

[220] Ministry of Health (Lesotho) and ICF (November 2024), op. cit., domestic violence help-seeking module. Figures: 45% sought no help and told no one; 49% turned first to own family; 29% sought help from the police.

emotional and safety barriers, while men are more likely to minimise or downplay the incident. These findings are consistent with the 2013 baseline's finding that women feared arrest of the breadwinner, social stigma, and being unable to support children. For men, all named reasons are substantially lower. A more detailed analysis of non-reporting barriers, drawing on 229 verbatim open-ended responses, is presented in the TFGBV section 6.7.2 below.

6.4.2 The justice pipeline, from report to conviction

Among the small proportion of survivors who did report to police, the justice pipeline is narrow and inefficient. Of those who reported, only 15.6% had their perpetrator arrested (CI: 7.3-24.0%), meaning that four in five police reports do not result in an arrest. Of those arrested, the survey data suggest that 68.3% were convicted (CI: 50.0-86.7%). Still, this figure is based on very small sub-samples (N=16 women and N=5 men who had a convicted perpetrator) and must be treated as illustrative only.

The combined effect of low reporting (9.9%), low arrest rates (15.6% of reporters), and subsequent attrition through prosecution and trial means that for the full population of women IPV survivors, the proportion who see a perpetrator convicted is vanishingly small, approximately 1% of all women survivors. The scale of current prosecution activity is captured in press reporting: Newsday documented 91 rape cases before the courts in the first four months of 2025 alone, cases that enter the pipeline but, against the backdrop of the forensic laboratory collapse (see Section 6.3.2), face systemic evidence delays that impede conviction outcomes. This calculation is indicative only, given the small sub-samples, but its order of magnitude is consistent with justice attrition patterns documented in similar settings across sub-Saharan Africa.[221]

6.4.3 Satisfaction with police response, a critical finding

The most damning indicator in the police response data is the satisfaction figure: only 1.4% of all IPV survivors (1.2% women; 1.9% men) report being satisfied with the police response to their situation. This figure encompasses all survivors, not only those who reported. It likely captures both negative direct experiences with police and the accumulated experience of being in a context where police response to GBV is widely perceived as ineffective, unsympathetic, or absent. Fewer than one in 66 IPV survivors in Lesotho expresses satisfaction with the police response. This is not merely a service quality issue, but a legitimacy crisis for the CGPU's community-facing mission.

The political discourse analysis documents that during the March 2025 parliamentary press conference, Minister of Law and Justice Ramoeletsi presented CGPU district-level data showing reported GBV cases: Mafeteng (125), Qacha's Nek (51), Mohale's Hoek (49), and Quthing (49) for the period March 2024-March 2025. These figures, while not publicly released in full statistical report form by CGPU, provide a partial window into the formal system case-load. The prevalence survey's finding that only 9.9% of survivors reported means that these case numbers represent a small fraction of actual GBV incidence, and that even within reported cases, the conversion to arrest, prosecution, and conviction is very low.

[221] Decker, M.R. et al. (2009), "Violence against women in Lesotho: Prevalence, causes, and prevention strategies," Violence Against Women, 15(11), 1376-1399; Kelly, L. et al. (2005), A Gap or a Chasm? Attrition in Reported Rape Cases. Home Office Research Study 293. London: Home Office.

The 2025 survey finds that only 1.4% of survivors were satisfied with police response, the lowest satisfaction rate of any institution. This satisfaction rate reflects interactions in which survivors felt their reports were not taken seriously and these accounts capture the specific dismissive response that drives the finding:



"Even when I try to report him, the police ask me what I want them to do, as if my suffering is not serious. For nearly five years, I have endured this abuse, threats, and humiliation. He tells me that if I leave him, he will kill me, and I live in constant fear."

Butha-Buthe Participant 1

Not all police interactions produce negative outcomes. Where police successfully mediate and both parties leave committed to the resolution, the intervention functions as primary prevention:



"I decided on my own to report the matter to the police. I realised that because of anger, if I laid my hands on my wife, I could seriously harm or even kill her. I knew it was better to seek help than to end up in prison. The services I received from both the hospital and the police station were excellent. If I were to rate them, I would give them a thumbs up."

Thaba-Tseka Participant 1

When police response is prompt and survivor-centred, case progression is possible. This account from Berea documents a sexual assault case that progressed to arrest because the initial police response was supportive:



"The police gave me a medical form, took my statement, and supported me so that I could regain confidence. Later, I saw the perpetrator again at the same place of abuse, and I called the police. He was drunk and seemed unaware that his actions had not been forgotten. The police arrived and arrested him."

Berea Participant 5

When the officers who should arrest the perpetrator are his social companions, arrest becomes impossible, and the perpetrator's impunity is actively reinforced by the very institution designed to end it.



"When I try to report him to the police, it feels useless because sometimes they are his drinking companions. Neighbours are the ones who occasionally help me, but when they call the police, he insults them too. Even when the police arrest him, they later release him, and he returns to drink with them. Afterwards, he mocks me, saying that he was drinking with the same officers who are supposed to protect me. This gives him power over me, and I feel completely unsafe. He has assaulted me several times, and I have been hospitalised because of his violence. When I went to the police for the first time, he twisted the story, and in the end, his word prevailed."

Thaba-Tseka Participant 1

6.4.4 CGPU administrative data 2021-2025

The survey-derived findings in Sections 6.4.1-6.4.3 are grounded in survivor-reported experiences. Administrative data from the CGPU, covering case-level microdata for 2023-2025 and consolidated summary data for 2021-2024, provide a complementary institutional perspective on the same justice pipeline. These data, obtained directly from CGPU records, cover 1,726 adult GBV cases and 991 children's GBV cases in the microdata period (2023-Aug 2025), plus national summary statistics for 2021-2024. They enable, for the first time in the GL-Lesotho series, a triangulation between what survivors report and what the police system formally records.

Three analytically significant findings emerge from the CGPU data. A corroborating decline in reported cases aligned with the survey's prevalence trend; a conviction collapse from 74 adult convictions in 2021 to 1 in 2024, almost certainly connected to the closure of the national forensic laboratory; and a systematic mismatch between the GBV types the police system captures (predominantly stranger sexual violence) and the GBV types the survey measures as most prevalent (predominantly intimate partner violence). Together, these three findings reveal a justice system that is receiving fewer cases, processing almost none to conviction, and structurally missing the most common form of violence experienced by Basotho women and men.

Table 6.4: CGPU adult GBV cases, national trends by offence type, 2021-2025

Offence type	2021	2022	2023	2024	2025*	Change 2021-24	Direction
Sexual offence	728	259	557	425	278	-41.6%	⇣ Decreasing
Assault and GBH	273	108	229	182	184	-33.3%	⇣ Decreasing
Abduction	30	5	49	16	7	-46.7%	⇣ Decreasing
CPWA	24	10	27	20	19	-16.7%	⇣ Decreasing
Total cases	**1,044**	**393**	**857**	**643**	**582**	**-38.4%**	**⇣ Decreasing**

*Note: Source: LMPS CGPU consolidated summary data (2021-2024) and case-level microdata (Jan-Aug 2025). *2025 figures cover January-August only and are not annualised. CPWA = Children's Protection and Welfare Act. Sexual offence includes all sub-types (rape, attempted rape, indecent assault) recorded under a single category; CGPU does not disaggregate by sub-type. Adult = victim aged 18+.*

Table 6.4 confirms the direction of the household survey's prevalence finding in administrative terms. Adult GBV cases reported to the CGPU fell by 38.4% from 1,044 (2021) to 643 (2024), with sexual offences, the largest single category, declining by 41.6% over the same period. This downward administrative trend, while measured on a different population (reported cases, not survivor prevalence), provides important corroboration for the survey's finding of meaningful GBV reduction since 2013. The two data sources, the household survey and the police administrative records, are telling the same directional story about GBV in Lesotho between 2013 and 2025.

Two important caveats apply. First, changes in reporting behaviour and police recording practices may partly explain administrative case trends independently of changes in actual GBV incidence; a fall in reported cases does not necessarily mean a proportional fall in experienced violence. Second, CGPU data captures only reported GBV, and as established in Section 6.4.1, fewer than 10% of survivors report to the police. The administrative data, therefore, reflects a small and systematically non-representative fraction of all GBV experienced.

Table 6.5: CGPU adult GBV cases, case status pipeline, 2021-2025

Case status	2021	2022	2023		2024		2025*		Notes
	N	N	%	N	%	N	%	N	
Pending investigation	553	251	72.3	402	61.1	355	72.2	420	Consistently, the largest category
At the prosecution stage	191	93	21.4	119	26.9	156	16.0	93	Sent to court
Withdrawn	104	14	5.4	30	1.4	8	5.0	29	Includes victim-initiated withdrawals
Convicted	74	12	0.4	2	0.2	1	0.9	5	**Critical:** near-zero 2023-25

Note: 2021-2022 status figures are from CGPU consolidated summaries (all GBV offences combined). 2023-2025 figures are from case-level microdata with percentages shown in parentheses. 2025 = January-August only. *Source: LMPS CGPU data*

6.4.5 The conviction collapse, administrative evidence of the justice system's failure

The single most alarming finding in the CGPU administrative data is the near-total collapse of adult GBV convictions between 2021 and 2024. In 2021, CGPU recorded 74 adult GBV convictions. By 2022, this had fallen to 12. By 2023 to 2. In 2024, there was 1 adult GBV conviction recorded across all ten districts of Lesotho. In January-August 2025, there were 5. For children's cases: 64 convictions in 2021, falling to 6 in 2024 and 4 in the first eight months of 2025.

This is not a data entry artefact. The CGPU analysis flags it as a potential "reporting lag"; some convictions may not yet be updated in the system, but even accounting for data lag, the scale of the decline from 74 to single digits is too large to explain by recording delays alone. The most analytically consistent explanation connects directly to the finding documented in Section 6.3.2: the national forensic laboratory burned down, with specimens now sent to Pretoria for processing. Sexual offences, which constitute approximately 59% of all adult CGPU cases, depend heavily on forensic evidence for prosecution. If forensic results are delayed by months, cases cannot proceed to trial, prosecutors cannot build cases, and convictions do not occur. The forensic lab's closure is not merely an infrastructure inconvenience. The CGPU data shows it correlates directly with the near elimination of the conviction pathway for GBV cases in Lesotho's criminal justice system.



Lesotho police officers during GL Cyberdialogues. *Photo: Thandokhule Dlamini*

The CDV Act offence data adds a further accountability dimension. In 2023, the first year after the Act's enactment, CGPU recorded 37 cases under the Counter Domestic Violence Act offence category. In 2024, 1 case. In January-August 2025, 1 case. This near-total abandonment of the CDV Act offence category after its inaugural year suggests that either police officers reverted to using older offence categories (Sexual Offences Act, Penal Code) for the same conduct, or that CDV Act enforcement essentially ceased. Either way, the data document that Lesotho's landmark domestic violence legislation is, in practice, generating almost zero formal case records.

Table 6.6: CGPU adult GBV victim profile, sex, age group, and relationship to perpetrator, 2023-2025

Profile Item	2023	2024	2025 (Jan-Aug)	Notes
Female victims (%)	98.5%	98.5%	91.1%	Consistent female majority; slight 2025 increase in male victims
Male victims (%)	1.5%	1.5%	8.9%	Still very low but rising in 2025 microdata
Age 18-24 (% of victims)	32.2%	27.4%	25.4%	The highest-risk adult age group
Age 25-34 (% of victims)	32.8%	30.8%	29.8%	Second highest
Stranger perpetrator (%)	49.9%	57.3%	45.9%	The majority of CGPU cases involve strangers
Spouse/intimate partner (%)	35.0%	27.9%	31.9%	IPV cases: a minority of police caseload
Family member (%)	6.7%	6.9%	13.7%	Rising family member perpetration 2025

Note: N = 1,726 adult cases (microdata 2023-Aug 2025). All percentages are survey-weighted each year. 2025 = January-August only.
Source: LMPS CGPU case-level microdata

6.4.6 The survey-administration data mismatch

The DPP's own account of operational constraints provides insider confirmation of the attrition dynamics documented above. With only 12 prosecutors serving all of Maseru district, caseloads make the 90-day case completion target largely unachievable. The DPP reported that no witness support services, no court-based counsellors, and no disability intermediaries are available at any court in the country, meaning survivors testify without psychological preparation, child witnesses face adult courtroom procedures, and witnesses with disabilities receive no communication support. Family pressure to withdraw cases is so pervasive that prosecutors reported anticipating withdrawal in relationship-based violence cases and deprioritising them accordingly, creating a self-fulfilling cycle in which institutional expectations of attrition produce the very attrition they predict.

LNFOD (Lesotho National Federation of Organisations of the Disabled) corroborated the absence of disability intermediaries from the demand side. While the Persons with Disabilities Equity Act (2021), Section 32, mandates that the Chief Justice enact rules governing court accommodations, including intermediaries for intellectually disabled survivors, guides for visually impaired witnesses, and accessible holding cells, LNFOD reported that government budgets contain no line items for these accommodations, forcing the organisation to fundraise on a case-by-case basis to secure interpreters and assistive devices for court proceedings. As LNFOD's representative stated: "*Even if we have laws saying how everything should be done, but without the budget, those laws cannot be imple-mented fully.*" The convergence of DPP and LNFOD accounts confirms that the disability access gap is not a matter of missing legislation but of systematic failure to fund its operation-alisation.

Table 6.6 reveals a fundamental structural mismatch between what the police system records and what the household survey finds as Lesotho's primary GBV problem. In the survey, intimate partner violence is the dominant GBV form: 45.7% of ever-partnered women experienced lifetime IPV. In the CGPU data, the perpetrator was a spouse or intimate partner in only 31.9% of 2025 adult cases, while strangers accounted for 45.9%. In 2024, strangers accounted for 57.3% of cases, a majority, while intimate partners constituted only 27.9%.

This is not a data error, but a systematic reporting pattern. Women are significantly more likely to report stranger sexual violence to police than intimate partner violence. The barriers to reporting IPV, fear of the perpetrator (19.5%), shame (15.6%), economic dependence, family pressure, and the perception

that police will not respond appropriately, are concentrated in the intimate partner context. Stranger sexual violence, while also under-reported, carries less social cost to report and is more readily recognised as a "real crime" by police officers and the community alike. The consequence is that Lesotho's police system is primarily a stranger-sexual-violence response system, not an intimate partner violence response system, even though IPV affects approximately 14 times more women per year (14.8% past-year prevalence in the survey) than stranger sexual violence. The CGPU's domestic vs non-domestic case breakdown confirms this: in 2024, only 34.8% of adult CGPU cases were in a domestic context. Most of the police system's GBV caseload is non-domestic violence, primarily stranger sexual assault. In contrast, the form of GBV that destroys women's lives day-to-day occurs almost entirely outside the police system's effective reach.

6.4.7 LGBTIQ+ practice, a documented gap across CGPU offices

The 2025 CGPU administrative records, together with the 2025 key informant interviews conducted with CGPU offices through the Thuso Project, reveal a systematic absence of LGBTIQ+ - inclusive response infrastructure. All three CGPU offices interviewed by the Thuso Project, Maseru, Berea, and Leribe, confirmed that current standard operating procedures (SOPs) do not explicitly include LGBTQI+ or transgender persons, that data-recording systems capture only male and female categories, and that no dedicated inclusive infrastructure exists within the unit.[222]

This institutional gap sits alongside documented high GBV prevalence within LGBTQI+ populations in Lesotho. The International Human Rights Lab reports that 69% of LGBTQI+ persons surveyed experienced GBV, with 62% experiencing physical violence and 22.5% sexual violence, figures substantially above the general population prevalence rates measured by this study.[223]

The Legal Aid Clinics Guidelines of December 2025, by explicitly naming sexual orientation and gender identity as protected grounds of non-discrimination in legal aid delivery, provide the first formal legal-aid framework that can respond to this population. Operationalising that framework at the CGPU and health-facility level is the next implementation step. CGPU SOP revisions, data-system amendments to include non-binary and transgender categories, and officer training on SOGIE-inclusive response are concrete, costed, and assignable actions within the ministry's direct authority.

Stakeholder feedback from the Ministry of Gender has reinforced the urgency of this gap. The Ministry's own standard operating procedures do not yet include gender identity as an explicit category, meaning that service providers across the GBV response system lack a common protocol for recording, referring, and supporting gender-diverse survivors. The study recommends that the Ministry of Gender issue revised SOPs that explicitly include gender identity, aligned with the Legal Aid Clinics Guidelines' non-discrimination framework, so that all GBV service providers across police, health, shelters, and social welfare operate from a single, inclusive standard.

The CGPU data analysis also documents important information gaps that limit the justice system's capacity to monitor and respond to GBV. Human trafficking, recognised internationally as a form of gender-based violence, is not captured in the CGPU offence categories, and was not within the scope of this study. Given its relevance to the Lesotho context,

[222] Thuso Project - International Human Rights Lab (2025), CGPU Key Informant Interview Series, Maseru / Berea / Leribe. The three interviews independently confirmed absence of SOGIE-inclusive SOPs and male/female-only case recording.
[223] International Human Rights Lab / Thuso Project (2025), Baseline Study on GBV Against LGBTQI+ Persons in Lesotho. Maseru: HRL. Reported prevalence: 69% any GBV, 62% physical violence, 22.5% sexual violence.

future GBV research should incorporate human trafficking as a measured dimension. Rape, attempted rape, and sexual assault are not disaggregated within the "Sexual Offence" category. Femicide is not identifiable from case data. Police officer training numbers are not recorded in case data systems. And protection order applications, a key CDV Act mechanism, are not tracked by the police. These gaps mean that the CGPU cannot itself monitor whether the CDV Act's core provisions are being used, a fundamental data management failure for the institution tasked with primary GBV enforcement, and one that the Guidelines' oversight architecture could reasonably be extended to address.

6.5 Medical sector response to GBV

The health sector represents a critical response node for GBV survivors, the point of contact for treating physical injuries, post-exposure prophylaxis (PEP) for HIV, Pregnancy prevention (emergency contraception), conducting forensic examinations, Psychological First AID, counselling and follow-up, identifying and referring survivors to additional support services. In 2013, the study found that 52% of injured women sought medical attention, that health sector staff were undertrained in GBV clinical inquiry, and that official policy did not permit primary health care nurses to diagnose and treat mental health disorders independently. This section examines the 2025 evidence on health sector utilisation and disclosure and triangulates it with the DHS 2023-24 national help-seeking figures.

The Ministry of Health's GBV Supportive Supervision Report (March 2023) provides the first systematic assessment of hospital-level GBV case detection capacity across nine facilities in six districts. The supervision visits, conducted from 6-17 March 2023 following the October 2022 rollout of standardised GBV data collection tools, documented a total of approximately 340 SGBV cases recorded across the nine hospitals between 2019 and 2022, with a marked increase in recorded cases over time: from near-zero in 2019 to 181 cases in 2022 across the facilities visited. Quthing Hospital recorded the highest cumulative total (72 cases), followed by Mafeteng Hospital (53 cases) and Machabeng Hospital (45 cases). The age profile of recorded cases is striking: the 15-19 age group consistently records the highest number of cases across all facilities, followed by the 10-14 age group, indicating that adolescents and young women bear a disproportionate burden of health-facility-detected SGBV. The overwhelming majority of recorded cases (95-100% across facilities) were female. These administrative data, while not directly comparable to the population-based survey prevalence, provide important corroboration of the survey's finding that GBV affects women across all districts and that detection capacity exists but remains inconsistent.

The supportive supervision findings also illuminate the operational gaps in health-sector GBV response that contextualise the survey data on medical help-seeking. Key findings include: trauma counselling is provided by psychiatric nurses in most hospitals, but each hospital has only one psychiatric nurse with competing responsibilities, severely limiting counselling capacity; PEP provision is available but weekend access requires clients at some facilities to return on Monday for the complete package; medical forms are generally well completed but registers are inconsistently used, with only two of nine hospitals using the new standardised register by March 2023; district GBV task teams exist in some districts but several are not fully functional; and confidentiality protocols vary significantly across facilities, with some hospitals keeping records in open areas. These findings directly support the survey's recommendation for standardised clinical inquiry protocols and strengthened health-sector GBV response capacity.

Table 6.7: Medical care and injury consequences among physically injured survivors, 2025

Indicator	Women %	95% CI	Men %	95% CI	Total %	95% CI
Sought medical care	**47.9**	38.2-57.5	48.4	30.4-66.4	48.0	38.9-57.0
Told the doctor the cause of the injury	42.2	33.0-51.4	68.6	51.1-86.1	47.3	38.8-55.8
Had to stay in bed	56.4	45.9-66.9	56.1	38.7-73.5	56.3	47.3-65.3
Taking time off work or usual activities	23.9	15.6-32.3	45.1	27.1-63.2	28.0	20.8-35.2
Unable to stay home/care for children	51.1	41.3-60.8	30.7	11.7-49.7	47.2	38.0-56.3

Note: Denominator: Physically injured survivors (N=140 women; N=36 men). *Source: Lesotho GBV 2025 Prevalence Survey, Gender Links*

The medical care-seeking rate among injured survivors is 48.0% overall, virtually unchanged from 2013's 52% figure. This apparent stagnation masks an important distinction highlighted in Chapter 5, that the primary barrier to medical care is not disclosure once in the health system (82.8% of those who sought care told the provider the cause, per Chapter 5 Table 5.1), but access to the health system itself.

The DHS 2023-24 provides an independent national estimate of help-seeking behaviour across all formal channels, where 45% of women who experienced violence told no one and sought no help; 49% of those who did seek help turned to their own family first; and only 29% sought help from the police. Medical-sector help-seeking sits within this broader help-seeking pattern and is constrained by the same structural barriers, distance to facilities, economic cost, fear of partner retaliation, and the perception that the formal system will not meaningfully change the survivor's situation.[224]

Table 6.7 shows that 47.3% of those who sought medical care told the doctor the cause of injury. The discrepancy between the 82.8% disclosure figure in Table 5.1 and the 42.2% in Table 6.7 reflects different denominators and question framings; the former asks specifically about whether the cause was disclosed among those who told the provider, while the latter is a broader population estimate. The analysis in Chapter 5 on this point is the cleaner presentation. The 42.2% figure here represents the proportion of all injured patients who disclosed cause, including those who did not tell the provider.

The barriers to medical disclosure are captured in Table 6.8. Among injured survivors who did not disclose the cause to their health provider, "it is a private issue" is cited by 27.1% of women and 70.1% of men, a remarkable gender divergence that suggests men experience even stronger social norms around private disclosure of victimisation than women. 24.0% of women cite fear of their partner as a reason for non-disclosure, a reflection of the coercive control dimension of abusive relationships, where the partner's surveillance extends into healthcare settings. And 10.3% of women report that the health provider did not ask, a direct indicator of the failure of GBV clinical inquiry protocols in health facilities, representing a missed opportunity for identification and referral that the health system itself can correct through training and standardised clinical pathways.

The World Health Organisation does not recommend universal or routine screening for GBV in health-care settings. Rather, WHO guidance promotes indicator-based clinical inquiry: health-care workers should raise the topic of violence with women who present with injuries or conditions that they suspect may be related to violence, without pressuring disclosure. Where a health-care worker suspects violence but the client does not disclose, the recommended protocol is not to pressure, inform the client about available services, offer information about the effects of violence on

[224] Ministry of Health (Lesotho) and ICF (November 2024), op. cit., domestic violence help-seeking module. Figures cited: 45% told no one and sought no help; 49% went to own family first; 29% sought police help.

health, and offer a follow-up visit (WHO Clinical Handbook for IPV Management, p. 8). The Ministry of Health has a GBV training manual for service providers that aligns with this guidance. Recommendations in this report therefore use the term "clinical inquiry" rather than "screening" to reflect the WHO-recommended approach, which is survivor-centred and indicator-driven rather than universal.

Table 6.8: Reasons for not disclosing cause of injury to health provider, 2025

Reason for non-disclosure	Women %	95% CI	Men %	95% CI
It is a private issue	27.1	12.6-41.6	**70.1**	45.5-94.7
Scared of partner	**24.0**	13.9-34.0	0.0	-
The health provider did not ask	**10.3**	1.3-19.3	0.0	-
Ashamed or embarrassed	4.3	-2.0-10.5	15.4	-7.9-38.8
Other reason	**34.4**	22.2-46.5	**14.4**	-6.5-35.4

Note: Denominator: Injured survivors who did not disclose cause to health provider (N=76 women; N=10 men). Men's sub-sample very small, figures indicative only. *Source: Lesotho GBV 2025 Prevalence Survey, Table 6.4*

The 10.3% of women citing that the health provider did not ask is analytically critical. It means that even when GBV survivors reach a health facility, overcoming all the barriers of fear, stigma, financial cost, and geographic access that prevent the majority from seeking care, the health system itself fails to create the conditions for disclosure. The WHO clinical guidelines on health-sector response to violence against women (2013, updated 2021) recommend structured GBV inquiry as a routine component of clinical assessment for reproductive health visits and injury presentations.[225]

The National Reproductive Health Policy provides GBV components within essential health packages. Still, implementation of standardised GBV clinical inquiry protocols in Lesotho's primary health care facilities appears to remain ad hoc. The WHO Country Cooperation Strategy 2024-2027 identifies interpersonal violence as a leading cause of mortality in Lesotho and prioritises health-system strengthening in this area, creating a planning window for Lesotho to move from ad hoc to systematic GBV clinical inquiry in the primary health care platform.[226]

The 2025 data also underline a gender asymmetry in medical disclosure barriers. For men, the overwhelming barrier is the perception that victimisation is a private issue (70.1%), consistent with masculine norms around stoicism and self-reliance documented across the GL multi-country study. Zero men in the sub-sample cited fear of partner or non-enquiry by the provider, figures that should be treated with caution given the very small N (10), but that directionally suggest men's non-disclosure in health settings is primarily normative rather than fear-based. This distinction matters for the design of clinical protocols: for women, creating a safe space for disclosure requires addressing partner surveillance and provider training; for men, it requires broader normative and masculine identity shifts that medical training alone cannot produce.



Nurse Motanyane and participant Letlatsa showing how the women condom is used. *Photo: Ntolo Lekau*

[225] WHO (2013), Responding to Intimate Partner Violence and Sexual Violence Against Women: WHO Clinical and Policy Guidelines. Geneva: WHO; WHO (2021), Violence Against Women Prevalence Estimates 2018: Global, Regional and National Prevalence Estimates for Intimate Partner Violence Against Women and Global and Regional Prevalence Estimates for Non-Partner Sexual Violence Against Women. Geneva: WHO.
[226] WHO Regional Office for Africa (2024), Country Cooperation Strategy - Lesotho 2024-2027. Brazzaville: WHO AFRO.

6.6 Courts and the children's justice system

The formal court system in Lesotho, comprising the Court of Appeal, the High Court, Magistrates' Courts, the Children's Court, and traditional local courts, provides the institutional architecture through which criminal accountability for GBV is pursued. Section 6.4 established that approximately 1% of all women IPV survivors in Lesotho see a perpetrator convicted through this system. This section examines the operational reality of the courts from two complementary perspectives: the findings of the research team's learning visit with magistrates in March 2026, and the institutional landscape revealed by those interviews for both adult and children's matters.

A landmark judicial development relevant to GBV and disability access to justice is the High Court's 2019 decision in Koali Moshoeshoe and Others v Director of Public Prosecutions and Others (Constitutional Case/14/2017). In this case, a man with an intellectual disability who had been sexually assaulted was denied access to justice because Section 219 of the Criminal Procedure and Evidence Act categorically barred persons "of unsound mind" from giving testimony. The High Court, in a unanimous decision, declared Section 219 unconstitutional and null and void, finding it "totally inconsistent with [the] rationale of the Constitution of Lesotho." The court ordered the DPP to prosecute the perpetrator. This judgment catalysed the Disability Equity Act 2021 and the Procedure Rules 2023, which now mandate accessible court proceedings, individualised needs assessments, intermediaries, and expedited processes for persons with disabilities. Rule 13(3) specifically provides that "survivors of sexual or gender-based violence must not be exposed to the accused while giving evidence." However, as the ICJ's September 2025 assessment documents, implementation of these rules remains severely constrained by judicial underfunding, with zero formally appointed intermediaries and most courts lacking basic accessibility infrastructure.

6.6.1 The Magistrates' Court, GBV case handling in practice

The magistrate interview (March 2026) reveals a court system that is operationally competent in individual case handling but structurally constrained by resource deficits, legislative implementation gaps, and system-wide attrition that begins with police investigations and compounds through each stage of the justice pipeline. Several findings are analytically significant for this study.



"I eventually opened a case at the police station and requested a protection order from the magistrate's court. I explained that I did not want him imprisoned but wanted safety for myself and my children. However, the police seemed to side with him, and even when I was called to court, my partner remained uncooperative.
For three months, I waited for progress, but my partner continued his abusive behaviour, even showing up at my workplace to insult me. The prosecutor explained that if the threats had come from someone outside the family, he would have been arrested immediately. Still, because he was my partner, the matter was treated differently."

Nothabo, Butha-Buthe*

The CDV Act 2022 was enacted precisely to end this double standard. An intimate relationship cannot be a reason to treat a threat less seriously than one from a stranger. The prosecutor's statement to Nothabo documents a breach of the Act's intent three years after enactment. A law on paper that magistrates and prosecutors cannot apply in practice is not yet a law in life.

Jurisdictional fragmentation under the CDV Act

Although the Counter Domestic Violence Act 2022 provides that every court shall sit as a Family Court within its area of jurisdiction (Section 16(2)), this provision has not yet been implemented. All magistrates currently hear GBV-related matters under the Sexual Offences Act, the Penal Code, and general criminal jurisdiction, meaning GBV cases are not systematically tracked as a distinct case category, are not handled by specially trained magistrates, and are not afforded the specific procedural protections the CDV Act intended. Magistrates note that the Act was enacted without sufficient judicial consultation, creating provisions that are legally present but operationally unworkable pending additional regulations and resources.

Several structural factors contribute to low arrest rates beyond police discretion. The dual legal system, in which customary and statutory law operate in parallel, often channels GBV cases toward mediation by traditional leaders rather than formal prosecution. Survivor withdrawal, frequently driven by economic dependence on the perpetrator, family pressure, or the prolonged timeframes involved in prosecution, removes cases from the justice pipeline before arrest can occur. The CDV Act's evidentiary requirements, combined with the forensic laboratory collapse documented below, mean that some cases lack the forensic foundation required for arrest to lead to successful prosecution. Additionally, resource constraints across CGPU offices, including limited transport, insufficient staffing, and the absence of dedicated victim support facilities, create practical barriers to arrest in rural and highland areas.

Case withdrawal dynamics

The Director of Public Prosecutions controls case withdrawal decisions; victim withdrawal requests do not automatically result in case withdrawal. Magistrates note that victim-initiated withdrawal requests typically reflect family pressure, economic dependence on the accused (particularly where the accused is the household breadwinner), reconciliation, and fear of ongoing violence. The DPP's oversight function is critical for preventing cases from being quietly withdrawn through social pressure on survivors. Still, the magistrate's warning about repeat victimisation in withdrawn cases indicates that this protection has limits when survivors remain economically and socially vulnerable to their perpetrators.

Sentencing and outcomes

Sentencing is guided by statutory provisions and judicial guidelines, with consideration of aggravating and mitigating factors, including prior convictions and victim impact. Custodial sentences are commonly imposed for serious sexual offences. The magistrate confirmed that high-status individuals, including soldiers and parliamentarians, have been prosecuted in the court under existing law. Non-custodial options include suspended sentences, fines, and community-based conditions. The survey conviction figure (68.3% among those arrested) must be treated as illustrative given very small denominators, but suggests that when cases do reach trial, the conviction rate is not negligible.

WLSA's operational experience reinforces the structural constraints described above. The organisation reported that prosecutors are overburdened, leading to repeated postponements and prolonged delays in justice delivery. Magistrates are unevenly distributed across districts, and Legal Aid offices are not available in all districts. Even where they exist, they do not adequately reach hard-to-reach areas. WLSA also identified the absence of digitised case tracking as a critical gap: court and registry records remain paper-based, making it impossible to quickly identify GBV or domestic violence cases, monitor progress, or generate trend data. The organisation recommended digitising legal services and decentralising them to districts and hard-to-reach areas as the two most impactful structural reforms.

The DPP further confirmed that court infrastructure is wholly inadequate for trauma-informed justice delivery. No disability intermediaries exist to support witnesses with communication difficulties, and no trained counsellors are available at courts to prepare survivors for the adversarial process of cross-examination. The Children's Court in Maseru is the only facility equipped with one-way glass for protected testimony; all other courts require child witnesses to testify in open court facing their alleged abuser. The DPP noted that court records remain entirely paper-based with no electronic case management, confirming WLSA's finding above that digitisation of the justice system has not progressed despite repeated recommendations.

6.6.2 The Children's Court, GBV against children and child perpetrators

Table 6.9: Children's Court operational data, GBV and child protection cases, 2025-2026

Category	Type of Matter	Volume	Notes
Civil caseload			
Civil	Maintenance cases	~800/year	Dominant caseload: 137 filed by 26 Feb 2026
Civil	Custody and access	~500-600/year	Second largest caseload: 72 filed by 26 Feb 2026
Criminal caseload (GBV and child protection)			
Criminal	Sexual offences (children)	24/year	Prior year total from the court register
Criminal	Assault cases	20/year	Prior year total
Criminal	Murder cases	5/year	Prior year total
Total criminal GBV-related		**49/year**	**Prior year: 5 criminal cases filed by interview date in 2026**
Case outcomes			
Outcomes	New cases filed	44/year	Criminal new filings
Outcomes	Cases withdrawn	1/year	Very low formal withdrawal rate
Outcomes	Guilty verdicts	12 verdicts	Prior year

Note: *Source: Children's Court register data, collected during research team learning visit with magistrates, March 2026. Child defined as under 18; consent threshold for sexual acts set at under 16. JTC = Juvenile Training Centre (maximum custodial commitment 3 years). Civil caseload data from the court register at the time of the visit.*

The Children's Court, established under the Children's Protection and Welfare Act 2011 to domesticate CRC obligations, handles child-related civil and criminal matters, including GBV cases involving child victims and child perpetrators. The March 2026 learning visit with

Children's Court magistrates revealed a system under significant strain, overwhelmed by civil caseloads, under-resourced for criminal GBV cases, and structurally dependent on donor funding for basic operational infrastructure.

The Children's Court data reveal an institution whose criminal GBV-related caseload (49 cases per year) is dwarfed by civil maintenance and custody caseloads (~1,400 combined). This distribution reflects the architecture of family-level GBV's economic dimensions, maintenance and custody disputes often arise from or accompany abusive relationships, but it means that the criminal GBV function of the court receives far less institutional attention and resources than its volume might suggest is warranted.



Victims in children's court GBV cases range in age from 2 years upwards. Perpetrators include adolescents

Victims in children's court GBV cases range in age from two years upwards. Perpetrators include adolescents. The magistrates described a 14-year-old perpetrator of sexual assaults as an example of child perpetrators who enter the criminal pathway. The court procedure for child perpetrators involves a mandatory preliminary inquiry within 48 hours of arrest, probation assessment, and diversion for minor offences, with serious sexual offences explicitly excluded from diversion.

Three significant operational gaps emerged in the learning visit. First, post-sentencing tracking is weak. Magistrates frequently do not know what happens to children committed to the Juvenile Training Centre (JTC), and systematic follow-up of outcomes after sentencing is absent. Second, sign language and interpreter capacity are severely limited. Children who are deaf or have communication difficulties face significant barriers to accessing justice, and there are no qualified legal interpreters with sign language capacity available in most districts. Third, the family court rules required to operationalise the Counter Domestic Violence Act for civil domestic violence matters have not been promulgated, leaving the court without a clear jurisdictional framework for the CDV Act's civil protection order provisions as they affect children and families.

This finding supports a specific recommendation: law enforcement officers, magistrates, and court staff should receive training in basic sign language and in protocols for working with persons with disabilities and other vulnerable groups. The absence of sign language interpretation in courts and police stations creates a structural barrier that effectively denies persons with hearing impairments access to the justice system. This training should be integrated into the national GBV training curriculum recommended under Recommendation B5.

The infrastructure improvements that have been made deserve recognition. Several districts now have child-friendly "park home" court facilities funded through EU, UNICEF, and World Vision support, and an audio-visual system installed at the Maseru Children's Court allows child testimony to be given from a separate room with a screen, avoiding confrontation between the child and the accused. These investments represent meaningful improvements in the child survivor's experience of the justice system, even as structural gaps in staffing, training, and post-sentencing support persist.

Informal out-of-court settlements for sexual violence operate alongside, and often instead of, the formal criminal justice process. The following accounts illustrate these dynamics: perpetrator family pressure, compensation negotiation, and police facilitation.



"Through police mediation, I met with the perpetrator's parents, who asked me to speak with my parents and me. The perpetrator expressed remorse, claiming he was under the influence of alcohol. He apologised and offered compensation. After negotiations, they agreed he would pay seven thousand maloti, though he initially promised ten thousand."

Nthabiseng, Leribe*

Conviction without adequate deterrence, where a perpetrator pays a fine and continues the abusive pattern, is one of the justice pipeline failures this chapter documents.



"He was sentenced to either pay a fine or serve nine months in prison, but he chose to pay. Despite the judgment, he continued his abusive behaviour. His actions left me emotionally broken, and I realised that the justice system did not protect me adequately. Even after being convicted, he showed no remorse."

Maseru Participant 4

6.7 Survivor disclosure and help-seeking

Understanding what survivors do, and do not do, in response to violence is essential for designing support systems that meet people where they are. The 2025 survey asked IPV survivors about their disclosure patterns (who they told about the violence), the response they received, and their public speaking behaviour. These data reveal both the primacy of informal family networks in Lesotho's GBV support ecosystem and the persistent marginalisation of formal services.

Table 6.10: Disclosure of violence, who IPV survivors told

Who they told	Women %	95% CI	Men %	95% CI
Among those who disclosed (N=114 women; N=38 men)				
Told family member	57.9	46.2-69.7	46.7	23.9-69.4
Told in-laws	16.6	7.9-25.3	19.4	4.6-34.1
Among all IPV survivors (N=1,035 women; N=416 men)				
Told my own family	6.2	4.2-8.3	4.3	1.1-7.5
Told friend	1.5	0.6-2.4	2.4	0.2-4.7
Told the community leader	0.8	0.1-1.5	1.3	0.1-2.4
Told a religious leader	0.7	-0.7-2.1	0.0	-
Told an NGO or shelter worker	0.4	-0.1-0.8	0.4	-0.5-1.3
Went to a shelter	**0.0**	**-**	**0.0**	**-**

Note: Two denominators used: disclosers sub-sample (N=114 women, N=38 men, those who told someone) and full survivor population (N=1,035 women, N=416 men). Family disclosure figure differs by denominator: 57.9% of disclosers told family, but only 6.2% of all survivors told family.

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

Table 6.10 shows that among those who disclosed, family is the overwhelmingly dominant channel, with 57.9% of women who disclosed telling a family member, as did 46.7% of men. This reflects the central role of extended family networks in Lesotho's social fabric and the logic of turning to the most trusted and proximate support source when formal systems are perceived as inaccessible, unresponsive, or actively harmful to the survivor's interests. In-laws are also significant disclosees (16.6% women, 19.4% men), reflecting the reality that many GBV situations play out within or adjacent to extended family settings where in-laws may be influential mediators.

The Demographic and Health Survey 2023-24 reports a consistent population-level pattern, where 45% of women who experienced physical or sexual violence told no one and sought no help; of those who did seek help, 49% turned first to their own family, 29% to the police, and small fractions to health providers, religious leaders, or formal services.[227] The convergence of two independent national datasets on this pattern strengthens the analytical weight of the finding: informal family networks are the primary site of GBV response in Lesotho, and any serious strategy to improve survivor outcomes must work with these networks rather than around them.

When the denominator shifts from "those who disclosed" to "all survivors", the picture becomes sharper. Only 6.2% of all women survivors and 4.3% of all men told their own family about the violence. Most survivors tell no one. Religious leaders (0.7%), community leaders (0.8%), NGO workers (0.4%), and shelters (0.0%) account for near-negligible fractions of disclosure pathways. The formal support sector, NGOs, shelters, and social workers, is effectively invisible in survivors' help-seeking behaviour as measured by these data.

Table 6.10 reveals an additional barrier: 8.3% of women and 10.4% of men who disclosed were challenged to tolerate the violence or keep quiet about it. Among those who turned to family, the most used channel, some received actively harmful responses that reinforced silence rather than enabling safety. This "silence mandate" from social networks constitutes a social re-victimisation that compounds the original violence and may deter future disclosure attempts.

Community-level evidence from the Mosepele Foundation illuminates the social mechanisms behind these disclosure patterns. Working with adolescent girls and young women aged 15-29 in Maseru, the Foundation documented a powerful norm that "family issues stay within the family," leading families to pressure survivors to resolve cases privately and actively discourage formal reporting to protect reputation. Parents, area chiefs, and some community leaders frequently disbelieve survivors or blame them, citing dress, time of night, or behaviour, which deters reporting even when survivors are willing. Chiefs sometimes minimise reports or redirect cases back to families for private resolution. Beyond family pressure, confidentiality failures at the point of service further suppress disclosure: village health workers (VHWs) may inform parents and community members, while police station environments expose survivors to public questioning, creating retraumatisation risk and fear of perpetrator retribution. These findings suggest that the low reporting rates captured in the survey data are sustained by an interlocking system of family secrecy norms, victim-blaming by gatekeepers, and institutional confidentiality failures.

[227] Ministry of Health Lesotho and ICF, Lesotho Demographic and Health Survey 2023-24 Final Report, Table 17.21 (Help-Seeking). Denominator: ever-married women age 15-49 who experienced physical or sexual violence. Two independent national datasets - the DHS 2023-24 and the Lesotho GBV 2025 Prevalence Survey - converge on the same finding: formal services remain at the margin of survivor help-seeking.

6.7.1 Speaking out, public disclosure behaviours

Table 6.11: Speaking out about abuse, among IPV survivors, 2025

Indicator	Women %	95% CI	Men %	95% CI
Spoke out publicly about abuse	**18.4**	14.9-21.9	10.9	7.1-14.8
Spoke to family	10.5	7.8-13.1	2.4	0.3-4.6
Spoke to friends	10.0	7.2-12.7	8.8	5.5-12.0
Spoke to colleagues	6.2	2.2-10.3	10.2	0.5-20.0
Spoke to the community	1.4	0.3-2.4	0.6	-0.2-1.4
Spoke to a religious leader	0.9	-0.0-1.8	0.0	-
Spoke to the media	**0.0**	**-**	**0.0**	**-**

Note: Denominator: IPV survivors (N=1,033 women; N=411 men for general items; N=190 women; N=42 men for colleagues and media items).
Source: Lesotho GBV 2025 Prevalence Survey, Table 6.6

Table 6.11 shows that 18.4% of women survivors and 10.9% of men have spoken out publicly about their abuse, a substantial minority who have broken the silence barrier in some form. The primary venues for speaking out are family (10.5% women) and friends (10.0% women), confirming that informal networks dominate public as well as private disclosure. Community-level speaking out is marginal (1.4% women), and media speaking out registered zero, reflecting both the absence of safe platforms for survivor public voice and the absence of media infrastructure for survivor-centred GBV storytelling beyond the Gender Links "I" Story model.

The gender gap in public speaking out (18.4% versus 10.9%) mirrors the gender gap in overall disclosure. It likely reflects both the greater social legitimacy of women seeking help for violence in some informal networks and the stronger masculine norms around stoicism and privacy that prevent men from speaking out. This gap has implications for prevention programming: peer-led male survivor disclosure initiatives, where men who have experienced IPV speak publicly to other men, remain a largely unexplored prevention resource in Lesotho.

6.7.2 Technology-facilitated GBV, barriers to reporting online abuse

The 2025 survey documents substantial technology-facilitated GBV prevalence: 18.2% of women and 21.0% of men reported experiencing at least one form of TFGBV (Chapter 3, Section 3.15). Yet among the 364 respondents who experienced online abuse and were asked whether they reported the incident, only 69 (19.0%) did so, while 295 (81.0%) did not. The gap between prevalence and reporting is stark: roughly one in five Basotho adults experiences technology-facilitated violence, but four in five of those who do never report it.

Normalisation of online abuse is the dominant barrier, "it was not a significant issue," "it's just Facebook drama," and the Sesotho ke ne ke sa e nkela hloohong ("I did not take it seriously")

Those who did not report were asked to give their reason in an open-ended response. The resulting 296 verbatim responses, 113 from women and 116 from men, with the remainder providing no text, were thematically coded into the five standard non-reporting categories used elsewhere in the survey (fear of consequences, shame, minimisation, resolved/stopped, and personal/private). However, the overwhelming majority (229 of 296, or 77.4%) did not fit any of these categories and were coded as "other reason."

A post hoc thematic analysis of these 229 verbatim responses reveals that the "other" category is not an analytical dead end but a window into the distinct barriers that prevent survivors from reporting technology-facilitated violence. Table 6.12 presents the emergent themes.

Table 6.12: Analysis of "other reason" for not reporting online abuse

Emergent theme	Women (n=113)	Men (n=116)	%	N
Considered minor / not worth reporting	41.6%	22.4%	32.3	74
Self-resolved (blocked, confronted, changed settings)	21.2%	11.2%	16.2	37
No reason given / vague	15.0%	12.1%	14.4	33
Did not know where or how to report	3.5%	17.2%	10.9	25
Not applicable (never experienced)	7.1%	9.5%	8.3	19
Forgave / resolved between parties	1.8%	7.8%	4.8	11
Hopelessness / no help available	4.4%	4.3%	4.4	10
Fear / felt threatened	1.8%	6.9%	4.4	10
Did not recognise as abuse / lacked awareness	1.8%	2.6%	2.2	5
Privacy / chose not to disclose	0.0%	4.3%	2.2	5

Note: Percentages are within each sex group (column percentages). Responses were in English and Sesotho; Sesotho responses were translated for thematic coding.
Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

Three findings stand out. First, normalisation is the dominant barrier. One in three respondents (32.3%) considered the online abuse too minor to warrant reporting, using language such as "it was not a significant issue," "it's just Facebook drama," and the Sesotho ke ne ke sa e nkela hloohong ("I did not take it seriously"). Women are nearly twice as likely as men to cite this reason (41.6% versus 22.4%), suggesting that women's higher exposure to online harassment may lead to a greater tendency to normalise it as an unavoidable feature of digital life.

Second, digital self-help is a de facto response strategy. One in six respondents (16.2%) resolved the situation themselves by blocking the perpetrator, changing account passwords, deleting posts, or confronting the person directly. As one woman explained, "it was not an issue because someone just stole my pictures. I just reported the Facebook account." Another described reopening a new account after hers was compromised. These actions represent a form of survivor agency that the formal response system neither recognises, tracks, nor supports.

Third, the gender gap in knowledge of reporting pathways is striking. Among men, 17.2% did not know where or how to report online abuse, compared to only 3.5% of women - a fivefold difference. Responses included "I didn't know where to report, *ke ne ke sa tsebe ke tlaleha kae* ("I did not know where to report"), and "I considered it as usual non-addressed cyber crime and saw it unworthy to report." This finding suggests that men's low reporting of online abuse is driven less by masculine stoicism than by a practical absence of visible, accessible reporting mechanisms.

The 8.3% who reported never having experienced online abuse likely reflect a question-routing artefact, where respondents

who answered the earlier screening question ambiguously were nonetheless routed to the non-reporting follow-up. The remaining themes, hopelessness (4.4%), fear (4.4%), forgiveness (4.8%), and failure to recognise the experience as abuse (2.2%), are consistent with the barriers documented for other forms of GBV but appear at lower frequencies, suggesting that online abuse non-reporting is shaped more by normalisation and system invisibility than by the fear and shame that dominate IPV non-reporting.

Taken together, these findings indicate that the formal response system for technology-facilitated GBV faces a triple barrier: survivors do not perceive the violence as serious enough to report, those who do act prefer digital self-help over formal channels, and those who might report, particularly men, do not know where to go. With one in five adults experiencing TFGBV but only one in five of those reporting it, the effective reach of the formal response system covers approximately 4% of the TFGBV-affected population. Addressing this gap requires both awareness campaigns that explicitly name TFGBV as reportable violence and the establishment of visible, accessible online reporting pathways that meet survivors where they already are, on digital platforms.

6.8 Shelter and support services

Geographic access remains a fundamental barrier to GBV service utilisation, particularly in highland and southern districts. The MCA service mapping documents that Mokhotlong district has approximately 16 GBV service providers compared to Maseru's 59, and specialised services such as legal aid clinics, dedicated GBV units, and shelters are concentrated almost entirely in Maseru. For survivors in Mokhotlong, Thaba-Tseka, and Qacha's Nek, accessing a specialised legal service or shelter requires travel to Maseru, often involving multiple modes of transport over mountainous terrain at significant cost. This geographic inequality directly affects the survey's finding that rural women report lower service utilisation than urban women. The barrier is not only awareness or willingness, but physical access to services that do not exist in their district.

Access to emergency shelter is a foundational component of GBV response: it provides the physical safety that enables survivors to remove themselves from danger while longer-term options are considered. In 2013, the study noted that Lapeng Care Centre in Maseru was the primary temporary shelter for GBV survivors, offering day-to-day services for men, women, boys, and girls alongside mediation, counselling, life skills, and referral services. A decade later, the 2025 data reveal that shelter utilisation has not improved. It has, if anything, approached the floor of measurability.

Table 6.13: Shelter access and outcomes, among IPV survivors, 2025

Indicator	Women %	95% CI	Men %	95% CI
Went to shelter (any IPV survivors)	**1.0**	**0.2-1.8**	**1.3**	**-0.1-2.7**
Among those who went to shelter (N=14 women; N=5 men, extreme caution)				
Got a job / economic opportunity	14.2	-3.9-32.3	10.0	-11.0-31.0
Help to look after children	18.8	-4.7-42.3	18.4	-16.9-53.7
Empowered to make decisions	6.2	-6.1-18.6	35.9	-17.9-89.8
Helped end the abuse	**42.3**	16.7-67.9	29.1	-19.7-78.0

Note: Denominator: IPV survivors (N=1,033 women; N=411 men) for shelter access rate. Shelter outcomes restricted to those who went to shelter (N=14 women; N=5 men), all confidence intervals are extremely wide, and figures are illustrative only.

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

Table 6.13 shows that the shelter utilisation rate among IPV survivors is 1.0% for women and 1.3% for men, effectively zero at the population level. This means that of the approximately 1,055 ever-partnered women in the survey sample who experienced IPV (45.7% of N=2,310), fewer than eleven went to a shelter. The World Food Programme's 2025 GBV Mapping Report locates this finding in a sharply constrained service landscape, where only one functioning shelter (Lapeng Care Centre, Maseru) serves the entire country, with an annual capacity of approximately 120 survivors; nine of ten districts have no dedicated GBV shelter; and admission criteria currently exclude self-referred survivors, adult male survivors, and boys over the age of 13.[228] The causes of near-zero shelter utilisation are therefore structural rather than attitudinal: extremely limited shelter infrastructure; lack of awareness of shelter services; economic barriers; fear that leaving for a shelter will trigger more severe retaliatory violence; concerns about children; and the social stigma associated with leaving a marriage.

The shelter landscape in Lesotho remains severely constrained. Thuso, located in Maseru, is the only fully functional shelter serving GBV survivors nationally. A shelter in Leribe exists but is currently non-functional. A new shelter supported by the Global Fund is under construction and nearing completion, which will provide the first additional functional shelter capacity outside the capital. The MCA/FHI 360 GBV service mapping exercise, which comprehensively mapped service providers across all ten districts, documented no dedicated GBV shelters or safe houses in its directory of approximately 288 providers, underscoring the severity of the gap. The shelter assessment tool used in this study has been revised following stakeholder feedback to remove the signage criterion, recognising that GBV shelter best practice requires shelters to maintain a low profile for the safety and confidentiality of residents, rather than displaying visible signage.

Among the very small group who did access shelter services (N=14 women), 42.3% report that the shelter helped end the abuse, a directionally positive outcome, though the confidence interval (16.7-67.9%) is extremely wide and the sub-sample too small for robust inference. What these figures do establish is that when shelter is accessed, it can be effective. The barrier is overwhelmingly access and awareness, not quality. Shelter is not failing the survivors who use it, but it is failing the survivors who cannot reach it.

The 'I' Stories collected for this study reinforce this pattern, no participant mentions accessing a formal shelter, but those who found any form of refuge report tangible improvement. A woman fleeing alcohol-fuelled IPV in Berea took refuge at the chief's compound with her children. The chief advised her to escalate, the police warned her partner that further violence would result in imprisonment, and she reports improvement since then. The chief's compound functioned as an informal place of safety, and the combined chief-plus-police intervention produced a positive outcome.



"He threatened to kill me, forcing me to flee to the chief for safety... The police intervention has helped me find peace of mind, and I feel more relieved now."

Berea, Participant 2

[228] World Food Programme Lesotho, GBV Mapping Report (Maseru: WFP, April 2025). Commissioned under the EU-funded support programme to CSO-led GBV initiatives.

The 2025 shelter landscape calls for urgent mapping and expansion. Priority actions flagged by the WFP mapping include compiling a national inventory of shelter facilities by district with capacity, services offered, and operational status; producing referral pathway maps from police, courts, and health facilities to shelters; and conducting a needs assessment of the minimum shelter infrastructure required to serve the estimated survivor population across all ten districts. The absence of any shelter utilisation recorded in six of the ten districts almost certainly reflects the absence of accessible facilities rather than the absence of need.

6.9 Institutional GBV

GBV also intersects with institutional systems in ways that produce harm through bureaucratic processes rather than direct violence. The following account documents salary freezing and document manipulation as compounding forms of institutional abuse.



"To this day, my salary remains frozen. The bank has refused to provide me with my bank statements. I feel that the system that is supposed to protect me has completely failed. I believe this amounts to cyber fraud and financial manipulation. I hate corruption and fraud, and it pains me to see law enforcement failing to act."

Mamello, 45, Qacha's Nek*

6.10 Legal knowledge, campaign awareness, and information access



Lesotho High Court in Majara Molupe. *Photo: GL Lesotho*

For GBV laws and services to be effective, potential users must know they exist. This section examines awareness of legal protections (protection orders, the CDV Act, the Sexual Offences Act) and GBV campaign exposure among the general population.

The legal awareness data reveal a hierarchy of knowledge that tracks inversely with the recency of legislation, where 57.3% of all respondents know that laws protecting women exist, a significant majority and higher than the 41% of women in 2013 who reported the same. Yet this general knowledge does not translate into specific legal literacy: only 25.3% have heard of protection orders, 22.6% have heard

Table 6.14: Legal knowledge and campaign awareness, all respondents

Awareness Indicator	Women %	95% CI	Men %	95% CI	Total %
Legal protections awareness (all respondents)					
Know laws exist to protect women	57.5	53.3-61.6	57.1	52.9-61.3	57.3
Heard of protection orders	25.6	22.5-28.6	24.8	21.4-28.1	25.3
Heard of the Sexual Offences Act	20.7	18.3-23.1	25.3	22.1-28.5	22.6
Heard of the Counter Domestic Violence Act 2022	**11.9**	**10.2-13.7**	**12.3**	**10.0-14.6**	**12.1**
Campaign and GBV awareness (all respondents)					
Heard of GBV awareness campaigns	26.2	22.7-29.7	29.0	25.3-32.6	27.3
Heard of 16 Days of Activism (among campaign-aware)	**45.8**	41.3-50.3	44.7	36.9-52.5	45.3
CDV Act information sources (among those who heard of the CDV Act)					
Radio	**47.0**	39.4-54.5	53.1	43.8-62.4	49.4
Community meetings	30.0	23.7-36.2	33.6	26.3-40.8	31.4
Online/social media	15.0	9.7-20.3	13.8	6.7-20.8	14.5
Television	18.8	11.9-25.8	19.0	11.5-26.5	18.9

Note: Denominators vary. Legal awareness: all respondents (N≈2,274-2,423 women; N≈1,466-1,610 men). CDV Act sources: among those who heard of the Act (N=300 women; N=214 men).
Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

of the Sexual Offences Act (broadly similar to the 35% who knew about the SOA in 2013 among a different sub-population), and only 12.1% have heard of the CDV Act 2022, Lesotho's most important recent GBV legislation, enacted three years before this survey but not yet accompanied by a structured public dissemination campaign. This awareness figure is extraordinarily low for a law that was explicitly designed to protect the population from the most prevalent form of GBV.

For GBV laws and services to be effective, potential users must know they exist

The pattern suggests a structural communications gap in the dissemination of new GBV legislation. Radio remains the dominant information channel (49.4% of CDV Act-aware respondents), consistent with the 2013 finding that 77% of SOA-aware women heard about it through radio. Community meetings (31.4%) are the second channel. Social media (14.5%) and television (18.9%) are emerging channels, reflecting Lesotho's growing digital penetration, but remain minority channels for legal information. Newspapers reach only 4.5% of the CDV Act-aware group.

Campaign awareness is also limited: only 27.3% of all respondents have heard of any GBV awareness campaign. Among those who have, 45.3% recognise the 16 Days of Activism campaign, meaning that only approximately 12.4% of all Basotho adults (27.3% _ 45.3%) are aware of the single most prominent international GBV awareness campaign. This figure, while low, reflects progress: the 16 Days campaigns have been conducted in Lesotho since the early 2010s, and their recognition among those with any campaign exposure (45.3%) is relatively high.

6.11 Political discourse and state accountability on GBV

The quality of state response to GBV is ultimately determined by political will, the demonstrated commitment of elected officials to allocate resources, enforce laws, hold institutions accountable, and publicly challenge norms that perpetuate violence. The 2025 Political Discourse Analysis (Chidhakwa, 2026), a systematic review of 156 news articles, 45 primary source documents, and 22 ministerial statements from January to December 2025, provides an unprecedented analysis of GBV in Lesotho's political arena.

Its overarching finding is that Lesotho has moved beyond denial of the problem but has yet to move into sufficient and effective action. The language of crisis is present, the legal framework exists, the institutions are in place. What is missing is the bridge between rhetoric and reality, the specific commitments, the budget allocations, the accountability mechanisms, and the engagement with traditional authority that would transform discourse into outcomes. The analysis identifies this pattern as a "performative consensus": a shared political language that signals alarm and commitment to ending GBV without the operational specificity (budgets, human and infrastructure resources, timelines, accountability mechanisms) that would make that commitment actionable. The five themes examined below- that is, parliamentary advocacy, executive discourse, traditional authority, media framing, and civil society accountability, collectively document this gap.

6.11.1 The Parliamentary Women's Caucus as the primary GBV voice

The most significant political development documented in 2025 is the emergence of the Parliamentary Women's Caucus (PWC), comprising 43 women members of the National Assembly, as the most consistent and articulate political voice on GBV in Lesotho's political discourse. The PWC's 30 March 2025 press conference, at which Chairperson Makatleho Motsoasele called on Prime Minister Ntsokoane Matekane to declare a state of emergency over GBV, was the single most prominent GBV-related political event of 2025.[229] At the same event, the Minister of Law and Justice Richard Ramoeletsi presented district-level police case data (Mafeteng: 125 cases; Qacha's Nek: 51; Mohale's Hoek: 49; Quthing: 49 for March 2024 to March 2025), providing a rare public window into official GBV caseload statistics.

The PWC's advocacy positions, calling for an emergency declaration, oversight of law implementation, and budget allocation, represent a structurally important shift. In 2013, GBV was largely addressed through executive-driven programming and civil society advocacy outside Parliament. By 2025, it had become a subject of active parliamentary oversight, with the PWC explicitly acknowledging its own institutional constraints. As Motsoasele stated, "after laws are enacted, they are handed over to other stakeholders for implementation. However, it is still our duty, through oversight, to ensure they are being enforced effectively." This acknowledgement of the legislation-implementation gap from within Parliament itself is analytically significant as it identifies precisely the structural constraint that this chapter documents in operational terms.

[229] Motaung, N., "Women MPs Urge State of Emergency Over GBV Crisis," Newsdayonline, 31 March 2025. Corroborated by Lesotho Times. Cited in Chidhakwa, K. (2026), op. cit., Key Finding 1.

6.11.2 Executive discourse, policy fluency, meeting budget specificity

The political discourse analysis examined 22 ministerial statements on GBV during 2025. Its finding is arresting. It shows that 93% of ministerial statements contained no specific mention of government budget allocations for GBV. Ministers demonstrated considerable fluency in international frameworks, referencing CEDAW commitments, GIZ Male Engage Initiative programmes, and SADC Protocol obligations, but this discursive sophistication was not matched by equivalent budget transparency or resource-commitment specificity.[230] The structural constraints on domestic GBV financing are evident in the composition of the Ministry of Gender, Youth and Social Development's own budget. In 2024/2025, social protection transfers,[231] principally the Old Age Pension, which alone absorbed 75% of the social protection allocation (M917.8 million for 82,500 recipients), consumed 88% of the Ministry's M1,381.5 million recurrent budget, leaving approximately 12% for all gender, youth, and social development programming combined (Ministry of Finance and Development Planning, 2024).

The gap between rhetorical commitment and budgetary action is the defining characteristic of Lesotho's political response to GBV in 2025. The political discourse analysis recommends that the PWC establish a public GBV implementation tracker, a publicly accessible dashboard monitoring executive implementation of GBV legislation, budget allocations, and performance indicators, as the most concrete accountability mechanism available within the legislature's oversight function.

6.11.3 Traditional authority, the unchallenged space

Lesotho's dual governance system, in which 22 Principal Chiefs sit in the Senate as ex officio members and customary court authority operates in parallel to the statutory system, creates a structural tension in GBV response that political discourse has not yet resolved. The 2025 political discourse analysis found no documented instance of an elected official publicly challenging a Principal Chief or traditional leader for discourse legitimising GBV or harmful practices.[232] This does not mean that no such challenge occurred, only that none was captured in the accessible public record. Still, it is consistent with the broader political pattern of avoiding confrontation between elected and customary authority on normative questions.

This silence has practical consequences. The Laws of Lerotholi and the dispute-resolution practices of local courts remain the primary justice-access point for the majority of Basotho in rural and mountain districts, the same districts with the highest GBV prevalence. Where customary mechanisms prioritise reconciliation over rights, and where traditional leaders do not face political accountability for responses that silence survivors, the formal legal framework's protections remain inaccessible to those who need them most.

One 'I' Story participant from Butha-Buthe reported her husband's violence to both the chief and the police. The chief, whom her husband had publicly insulted, was unable or unwilling to intervene; the police, who described themselves as friends of the perpetrator, dismissed her case. "*Despite numerous reports and case files, nothing has been done,*" she said, a lived illustration of the institutional paralysis that results when neither customary nor formal systems hold perpetrators accountable.

[230] Chidhakwa, K. (2026), op. cit., Key Finding 2: "93% of 22 ministerial statements reviewed contained no specific mention of government budget allocations for GBV."
[231] Ministry of Finance and Development Planning. (2024). Social Budget Sector Brief 2024-2025. Maseru: Government of Lesotho. Available at: https://www.cabri-sbo.org/uploads/bia/Lesotho_2024_Formulation_External_BudgetFramework_Institution_SADC_English_5125ed.pdf
[232] Chidhakwa, K. (2026), op. cit., Section 3.3: "Review of 156 articles found no documented instance of an elected official publicly challenging a Principal Chief or traditional leader for discourse legitimising GBV."

Thabiseng's story, presented in full in Chapter 8, provides the most sustained account of this dynamic. Over the course of her marriage, she approached the chief on four separate occasions. Each time, she was sent back to her abusive home. The chief, she recounted, *"was afraid of my husband's family and blamed me for everything. I was told that because bohali had been paid, I belonged [to his family]."* When she tried a final time, the chief refused to get involved altogether. Together, these accounts illustrate a pattern in which customary authority, rather than functioning as a protective mechanism, operates as a gatekeeping structure that returns survivors to the conditions from which they sought escape.

6.11.4 Media discourse

The political discourse analysis coded 156 news articles from six media outlets (Lesotho Times, Public Eye, LENA, The Reporter, Moopo, and Newsdayonline) and found that media functioned primarily as passive amplifiers of political discourse rather than active interrogators of it. Half of all articles (50%) were classified as passive transmission, that is, reproducing government statements and press conference content without contextual analysis or follow-up questions. A further 35% provided some contextualisation, locating statements within their policy context. Only 8% engaged in critical interrogation of political claims, and just 4% pursued investigative follow-up on commitments made. This framing distribution matters because media coverage is a primary mechanism through which political discourse on GBV reaches the public. When political statements are transmitted without scrutiny, the gap between commitment and implementation is not visible to the electorate.

6.11.5 Civil society and international partners

The contrast between government budget silence and international partner specificity is stark. The European Union's M168.5 million commitment to CSO-led GBV initiatives, announced in November 2025 through the #JusticeForAll campaign, with named recipients, amounts and timelines, represented the largest single GBV resource announcement of the year. Still, it was a donor commitment rather than a government budget allocation. No comparable specificity was documented in any government communication. This pattern reveals a structural dependence. The accountability functions that would ordinarily be performed by parliamentary oversight, executive budget reporting, and media scrutiny are instead being performed by internationally funded civil society.

The Ke Kabelo Ea Ka initiative, a community-level dialogue programme implemented by the Council of Churches in Lesotho and the GEM Institute, with support from GIZ, demonstrated a model of constructive engagement with traditional and religious leaders that elected officials have not yet replicated through political channels. These civil society contributions deliver results, as the service-delivery achievements documented throughout this chapter demonstrate, but they raise a sustainability question that the next generation of GBV policy must address: *what institutional mechanisms will sustain accountability when external funding cycles end?*



The Ke Kabelo Ea Ka initiative demonstrated a model of constructive engagement with traditional and religious leaders that elected officials have not yet replicated through political channels

Conclusion

The chapter finds:

- ***A strengthened legal framework, with implementation as the next frontier:*** The legal architecture governing GBV response in Lesotho is significantly stronger in 2025 than in 2013. The Counter Domestic Violence Act 2022 provides comprehensive legal protection, a statutory definition of domestic violence, a protection-order regime, and the designation of all courts as Family Courts for domestic violence matters, provisions which were absent twelve years ago. The CDV Act, alongside the Sexual Offences Act 2003, the Legal Capacity of Married Persons Act 2006, and the Children's Protection and Welfare Act 2011, constitutes a legislative framework broadly consistent with CEDAW, the SADC Protocol on Gender and Development, and the Maputo Protocol. Since the 2013 baseline, three further advances deserve recognition: Lesotho ratified ILO Convention 190 on Violence and Harassment in the World of Work in 2019, enacted the Labour Act 2024 with explicit anti-harassment provisions, and published the Legal Aid Clinics Guidelines (December 2025), the country's first national standard for legal-aid provision, EU-funded, and the first national instrument to include explicit non-discrimination language covering sexual orientation and gender identity. These are substantive gains that reflect sustained political and civil-society advocacy.

  Yet the 2025 evidence demonstrates that the law on paper and the law in practice still need to converge. The Family Court system has not yet been operationalised, presiding officers have not been designated, and family court rules have not been promulgated. Only 12.1% of the population has heard of the CDV Act, a figure that reflects the absence of a structured public dissemination campaign following enactment rather than public disengagement, and just 1.4% of IPV survivors express satisfaction with the police response. Persons with disabilities face these same implementation gaps compounded by the absence of sign language interpreters, disability intermediaries, and physically accessible court infrastructure. The strengthened legal framework is a platform built. The task now is to activate it. Each outstanding gap is specific, assignable, and costable. None requires further legislation.

- ***Survivors are responding rationally to a system being built around them:*** The lack of utilisation of formal GBV services, police (9.9%), shelters (1.0%), NGOs (0.4%), should not be read as survivor passivity or ignorance. It reflects a rational calculation. Survivors have assessed the costs (stigma, partner retaliation, loss of economic support, family pressure) and benefits (justice, safety, services) of engaging formal systems and, at present, find the calculus unfavourable. This calculation is grounded in experience: when survivors do report to police, four in five cases do not result in an arrest, a pattern driven by mediation practices, withdrawal of complaints under family pressure, evidentiary barriers, and limited CGPU capacity in remote stations. When they reach the health system injured, the provider may not ask about the cause. When they turn to family, one in ten is told to keep quiet. The DHS 2023-24 help-seeking pattern (45% told no one, 49% went first to their own family) corroborates this calculation at the national scale. The response system must now demonstrate, at the population level, that engaging in it produces better outcomes than silence. The expansion of shelter infrastructure to all ten districts, the operationalisation of the Legal Aid Clinics Guidelines across the 56 existing providers,

particularly in hard-to-access areas, and the promulgation of the CDV Act's family court rules are three near-term actions that can begin to shift that calculation.

- ***The political arena is active, but it needs to connect to accountability mechanisms:*** The emergence of the Parliamentary Women's Caucus as a structured, persistent, and articulate political voice on GBV is the most significant institutional development of the 2013-2025 period in the political-response domain. The PWC's March 2025 state-of-emergency call, its oversight function, and its explicit acknowledgement of the implementation gap give the GBV agenda a parliamentary champion that did not exist in the same form in 2013. The finding that 93% of ministerial statements contain no budget specificity reveals that parliamentary advocacy and executive accountability are not yet connected by the mechanisms, budget oversight, performance tracking, and consequences for non-implementation that convert political rhetoric into operational change. The political discourse analysis's recommendation for a public GBV implementation tracker merits serious consideration: transparency and accountability in GBV law implementation should not be contingent on advocacy capacity alone but embedded in routine parliamentary oversight.

- ***The infrastructure for justice is ready to be rebuilt:*** Several of the response gaps documented in this chapter are infrastructure problems with known solutions. The forensic laboratory must be rebuilt; its absence is a physical constraint that is measurably impeding the prosecution of sexual violence. Shelter infrastructure must be geographically distributed across all ten districts. WFP estimates a minimum need for nine additional shelters to match survivor demand. The CDV Act's family court rules must be promulgated, a regulatory action within the executive's direct power that would unlock the Act's civil protection mechanisms without requiring new legislation. The Children's Court must be resourced with probation hostels, sign-language interpreters, and post-sentencing tracking capacity, investments that are small in fiscal terms relative to their impact on justice outcomes for child survivors and perpetrators. The Legal Aid Clinics Guidelines (December 2025) provide the national framework for consolidating the 56 existing legal-aid providers into a single quality-assured system, extending the FIDA paralegal model (72 paralegals, four districts, 11 trafficking cases in 2023-25) to a national footprint. GBV clinical inquiry protocols must be standardised and enforced in primary health care, so that the 10.3% of women who do not disclose because the provider did not ask falls to zero. These are not aspirational goals requiring long-term systemic transformation. They are specific, costed, and assignable actions that can and must be taken immediately.

CHAPTER 7
SUPPORT SERVICES FOR GBV SURVIVORS



Sunrise Campaign: Entreprenuership training, Sephokong Council in Lesotho, 2019. *Photo: Ntolo Lekau*

Key findings

- Family remains the primary support source for GBV survivors (women 56.6%; men 37.8%), with men relying more on friends (39.9% vs 25.8%), a pattern independently confirmed by the DHS 2023-24.
- Only 29.1% of all respondents know where to get help for GBV (women 34.9%; men 20.6%), and just 12.4% are aware of community GBV services.
- Police reporting (9.9% women; 7.5% men) and shelter utilisation (1.0% women, reflecting that a dedicated shelter exists only in Maseru) remain structurally unchanged from 2013.
- Lesotho has one functioning dedicated shelter (Lapeng, 120 places/year) against a mapped deficit of nine additional facilities (WFP, 2025).
- All ten district hospitals provide 24-hour post-sexual-violence care, an existing infrastructure base for standardised clinical inquiry.
- The Legal Aid Clinics Guidelines establish the first national standard across 56 providers, with explicit LGNTIQ+ non-discrimination provisions.
- Adolescent support-seeking is the lowest of any age group (12.8%), rising to a peak of 27.5% among those aged 35-44.
- The Nokaneng app, zero-rated on Vodacom, provides the first digital GBV information platform in SADC, though population-level awareness remains at 4.2%.
- Women with disabilities report higher lifetime IPV (50.9% versus 44.6%) yet face inaccessible formal services.
- LGBTQI+ survivors have no dedicated referral pathway within the formal support system.

From silence to healing



"I first experienced abuse when I was very young, though at the time I did not recognise it as such. I grew up exposed and vulnerable, often neglected. A man from the village found me and abused me sexually, threatening me with a sharp weapon if I ever spoke out. I carried pain and shame silently, and as I grew, I became withdrawn and isolated. Later, I met a man who showed me love and support. He married me, despite his parents' disapproval, and we moved to Maseru, where he cared for my child. For a time, life seemed better, but soon he began to abuse me, too. He beats me often, even in front of the children. Eventually, I sought help from SHE HIVE, where I shared my story and began to heal. My life has been marked by repeated abuse, silence, and survival. Yet through support groups and resilience, I continue to fight for myself and my children, hoping for a life free from violence and fear."

Mathuto, Maseru*

Mathuto's story opens this chapter because she navigated virtually every support pathway this chapter examines, that is, neighbours, police, informal community structures, and finally a civil society organisation (She-Hive). The 0.3% NGO disclosure rate in the survey means almost no survivors in Lesotho are finding what Mathuto found. Her story shows what they are missing, not just services, but the beginning of healing.

Overview

This chapter maps the support landscape available to GBV survivors in Lesotho. It traces the pathways survivors use, from informal disclosure to family and friends through to formal services including police, health, legal aid, psychosocial counselling, and shelter. The chapter documents service awareness levels, examines the civil society support architecture, and assesses disability-inclusive and LGBTQI+-inclusive practice. It tracks changes in the support landscape since the 2013 baseline and identifies the structural gaps, geographic concentration, limited specialisation, and fragile funding that the recommendations in Chapter 10 are designed to address.

7.1 Introduction

Support for survivors of gender-based violence encompasses a continuum from immediate crisis response through to long-term recovery, spanning physical safety, psychological healing, economic independence, and social reintegration. In Lesotho, as across sub-Saharan Africa, this continuum is provided through a layered ecosystem of informal and formal support structures whose relative roles, strengths, and limitations have been shaped by cultural norms, resource constraints, and the geographic and institutional architecture of services. The 2013 baseline study found that informal support, particularly family, dominated survivors' actual help-seeking, while limited reach, inadequate resources, and survivor experiences of re-victimisation characterised formal services. This chapter examines what has changed in support of service access, utilisation, and quality over the twelve years

since the baseline. It identifies the concrete investments that can close the access gap at the national scale.

The chapter draws on the 2025 survey's support-seeking data (Tables 7.1-7.5) alongside the qualitative evidence from the 2013 case studies and "I" stories, updated with the current civil society landscape documented in the World Food Programme's 2025 GBV Mapping Report.[233] The WFP mapping is the most comprehensive national inventory of GBV service providers available in 2025 and provides the primary service-landscape evidence for this chapter. It complements the MCA-commissioned GBV service mapping (FHI 360/EGPAF, Assessment 5), which mapped approximately 288 providers across all ten districts with a focus on health-facility readiness and GBV case management capacity. The WFP mapping emphasises referral pathways and service coordination, while the MCA mapping provides the facility-level clinical capacity baseline. Together, they constitute the most complete picture of Lesotho's GBV service landscape to date. That mapping, the first national inventory of GBV service providers since 2013, documents 57 Child and Gender Protection Unit offices, one functioning dedicated shelter (Lapeng Care Centre) with an annual capacity of approximately 120 survivors, and a service deficit of nine additional shelters to match survivor demand across the ten districts. Complementary evidence is drawn from the Demographic and Health Survey 2023-24 (help-seeking data at national scale), the Thuso Project 2026 shelter assessment and CGPU key informant interviews (SOGIE-inclusive practice), the MCA District Directory (health facility inventory), LNFOD (disability-inclusive service provision), and key informant interviews with LPPA, FIDA, Kick4Life, Care for Basotho, She-Hive, and Vodacom Foundation conducted during the 2025 round.

The analytical framework distinguishes four tiers of support:

- immediate informal support (family, friends, community);
- traditional and customary support (chiefs, community elders, local courts);
- formal statutory support (police, health system, courts, social welfare), and
- civil society and specialist support (NGOs, shelters, counselling services, psychosocial programmes).

These tiers are not mutually exclusive; survivors may move between them simultaneously or sequentially, but they operate under different norms, with different accountability structures, and with different capacities to provide safe, rights-based support. The 2025 data show that the informal tier dominates actual utilisation, while the formal and civil society tiers, where rights protections are strongest, remain within reach of a small fraction of survivors. Closing that gap is the central practical agenda of this chapter.

All ten district hospitals provide 24-hour post-sexual-violence care, an existing infrastructure base for standardised clinical inquiry

[233] World Food Programme Lesotho, GBV Mapping Report (Maseru: WFP, April 2025), commissioned under the EU-funded support programme to CSO-led GBV initiatives. Consultant: Dr Elmon Hapazari (NUL Sociology). The WFP mapping is the most comprehensive national inventory of GBV service providers available in 2025 and provides the primary service-landscape evidence for this chapter.

7.2 Informal support: family as the primary safety net

Research consistently finds that survivors of intimate partner violence first disclose to informal networks, typically family members and close friends, before or instead of engaging formal services.[234] Lesotho is no exception. The 2013 study found that 63% of women who had experienced abuse told someone in their family, with 73% of those disclosures going to female family members and 88% receiving supportive responses. These high rates of family disclosure and positive family reception constituted one of the more encouraging findings of the 2013 report, suggesting that the informal network, while not a rights-based protection mechanism, provided genuine emotional support for most women who used it.

Table 7.1: Disclosure of violence, GBV survivors, 2025

Disclosure outlet	Women %	95% CI	Men %	95% CI	Total %	p-value
Among those who disclosed to someone (N≈116 women; N≈38 men)						
Told a family member	**57.7**	46.1-68.5	46.0	25.6-67.8	54.8	0.411
Among all GBV survivors (N≈1,706 women; N≈783 men)						
Told partner's family	1.1	0.6-2.0	0.9	0.4-2.2	1.1	0.693
Told the religious leader	0.1	0.0-0.4	0.0	-	0.1	0.407
Told the NGO worker	0.3	0.1-0.7	0.2	0.0-1.9	0.3	0.782

Note: Two denominators: "among those who disclosed" (N≈116 women, N≈38 men - weighted) for family disclosure; "all GBV survivors" (N≈1,706 women, N≈783 men - weighted) for remaining items. *Source: Lesotho GBV 2025 Prevalence Survey, Gender Links*

Table 7.1 confirms that family remains the primary disclosure channel for GBV survivors in 2025. Among those who disclosed to anyone, 57.7% of women and 46.0% of men told a family member, proportions broadly consistent with the 2013 finding of 63% family disclosure among women. The gender difference in family disclosure (57.7% versus 46.0%) is not statistically significant (p=0.411), suggesting that both women and men turn to family as their primary disclosure outlet when they do disclose. However, the overall disclosure rate is lower for men than for women, as established in Chapter 6.

The Demographic and Health Survey 2023-24 independently confirms this pattern at the national scale. Forty-five % of ever-married women who experienced physical or sexual violence told no one and sought no help. Of those who sought help, 49% turned first to their own family, 29% to the police, and small fractions to health providers, religious leaders, or formal services.[235] The convergence of two independent national datasets, the GL 2025 survey and the DHS 2023-24, on the same pattern gives Lesotho an unusually robust evidence base for service design. Any strategy to improve survivor outcomes must work with informal family networks rather than around them and must design formal services that survivors can reach from within those networks rather than in place of them.

At the population level, among all GBV survivors, rather than only those who disclose, the picture is characteristically sparse. Only 1.1% told a partner's family, 0.1 % told a religious leader, and 0.3 % told an NGO worker. These near-zero figures across all population-level disclosure channels outside immediate family

[234] Ansara, D.L. and Hindin, M.J., "Formal and Informal Help-Seeking Associated with Women's and Men's Experiences of Intimate Partner Violence in Canada," Social Science & Medicine 70(7) (2010): 1011-1018; Coker, A.L. et al., "Social Support Reduces the Impact of Partner Violence on Health," Preventive Medicine 30(4) (2000): 321-329.

[235] Ministry of Health, Lesotho, and ICF, Lesotho Demographic and Health Survey 2023-24 Final Report, Table 17.21 (Help-Seeking). Denominator: ever-married women aged 15-49 who experienced physical or sexual violence.

confirm what Chapter 6 established. The overwhelming majority of GBV survivors in Lesotho share their experience with no one outside their immediate family, and formal and civil society support channels remain within reach of a small fraction of the survivor population they are designed to serve.

The 2013 study found that when the family was told, 88% of respondents received supportive responses, with only 1% told to keep quiet and less than 0.5% blamed for the abuse. The Chapter 6 data on response to disclosure (Table 6.10) show that 8.3% of women and 10.4 % of men who disclosed in 2025 were challenged to tolerate or keep quiet, a higher rate of harmful responses than recorded in 2013. This directional shift likely reflects both the more complex relational contexts in which disclosure now occurs and the greater assertiveness of survivors in naming experiences as abuse, which is itself a positive change that carries transitional costs.

7.2.1 Disability-sensitive informal support

The 2025 survey finds that women with any disability report a lifetime IPV prevalence of 50.9%, compared with 44.6% among women without disabilities. For men, the pattern is less pronounced: 27.3% with disability versus 28.3% without, suggesting that the disability-violence intersection operates differently across genders and warrants further investigation. The Lesotho National Federation of Organisations of the Disabled (LNFOD), the umbrella body representing eight disability-focused member organisations, provides the qualitative context for this disparity.[236] LNFOD's 2024 study found that 74% of respondents agreed women and girls with disabilities are the group most affected by GBV in Lesotho; sexual violence affected 38% of persons with disabilities surveyed, and emotional violence 44%. LNFOD also established district offices in Berea, Leribe, Butha-Buthe, and Mohale's Hoek in 2024, with community paralegals and focal persons trained to accompany survivors through justice processes. Section 32 of the Persons with Disabilities Equity Act 2021 mandates the Chief Justice to rule on how courts accommodate survivors with disabilities, an enabling legal framework that, once operationalised, would address the interpreter, accessible facility, and assistive-device gaps LNFOD documents across the justice system. LNFOD's GBV-CW Disability Inclusion Guidance, published in 2025, offers the first national checklist for providers on disability-inclusive GBV service delivery, and is the reference that the next service-mapping cycle should be used to audit each district's compliance.

7.3 Support sources and gender differentials

Table 7.2 extends the disclosure analysis to the sources of support accessed by GBV survivors, distinguishing who provided support from who was merely told about the violence. This distinction matters. Survivors may disclose to family but receive their primary emotional support from friends or may access multiple support sources simultaneously. The data reveal striking gender differentials in support-seeking patterns that carry direct implications for service design.

[236] Lesotho National Federation of Organisations of the Disabled, Gender Analysis Study (Maseru: LNFOD, 2024). The 2024 study updates LNFOD's 2020 baseline and uses mixed methods across all ten districts.

Table 7.2: Support sources accessed by GBV survivors

Support source	Women %	95% CI	Men %	95% CI	Total %	p-value
Informal support sources (all GBV survivors, N≈1,706 women; N≈783 men)						
Support from family	**56.6**	52.8-60.4	**37.8**	33.7-42.1	**50.7**	<0.001
Support from friends	25.8	22.8-29.0	**39.9**	35.1-44.9	30.2	<0.001
Support from spouse/partner	17.2	14.9-19.7	**28.5**	24.4-33.0	20.7	<0.001
Support from a religious leader	3.3	2.3-4.6	3.3	2.0-5.5	3.3	0.948

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

7.3.1 The family support advantage

Family is the dominant support source for women survivors, with 56.6 % of women GBV survivors reporting receiving support from family, compared with 37.8 % of men, a statistically significant 18.8 percentage-point gender gap (p<0.001). This gap has two likely explanations. First, women's social networks in Lesotho are more centred on extended family than men's, consistent with the patrilocal marriage system, where women move into their husband's family at marriage but often retain strong ties to their birth family as a refuge. Second, the female family members who constitute the primary disclosure recipients (73 % in 2013) may be better positioned to offer practical and emotional support to female survivors than the mixed-gender or male-dominated networks through which male survivors may seek help.

The gender asymmetry inverts for friend-based support, with 39.9 % of men receiving support from friends compared with 25.8 % of women, a significant 14.1-% percentage-point gap (p<0.001). This finding is consistent with research across sub-Saharan Africa showing that men's social support networks are more peer-centred and friendship-based than women's, reflecting masculine norms that channel emotional disclosure toward peers rather than family.[237]

For male GBV survivors specifically, peer networks of male friends who can receive disclosures about victimisation without the social stigma attached to formal disclosure may constitute a critical informal support pathway that is largely invisible to formal service systems and programme designers. Peer-led male survivor support initiatives, where friends actively support male victims, are an underexplored and potentially high-impact intervention pathway in the Lesotho context.

A clarification on service availability for male GBV survivors is warranted. While the survey documents that men also experience intimate partner violence and other forms of GBV (28.2% lifetime IPV), the service landscape in Lesotho is almost exclusively oriented toward female survivors. No dedicated shelter, counselling centre, or support group for male GBV survivors was identified in either the survey's service assessment or the MCA service mapping exercise. Men who seek support typically access general psychosocial services through health facilities or NGOs such as the Lesotho Planned Parenthood Association (LPPA), but these services are not specifically designed to address male experiences of GBV. This service gap is significant because the survey data on male victimisation suggests a population-level need that is entirely unmet by the current service architecture.

Informal support from family, friends, community, and places of worship remains the primary recovery system for the majority of GBV

[237] Jewkes, R., Morrell, R., Hearn, J. et al. (2015). "Hegemonic masculinity: Combining theory and practice in gender interventions." Culture, Health & Sexuality, 17(sup2), 112-127.

survivors in Lesotho. This is not a gap. It is a resource. The account below illustrates how informal networks operate in practice, and both their power and their limits:



"Through prayer and support from members of their faith community and friends, I found the strength to cope. A businessman even bought me an expensive rosary and sponsored a trip to Durban, which helped me heal. During this time, some of my friends became distant. I felt abandoned. But one trusted family member encouraged me not to fight for the relationship, but to fight for my justice, to reclaim what was forcefully taken from me and to stand up for myself."

Berea Participant 8

7.3.2 Spouse and partner as support source - a complex finding

The finding that 28.5% of male GBV survivors receive support from their current spouse or partner is significantly higher than the 17.2% of women survivors ($p<0.001$) and requires careful analytical framing. In the bidirectional framework of the 2025 study, "GBV survivor" includes men who have experienced IPV from their female partners as well as men in mutual-violence relationships. For men whose GBV experience occurred outside their current relationship, the current spouse or partner may indeed be a genuine support source. Where the IPV experience involves the current partner, "support from spouse/partner" may reflect complex dynamics of reconciliation, minimisation, or continuation of the abusive relationship that do not constitute genuine protective support. This ambiguity warrants a qualitative investigation in the next round.

For women, the lower rate of spousal/partner support (17.2%) reflects the more typical IPV dynamic. Where the partner is the perpetrator, the partner cannot simultaneously be the support source. Women's higher family support rates (56.6%) relative to men's (37.8%) likely compensate for this structural limitation. Women in abusive relationships turn to their birth family as the primary alternative to partner support that is unavailable or unsafe.

7.3.3 Emerging engagement opportunity with religious leaders

In this report, the term 'place of worship' is used rather than 'church' to reflect Lesotho's religious diversity. While Christianity predominates, the survey's questions about faith-based support and coping are not limited to Christian institutions. Respondents who reported seeking support from religious leaders or faith communities may have accessed a variety of religious institutions. The use of inclusive terminology reflects the survey instrument's intent to capture all faith-based support, not only that provided through Christian denominations.

Religious leaders provide support to 3.3 % of GBV survivors, an identical rate for women and men ($p=0.948$). In a country where religious institutions are ubiquitous and deeply embedded in community life, this figure represents a significant opportunity for growth. The 2025 gender attitudes data (Chapter 4) showed that 74.2 % of women and 64.6 % of men agree that women and men should be treated equally, a normative foundation on which faith-based GBV programmes can build. The Ke Kabelo Ea Ka programme represents one

active effort to engage religious leaders in GBV prevention. Its community dialogue model is designed to scale, and progress in religious leader engagement as a support source for survivors should be a measurable outcome in the next round.

7.4 Formal support (police, health, and legal aid services)

The formal justice and legal system as a support pathway for GBV survivors was examined in depth in Chapter 6. This section contextualises those findings within the support framework, focusing on the quality of the support experience within formal systems and on the practical barriers that the 2025 mapping exercise identifies as addressable.

7.4.1 The Child and Gender Protection Unit

The CGPU is Lesotho's specialist police response to GBV and child protection. The WFP 2025 GBV Mapping Report documents 57 CGPU offices across the country, one in every district and substations in higher-demand areas, supported by 21 dedicated personnel at the central level.[238] The CGPU also maintains three safe spaces (northern, central, and southern), providing 48-hour emergency shelter within police compounds. These were funded through the Global Fund and are now transitioning to government sustainability. As established in Chapter 6, police reporting rates among IPV survivors are 9.9% for women and 7.5% for men, meaning many survivors do not currently engage the police as a support resource. Among those who do report, 1.4% of all IPV survivors express satisfaction with the police response. These figures establish the baseline against which CGPU reforms, including the SOGIE-inclusive SOP reforms flagged in 6.4.7, will be measured in the next round.

The Thuso Project's CGPU key informant interviews (2025) confirm a specific gap that current reform can close. None of the three CGPU offices sampled, Maseru, Berea, and Leribe, had standard operating procedures that explicitly included LGBTQI+ or transgender persons. Data systems recorded only male or female, and inclusive infrastructure was absent.[239] The Legal Aid Clinics Guidelines provide the first national legal anchor for SOGIE-inclusive practice across all service points and offer a ready template for updating CGPU SOPs, intake forms, and training curricula.

7.4.2 Health sector support

Lesotho's health system provides an infrastructure base for GBV support that the 2013 baseline did not fully document. The Millennium Challenge Account (MCA) District Health Facility Directory, complemented by the MCA GBV Service Mapping under Primary Healthcare (FHI 360/EGPAF, Assessment 5) and Facility Mapping under Digital Health, confirms that all ten district hospitals and the majority of major health centres offer 24-hour post-sexual-violence care, including sexually transmitted infection prophylaxis, comprehensive Post Exposure Prophylaxis for STIs and HIV (PEP), emergency contraception, and crisis counselling referrals.[240]

[238] WFP (2025), op. cit., Chapter 3 (Police and Justice Service Providers). CGPU established 2002; expanded to district coverage following the Sexual Offences Act 2003.
[239] Human Rights Lab Lesotho, Thuso Project Baseline Study + Datasets (Maseru: HRL, February 2026), CGPU Key Informant Interviews section.
[240] Millennium Challenge Account Lesotho, District Health Facility Directory (Maseru: MCA, 2024). The Directory is part of a broader MCA mapping architecture that includes the GBV Service Mapping under Primary Healthcare (FHI 360/EGPAF, Assessment 5, covering approximately 288 providers across all ten districts) and the Facility Mapping under Digital Health.

The practical constraint is that this infrastructure is not systematically linked to CGPU and civil society referral pathways, and that GBV clinical inquiry protocols in primary health care, as outlined in the WHO Clinical Management of Rape and Intimate Partner Violence Survivors (WHO/UNFPA/UNHCR, 2020) and accompanying job aids, are not standardised.[241] The 10.3% of women survivors in the 2025 survey who did not disclose because the health provider did not ask about the cause of their injuries represents a correctable gap. Standardising indicator-based clinical inquiry at antenatal, outpatient, and emergency presentations would convert existing health infrastructure into an active disclosure pathway.

Specialist sexual and reproductive health NGOs provide complementary capacity. The Lesotho Planned Parenthood Association (LPPA) operates four clinics that provide a minimum SGBV package, which includes HIV testing, STI prophylaxis, emergency contraception, comprehensive PEP, psychosocial support, and referral free of charge to survivors. LPPA reports approximately one to five SGBV cases per week across its four clinics, acknowledging that low uptake partly reflects the incomplete service cascade that routes complex cases to larger facilities. LPPA's non-re-traumatising counselling protocol ("we don't force them to recall") represents a survivor-centred practice approach.

7.4.3 Legal aid, a landscape now under national standards

Legal aid services present the clearest structural advance of the 2013-2025 period. At baseline, legal representation in GBV matters was largely contingent on financial capacity and concentrated in Maseru. The Legal Aid Clinics guidelines, discussed in Chapter 6, establish the first national standard for legal-aid provision across 56 providers, with explicit non-discrimination language and EU support.[242]

Administrative data from the **Legal Aid office** (January 2025 to March 2026) provides a quantitative window into the volume and nature of GBV-related cases entering the formal justice system. During this period, Legal Aid handled 45 divorce cases citing financial abuse (44 women, 1 male applicant) and 14 domestic abuse divorce cases (12 women, 2 men), confirming that economic IPV is the dominant trigger for legal separation, consistent with the survey's finding that economic abuse remains the most resistant form of IPV to change. In the public violence category, Legal Aid recorded 28 sexual abuse cases, 16 physical assault cases, and 3 emotional abuse cases. A critical caveat applies. Legal Aid primarily represents perpetrators (defendants) in these matters, meaning the data reflect perpetrator demographics rather than survivor outcomes. Nevertheless, the gender skew (overwhelmingly female applicants in divorce, predominantly male defendants in violence cases) and the volume of cases processed within 15 months indicate sustained demand on a service that operates in only some districts.

WLSA's paralegal model represents an additional dimension of the legal aid landscape. Under its "Stepping Up Universal Access" project (a multi-sector partnership response to TB and HIV under the Global Fund), WLSA deploys paralegals and team leaders in six districts who provide legal education, screen beneficiaries, particularly adolescent girls and young women aged 15-24, and refer GBV-related cases to project lawyers. As of February 2026, WLSA had received 1,549 cases through paralegal referrals, covering GBV (emotional, economic, sexual, and physical abuse), violence against children, and human rights violations. The organisation provides mediation, court representation across all districts, and transport

[241] WHO (2013). Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva: World Health Organization. ISBN: 978-92-4-154859-5.
[242] Ministry of Law and Justice, Legal Aid Clinics Guidelines (Maseru: MoLJ, December 2025). EU-funded. First national instrument to include explicit non-discrimination language covering sexual orientation and gender identity.

assistance for vulnerable beneficiaries who cannot physically reach services. However, the Law Society's withdrawal of practising certificates for NGO lawyers currently limits WLSA's direct court representation capacity, forcing reliance on costlier external law firms.

The **Federation of Women Lawyers (FIDA)** Lesotho paralegal network, with 72 trained paralegals across four districts, 11 trafficking-in-persons cases identified through community referral in 2023-25, 56 direct cases handled at Maseru clinic in 2024 (11 domestic violence, 16 maintenance, 6 custody), represents the community legal-support model the guidelines seek to standardise and expand. The survey finds that a significant proportion of survivors who report do not pursue charges to conclusion. This is not reluctance, but it is the rational calculation of a person facing economic dependence, family pressure, and prior experience that the system will not protect her.



"Not long after I dropped the case, he started beating me again. This time, the violence was worse, my eyes were swollen shut. I reported him to his family many times, and they saw the injuries he caused. Instead of holding him accountable, they paid bail for him. To this day, the case has never been properly attended to."

Thaba-Tseka Participant 6

7.5 Psychosocial support and counselling services

The mental health consequences of GBV, established in Chapter 5, with 65.8 % of women survivors and 60.2 % of men who experienced IPV meeting the CES-D threshold for clinically significant depression, and approximately one in four meeting the PCL-5 threshold for probable PTSD, constitute a substantial unmet need for psychosocial support. The 2013 study documented a mental health system characterised by severe under-resourcing: a psychiatrist-to-population ratio of 0.05 per 100,000, 2.9 psychiatric beds per 100,000, and PHC-level nurses prohibited by policy from independently diagnosing and treating mental health conditions. At the hospital level, psychiatric nurses are permitted to perform such services, but this capacity does not extend to primary care facilities. This section examines what psychosocial support resources currently exist for GBV survivors and where expansion is needed.

The qualitative evidence from the administrative data fills out this picture. **LPPA** confirmed that its SGBV services are free and that psychosocial counselling avoids re-traumatisation. However, it noted that some survivors do not return for follow-up, pointing to the need for community-based outreach to complement facility-based services.

The qualitative evidence from the 2013 case studies, the **Lesotho Child Counselling Unit** and She-Hive, continues to anchor the specialist psychosocial landscape. Both operate from Maseru. The Lesotho Child Counselling Unit, targeting traumatised children aged 2-17, offers individual, group, and family therapy, temporary shelter for up to 40 children, and community outreach. Its sustainability challenges (children sometimes accommodated for more than five years due to the absence of a family willing or able to take them; dependence on donor funding addressed through income-generating projects, including poultry farming) reflect the broader vulnerability of child-focused psychosocial services.

She-Hive, a survivor-led organisation providing monthly survivor circles, counselling, legal

advice, and school-based human rights clubs, demonstrates the power of peer-led survivor support in creating safe disclosure spaces. She-Hive also led a landmark 2024 pregnancy termination rights case that established an important precedent on survivor access to safe termination services under Lesotho law.

A current national inventory of psychosocial support providers across the ten districts, with estimated reach, funding base, and bi-directional service capacity (women and men survivors, and therapeutic intervention for perpetrators), is a priority for the next round. The WFP 2025 mapping provides the starting baseline, and the Legal Aid clinics guidelines (2025) provide the standards framework for consolidating it into a national service directory.

Multiple institutional informants independently confirmed a critical gap in psychosocial support for GBV survivors. The DPP stated that no counselling services exist for witnesses at courts, perpetrators in prison receive counselling, but complainant witnesses who undergo the trauma of testifying receive none. The **Lesotho National Broadcasting Service (LNBS)** noted that when survivors contact its programmes



Sesotho Media at Lekope FM addressing issues related to GBV, HIV & AIDS and SRHR in 2025. *Photo: SM&D*

seeking support, staff have no free counselling services to refer them to and sometimes use personal funds to assist callers in distress. The Ministry of Health confirmed that psychosocial support typically ends after the immediate clinical intervention, with no structured community reintegration or follow-up counselling available. This convergence of evidence from justice, media, and health actors indicates a systemic absence rather than isolated service gaps.

7.6 Shelter and safe houses

The evidence on shelter access and utilisation from Chapter 6 (Table 6.13) established that only 1.0 % of women IPV survivors and 1.3 % of men accessed shelter, near-zero utilisation driven by infrastructure scarcity rather than service quality. The WFP 2025 GBV Mapping Report quantifies the supply side of that finding with precision. Lesotho has one functioning dedicated GBV shelter (Lapeng Care Centre, Maseru), with an annual capacity of approximately 120 survivors (around 10 per month), and a national deficit of nine additional shelters to match estimated demand across the ten districts.[243] A shelter in Leribe exists but is currently non-functional following storm damage, and a new Global Fund-supported shelter is nearing completion.

Administrative data from **Lapeng Care Centre**, one of Lesotho's few residential shelters, provide concrete evidence of shelter utilisation patterns. Between 2023 and 2026, the Centre accommodated approximately 60 residents across three annual intake cohorts (25 in 2023/24, 25 in 2024/25, and 10 in the current incomplete year). The age profile is striking. Approximately 60% of residents are children aged 0-18, reflecting the Centre's dual role as both a GBV

[243] WFP (2025), op. cit., Chapter 4 (Shelter and Safe Accommodation). The nine-shelter deficit is based on the WFP mapping's geographic distribution of caseload versus facility availability.

shelter and a child protection facility. Sexual abuse (including incest) is the most prevalent reason for admission (21 cases), followed by physical abuse (16), child neglect (10), financial abuse/destitution (4), and emotional abuse (2). Geographically, residents come predominantly from Maseru and Mafeteng districts. The data confirm that shelter capacity in Lesotho remains severely constrained, against a population in which 45.7% of ever-partnered women report lifetime IPV.

Lapeng's admission criteria are a separate constraint. The facility does not accept self-referred survivors (referrals are limited to police, courts, and partner NGOs), does not accommodate adult male survivors, and accommodates boys only between the ages of 8 and 13. These criteria are the documented reason that no adult male survivor and no self-referred survivor in the 2025 sample reached the facility.

7.6.1 Inclusive shelter practice

The Thuso Project's November 2025 shelter assessment of Lapeng Care Centre applied a 12-criterion inclusion checklist (designed for LGBTQI+ inclusion).[244] Lapeng passed on four criteria (safe and discreet location; bathroom privacy; neutral toilet signage; inclusive dining and communal areas); partially passed on two (counselling room doubles as administrative office; exterior signage, though the absence of signage is a deliberate safety measure consistent with international shelter practice, not a deficiency, and the assessment tool has been adapted accordingly); and did not meet four inclusion criteria (intake forms female-only with no non-binary options; women-specific branding; absence of gender-neutral accommodation; shared rooms with limited in-room privacy). The Thuso assessment's conclusion captures a dual reality. Lapeng's female-specific design reflects its founding mandate to serve women and girl survivors, while the inclusion criteria identify where the next generation of shelters can expand access to transgender, non-binary, and male GBV survivors without compromising the safety principles that Lapeng's design embodies.

7.6.2 The one-stop centre opportunity

The Multi-Purpose Centre in Maseru, renovated by the Vodacom Foundation and launched in November 2025, represents a meaningful advance and a model for replication. UNFPA confirmed physical rehabilitation was complete, and logistical planning for its operation was underway. From an international best-practice perspective, the one-stop centre model, providing integrated health, legal, counselling, and shelter services from a single facility, ideally co-located with a health facility, is the most effective documented approach to comprehensive GBV survivor support in low- and middle-income country settings.[245] South Africa's Thuthuzela Care Centre[246] - the model is the regional benchmark, and Lesotho's Multi-Purpose Centre provides the national pilot from which a nine-facility national rollout can be costed and sequenced. In addition, a new shelter supported by the Global Fund is nearing completion, which will provide the first additional functional shelter capacity outside Maseru. Together with the Leribe shelter currently being revamped after storm damage, these facilities represent the beginning of the geographic expansion that the nine-shelter deficit demands.

[244] Human Rights Lab Lesotho, Thuso Project Shelter Assessment (Maseru: HRL, November 2025). Assessment tool adapted from UNHCR LGBTI-inclusive shelter standards.
[245] Colombini, M. et al., "One-Stop Shop Models of Care for Survivors of Intimate Partner Violence: A Global Review," Reproductive Health Matters 19(37) (2011): 11-21; United Nations, Ending Violence Against Women: From Words to Action (New York: UN, 2006).
[246] Thuthuzela Centres Google My Maps. Available at: https://www.google.com/maps/d/viewer?mid=1J5vQRQD2NXR36hwuig8OhV8uO2B5JX0i (Accessed: 5 June 2026).

A minimum national shelter and one-stop centre standard for Lesotho should include:

- at least one dedicated safe house or shelter facility in each of the ten districts, with priority for the highest-prevalence districts of Mohale's Hoek, Quthing, Mokhotlong, and Maseru as established in Chapter 3;
- 24-hour accessible services including emergency medical care, Comprehensive Post Exposure Prophylaxis for STIs and HIV (PEP), trauma counselling, and legal information;
- physically accessible facilities compliant with disability-inclusive design standards, including for survivors with mobility, sensory, and cognitive impairments;
- trained staff with GBV-specific, SOGIE-inclusive, and disability-responsive competencies;
- referral pathways from police, CGPU, and health facilities; and
- accessible transport arrangements for survivors in remote communities and survivors with disabilities.

The funding pathway should align government budget allocation with the EU's M168.5 million CSO commitment and the Global Fund's existing CGPU safe-space base.

7.7 Service awareness and digital service directories

Awareness of available support services is a necessary condition for utilisation. Table 7.3 examines awareness of GBV services and digital tools among all respondents, while Table 7.4 examines how support-seeking behaviour varies by age, education, and settlement type among GBV survivors.

Table 7.3: GBV services knowledge

Knowledge item	Women (%)	N	Men (%)	N	Total (%)	N	p-value
Aware of local places to get help	54.1	2448	48.6	1614	51.9	4062	0.0081
Know where to get help for GBV	34.9	2255	20.6	1547	29.1	3802	0.0000
Heard of the Sexual Offences Act	20.7	2410	25.3	1597	22.6	4007	0.0114
Aware of community GBV services	14.2	2565	9.5	1689	12.4	4254	0.0019
Know about GBV-related apps	5.4	2565	2.4	1689	4.2	4254	0.0000

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

The awareness findings in Table 7.3 reveal a substantial knowledge gap. Only 29.1% of all respondents know where to get help for GBV, with a pronounced gender gap: 34.9% of women versus 20.6% of men. Awareness of local places to get help is higher (51.9%), suggesting that general service awareness exceeds GBV-specific knowledge; that is, respondents may know where the nearest clinic or police station is without knowing these are entry points for GBV services.

Awareness of community-based GBV services is low at 12.4% overall (women: 14.2%; men: 9.5%), indicating that the community-level response infrastructure documented in Chapter 6, including CGPU offices, legal aid clinics, and shelter services, is reaching only a small fraction of the population. Knowledge of GBV-related digital tools and apps, measured through unprompted recall, is lower still at 4.2% (women: 5.4%; men: 2.4%), confirming that digital service directories have not yet achieved meaningful

population-level penetration in Lesotho. Awareness of the Sexual Offences Act stands at 22.6% overall, with men slightly more aware (25.3%) than women (20.7%), a finding that inverts the general pattern where women are more aware of GBV services. This may reflect the Act's association with criminal prosecution, which men encounter more frequently as accused persons or through community policing awareness.

Table 7.4: Support-seeking by demographics

Demographic group	Support sought (%)	N
Age 15-17	12.8	79
Age 18-24	14.6	284
Age 25-34	22.2	376
Age 35-44	27.5	298
Age 45-54	22.0	221
Age 55+	20.5	453
Primary education or less	29.8	38
Secondary education	19.3	1258
Higher education	25.5	417
Urban settlement	23.6	211
Rural settlement	18.4	904

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

Table 7.4 reveals that support-seeking among GBV survivors varies significantly by age and modestly by settlement type. Adolescents aged 15-17 have the lowest support-seeking rate (12.8%), rising to a peak of 27.5% among those aged 35-44 before declining slightly among older groups. The low adolescent rate is particularly concerning, given the 2025 study's deliberate inclusion of 15-17-year-olds and the ACE findings in Chapter 4 showing that childhood adversity is the dominant driver of adult IPV. Young survivors who do not seek help during their first experiences of violence enter adulthood without having accessed the support systems that could interrupt the intergenerational cycle.

Education shows a modest gradient. Survivors with primary education or less seek support at 29.8%, compared with 19.3% for secondary-educated survivors and 25.5% for those with higher education. The lower rate among secondary-educated survivors may reflect the empowerment-without-resources pattern documented in Chapter 4, that is, enough education to recognise abuse but insufficient economic independence to act on that recognition. Urban survivors seek support at a higher rate (23.6%) than rural survivors (18.4%), consistent with the greater concentration of formal services in urban areas documented in Chapter 6.

These findings converge on a clear programme implication. Awareness campaigns must move beyond general messaging to GBV-specific service information, with particular attention to adolescents, rural populations, and men, the three groups with the lowest awareness and support-seeking rates. The 4.2% awareness of digital tools suggests that Lesotho is not yet positioned for a digital-first service directory strategy, and that community-level, face-to-face awareness approaches remain the primary channel for reaching most of the population.

In cases of child sexual abuse within the household, removal to a safer environment may be the most effective protection available, though separation from siblings creates its own costs.



"The boy expressed that he feels safe and happy there and does not wish to go back home, although his younger siblings still want to reunite with him. This case illustrates the complex dynamics of abuse, fear, and family separation, as well as the challenges children face in finding safety and stability when exposed to violence within the household."

Berea Participant 1 (Teboho's uncle)*

On the digital service-awareness dimension, Lesotho has made a notable advance. The Vodacom Foundation, in partnership with UNFPA, Gender Links and GIZ, launched the zero-rated Nokaneng app, the first consolidated, publicly accessible GBV information platform in Lesotho, free of data charges on Vodacom's network.[247] While the MCA-Lesotho primary healthcare and facility mapping (FHI 360/EGPAF Assessment 5) provides a comprehensive facility-level inventory for programme planning, Nokaneng is the first platform that places GBV service information directly into the hands of the public through a mobile application. The Nokaneng rollout provides the first measurable baseline for digital GBV service awareness, and its integration with the Legal Aid Clinics Guidelines' 56-provider registry would convert the app into the authoritative national service directory. Chapter 6's finding that 14.5% of CDV Act-aware respondents learned about the Act through social media indicates that digital channels are maturing as awareness pathways, particularly for younger, more digitally connected cohorts.

The MCA-commissioned mapping of district-specific GBV service providers provides the most comprehensive inventory of GBV services in Lesotho to date. The mapping documents approximately 288 providers across all ten districts: 17 hospitals, 139 health centres, 53 police stations/posts, 11 magistrate courts, 17 government offices, and 51 NGOs/CSOs. The geographic distribution reveals significant concentration, where Maseru has approximately 59 providers while Mokhotlong, the most underserved district, has only 16. Highland districts (Mokhotlong, Thaba-Tseka, Qacha's Nek) have far fewer NGO and specialised service providers than lowland districts. All hospitals provide 24-hour post-sexual violence care, but several health centres offer only partial rather than comprehensive services. Specialised legal services, including FIDA and the Women's Law Clinic, are concentrated exclusively in Maseru. This geographic concentration has direct implications for the survey's findings on low service utilisation. Survivors in rural and highland areas face substantial distance and transport barriers to accessing the most basic GBV response services.

7.8 Civil society support landscape

Civil society organisations are the primary specialist support providers for GBV survivors in Lesotho, filling gaps left by inadequate state service provision. This section provides an overview of the civil society support landscape as documented in the WFP 2025 Mapping, the 2025 key informant interviews, and the Political Discourse Analysis findings. It notes that the sector has grown since 2013 and that the Legal Aid Clinic's Guidelines and the EU M168.5 million commitment provide the funding and standards framework to consolidate that growth into a coherent national support system.



Civil society organisations are the primary specialist support providers for GBV survivors in Lesotho

[247] Vodacom-UNFPA partnership agreement (August 2025) and Vodacom Foundation Key Informant Interview (2025). The Nokaneng app addresses fragmentation identified in the WFP 2025 mapping: "GBV data in Lesotho is so fragmented. We don't have a directory of services where we can say, I could go to this portal to check."

7.8.1 Survivor-centred civil society support

The 2013 study profiled **She-Hive** and the **Lesotho Child Counselling Unit** as the primary specialist support organisations. By 2025, the civil society landscape had expanded. The 2025 Political Discourse Analysis and the WFP 2025 Mapping reports, identify **Women and Law in Southern Africa (WILSA) Lesotho**, a long-standing legal rights organisation providing paralegal support and legal education; **Seinoli Legal Centre**, providing legal aid and access to justice, including for GBV matters; **People's Matrix Association**, working on inclusion for marginalised groups including LGBTIQ+ persons whose specific GBV vulnerabilities were not addressed in the 2013 baseline; and **Sesotho Media and Development**, working on communication for social change. The **RISE** project (Reform for Inclusion, Support and Empowerment), launched in September 2025 and funded by the EU through a consortium of ICJ, Seinoli Legal Centre, and People's Matrix Association, provides a new two-year platform for legal reforms and access to justice for GBV survivors, including women and LGBTIQ+ persons.

Kick4Life, a sport-for-development organisation operating in Lesotho since 2005, has reached more than 260,000 young people through its Girls and Boys programmes (ages 13-21), which combine football-based engagement with structured curricula on gender, rights, and violence prevention.[248] Although Kick4Life is primarily a prevention programme, its community footprint also positions it as a point of entry for adolescent survivors into the referral pathway.

Care for Basotho, operating across eight districts through a peer educator and peer navigator model, serves female sex workers, men who have sex with men, transgender people, and people who use drugs, with GBV education mainstreamed into regular programme activities and legal referrals routed through WILSA. Its community-based model is particularly relevant for reaching populations underserved by facility-based services.

The Ke Kabelo Ea Ka programme, implemented by the **Christian Council of Lesotho and the GEM Institute** with GIZ support, represents an important community-level GBV support and prevention initiative that explicitly engages men and religious leaders. Its community dialogue model, documented in a UN Women August 2025 feature, provides an example of how faith-based organisations can be mobilised as GBV prevention and community support resources, complementing the survey finding that 3.3 % of survivors currently receive religious leader support.

The **Mosepele Foundation** adds a youth-specific community-based model to this landscape. Operating primarily in Maseru district, the Foundation targets out-of-school adolescent girls and young women aged 15-29 through community group sessions, stakeholder dialogues, and economic empowerment activities. The programme recruits participants through area chiefs and parents, forms community groups with elected team leaders who serve as local focal points for referrals and conducts regular dialogues that bring together Village Health Workers (VHWs), community policing forums (Mahokela), area chiefs and their wives, nurses, and CGPU officers. While the programme reaches approximately 200-250 participants annually and has demonstrated success in building local awareness and referral linkages, it faces significant sustainability challenges. Individual casework ceased in 2022 when funding reductions eliminated social worker positions, and current coverage is limited to Maseru due to resource constraints.

[248] Kick4Life Programme Profile 2026 (Maseru: Kick4Life, 2026). Internal programme evaluations report that 93 % of participants improved attitudes toward women's roles following the Boys programme, a prevention-relevant outcome discussed in Chapter 8.

The **Migrant Workers Association** of Lesotho (founded 2016) represents an emerging but under-documented element of the GBV support landscape. The Association serves Basotho migrants and their families both inside Lesotho and in destination countries (primarily South Africa), providing pre- and post-departure orientation, labour rights support, anti-trafficking awareness, and GBV advocacy. Its focus on culturally entrenched norms that increase the risk of gender-based violence among migrant populations addresses a gap that static, traditional, and district-based service models do not reach. However, the association's outreach, case volume, and impact metrics require follow-up.

7.8.2 Regional comparative evidence

A 2025 study of IPV help-seeking in the Democratic Republic of Congo, published in BMC Public Health, provides a useful regional comparator.[249] The DRC study reports near-identical family-first disclosure patterns, similar low formal-service utilisation, and a similar gender gap in peer support access. The consistency across high-prevalence Southern and Central African settings reinforces the finding that informal family networks are structurally central to GBV response, and that effective support systems must be built around, not in place of, these networks.

7.8.3 Government, CSO partnership - the path to system architecture

A consistent structural feature of Lesotho's GBV support landscape has been the absence of systematised referral pathways connecting government services (police, health, courts) with civil society support providers. The 2013 study noted that CGPU officers referred cases to civil society, but that these referrals were ad hoc. The CDV Act 2022's multi-sectoral response mandate requires formal referral coordination, and the Legal Aid Clinics Guidelines (2025) provide the first national instrument for standardising that coordination. Under the WFP 2025 Mapping, the WFP Diagram 1 (Referral Pathway for GBV Service Providers in Lesotho) is the current reference map for the architecture that the guidelines now authorise.

The EU's M168.5 million commitment to CSO-led GBV initiatives (November 2025) is the largest single injection of resources into the civil society support landscape in recent years and provides a funding platform for the structural investments described above. The political accountability question, whether government budget allocations will match this donor commitment in subsequent budget cycles, remains the medium-term test of whether the strengthened system architecture can be sustained.

7.9 Tracking change: 2013 to 2025

The 2013-2025 comparison in support services reveals a system in transition. Several indicators show structural persistence, and several show meaningful advances. The table below summarises the trajectory of the primary dimensions.

[249] Makombi, E. et al., "Help-Seeking Behaviour among Women Experiencing Intimate Partner Violence in the Democratic Republic of the Congo," BMC Public Health 25 (2025). The study uses comparable DHS-derived help-seeking measures to those used in Lesotho.

Table 7.5: Key support indicators - 2013 baseline vs 2025

Indicator	2013 baseline	2025 finding	Direction	Interpretation
Informal support				
Family disclosure (women survivors)	63% told family	57.7% (of disclosers)	Stable	Broadly consistent; different denominators limit comparison
Family support receipt (women survivors)	88% of disclosers supported	56.2% of women IPV survivors identify family as their primary support source; among those who told family, 77.8% also received family support (49 of 63)	Comparable	Family remains the dominant support channel, though the question framing differs between rounds
Challenged to keep quiet	1% told to keep quiet	8.3% women; 10.4% men (Ch. 6)	Shift	Apparent increase may reflect greater naming of experiences as abuse
Formal support - police				
Police reporting rate	~10% (2013)	9.9% women; 7.5% men	Unchanged	Structurally unchanged - the gap the reform agenda now addresses
Satisfaction with police	Not measured	1.4% all survivors	New	First measurement - the baseline for CGPU reform metrics
Formal support - professional				
Sought professional help (women survivors)	Not directly comparable	13.3% of women IPV survivors 10.5% of women IPV survivors received material support; primarily money/cash	New	Among those who accessed professional help, 79.7% found it very helpful
Material support received	Not measured	(54%) and food/groceries (38%)	New	First measurement of tangible support provision
Shelter				
Shelter utilisation	~5% ever went	1.0% women; 1.3% men (Ch. 6)	Unchanged	Infrastructure gap mapped by WFP - now costable and sequenced
Number of functioning dedicated shelters	1 (Lapeng)	1 (Lapeng)	Unchanged	WFP documents 9-shelter deficit; Multi-Purpose Centre (Nov 2025) provides pilot
Legal and service architecture				
National legal-aid standards	None	Legal Aid Clinics Guidelines 2025	Advance	First national framework - 56 providers; EU-funded; SOGIE-inclusive
General legal awareness	41% women knew the laws	57.3% know laws exist	Improve	Meaningful increase; CDV Act-specific awareness (12.1%) remains the next target
Digital service directory	None	Nokaneng app (2025)	New	Zero-rated on the Vodacom network; consolidates fragmented information
Service awareness (new 2025)				
Know where to get help for GBV	Not measured	29.1% overall (women 34.9%; men 20.6%)	New	Significant gender gap - men are substantially less aware
Aware of community GBV services	Not measured	12.4% overall (women 14.2%; men 9.5%)	New	Community-level services reach only a small fraction
Know about GBV-related apps	Not measured	4.2% overall (women 5.4%; men 2.4%)	New	Digital tools are not yet at meaningful population penetration
Support-seeking by age (new 2025)				
Adolescents (15-17) sought support	Not measured	12.8%	New	Lowest of any age group - critical gap for early intervention
Adults 35-44 sought support	Not measured	27.5%	New	Peak support-seeking age - programme targeting opportunity

Note: 2013 figures from Gender Links and LBOS (2013). 2025 figures from survey data, Chapter 6, WFP 2025 GBV Mapping Report, and the Legal Aid Clinics Guidelines (Dec 2025). Denominators differ between study rounds in some cases; comparative figures are directional indicators.

Source: Tables 7.1, 7.7 and Chapter 6 data

The 2013-2025 comparison reveals a support landscape with two parallel trajectories. On survivor-level indicators, police reporting, shelter utilisation, and family disclosure, the system is structurally unchanged, and the 2025 round provides the first national baseline for satisfaction with police response (1.4%) against which reform prog-ress can be measured. On system-level indicators, national legal-aid standards, digital service directories, general legal awareness, and formal recognition of SOGIE-inclusive practice, the period shows clear advances. The 2025 round also establishes first-time baselines for service awareness (29.1% know where to get GBV help), professional help-seeking (13.3% of women IPV survivors), material support receipt (10.5%), and age-disaggregated support-seeking behaviour, filling measurement gaps that the 2013 study did not address. The strategic task for 2025-2035 is to translate the system-level advances into survivor-level change, with urgency for adolescent support-seeking (12.8%) and men's service awareness (20.6%).

The Legal Aid Clinics guidelines establish the first national standard for legal aid provision across 56 providers. The urgency of this framework is captured in the experience of Mphonini* from Qacha's Nek, whose case illustrates the most common form of post-separation economic GBV in the 2025 survey, property expropriation:



"I worked very hard, and with the salary I earned from the factories, I built a house for my family. That house was built with my own sweat and sacrifice. When my husband returned permanently from the mines, he started staying at our shop with another woman. Then he began forcing my children and me to move out of the very same house that I built with my own factory salary. He says, 'I don't love you anymore. Leave my house.' But how can it be his house when I am the one who built it with my blood and sweat? I have nowhere else to go. That is why I am still in this house, and the matter is now before the court. Right now, I am fighting in court for the house that I personally built. I believe the government should make court procedures faster because the long process causes emotional stress and increases tension between people."

Mphonini, Qacha's Nek*

Mphonini* built the house with her factory wages; her husband is attempting eviction under customary law. The 2024 Administration of Estates Act was designed to protect exactly this scenario. She is now in court at 62, without income, carrying legal costs that her children should be shouldering. The Legal Aid Clinics Guidelines provide the framework to bring standardised legal aid within her reach, but only if they are operationalised at the district level where women like Mphonini* live.

Conclusion

The chapter finds:

- ***Family is the main support:*** The dominant finding of this chapter is that informal family networks, not the state, not civil society, not formal support services, are the primary support system for GBV survivors in Lesotho. More than half of women survivors and nearly four in ten men receive support from family. For women, this informal system compensates for the low reach of formal services. For men, peer friendship networks play a comparably central role. The family's primacy as a support source is not a deficit finding. It is a relational asset that the GBV response strategy should build around. What families do well, that is, emotional support, relational containment, and early awareness of the abuse, they should continue to do. What families cannot provide, such as medical care, legal advice, safe housing, psychosocial therapy, perpetrator accountability, the formal and civil society sectors must reliably provide, with the referral pathways, professional backup, and legal protections that equip families to route survivors to those services. The strategic frame is not substitution but complementation.



Group inheritance discussion during the 16 Days of Activism in Siloe.
Photo: Ntolo Lekau

- ***Gender-responsive support for women and men:*** The 2025 data reveal that women and men GBV survivors navigate meaningfully different support landscapes. Women turn more heavily to family (56.6 % versus 37.8 %); men rely more on friends (39.9 % versus 25.8 %) and more often report partner support (28.5 % versus 17.2 %). These differences are statistically significant and analytically important. A single-model support system designed primarily around women's help-seeking pathways will systematically underserve male survivors. Programmes that engage male peers as active support agents, training friends and colleagues in how to respond when a male peer discloses GBV experience, represent an underexplored and potentially high-impact intervention pathway in the Lesotho context. Bidirectional programme design, already embedded in the 2025 GL study framework, is the template for the next generation of support services.

- ***The system architecture is now in place; activation is the next task:*** Lesotho's civil society GBV support sector, WILSA, Seinoli, the Lesotho Child Counselling Unit, She-Hive, LPPA, FIDA, Kick4Life, Care for Basotho, LNFOD, and the organisations supported through the RISE project and EU funding, have real capacity and demonstrated impact at the individual level. The 2025 period has added the architecture the sector has long needed: the WFP 2025 GBV Mapping as the national service inventory; the Legal Aid Clinics Guidelines, as the first national standards framework; the Nokaneng app as the consolidated digital information platform; the CDV Act 2022's multi-sectoral response mandate as the legal anchor for coordinated referral; and the EU M168.5 million commitment as the catalytic funding platform. Activating this architecture, by enacting the CDV Act's family court rules, rolling out standardised CGPU SOPs consistent with the Legal

Aid Guidelines, sequencing the nine-shelter deficit against the highest-prevalence districts, and standardising GBV clinical inquiry protocols in primary health care, is the operational agenda for 2025-2030. This architecture must be disability-inclusive and SOGIE-inclusive, embedding the standards that the Legal Aid Clinics Guidelines and LNFOD's GBV-CW Disability Inclusion Guidance now provide.

- Service exclusion gaps need to be closed: Five service-exclusion gaps emerge from the 2025 evidence as specific, addressable priorities.
- Self-referred survivors are currently excluded from Lapeng by admission criteria, a protocol reform that does not require new infrastructure.
- Adult male survivors have no dedicated shelter in Lesotho, a gap the nine-shelter expansion can directly address by embedding bidirectional design standards.
- LGBTQI+ and transgender persons have no SOGIE-inclusive protocols at any CGPU or shelter, a gap the Legal Aid Clinics Guidelines now provide the standards framework to close.
- Highland-district residents face transport and geography barriers that the community-paralegal model (LNFOD, FIDA) can directly address through district-based expansion.
- None of these exclusions require new legislation. All require coordinated implementation of the frameworks Lesotho already has in place.

CHAPTER 8
PREVENTION OF GENDER-BASED VIOLENCE



Women gather to commemorate 16 Days of Activism in Qomo Qomong council, Lesotho. *Photo: Ntolo Lekau*

Key findings

- Only 27.3% of adults have heard any GBV campaign in the past 12 months; only 12.1% have heard of the CDV Act three years after enactment. No single communication channel reaches more than 15% of the population.
- Only 18.4% of adults have participated in any GBV prevention activity; 15.4% have intervened when witnessing GBV.
- Support for the notion that a woman should obey her husband has shifted significantly from 97% (women) and 96% (men) in 2013 to 34% and 49%, respectively, in 2025. Still, persistent gender regressive norms remain: 39% of women and 40% of men believe a woman cannot refuse to have sex with her husband, and 46.4% of all respondents agree that women sometimes claim rape falsely.
- Rape myths, not general gender attitudes, are the independent attitudinal predictor of IPV perpetration (men: OR 1.72, p=0.006), making rape myth reduction the most evidence-justified attitudinal prevention investment.
- Secondary prevention targeting adults with 4+ ACEs does not exist at scale: no ACE-informed assessment in primary health care, no ACE-informed parenting support. This is the most significant prevention gap in the 2025 landscape.
- Tertiary prevention, court-mandated perpetrator programmes, is effectively absent, despite evidence that perpetrators carry a substantial depression burden, creating a therapeutic opening for intervention.
- Prevention campaigns have not been assessed for accessibility to persons with disabilities or relevance to LGBTQI+ communities, despite the elevated GBV prevalence documented for both groups.

Sixteen and sold, a story of abuse and survival



"My name is Thabiseng*, a 46-year-old Mosotho woman. I am an orphan who was forced into marriage at a young age to a man I did not know.

I lost my parents when I was still very young and went to live with my uncles. At the age of 16, my uncles gave me away in marriage to a man who had been widowed before. I did not want to get married, but my uncle brutally beat me until I agreed. I was taken to the marriage while injured and traumatised.

From the time I arrived, I never experienced happiness. My husband and his mother abused me emotionally, physically, and verbally. I wanted to run away, but I was afraid my uncles would kill me. My mother-in-law controlled every aspect of my life. She bought my clothes, even underwear, and I was not allowed to handle money or buy anything for myself. All the money went to her.

I often ran to the chief for help. When my husband and his mother were summoned, they would refuse to go, and the chief would send me back to my abusive home. I was told that because bohali had been paid, I belonged to my husband. I did not know that I could report the abuse elsewhere. I lacked education about gender-based violence, and this was a major barrier. I stayed for a long time only because of my children. There is a saying that orphans do not stay long in marriage, and I feared people would say my situation was expected. This year, I decided to put my life first, because life is lived only once.

My husband once admitted that he never loved me and only married me to please my uncles. I developed a fear of men because I was married to a stranger at a young age, tied with ropes to prevent escape. Now, I am slowly healing. My wish is for GBV educators to visit rural villages, including mine, to educate communities. Harmful traditional practices still exist and continue to promote gender-based violence, especially against young women forced into marriages without consent."

Thabiseng, Thaba-Tseka*

Thabiseng's* story is featured in Chapter 8 because she names the prevention failure directly. She did not know she could report. Not because the law did not exist, but because no educator, no teacher, no community leader ever reached her village. Chapter 8's central argument is that this gap, between *law on paper and knowledge in communities*, is the prevention system's primary failure.

Overview

This chapter evaluates the prevention landscape in Lesotho, from primary prevention campaigns and community mobilisation through to secondary and tertiary prevention. It establishes the prevention baseline by assessing campaign awareness and information reach, then examines specific prevention domains: gender attitudes and rape myths, the 16 Days of Activism, radio and digital channels, male engagement, faith and traditional leadership, school-based and youth programming, economic empowerment, workplace prevention, and perpetrator programmes. The chapter connects the attitudinal

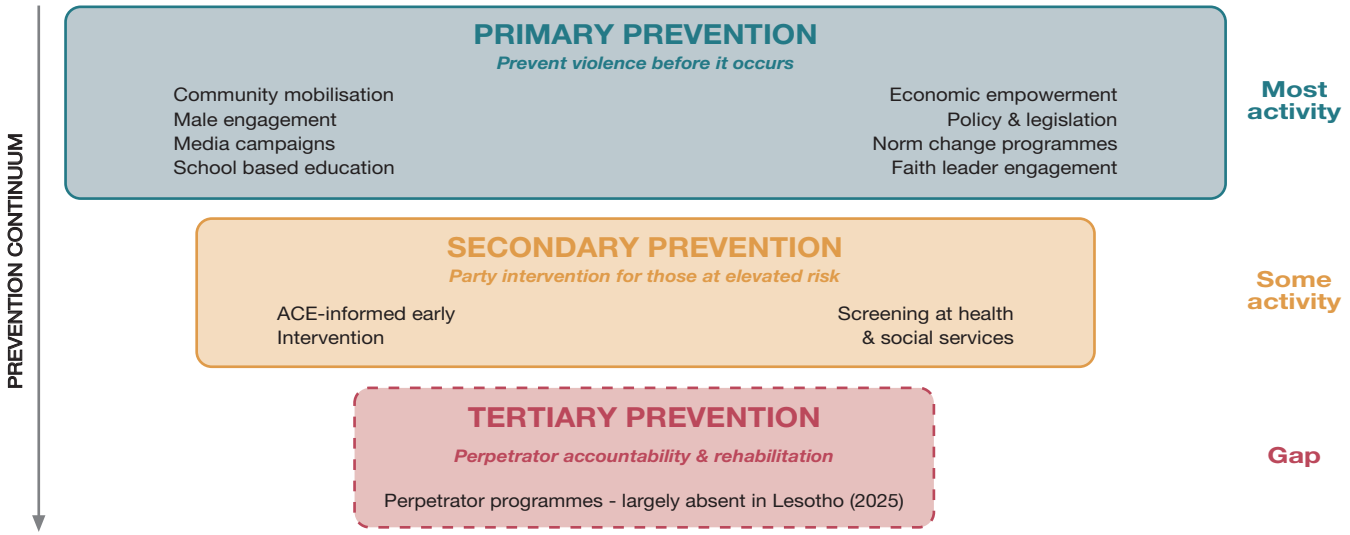
and normative data from Chapter 4 to current prevention programming, identifying where investment is producing measurable change and where it is not yet reaching the populations at highest risk.

8.1 Introduction - from response to prevention

For most of Lesotho's documented GBV history, the policy and programming response has been predominantly reactive, focused on the treatment of injuries, the prosecution of perpetrators, and the support of survivors after violence has occurred. The 2013 GL-Lesotho baseline study recognised this orientation explicitly, noting that 'for a long period, efforts to address VAW have been more inclined to be more responsive rather than preventive.' Twelve years later, this chapter asks a harder version of the same question. Given what the 2025 study now knows about who experiences GBV, who perpetrates it, under what conditions it is most likely to occur, and what attitudes sustain it, **is Lesotho's prevention architecture proportionate to the scale and architecture of the problem?**

The evidence from preceding chapters provides the analytical foundation for this assessment. Chapter 3 established that IPV remains endemic, affecting 45.7% of ever-partnered women in their lifetime experience, even as rates have declined from the 2013 baseline. Chapter 4 identified the dominant risk factors, that is, adverse childhood experiences (with adjusted odds ratios up to OR 6.68 for women and 4.75 for men), rape myths acceptance (OR 1.72 for men's perpetration), and persistent harmful gender norms, including the belief that a woman should obey her husband, which, while dramatically reduced from 97% to 33.9% for women, still affects one in three women and one in two men. Chapter 5 documented the mental health consequences, with 65.8% of women survivors at the depression threshold, 25.8% with probable PTSD. These findings define the prevention target. This chapter evaluates the extent to which current prevention efforts are aimed at that target, are reaching those most in need, and are generating measurable change.

The chapter is organised around the three-tier prevention framework drawn from the public health and GBV prevention literature.[250]



[250] Dahlberg, L.L. & Krug, E.G. (2002), 'Violence - a global public health problem,' in E.G. Krug et al. (eds.), World Report on Violence and Health. Geneva: WHO, 1-56; WHO (2010), Violence Prevention: The Evidence. Geneva: WHO.

Primary prevention addresses GBV before it occurs. This includes changing the norms, attitudes, and conditions that make violence likely through campaigns, community mobilisation, male engagement, school-based education, economic empowerment, and policy.

Secondary prevention targets those at elevated risk, such as survivors of childhood adversity, men at risk of perpetration, and women in controlling relationships, with early intervention before violence escalates or repeats.

Tertiary prevention focuses on perpetrator account-ability, therapeutic rehabilitation, and recidivism reduction. Most of Lesotho's documented prevention activity in 2025 operates at the primary and, to a lesser extent, secondary level. Tertiary prevention, perpetrator programmes - remain a largely absent component of the prevention architecture.

The WHO Country Cooperation Strategy 2024-2027 for Lesotho reinforces the prevention imperative by embedding gender, equity, and human rights as a cross-cutting priority across health-systems strengthening, identifying GBV response capacity as integral to the universal health coverage agenda.[251]

The chapter draws on analysis covering campaign awareness, CDV Act knowledge, gender attitudes, rape myths, the personal-community norms gap, prevention activity participation, perceptions of key actors, and 2013 comparisons. These are supplemented by qualitative evidence from organisational case study interviews, community voices, and desktop government data.

8.2 The prevention baseline, campaign awareness and information access

Effective prevention begins with awareness that GBV is a crime rather than a private matter, that laws exist to protect survivors, and that services are available for those who experience violence. The 2025 survey provides a baseline measurement of campaign exposure, information access, and prevention activity participation across the general population.

Table 8.1: Awareness of GBV campaigns

Campaign awareness	Women (%)	N	Men (%)	N	Total (%)	N	p-value
Heard of any GBV campaign (past 12 months)	26.2	2565	29.0	1689	27.3	4254	0.2388
Campaign source							
Radio	42.7	673	49.5	490	45.6	1163	0.1753
Television	24.5	673	20.2	490	22.7	1163	0.3434
Online/internet	24.7	673	22.8	490	23.9	1163	0.5956
Community event	30.7	673	34.6	490	32.4	1163	0.2387
Newspaper/print	2.1	673	4.1	490	3.0	1163	0.2589
Friends/word of mouth	5.6	673	9.7	490	7.3	1163	0.0795

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

[251] WHO, Country Cooperation Strategy: Lesotho 2024-2027. Geneva: World Health Organization, 2024. Section 2.2: Gender, equity, and human rights as cross-cutting priorities.

The campaign awareness data establishes the reach and limits of Lesotho's current GBV information ecosystem. Overall, 27.3% of all respondents have heard of any GBV campaign in the past 12 months (women 26.2%; men 29.0%), meaning nearly three in four adults report no recent exposure to GBV prevention messaging. Among those who did hear a campaign, radio remains the dominant channel (45.6%), followed by community events (32.4%), online/internet (23.9%), and television (22.7%). Newspaper/print reaches just 3.0%, while friends and word of mouth account for 7.3%. Men are slightly more likely than women to have heard campaigns through radio (49.5% vs 42.7%) and community events (34.6% vs 30.7%), though neither difference reaches statistical significance.

The 2013 study found that 55-57% of women and men heard about VAW campaigns through the radio, and that 64% of men and 44% of women had heard of the 16 Days of Activism. The 2025 campaign awareness figure of 27.3% is not directly comparable due to different question framings. Still, the broad picture suggests that overall campaign penetration has not increased despite a decade of expanded programming. Radio's dominant position has been maintained, but online/internet (23.9% of campaign-exposed respondents) has emerged as a significant new channel that was not present in 2013, reflecting Lesotho's expanding digital connectivity, particularly among younger cohorts.

Table 8.2: Knowledge of the CDV Act

CDV Act knowledge	Women (%)	N	Men (%)	N	Total (%)	N	p-value
Heard of the CDV Act (Counter Domestic Violence Act)	11.9	2385	12.3	1548	12.1	3933	0.8027
Source							
Radio	47.0	300	53.1	214	49.4	514	0.3362
Television	18.8	300	19.0	214	18.9	514	0.9725
Online/internet	15.0	300	13.8	214	14.5	514	0.7936

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

CDV Act awareness tells the same story in a more specific register. Only 12.1% of all respondents have heard of the Counter Domestic Violence Act (women 11.9%; men 12.3%). Among those who have heard of it, radio is the primary source (49.4%), followed by television (18.9%) and online/internet (14.5%).

This means that three years after Lesotho's most significant GBV legislative reform, fewer than one in eight adults are aware that the law exists, and the primary national communication channels are reaching fewer than one in twenty with CDV Act-specific information.

Table 8.3: Participation in GBV prevention activities

Prevention activity	Women (%)	N	Men (%)	N	Total (%)	N	p-value
Participated in any GBV prevention activity	16.4	2565	21.5	1689	18.4	4254	0.0019
Aware of community GBV services	14.2	2565	9.5	1689	12.4	4254	0.0019
Ever intervened when witnessing GBV	14.5	2565	16.8	1689	15.4	4254	0.2085

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

Table 8.3 provides a national measurement of active engagement in GBV prevention. Overall, 18.4% of all respondents have participated in any GBV prevention activity (women 16.4%; men 21.5%). Men's higher participation rate is consistent with the campaign awareness pattern and may reflect the growth of male engagement programmes such as GIZ's male champions networks and Kick4Life's Boys Module. Awareness of community GBV services stands at 12.4% (women 14.2%; men 9.5%), an inversion of the participation pattern, suggesting that women are more aware of services while men are more engaged in prevention activities. Notably, 15.4% of all respondents report having ever intervened when witnessing GBV (women 14.5%; men 16.8%), indicating that bystander intervention is already occurring at a meaningful rate even in the absence of formal bystander programmes, a foundation that structured bystander training could build upon.

The WFP 2025 GBV Mapping Report corroborates these coverage findings: while it documents sixteen or more GBV service providers implementing awareness campaigns through community gatherings, festive events, school outreach, and media, the mapping identifies a persistent gap in the GBV referral pathway and recommends that awareness campaigns encompass all ten districts with the explicit inclusion of financial literacy for household resource management. Hope for Women Assembly's targeting model, four GBV hotspot villages per district for intensive awareness raising, illustrates the kind of geographically targeted approach the WFP mapping implicitly recommends.

8.3 Targeting gender attitudes and rape myths for prevention

Chapter 4 established that rape myth acceptance is the most consistent attitudinal predictor of IPV in the 2025 data, retaining independent significance in the adjusted regression for both women (OR 1.48, p=0.015) and men (OR 1.72, p=0.006), while general gender inequitable attitudes lose significance after adjustment. The normative landscape has also shifted dramatically since 2013, with agreement that a woman should obey her husband collapsing from near-universal to a minority position. These findings carry direct implications for how Lesotho designs its next generation of prevention programming.

What the data tells prevention programmers

The Chapter 4 analysis identifies three distinct categories of gender norms, each requiring a different prevention approach.

Norms that have shifted and should be accelerated. Agreement that a woman should obey her husband fell from 97% (women) and 96% (men) in 2013 to 34% (women) and 49% (men) in 2025. Endorsement of a husband's right to punish his wife fell from 26% (women) and 41% (men) to 11% and 17%, respectively. These shifts confirm that sustained investment in norm change, through community dialogue, media, and education, produces measurable results over a decade. The prevention task here is acceleration: maintaining the programming that produced this change and extending it to the populations where endorsement remains highest (older men, rural communities, those with lower education).

Norms that have shifted insufficiently and require targeted intervention. Women needing a husband's permission to work remains at 66%

(women) and 74% (men), down from 81% and 83% in 2013, only 15 percentage points in twelve years. The belief that a woman cannot refuse sex with her husband stands at 39% (women) and 40% (men), down from 55% and 58%. These norms are more resistant because they are embedded in economic dependence and sexual entitlement structures. Generic awareness messaging will not shift them. Prevention programmes addressing these norms need to work within specific relational and economic contexts, couples-based economic empowerment with integrated gender norm components, community dialogue specifically targeting sexual consent within marriage, and male engagement programmes that directly address sexual entitlement.

Norms requiring entirely new programming: rape myths. The Chapter 4 regression finding that rape myths, not general gender attitudes, are the independent attitudinal predictor of IPV means that rape myth reduction should be treated as a distinct prevention investment, not subsumed within generic gender equality programming. The five rape myth items measured in 2025, identify the specific beliefs to target: 46.4% of all respondents agree that women sometimes claim rape falsely; 30.4% agree that a man cannot control himself when sexually aroused; 19.8% agree a woman is partly responsible if she was drinking alcohol; 19.4% agree that if a woman said no but did not physically resist, it was not rape; and 14.0% agree a woman is partly responsible if dressed provocatively. Each of these beliefs functions as a cognitive permission structure for sexual violence, a framework that enables perpetrators to minimise, justify, or deny coercion. Prevention programmes that specifically name and challenge these beliefs, using scenario-based and participatory methods rather than didactic messaging, are more analytically justified than broad gender equality campaigns.

The pluralistic ignorance opportunity

The norms gap analysis (Chapter 4) revealed that both women and men privately hold more equitable views than they believe their communities hold, the pluralistic ignorance pattern. This creates a specific prevention opportunity: social norms marketing and community dialogue approaches that make visible the actual distribution of community attitudes. When individuals discover that their neighbours privately hold more equitable views than anyone assumed, the social cost of expressing those views publicly drops, and the norms that have already shifted privately can be expressed behaviourally. Programmes such as the SASA! community mobilisation model, which reduced IPV by 52% in Uganda (Abramsky et al., 2014), is designed to exploit exactly this mechanism. Lesotho's confirmed pluralistic ignorance pattern suggests the country is well-positioned for this type of intervention.

What is already working, and what is missing

Several programmes currently operating in Lesotho are targeting attitudes through evidence-informed approaches. GIZ's PFP programme works through faith and traditional leaders, public transport settings, and male champions networks, a multi-setting approach consistent with the ecological model. Kick4Life reaches young men with gender norm and violence prevention content before perpetration patterns become entrenched, directly addressing the Chapter 4 finding that men aged 35-44 have the highest perpetration rates and that earlier intervention is needed. The Ke Kabelo Ea Ka faith-based programme engages religious leaders as norm change agents in a context where 3.3% of survivors already turn to religious leaders for support.

What is missing is programming that specifically targets rape myths as distinct from general

gender attitudes. The regression evidence makes a clear case: investing in rape myth reduction will produce a larger return in IPV prevention than investing in general gender equality messaging, because rape myths, not general attitudes, retain independent predictive power after full adjustment. This does not mean abandoning gender equality programming; it means adding a specific, evidence-targeted rape myth reduction component to the existing prevention portfolio.

The 16 Days of Activism and campaign effectiveness

Table 8.1 shows that only 27.3% of adults have heard any GBV campaign in the past 12 months, and only 12.1% have heard of the CDV Act. The 16 Days of Activism against Gender-Based Violence (25 November - 10 December) provides the highest-profile annual platform for GBV prevention messaging. The Friends of the CDVA multi-stakeholder group (May 2026) identified the 16 Days as a concrete advocacy platform for CDVA implementation, an opportunity to move campaign content from general awareness toward specific legal literacy (for instance, what the CDV Act protects, how to access a protection order, where to get legal aid). Campaigns that shift from "GBV is wrong" to "here is what you can do about it" are more likely to convert awareness into behaviour change.

8.4 Primary prevention, campaigns and community mobilisation

Public awareness campaigns are the most visible face of GBV prevention in Lesotho, such as the 16 Days of Activism, radio programmes, community meetings, and visual media that carry the message that violence against women is a crime, not a private matter. Their reach, however, as established in Section 8.2, remains below what the scale of the problem demands.

8.4.1 The 16 Days of Activism against GBV, reach and limitations

Community-based prevention models operating outside the campaign calendar provide continuous engagement that supplements time-bound events. The Mosepele Foundation's group-based approach in Maseru, targeting out-of-school adolescent girls and young women aged 15-29, illustrates a prevention model that combines regular dialogue sessions with stakeholder engagement. The programme convenes VHWs, community policing forums, area chiefs, and CGPU officers in structured dialogues that address GBV definitions, rights, and reporting pathways, creating a year-round prevention presence that campaign models cannot sustain. The Foundation's radio programmes extend their reach beyond group participants. Similarly, the Migrant Workers Association of Lesotho uses advocacy and community education to address cultural norms that increase GBV risk among migrants, recognising that pre-departure orientation is itself a prevention tool for populations facing elevated vulnerability at destination.

The 16 Days of Activism (25 November-10 December) is Lesotho's most prominent annual GBV prevention event. The 2013 study found that 44% of women and 64% of men had heard of the 16 Days campaign. In 2025, Chapter 6's data showed that 45.3% of those who had heard of any GBV campaign recognised the 16 Days, meaning that this flagship campaign remains the most recognised single GBV prevention initiative in the country.

However, recognition of a campaign's name is not the same as exposure to its content, change in attitude, or change in behaviour. The 2025 data on police reporting (9.9%, unchanged), shelter utilisation (1.0%, unchanged), and legal awareness (CDV Act: 12.1% after three years) suggest that positive campaign reception has not translated into measurable changes in the system outcomes that matter most. The 16 Days campaign, as currently structured, appears more effective at generating awareness that GBV is a problem than at informing survivors about specific services or motivating action by the political and institutional actors who control resource allocation.

The WFP 2025 GBV Mapping Report confirms the 16 Days as the focal coordination moment: GIZ reported dissemination activities reaching all ten districts via SheHive and partner organisations, while the EU's #JusticeForAll campaign provided an additional coordination moment where Gender Links, the RISE consortium, Sesotho Media and Development, and other civil society actors jointly presented milestones. The WFP mapping's recommendation that community sensitisation should involve chiefs and local leaders to promote gender equality identifies the critical actor class that current 16 Days activities reach unevenly.[252]

The campaign's content in 2025 notably included CDV Act-specific messaging for the first time at scale, for example, Sesotho Media and Development was specifically funded by the EU to use documentary and media campaigns to advocate for the CDV Act. This is an analytical advance over the 2013 campaign period, when awareness messaging was primarily about the existence of violence rather than the legal protections available to survivors. However, as the media influencer Lintle Ramatla documented, social media algorithms[253] actively suppress GBV keyword content, meaning that digital campaign amplification faces structural platform barriers that no amount of content quality can overcome without deliberate countermeasures.

Prevention campaigns have not been assessed for accessibility to persons with disabilities or relevance to LGBTQI+ communities, despite the elevated GBV prevalence documented for both groups

> *"The algorithm will just hide your video... when people go to your wall, they won't see it."*
> Lintle Ramatla, social media GBV advocate (140,000 Facebook followers).

The reporting barriers identified in the Section 6.7.2 qualitative analysis reinforce this concern from the survivor side, with 18.2% of women and 21.0% of men experiencing technology-facilitated GBV but 81% never reporting it. One in three survivors considered the experience

[252] WFP, GBV Mapping Report, 13 April 2025. The report recommends that awareness campaigns encompass all 10 districts and explicitly include chiefs and local leaders.
[253] Social media algorithms are automated systems used by platforms to determine which content appears in a user's feed. They act as personalized curators, filtering and ranking billions of posts to show users the content they are most likely to engage with based on past behavior, interests, and interactions Sprout Social+2. Unlike chronological feeds of the past, modern algorithms prioritize relevance, engagement, and predicted user interest to manage information overload

too minor to report, and one in ten did not know where to report. Prevention messaging must therefore explicitly name TFGBV as real violence and communicate accessible reporting pathways, addressing both the algorithmic suppression that limits campaign visibility and the minimisation that prevents survivors from recognising their experience as reportable.

8.4.2 Radio as the primary prevention channel

Radio is the dominant GBV information channel in Lesotho, reaching 12.4% of all respondents with general GBV campaign content and 5.5% with CDV Act-specific information in 2025. The 2013 baseline found 55-57% of women and men accessed VAW campaign information through radio, suggesting that while radio's primacy is maintained, its absolute reach may have declined in a more fragmented media environment. Online/internet channels now reach 6.9% of all respondents with GBV campaign information, a channel absent from the 2013 findings.

The strategic implication is a dual-channel imperative: radio must be sustained and deepened as the primary mass communication vehicle for GBV prevention content, with content moving beyond general awareness to specific legal information, service pathways, and survivor testimonies, while digital channels must be developed as supplementary channels targeting younger, more digitally-connected age cohorts who are simultaneously among the highest-risk groups (Chapter 4 established that ages 18-34 show elevated IPV rates for women).

Two broadcasting organisations illustrate both the potential and limitations of media-based GBV prevention in Lesotho. The Lesotho National Broadcasting Service (LNBS) has operated "Mots'eo," a women's empowerment television programme, for eight years, supplemented by a "Survivor" programme that broadcasts abuse testimonies. LNBS reported that these programmes generate significant audience engagement and that they refer callers to CGPU for formal assistance. However, the programmes are studio-based with no field outreach, and LNBS acknowledged that counselling services to which it could refer survivors are inadequate or financially inaccessible. Harvest FM, a community radio station, reported covering GBV primarily during the 16 Days of Activism campaign, with no dedicated year-round GBV programming due to funding constraints. Staff reported using personal money to assist survivors who contact the station in distress. Both outlets are Maseru-based, meaning their reach into rural and mountainous districts, where GBV prevalence is highest, is limited by transmission geography.

8.5 Engaging men and boys in prevention



"The biggest change that they had was when they got the training about gender and GBV... challenging the gender norms and stereotypes helped them to realise that patriarchy is not just harming women, but it's also harming them as well."

GIZ key informant

The Chapter 4 regression analysis established that rape myth acceptance (OR 1.72) is a significant independent predictor of men's IPV perpetration after controlling for all other measured factors, and that ACEs (OR 4.75 for 4+ ACEs) dominate as the upstream driver. These findings locate the primary prevention target for men squarely in (a) attitudes specifically legitimising sexual violence, and (b) childhood adversity and its neurobiological and social-learning consequences.

The Kick4Life Programme Profile 2026 provides the most comprehensive reach data available for any male engagement programme in Lesotho. Over 260,000 young people engaged with programming cumulatively, with the Lesotho United Boys Module specifically targeting males aged 13-19 with curriculum content on gender rights, prevention of and response to violence against women and girls, conflict management, and self-esteem building.[254]

Critically, Kick4Life's Good Health and Wellbeing programme documents measurable attitude change. Among over 6,000 youth engaged, 91% showed increased HIV prevention knowledge and 93% improved attitudes toward women's role in society. These self-reported attitudinal shifts, while subject to social desirability bias, represent the strongest documented prevention outcome data from any male engagement programme currently operating in Lesotho.[255]

GIZ's public transport flagship trained 20 male champions, taxi marshals, drivers, and conductors in Leribe district (Maputsoe and surrounding localities). These champions reached over 800 public transport workers through peer-educator dialogue, GBV flipbook sessions, radio shows, and stickers on taxis. Critically, the programme embedded GBV prevention language into the taxi association's constitution, converting a temporary programme intervention into a permanent institutional commitment.



"I want to emphasise that I used to work in the mines. Now that I live with my partner, I see the signs of abuse more vividly. She controlled all the money from our business ventures, and I was accused of wasting money whenever I consulted traditional healers, even though I also paid for private doctors. This situation reflects a broader reality: men also suffer abuse, though society often silences us. The saying 'a man is a sheep, he does not cry' reflects how men are expected to endure quietly. Many men die from stress-related illnesses such as heart disease. I live with diabetes and high blood pressure. My doctors warned my family to avoid causing me extreme anger or excitement, as it could trigger fatal complications. Yet my partner deliberately provokes me, knowing my health risks."

Butha-Buthe Participant 9, former mine worker

The 2025 survey finds that 90.7% of male survivors never told anyone about their GBV experience. This account explains exactly why the Sesotho cultural mandate ('a man is a sheep does not cry') produces silence that has measurable health consequences. Male engagement programmes that do not address this cultural framework are working at the wrong normative level.

The Lebollo la banna, a cultural and traditional practice that transitions boys into manhood,

[254] Kick4Life, Programme Profile 2026. The Boys Module uses a sport-based methodology with young leader coaches as role models, complemented by mixed-gender tournaments for integration.
[255] Kick4Life, Programme Profile 2026. The 93% figure refers to participants in the Good Health and Wellbeing programme showing improved attitudes toward women's role in society in pre/post assessments.

identified in the 2013 study as a potentially positive masculinity-formation framework that can be engaged for GBV prevention, remains relevant in 2025. GIZ's collaboration with the Christian Council of Lesotho produced a contextualised Bible study manual. It engaged traditional leaders in initiation schools, producing a public commitment statement from traditional leaders acknowledging harmful norms embedded in initiation teaching. Where traditional masculine identity structures are being actively engaged by GBV prevention programmes, connecting the lebollo value system to contemporary messages about respect for women, there is evidence from similar Southern African contexts that they can be powerful vehicles for norm change.

8.6 Faith and traditional leadership as prevention actors

Religious leaders provide support to only 3.3% of GBV survivors (Chapter 7), and no elected official publicly challenged traditional leaders for GBV-legitimising discourse in 2025 (Chapter 6). Yet faith institutions are among the most universally accessed community structures in Lesotho, providing regular contact with large segments of the population, and traditional authority remains the primary justice referent for many rural communities. These two facts together define both the missed opportunity and the strategic potential of faith and traditional leader engagement in GBV prevention.

The WFP 2025 GBV Mapping Report identifies this opportunity explicitly. It recommends that community sensitisation should involve chiefs and local leaders to promote gender equality, recognising that traditional authority structures remain the most trusted and geographically distributed institutional network in Lesotho, reaching communities that no formal NGO programme covers.[256]

Pastor Rajaani of the Local Leadership Centre operates free counselling, home visits, a local radio programme, and community events. He is candid about his capacity limits and identifies the key cultural barrier to male engagement directly.

> *"In our Sesotho culture, we have a saying. As a man in our culture, if you cry, if you report, it's a sign of weakness."*
>
> Pastor Rajaani, Local Leadership Centre.

> *"Be patient with us. Help us. Try to help us understand the message (GBV). When we understand the message, we will use our influence and help the people."*
>
> Pastor Rajaani, requesting capacity building for faith leaders.

Right Reverend Dr Benedict of the Catholic Diocese of Mohale's Hoek describes the church's model as protection-prevention-restoration. That is, preaching human dignity, running workshops and men's retreats, applying diocesan safeguarding policies, and referring survivors to social workers, medical services, police, and the church's Justice and Peace office. He also documents technology-facilitated GBV from his own experience with

[256] WFP, GBV Mapping Report, 13 April 2025. Recommendation on community-level engagement.

hacking, photoshopping, and AI-generated deepfakes to identifying an emerging prevention challenge that the traditional faith-leader toolkit is not yet equipped to address. While institutional models like Dr Benedict's demonstrate what faith-based prevention can look like at its best, the case for scaling this work is made most forcefully not by programme designers but by survivors themselves:



"I believe preventing abuse requires more than telling women to be careful. Boys and men must be taught from a young age about respect, consent, and emotional control. Communities must stop protecting perpetrators simply because they are relatives. Parents must believe victims first before defending their sons. Traditional leaders, places of worship, and community councils must speak openly against gender-based violence instead of treating it as a private matter."

Pulane, 34, Mafeteng - survivor of sexual violence*

Pulane* speaks from inside a forest, forty minutes after fighting off a rapist with her hands, her legs, and her teeth. Her call for traditional and community leaders to speak openly against GBV, delivered from this position, is the most powerful argument available for why the faith and traditional leader prevention programme is not optional but urgent.

8.7 School-based prevention and youth engagement

Chapter 4's ACE data established that physical abuse in childhood (63.6% women, 68.7% men) and witnessing IPV (21.9% women, 14.1% men) are pervasive formative experiences that generate the next cohort of GBV survivors and perpetrators. Chapter 3 documented that sexual harassment at school affects 2.6% of all women and 1.8% of all men in population-level terms, and that among women who experienced any harassment, 12.3% experienced it in school settings.



"The next day at school, I struggled to concentrate because of the trauma, especially since we were taking a test. My teacher noticed that I was not well and asked me privately what was wrong. I explained everything, and she advised me to go with my grandmother the following day to report the matter.

Later, my grandmother and I went to the police station and filed a report. A few days later, the police informed us that he had been arrested, and we were given a court date. Although I did not hear the exact sentence he received, I was told he was convicted and imprisoned.

I felt relieved and satisfied with the justice process because it allowed me to heal and focus again on my studies. Today, I am doing well in school, and I feel safe knowing that people like him are held accountable."

Lerato, (minor), Leribe*

Lerato's teacher had no formal training in GBV disclosure protocols. She acted on instinct and human decency. The perpetrator was convicted. This section's recommendation for a national teacher training module with a standardised disclosure protocol would codify what her teacher knew to do by instinct, making Lerato's outcome replicable by every teacher in every school.

An important existing institutional mechanism that the study's school-based prevention recommendation should build on is the Ministry of Education and Training's (MOET) Life Skills Based Sexuality Education (LBSE) programme. The LBSE curriculum comprises six themes, of which Theme 3 addresses gender norms and gender equality. One of its stated learning outcomes is that learners will apply skills to protect themselves from all forms of violence, including bullying and sexual exploitation. Discussions with the MOET confirmed that this curriculum is currently being implemented in schools. The study's recommendation to integrate GBV prevention into the national school curriculum (Recommendation C3) should therefore explicitly engage with and build on the LBSE framework rather than creating a parallel structure, strengthening the existing Theme 3 content with the evidence-based ACE and gender norms data documented in this report.

8.7.1 Institutional prevention, tertiary education models

Two Lesotho tertiary institutions, the National University of Lesotho (NUL) and the Lesotho College of Education (LCE), have developed distinct but complementary approaches to embedding GBV prevention in higher education, each offering a model that, if replicated, would extend structural prevention across the education system.



The NUL policy framework

The National University of Lesotho adopted two landmark prevention instruments in 2024: the Sexual Harassment and Gender-Based Violence Policy (S.P. 2024-50) and the Standard Operating Procedures for Sexual and Gender-Based Violence (S.P. 2024-51). Together, they establish an institutional framework covering all staff, students, visiting researchers, and contractors, applying both on campus and during university-related activities. The policy commits the institution to preventing and eradicating SGBV, raising awareness, promoting dialogue, and ensuring that perpetrators cannot evade accountability. The accompanying SOPs establish a survivor-centred approach as the guiding principle, with mandatory sexual harassment training and compliance requirements, clear reporting procedures, investigative protocols, psychological first aid, and ethical guidelines.

A 2022 internal NUL survey provides the institutional baseline that informed the policy's design. It showed that, 55% of GBV survivors within the university community were female and 5% male, with students identified as the group most likely to be survivors. These data established that institutional GBV is measurable and addressable when institutions commit to documentation and response.[257]

[257] NUL S.P. 2024-51, SOPs for SGBV, citing the 2022 internal survey results.

From policy to pedagogy, GBV in teacher training

Dr Kelello Rakolobe's GBV content within NUL's Faculty of Education teacher training programme complements the institutional policy by extending prevention beyond the campus into the profession. Every teacher trained at NUL receives GBV content before entering the classroom through a Year 1 "Contemporary Issues in Education" module. However, the module remains discretionary and instructor-driven rather than institutionalised. The 2024 policies, which now mandate training, create the institutional foundation for converting this discretionary module into a compulsory, assessed component of teacher preparation.

LCE takes this integration further. Rather than treating gender-based violence as a standalone module, LCE embeds GBV content across all teacher-training programmes, teaching student teachers the provisions of the CDV Act 2022, the Sexual Offences Act, and the Children's Protection and Welfare Act as part of their professional preparation. The College maintains a Student Grievances Policy and a handbook specifying disciplinary consequences for gender-based misconduct and reported documented cases in which the institution acted, a male student disciplined for pushing a pregnant female student, and a lecturer dismissed for sexual exploitation of students. This integration model, embedding GBV awareness in a profession that subsequently reaches every community through the education system, represents a structural prevention pathway that multiplies impact beyond the training institution itself.

Taken together, the NUL and LCE models illustrate two ends of a spectrum: NUL has built a comprehensive policy architecture that is now extending into curriculum, while LCE has prioritised curricular integration backed by institutional enforcement. A national tertiary prevention framework that combined NUL's policy rigour with LCE's cross-programme embedding would create the foundation for a systematic school-based prevention model.[258]

8.7.2 Community-based youth prevention

Kick4Life's Lesotho United Girls Module (ages 13-20) and Boys Module (ages 13-19) use a sport-based methodology with young leader coaches as role models. The Girls Module covers life skills, sexual and reproductive health, HIV prevention, conflict management, gender rights, and GBV tackling, culminating in mixed-gender tournaments that integrate boys and girls in a shared prevention framework.[259]

The programme reaches approximately 800 community youth per year in Maseru and Berea, reduced from a historical high of 5,600 due to funding contraction since 2023. The Country Director described the disclosure dynamic that defines the programme's most critical prevention function. That is, young people who have been carrying undisclosed experiences of violence find the programme environment safe enough to speak.

> *"There's one participant that will either break down in a session... I just realised I've been going through that for a long time, and I didn't know what to do."*
>
> Kick4Life Country Director, on disclosure during youth sessions.

[258] NUL, Senate Paper S.P. 2024-50: Sexual Harassment and Gender-Based Violence Policy; S.P. 2024-51: Standard Operating Procedures for Sexual and Gender-Based Violence. National University of Lesotho, 2024.
[259] Kick4Life, Programme Profile 2026. The sport-based methodology uses football as the entry point, with curriculum content delivered through structured session plans revised twice yearly based on monitoring and evaluation findings.



"My teacher noticed my sudden change in behaviour. She called me aside and spoke to me gently. I broke down and told her everything. She told me it was not my fault and that I did not deserve any of what happened to me. With her support, we reported the case to the police. The case was taken to court, and the judge found the old man guilty, and he was sentenced to 15 years in prison."

'Nono, 19, Qacha's Nek*

8.8 Economic empowerment as structural prevention

The relationship between economic factors and GBV in Lesotho is complex and non-linear, as established in Chapter 4. Women in the 'richer' wealth quintile report the highest lifetime IPV experience (55.1%), and employed women report higher rates than unemployed women (51.3% vs 43.3%). The empowerment backlash pattern, in which women's increasing economic agency generates controlling responses from male partners. True structural prevention requires economic empowerment in combination with male engagement, norm change, and legal protection, not as a standalone intervention.

8.8.1 Economic empowerment for key populations, Care for Basotho

Care for Basotho Association operates in four districts, namely, Maseru, Berea, Leribe, and Butha-Buthe, targeting vulnerable and marginalised individuals, including female sex workers aged 15-29 and above. Its programmes combine GBV prevention with economic empowerment through farmer group organisation and agribusiness training, recognising that economic vulnerability is a direct driver of transactional relationships that increase GBV exposure among key populations.[260]

The organisation's Ending Early and Forced Marriage (EEFM) project addresses the structural intersection documented in Thabiseng's opening I-Story, where economic vulnerability (orphanhood, dependency on male relatives) creates the conditions for forced marriage. The BEHKEP project operates Drop-in Centres in three districts, providing HIV testing, psychosocial support, condom access, and legal referrals, an integrated model that treats GBV prevention and health services as inseparable for the populations most at risk.

8.8.2 The Kick4Life climate enterprise incubator

Kick4Life's climate enterprise incubator selects female graduates of the City United programme, already exposed to GBV awareness, rights education, and peer-support networks, into a one-year mentorship cohort of approximately 10 young women. Participants receive mentorship from Kick4Life's social enterprise managers, technical business development support, and seed funding where available, with a specific focus on climate-smart enterprises.

[260] Care for Basotho Association, programme documentation. Projects include BEHKEP (Drop-in Centres in 3 districts), Karabo ea Bophelo (children of FSWs), and the Ending Early and Forced Marriage (EEFM) project.

"It's about empowerment and ensuring that they develop independence and self-reliance and not find themselves in situations that put them at risk of being exploited because of transactional relationships."

Kick4Life Country Director, on the Climate Enterprise Incubator.

The incubator model demonstrates what integrated economic-prevention programming looks like, sustained (one year), peer-supported, sequenced on prior GBV awareness training, explicitly framed around reducing economic vulnerability as a GBV risk factor, and designed to build ongoing peer networks. The missing component, male partner engagement, is identified in Chapter 10 Recommendation D3 (national male engagement scale-up).

8.9 Secondary and tertiary prevention

8.9.1 Secondary prevention, early intervention for high-risk groups

Secondary prevention targets individuals and groups at elevated risk before violence has become entrenched, survivors of childhood adversity, couples in early relationship formation, women in controlling relationships who have not yet experienced physical violence, and young men at risk of perpetration. The ACE dose-response data (Chapters 4 and 5) identify the most critical secondary prevention target. These are adults with 4+ ACEs, who face 6.68 times higher odds of IPV experience (women) and 4.75 times higher perpetration odds (men) than those with no ACEs. None of these secondary prevention mechanisms currently exists at scale in Lesotho's documented GBV response system. The psychosocial support sector, as mapped in Chapter 7, is too small, Maseru-concentrated, and too donor-dependent to provide secondary prevention at the population level. ACE-informed assessment is not embedded in primary health care. Couple-based intervention programmes are not documented in the landscape.

8.9.2 Workplace prevention: the Labour Act 2024 framework

The Labour Act 2024 establishes a statutory basis for workplace GBV prevention that did not exist in the 2013 prevention landscape. Part III of the Act establishes fundamental principles, including the prohibition of unfair discrimination and forced labour. At the same time, the institutional architecture, the National Advisory Committee, Wages Board, Industrial Relations Council, and Dispute Prevention Directorate, creates the regulatory framework through which workplace harassment and gender-based violence can be formally addressed.[261]

The Act's provisions are particularly significant in the context of GIZ's public transport flagship, which demonstrated that embedding GBV prevention language into the taxi association's constitution converted a temporary programme intervention into a permanent institutional commitment. The Labour Act 2024 provides the national legal framework within which similar sector-specific prevention commitments can be made enforceable rather than voluntary.

[261] Labour Act 2024, Government of Lesotho. Part III: Fundamental Principles; Part IV: Labour Institutions including the Dispute Prevention Directorate.

8.9.3 Tertiary prevention

Tertiary prevention focuses on preventing re-offending by perpetrators through accountability mechanisms (prosecution, protection orders), therapeutic rehabilitation (perpetrator counselling programmes),[262] and post-incarceration reintegration support.[263]

Chapter 5 established that IPV perpetration is independently associated with depression for both women (OR 1.36) and men (OR 2.07), the male perpetrator's depression odds exceeding even the survivor's in the adjusted model.



"I realised that because of anger, if I laid my hands on my wife, I could seriously harm or even kill her. I knew it was better to seek help than to end up in prison. Honestly, I see it as a blessing that I broke the same hand I usually use. I believe this incident prevented me from committing a crime that I would regret today, because I know I am short-tempered."

Ralitopo, Thaba-Tseka*

8.9.4 Perpetrator programmes

The absence of a court-mandated perpetrator rehabilitation programme means that men like Ralitopo*, who have the self-awareness to seek help before a serious offence occurs, have no formal pathway through which to do so.

The CDV Act 2022, specifically Section 26's rehabilitation provisions, provides the legal basis for courts to mandate perpetrator programmes, but as established in Chapter 6, the Act's operational provisions are yet to be fully implemented. Court-mandated perpetrator programmes, requiring convicted domestic violence perpetrators to complete a therapeutic programme as a condition of non-custodial sentencing, are not yet available in Lesotho's justice system.

Care for Basotho documented that police are among the perpetrators of GBV against key populations. Kick4Life documented a specific case of a policeman who murdered his wife. GIZ noted that police 'are some of the biggest perpetrators' and 'don't have sensitivity when it comes to GBV issues.' One of the documented 'I' Stories' documents abuse of a minor by a police officer in Mafeteng. These observations identify an institutional perpetrator population, LMPS officers, whose accountability and rehabilitation is the specific mandate of the institution responsible for GBV enforcement. The accountability paradox is complete, showing that the system designed to hold perpetrators accountable is itself a documented source of perpetration.

The **Solidarity Centre**'s Anti-Gender-Based Violence and Harassment (Anti-GBVH) programme in Lesotho's textile manufacturing sector provides a concrete example of workplace-based prevention operationalised at scale. Established in 2019 following reports of widespread sexual harassment and exploitation in garment factories, the programme trains workers, management, and factory owners on recognising and responding to GBVH; operates

[262] Gondolf, E.W (2012). The future of batterer programs: Reassessing evidence-based practice. The Future of Batterer Programs: Reassessing Evidence-Based Practice. 1-317.
[263] WHO (2010). Preventing Intimate Partner and Sexual Violence Against Women: Taking Action and Generating Evidence. Geneva: World Health Organisation.

an Information Line for anonymous reporting; and has assisted factories in developing formal GBVH workplace policies. The Solidarity Centre reported that GBVH case patterns fluctuate with economic conditions: during retrenchment periods, workers' vulnerability to sexual and financial abuse increases as desperation for employment grows. The organisation identified the Labour Act 2024's inclusion of GBV provisions, for which Solidarity Centre advocated, as a significant legislative advance, creating for the first time a statutory basis for workplace GBV prevention and response that the programme can reference in its training and policy development work.

8.10 Political commitment and prevention investment

Prevention programmes cannot function without funding, and funding does not materialise without political will. Chapter 6's political discourse analysis found that 93% of ministerial statements on GBV in 2025 **contained no specific budget allocation for GBV**, a finding that defines the accountability context for this prevention chapter.

The most significant resource announcement of 2025 was the EU's M168.5 million commitment to CSO-led GBV initiatives, a donor investment, not a government budget allocation. The implicit accountability question, whether government co-investment will match or sustain donor commitment beyond the grant period, remains unresolved. Prevention investment specifically should be tracked separately from response investment[264], since the ratio of prevention to response spending is itself a measure of political commitment to addressing the root causes of violence rather than merely managing its consequences.[265]

Conclusion

The chapter finds:

- ***The normative foundation is shifting:*** The gender attitudes data document genuine normative progress between 2013 and 2025. The near-universal agreement that a woman should obey her husband (97% in 2013) has collapsed to a minority position (33.9% of women, 49.2% of men in 2025). Men's endorsement of wife discipline has fallen from 41% to 7.2%. These are real gains. What remains, and what this chapter's data identify as the prevention priority, is the resistant minority of men who still hold violence-legitimating beliefs, and the specific attitudinal cluster of rape myths that retains independent predictive power for GBV perpetration. Prevention programming must now be precision-targeted. It must move from broad awareness campaigns to interventions specifically designed to challenge rape-justifying cognitions among men, particularly those in the 25-44 age group with elevated perpetration rates and high ACE burdens.

- ***More nuanced messaging:*** The norms gap data (-1.60 for women and -0.66 for men) establishes that Basotho adults already hold more equitable personal norms than they believe their communities hold, and that this

[264] UN Women (2015). A Framework to Underpin Action to Prevent Violence Against Women. New York: UN Women
[265] Our Watch, ANROWS & VicHealth (2015). Change the Story: A Shared Framework for the Primary Prevention of Violence Against Women and Their Children in Australia. Melbourne: Our Watch.

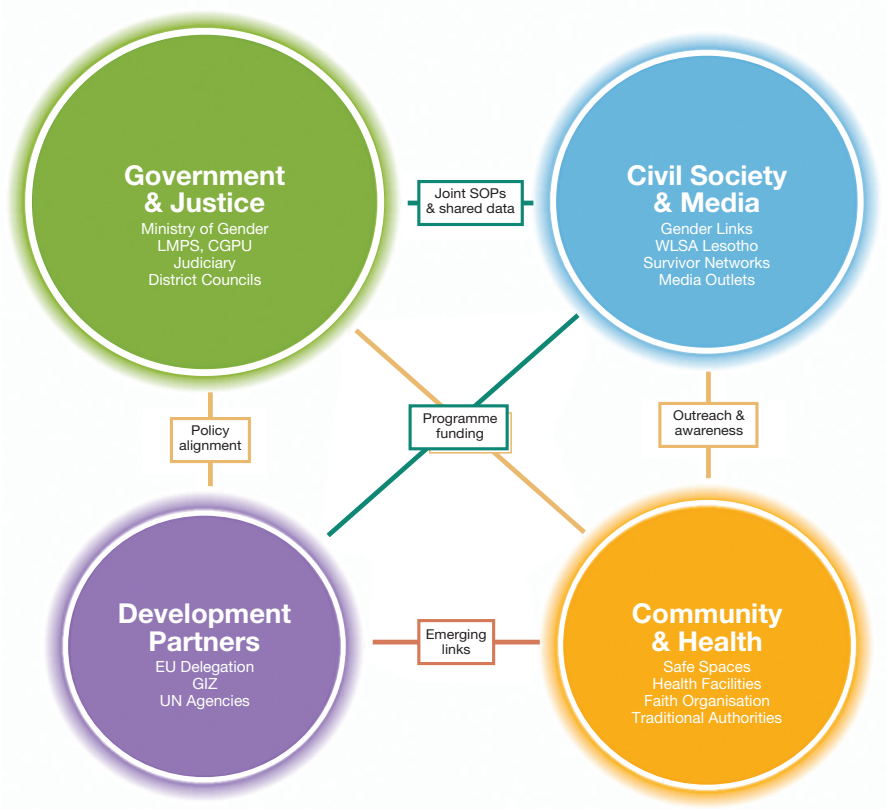
gap is largest among highly educated women (tertiary completed: -3.32; high school completed: -2.96). These women already hold equitable personal views but perceive their communities as more conservative than they are. By contrast, women with lower education show smaller norms gaps because their personal views are themselves less equitable (mean personal norms score: 24.0 for never-attended vs 29.4 for tertiary-completed). This distinction drives two different prevention strategies: for highly educated women, social norms revelation campaigns ('most people in your community already agree with you') can unlock behaviour change without requiring attitude shifts; for women with lower education, direct attitude programming addressing specific patriarchal norms remains the priority. Both approaches represent high-leverage prevention investments, but they target different populations with different mechanisms.

- ***Prevention must go upstream:*** The single most important prevention finding in this study is the ACE dose-response. Adults with four or more adverse childhood experiences face odds of adult IPV involvement 4.75 to 6.68 times higher than those with none, after controlling for all other measured factors. Every child in Lesotho who experiences abuse, neglect, household dysfunction, or witnesses IPV is being produced, statistically, as a higher-risk adult survivor or perpetrator of violence. A prevention architecture proportionate to this problem must include ACE-informed assessment in primary health care, ACE-informed parenting support, school-based early intervention targeting children with high adversity exposure, and therapeutic support for adults with ACE histories. Prevention must also reach persons with disabilities and LGBTQI+ communities through accessible formats and identity-affirming approaches that address the distinct drivers documented in this study.

- ***Emerging institutional prevention frameworks must be scaled and enforced:*** The 2025 assessment documents a new development absent from the 2013 baseline, the emergence of institutional prevention frameworks. NUL's SGBV Policy and SOPs create a comprehensive institutional prevention framework, while LCE's integration of GBV content across all teacher-training programmes demonstrates a complementary model that extends prevention into the profession itself. Together, they illustrate that institutional prevention can operate at both the policy level and the curricular level, and that the most effective national model would combine both.

  The Labour Act 2024's Dispute Prevention Directorate creates a statutory basis for workplace prevention. GIZ's embedding of prevention language in the **Leribe taxi Association**'s constitution demonstrates that institutional prevention commitments can be permanent rather than programme-dependent. The WHO Country Cooperation Strategy 2024-2027 integrates GBV response capacity into health-systems strengthening. These frameworks represent the shift from campaign-dependent, time-limited prevention to institutionalised, enforceable prevention, but they remain isolated examples rather than coordinated national institutional prevention architecture. Scaling the NUL model to all educational institutions, extending the Labour Act provisions to all employment sectors with documented GBV risk, and embedding ACE-informed assessment in the primary health care system through the WHO strategy framework would convert these emerging institutional instruments into a systematic prevention system.

CHAPTER 9
INTEGRATED APPROACHES



Graphic showing coordination assessment of GBV actors in Lesotho (2025).

Key findings

- Lesotho has a multi-sectoral GBV coordination body, the Anti-GBV Forum, but persistent challenges limit its functional capacity. The CDV Act 2022 creates a statutory multi-sectoral mandate for the first time, but its operational provisions remain unimplemented.
- No common GBV case registration form or data-sharing system exists across police, health, courts, and civil society, eleven years after UNODC identified this as a priority.
- The Legal Aid Clinics Guidelines establish the first documented cross-sector referral protocol across 56 providers with SOGIE-inclusive provisions, a template the Anti-GBV Forum should adopt as the national standard.
- Lapeng Care Centre, Lesotho's sole dedicated GBV shelter, continues to operate as the only functioning shelter nationally.
- Civil society referral networks function through personal relationships rather than formalised protocols, effective but fragile and unscalable.
- The Labour Act 2024 demonstrates that Lesotho can build coordination mechanisms with institutional specificity and accountability. The GBV coordination system lacks an equivalent architecture.
- 93% of ministerial GBV statements in 2025 contained no budget specificity. A public GBV implementation tracker maintained by the Parliamentary Women's Caucus is the most feasible accountability mechanism.

Three offices, three disclosures, no resolution



"My partner began supporting me financially, but the money was always minimal. At times, he would disappear for six months without returning home. When he returned from the mines in 2019, he initially seemed supportive but soon revealed his controlling and abusive nature. He once scolded me harshly and later pulled out a knife, leaving me terrified that he might harm the children or me.

At the police station, I felt unsupported and fearful, realising that my complaints were not taken seriously. I was advised to seek help from the gender office, where I finally received some assistance and encouragement. However, my partner continued to belittle me. The abuse escalated to physical violence, and even after I sought medical help and filled out forms documenting the abuse, the cycle of violence persisted."

Thabiseng, Thaba-Tseka*

Thabiseng* navigated police, the gender office, and medical documentation, three separate institutions, three separate appointments, three separate disclosures of the same abuse. The coordination system she needed would have linked these contacts into a single case record with a follow-up protocol. This chapter argues for exactly that system. Her story shows what the absence of it costs.

Overview

This chapter assesses whether Lesotho's GBV response functions as a coordinated system or as a collection of unconnected services. It examines the legislative mandate for coordination under the Counter Domestic Violence Act, the functioning of the Anti-GBV Forum, the Lapeng One Stop Centre, digital coordination tools, civil society coordination roles, the referral system, data management, and accountability mechanisms. The chapter documents what coordination infrastructure exists, where it breaks down, and what it costs survivors when institutions do not communicate, providing the evidence base for the institutional recommendations in Chapter 10.

9.1 Introduction - What coordination means and what it costs when it fails

A survivor of intimate partner violence in Lesotho who chooses to seek formal help must navigate a system that was not designed with their journey in mind. They may begin with the police, who may or may not have a CGPU officer, who may or may not know about the CDV Act 2022, and who may or may not have transport to respond. They may be referred to a health facility, where the provider may or may not ask about the cause of their injuries, and where post-exposure prophylaxis may or may not be available. They may be directed to a shelter if one exists in their district. They may be told to go to court, where the CDV

Table 9.1: 2013-2025 Coordination progress scorecard

Coordination element	2013/2014 UNODC status	2025 status	Direction
Multi-sectoral coordination body	Absent - recommended by UNODC 2014	The Anti-GBV Forum exists, but is underfunded and irregularly convening	Partial
Domestic violence legislation	DVA bill under review - not enacted	CDV Act 2022 enacted - not yet operationally implemented	Partial
Designated GBV courts	Not established	Required by CDV Act - not established	None
One-stop centre	Lapeng Centre - 'not utilised to the maximum	Lapeng continues; Thuso assessment: 4/12 criteria unmet. MPC launched in Nov 2025	Partial
Referral protocols	'Vague referral system'; referrals conceal gaps	Legal Aid Guidelines Dec 2025 - first standardised protocol; not yet cross-sector	Partial
Common GBV data system	Different forms across sectors - no shared data	No common case registration or tracking system	Unchanged
Digital service directory	Not available	Nokaneng app launched in 2025 - first digital GBV service directory	New
Civil society coordination	Multiple organisations 'not knowing each other'	RISE project, EU platform, GL coordination; informal networks improved	Improved
Parliamentary GBV oversight	Limited - ministerial leadership is a key need	PWC active - state of emergency call March 2025; oversight claimed	Improved
Workplace GBV coordination	Not addressed in the GBV framework	Labour Act 2024 - Dispute Prevention Directorate established	New
Budget transparency for GBV	**Not measured**	**93% of ministerial statements have no budget specificity (2025 PDA)**	**Deficit**

Note: *Sources: GL-Lesotho GBV Indicators Study 2013; UNODC Situational Assessment Workshop, April 2014; GL-Lesotho GBV Indicators Follow-up Study 2025 survey data and qualitative evidence; Chidhakwa (2026) Political Discourse Analysis; Thuso Project Baseline Study 2026; WFP GBV Mapping Report April 2025; Legal Aid Clinics Guidelines December 2025; Labour Act 2024; Magistrate interview March 2026*

Act's protection order provisions are not yet operationally implementable. At each of these transitions, they must re-tell their story to a new institution. At each of these transitions, there is no guarantee that the information they provided to the previous institution has been passed on. This is the lived experience of coordination failure in Lesotho, and it is the experience that this chapter examines.

Effective GBV coordination means a common framework for identifying survivors; shared referral protocols with defined responsibilities; joint case management for complex situations; a common data system that enables tracking of individual cases and aggregate outcome monitoring; regular multi-sectoral fora where frontline practitioners share learning, and political accountability mechanisms that ensure resource allocation matches coordination commitments. In international GBV literature, these elements are sometimes called an essential services package, the minimum coordinated infrastructure that a state owes to survivors of violence.[266]

The 2013 GL-Lesotho baseline study found the answer to be not very close. The 2014 UNODC situational assessment, convened a year after the 2013 study, produced a six-point diagnosis that was notably direct. It found that GBV was 'seen in isolation' across sectors; that there was 'a vague referral system among organisations'; that 'referrals are used as a scapegoat to conceal gaps in coordination'; and that survivors reported either to police, health facilities, or traditional leaders who used different forms and shared no data. The

[266] United Nations (2015), Essential Services Package for Women and Girls Subject to Violence: Core Elements and Quality Guidelines. New York: UN Women, UNFPA, WHO, UNDP, UNODC.

assessment recommended forming a multi-sectoral coalition and upgrading the Lapeng one-stop centre. Those recommendations were made in April 2014. This chapter asks: eleven years later, what has been built?

The answer is mixed and requires honest assessment. On the positive side, Lesotho enacted the CDV Act 2022, which, for the first time, creates a statutory multi-sectoral response obligation. The Parliamentary Women's Caucus emerged as a structured political oversight voice. International partners, GIZ, the EU, UN Women, and UNICEF have invested in coordination infrastructure. An Anti-GBV Forum was established as a multi-sectoral coordination body. The WHO Country Cooperation Strategy 2024-2027 for Lesotho identifies multi-sectoral action and health systems strengthening as interdependent priorities, reinforcing the argument that GBV coordination must extend beyond the justice sector into the health system.[267]

On the negative side, the CDV Act's operational provisions, the designation of courts as Family Courts, the protection order mechanism, and the promulgation of family court rules remain unimplemented. The Anti-GBV Forum has struggled with consistent funding and meeting regularity. And the frontline referral experience, for the survivor navigating between services, appears structurally similar to what UNODC documented in 2014.

9.2 The legislative mandate for coordination

The Counter Domestic Violence Act 2022 is not only criminal legislation, but it is also coordination legislation. Its multi-sectoral mandate imposes obligations on a range of state institutions to cooperate in providing comprehensive services to domestic violence survivors. The CDV Act's coordination-relevant provisions include: the designation of all courts as Family Courts for domestic violence matters within their areas of jurisdiction (Section 16(2)); a protection order regime requiring police, courts, and social welfare to cooperate; and the implicit but critical requirement that health, police, justice, and social services operate from a shared understanding of what domestic violence is and what their respective responsibilities are.

The gap between these legislative provisions and operational reality was documented in detail in Chapter 6. In summary, although the Act provides that every court shall sit as a Family Court, presiding officers have not been designated, and family court rules are yet to be promulgated, leaving the protection order mechanism not yet fully operational; and the forensic laboratory's closure means that even where the Act's criminal provisions are applied, the evidentiary infrastructure required to prosecute cases effectively is limited in-country.[268]

The Legal Aid Clinics Guidelines, published in December 2025 with EU funding, represent a significant new coordination instrument. By establishing standardised referral protocols across 56 legal aid providers, including explicit SOGIE-inclusive provisions and defined pathways between legal aid, police, health, and social services, the guidelines create the first documented cross-sector referral protocol in Lesotho's GBV response architecture.[269]

[267] WHO, Country Cooperation Strategy: Lesotho 2024-2027. Geneva: World Health Organisation, 2024. The strategy embeds gender, equity, and human rights as cross-cutting priorities across health-systems strengthening.
[268] US Department of State (2025). 2024 Country Reports on Human Rights Practices: Lesotho. Washington, DC: Bureau of Democracy, Human Rights, and Labor.
[269] Legal Aid Clinics Guidelines, December 2025, funded by the European Union. The Guidelines establish standardised service delivery protocols across 56 legal aid providers with explicit SOGIE-inclusive provisions.

This legislative-operational gap is itself a coordination failure of a particular kind: a failure of vertical coordination between the legislative branch (which enacted the Act), the executive branch (which must promulgate the regulations and allocate the resources), and the judicial and administrative institutions (which must implement it on the ground). Horizontal coordination between different sectors serving the same survivors cannot function if the legal framework that mandates it has not been operationalised.

9.3 The Anti-GBV Forum: Lesotho's multi-sectoral coordination architecture

The 2013 study found that 'several organisations are working towards one goal, yet they do not know each other.' The 2014 UNODC workshop recommended forming a multi-sectoral coalition. In the years since, an Anti-GBV Forum, referred to by some stakeholders as the GBV Stakeholders Committee, was established as Lesotho's primary multi-sectoral GBV coordination body. Three organisations interviewed independently confirmed its existence. GIZ confirmed that it played a role in establishing the Forum's structure. This represents a real institutional advance over the 2013 baseline.

> *"We go into a country just to be there temporarily... the project is temporary, it's not sustainable, so for us, establishing an anti-GBV coordination forum is a way of establishing sustainability."*
> GIZ key informant, on the Forum's founding rationale.

> *"We are working closely with the Minister of Gender to ensure that we mobilise the resources to have an active structure on an anti-GBV forum... quarterly... coordinating meetings."*
> CGPU national coordinator.

However, multiple interview sources indicate that the Anti-GBV Forum has faced persistent funding challenges since its establishment. The European Union delegation noted that a coordination forum existed but that meetings had lapsed, citing a concrete illustration: the EU and the Ministry of Gender held separate 8 March International Women's Day events on the same day, a duplication that a functioning Forum would have caught. UNFPA noted the absence of a national electronic GBV management system accessible across ministries, police, and courts.

The WFP 2025 GBV Mapping Report provides independent corroboration of the coordination deficit. While documenting sixteen or more GBV service providers across Lesotho, the mapping identifies a persistent gap in the GBV referral pathway and recommends that community sensitisation should involve chiefs and local leaders to promote gender equality. This recommendation implicitly acknowledges the Forum's failure to connect formal service providers with traditional community governance structures.[270]

The 2013 baseline referenced South Africa's National Council on GBV as a model for Lesotho, a body with a statutory mandate, diverse membership, and explicit responsibilities for monitoring implementation. A well-

[270] WFP, GBV Mapping Report, 13 April 2025. The mapping documents providers including CGPU/LMPS, Kick4Life, Hope for Women Assembly, FIDA, and others across Lesotho's ten districts.

functioning Anti-GBV Forum would, at a minimum, meet regularly with attendance from all relevant actors, have a defined coordination mandate, maintain a national GBV service directory, own a common referral protocol, track aggregate case data, and have a direct reporting line to the Ministry of Gender or the Parliamentary Women's Caucus.

The Forum's current condition illustrates a pattern familiar across sub-Saharan African GBV coordination mechanisms, where a structure is established during a funded project cycle and provides genuine value. In contrast, that cycle is active and then struggles to sustain operations when the primary funder's active involvement reduces.[271]

Effective GBV coordination entails shared protocols, joint case management, a common data system, and political accountability that ensures resources follow commitments

9.4 Lapeng One Stop Centre

In 2013, Lapeng Care Centre in Maseru was the flagship of Lesotho's integrated GBV response architecture, a one-stop centre meant to bring health, legal, counselling, and shelter services under one roof. The 2013 study and the 2014 UNODC assessment both identified Lapeng as an important resource "not being utilised to the maximum," and both recommended upgrading and replicating the model. Twelve years later, the 2025 survey's shelter utilisation figure of 1.0-1.3% of IPV survivors raises the question of whether the one-stop centre concept has fulfilled its potential.

The most significant recent development is the Multi-Purpose Centre (MPC), renovated with Vodacom Foundation support on a former UN compound and officially launched by Queen 'Masenate Seeiso on 24 November 2025 under the name *Boiketlo*. The centre was designed to co-locate services from the Ministry of Gender, Health, Police, UN agencies, and the Lesotho Defence Force under one roof. However, the MPC is not yet operational as a standalone institution, pending the legal framework required to establish it. In June 2026, Lapeng Care Centre relocated to the Boiketlo premises, where it currently provides psychosocial support (counselling), legal services, healthcare services, referral services, economic empowerment skills, and reintegration services. The relocation places Lapeng in a more suitable facility, but the full multi-purpose centre model, with multiple government ministries operating under a unified institutional frame-work, remains pending.

The THUSO Project Baseline Study 2026[272] provides the most systematic independent assessment of Lapeng's operational status. The shelter assessment evaluated Lapeng against twelve international criteria for safe accommodation and found that four were not met, including security provisions, intake protocols, and service integration standards. This assess-

[271] Jülich, S. & Landon, F. (2017), 'Multi-agency approaches to sexual violence,' Trauma, Violence & Abuse, 18(2), 227-244; Fulu, E. et al. (2014), Why Do Some Men Use Violence Against Women and How Can We Prevent It? Bangkok: UNDP/UNFPA/UN Women/UNV.
[272] Thuso Project, Baseline Study Report, February 2026. The assessment evaluated Lapeng against 12 criteria drawn from international safe accommodation standards, finding 4 criteria unmet.

ment establishes that even Lesotho's sole dedicated GBV shelter does not yet meet internationally recognised minimum standards, underscoring the urgency of both the Boiketlo legal framework and replication of the one-stop centre model in other districts.

Beyond Lapeng, three CGPU safe spaces within police compounds, funded initially by the Global Fund, provide 48-hour emergency shelter nationally, not the sustained, multi-service care that a genuine one-stop centre delivers. Effectively, Lesotho's integrated service capacity remains Maseru-based, although a Lapeng Care Centre in Leribe (at Ts'ifa-li-Mali) is currently being revamped after storm damage. For survivors outside Maseru, there is no reachable shelter, a reality consistent with the survey's near-zero utilisation rate.

9.5 Digital coordination

The Vodacom-UNFPA Nokaneng app, promoted nationally during the 2025 16 Days of Activism campaign period, represents the first publicly accessible digital GBV information platform in Lesotho. By providing a zero-rated mobile platform listing available GBV services by district with contact information, the app addresses one of the six infrastructure requirements identified in this chapter: a national GBV service directory accessible to both practitioners and the public. Its zero-rated status removes the data cost barrier that would otherwise exclude the most economically vulnerable users.[273]

The Nokaneng app, the first of its kind in the SADC region, represents an important foundation for digital GBV service coordination. It provides survivors with accessible information about available services and how to reach them. To realise its full potential, the app requires expanded coverage and sustained funding. Its next development phase could include linking service providers to each other. The app's value as a coordination instrument will depend on whether it is integrated into the broader referral architecture, for example, whether CGPU officers and health workers use Nokaneng as their standard service directory when making referrals, and whether its listing data are kept current by the Anti-GBV Forum secretariat.

9.6 Civil society as a coordinating actor

In Lesotho's GBV response system, civil society organisations do not merely fill service gaps; they constitute a significant portion of the coordination architecture itself. The UNODC 2014 assessment found that 'the CSOs give much of the support to victims of GBV' while government systems were limited and Maseru-concentrated. In 2025, that structural reality has not fundamentally changed: civil society organisations like WILSA Lesotho, Seinoli Legal Centre, Gender Links, She-Hive, the Lesotho Child Counselling Unit, and RISE project partners continue to deliver the majority of specialist survivor support.

Civil society's role in coordination goes beyond service delivery. NGOs are often the connective tissue of the coordination system, the organisations that know which referral to make, who to call at the CGPU, how to navigate the court system on behalf of a survivor, and how to bridge between what the formal system says

[273] Vodacom Foundation / UNFPA, Nokaneng GBV app. Zero-rated (no data costs) and promoted during the 2025 16 Days of Activism campaign period.

it offers and what it can deliver. This informal coordination function is what survives when coordination bodies like the Anti-GBV Forum go dormant.

Care for Basotho Association provides a specific example of how civil society coordination functions for marginalised populations. The organisation operates in four districts: Maseru, Berea, Leribe, and Butha-Buthe. It maintains a cross-referral relationship with WILSA for legal cases involving GBV perpetrated by law enforcement against key populations. This referral pathway, from a community-based organisation to a legal services provider, exists because of a personal relationship between named staff, not because of a formalised referral protocol.[274]

> *"We realised that no, they're not going... so we actually started a practice where we take them there ourselves."*
>
> Kick4Life Country Director, on why passive referral fails.

The EU's three complementary civil society grants - to Sesotho Media and Development (CDV Act advocacy via media), Gender Links (prevalence study and programming), and the ICJ-led consortium including Seinoli Legal Centre and People's Matrix Association (strategic litigation and access to justice) represent the most deliberately coordinated civil society architecture currently operating. The RISE project (Reform for Inclusion, Support and Empowerment), launched in September 2025 with EU funding, provides a two-year coordination platform for legal reform, access to justice, and civil society capacity building. These mechanisms provide shared visibility, but they are project-specific, time-bound, and do not constitute the systematic coordination that the CDV Act envisions.

The National University of Lesotho's standard operating procedures for SGBV (S.P. 2024-51) provide a model of institutional-level coordination that, if adopted by other institutions, would systematise the referral pathways that currently depend on individual discretion. The NUL SOPs establish clear reporting procedures, investigative protocols, psychological first aid protocols, and defined roles and responsibilities, the coordination infrastructure at an institutional scale that the CDV Act envisions at a national scale.[275]

9.7 The referral system, where survivors fall through

A GBV referral system is only as strong as its weakest link, and it typically has several. In Lesotho, the survey evidence from Chapters 6 and 7 enables a quantitative map of where survivors are lost from the support pathway.



[274] Care for Basotho Association, programme documentation. The organisation targets vulnerable and marginalised individuals, including female sex workers, MSM, and transgender people.
[275] NUL, S.P. 2024-51: Standard Operating Procedures for Sexual and Gender-Based Violence. National University of Lesotho, 2024.



"I was taken from one police officer to another, which was exhausting and frustrating. Being questioned about why I had delayed reporting discouraged me so much that I almost wanted to leave and drop the case entirely. It was only after my brother contacted the station manager that we received proper assistance. I also believe police stations should have private spaces for reporting such cases. Reporting in a crowded office is retraumatising."

Thaba-Tseka Participant 5

Chapter 6 established that only 9.9% of women IPV survivors report to the police, and the combined justice pipeline yields fewer than 2% of all women survivors seeing a perpetrator convicted (based on very small sub-samples at each stage). Chapter 7 established that only 0.3% of survivors disclose to an NGO worker, and that shelter utilisation is 1.0-1.3% of IPV survivors.

The WFP 2025 GBV Mapping Report identifies this referral gap as a systemic finding. While multiple service providers exist across Lesotho's ten districts, the mapping documents a persistent gap in the GBV referral pathway itself, the connection between providers that converts a landscape of services into a system of care. The WFP mapping's recommendation that awareness campaigns should encompass all ten districts, with the inclusion of financial literacy for household resource management, addresses the specific economic barrier, the breadwinner dilemma, that drives attrition at every step of the referral pipeline.[276]

The 2014 UNODC assessment identified a specific dysfunction: 'referrals are used as a scapegoat to conceal gaps in coordination.' This formulation, referral as deflection rather than connection, remains analytically sharp in 2025. When a CGPU officer tells a survivor to 'go to the shelter' without knowing whether the shelter has capacity, without providing transport, without making a call to confirm a placement, and without following up, that is not a referral. It is a discharge.

The coordination architecture faces a structural tension between formal mechanisms and operational reality. The Mosepele Foundation reported that organisations working on GBV in Lesotho frequently operate in silos and only meet during events; competition for donor funding actively reduces collaboration. While coordination platforms exist on paper, they are widely perceived as ineffective. The Foundation identified a need for the Ministry of Gender to operationalise a functional national coordination forum or, alternatively, to designate a civil-society convener to regularly coordinate local GBV service providers and reduce duplication. WLSA's experience corroborates this gap: the organisation is actively seeking memoranda of understanding with the prosecution's office and National Legal Aid to formalise coordination that currently depends on informal relationships and goodwill. Without formalised protocols, referral continuity depends on individual staff relationships rather than institutional systems.

Additional institutional voices reinforce this coordination deficit. The Department of Public Prosecutions reported that justice sector coordination meetings have collapsed entirely, with no functioning multi-agency forum and no memoranda of understanding between the prosecution service and GBV service providers. The Solidarity Centre identified "poor coordination of players" as the single most significant structural gap in Lesotho's GBV response, noting that organisations working in the same sector often duplicate efforts without awareness of each other's activities.

[276] WFP, GBV Mapping Report, 13 April 2025. Recommendations include extending awareness campaigns to all 10 districts and incorporating financial literacy for household resource management.

The Legal Aid clinics' guidelines provide the first documented standardised referral protocol in Lesotho's GBV sector. By specifying how 56 legal aid providers should receive, assess, refer, and follow up on GBV cases, including explicit provisions for SOGIE-inclusive practice, the guidelines create a template that could be adapted for the health, police, and social welfare sectors. The question is whether the Anti-GBV Forum will adopt the Legal Aid Guidelines' referral framework as the basis for a cross-sector protocol, or whether each sector will continue to develop its own approach in isolation.[277]

The infrastructure required for a functional referral system in Lesotho is specific and achievable. It includes a national GBV service directory updated at least annually; standardised referral forms used consistently across police, health, courts, and civil society; active referral protocols that define responsibility for the handoff; and case tracking, even in its most basic form, recording how survivors were referred in, what they received, and where they were referred on. None of these requires new legislation. Most can be implemented with existing resources and coordinated through the Anti-GBV Forum.

Stakeholder feedback has confirmed that standardised referral protocols between sectors remain absent. Civil society actors report no formal referral procedures for accessing shelters, and the referral pathways between police, health, social development, and legal aid services operate on an ad hoc basis rather than through documented, standard operating procedures. The Social Development Ministry maintains a comprehensive referral form for child protection cases, and the police-health interface uses the medical examination form as a de facto referral instrument, but no unified, multi-sectoral referral protocol exists that would ensure consistent service navigation regardless of a survivor's initial point of contact. The Legal Aid Clinics Guidelines (December 2025), which establish standards across 56 providers, and the CDV Act's multi-sectoral response mandate provide the legal and operational frameworks for building such a protocol.

9.8 Data management

The 2014 UNODC assessment identified a data management problem at the heart of Lesotho's coordination failure. Survivors report to police, health facilities, or traditional leaders, who all use different forms. A decade later, this problem has not been systematically resolved. The CGPU's full statistical report for 2024-2025 was not publicly accessible. The magistrate's interview confirmed that case tracking after sentencing is weak. The Children's Court register data had not been compiled into an available report.

The Lesotho Demographic and Health Survey 2023-2024 illustrates both the value of independent data and the coordination opportunity that shared data systems would create. The DHS provides nationally representative prevalence, attitudes, and help-seeking data that the administrative systems of police, health, and courts cannot generate because they do not share a common framework. If Lesotho's GBV administrative data system were functional, with standardised case registration, district-level aggregation, and annual publication, it would complement the DHS and periodic prevalence surveys by providing continuous monitoring data between survey rounds.[278]

[277] Legal Aid Clinics Guidelines, December 2025. The Guidelines establish standardised protocols for 56 providers, including FIDA (72 paralegals, 4 attorneys, 11 districts).
[278] Lesotho Demographic and Health Survey 2023-2024, Ministry of Health and ICF. The DHS captures nationally representative GBV data at five-year intervals.

A critical finding of this study's triangulation exercise is the absence of an interoperable case management system across GBV response sectors. The CGPU, magistrate courts, health facilities, shelters, social development offices, and legal aid providers each maintain separate recording systems with different categorical frameworks, different case identifiers, and no mechanism for tracking a single survivor's journey across the referral chain. This fragmentation means that no institution in Lesotho can currently answer the question: of the survivors who report to police, how many receive medical care, how many access legal aid, and how many receive psychosocial support? The planned GBVIMS+, under development by the Sustainable Irrigated Horticulture, Health and Business Development Programme Project Implementation Unit (SIHHBDP-PIU) under MCA-Lesotho, is designed to address this gap. Its successful implementation would represent a transformative advance in Lesotho's capacity to monitor, evaluate, and improve its GBV response system. The MCA-commissioned service mapping of 288 providers provides the provider database that GBVIMS+ requires.

A GBV data system serves three functions essential to coordination. First, at the individual case level, a shared record enables the next service provider to know what has already happened to a survivor. Second, at the service management level, aggregate data enable organisations and the Ministry of Gender to track how many people are being served and where pathways are failing. Third, at the accountability and policy level, reliable national GBV data enables politicians and donors to assess whether investment is reaching survivors.

The minimum data management infrastructure includes a standardised GBV case registration form used across CGPU, health facilities, Lapeng, and civil society providers, a district-level case register enabling aggregation at the national level, a defined data flow from district to national with regular publication, and privacy protections ensuring shared data do not compromise survivor safety. Several digital platforms, the Gender-Based Violence Information Management System (GBVIMS), used across seventeen countries, provide technical architecture.

9.9 The accountability deficit - coordination without consequences

Coordination mechanisms without accountability are conversation clubs. They generate goodwill, shared information, and occasional joint activities, but they do not change what happens to survivors at the point of service. Chapter 6's political discourse analysis provided the starting point, showing that 93% of ministerial statements on GBV in 2025 contained no specific budget allocation.

The Labour Act 2024 provides an instructive counter-example of what coordination with accountability looks like in Lesotho's institutional landscape. The Act's establishment of the Dispute Prevention Directorate, National Advisory Committee, Wages Board, and Industrial Relations Council creates a multi-body coordination architecture with defined roles, statutory mandates, and reporting obligations. The GBV coordination system, the Anti-GBV Forum, the CDV Act's multi-sectoral mandate, and the Ministry of Gender's oversight function have no equivalent institutional specificity. The Labour Act demonstrates that Lesotho can create statutory coordination mechanisms with accountability; however, the question is whether the political will exists to apply the same institutional design to GBV.[279]

[279] Labour Act 2024, Government of Lesotho. Part IV establishes Labour Institutions including the Dispute Prevention Directorate and National Advisory Committee.

The Parliamentary Women's Caucus Chairperson, Motsoasele, acknowledged that 'after laws are enacted, they are handed over to other stakeholders for implementation', and asserted the legislature's oversight responsibility. What effective accountability requires is a published national GBV coordination plan with specific commitments, annual parliamentary reporting on implementation progress, budget transparency on GBV-specific allocations, and civil society access to the monitoring process.

The political discourse analysis's recommendation for a public GBV implementation tracker, a dashboard accessible to citizens and civil society, maintained by the Parliamentary Women's Caucus (PWC) and updated quarterly, is the most feasible accountability mechanism given Lesotho's current governance context. It does not require new legislation. It requires political will from the PWC to establish it, and government agreement to report into it.

Conclusion

The chapter finds:

- ***Progress is real but dogged by operational challenges:*** Between 2013 and 2025, Lesotho made real coordination progress: the CDV Act 2022 created a legislative coordination mandate; an Anti-GBV Forum was established; the Parliamentary Women's Caucus emerged as a political oversight voice; and international partners invested substantially in coordination infrastructure. The Legal Aid Clinics Guidelines of December 2025 created the first cross-sector referral protocol. The Nokaneng app provided the first digital service directory. These are genuine advances. The challenge is that progress at the structural level has not yet translated into measurable change at the operational level, where survivors experience the system. Police reporting is unchanged at 10%. Shelter utilisation is unchanged at near-zero. No common referral form exists. No case tracking system operates across sectors.

- ***The Anti-GBV Forum is the right architecture; it needs the right resources:*** Lesotho does not need to build a coordination mechanism from scratch; it has one. The problem is not the Forum's existence but its resourcing. An underfunded coordination body that meets irregularly, with a voluntary secretariat and no statutory mandate, cannot perform the functions a coordinated system requires. Concretely, a government budget line for the secretariat, a mandate derived from the CDV Act's multi-sectoral provisions, quarterly meeting obligations with defined attendance, and an annual public report to Parliament. The Labour Act 2024's Dispute Prevention Directorate demonstrates that Lesotho can institutionalise coordination with statutory backing; the same institutional design should be applied to GBV.

- ***Data is the precondition; you cannot coordinate what you cannot see:*** Every coordination failure documented in this chapter has a data failure at its root. The Anti-GBV Forum cannot monitor the referral system because there is no common data system. Parliament cannot hold the Ministry of Gender accountable because no outcome data are published. The CDV Act cannot be assessed for implementation because no tracking mechanism exists. A GBV coordination system that generates no shared data is operating blindly. The minimum investment required is achievable: a standardised case registration form, a district-level register, annual publication of aggregated statistics, and a national secretariat to compile and report.

- ***New coordination instruments must be connected, not isolated:*** The 2025 assessment documents several new coordination instruments that did not exist in 2013: the CDV

Act's multi-sectoral mandate, the Legal Aid Clinics Guidelines' standardised referral protocol, the Nokaneng digital service directory, the NUL SGBV SOPs, the Labour Act 2024's Dispute Prevention Directorate, and the WHO Country Strategy's health-systems integration framework. Each of these instruments addresses a specific dimension of the coordination deficit. None of them is currently connected to the others. The Legal Aid Guidelines' referral protocols do not feed into the Nokaneng directory. The NUL SOPs do not reference the CDV Act's multi-sectoral obligations. The Labour Act's workplace dispute mechanisms do not link to the Anti-GBV Forum. The Anti-GBV Forum's mandate does not yet encompass the WHO health-sector integration agenda. The single most important coordination recommendation of this chapter is therefore not to create new instruments but to connect the ones that now exist, through the Anti-GBV Forum as the designated national coordination body, with the Legal Aid Guidelines' referral protocol as the starting template, the Nokaneng app as the service directory backbone, and the parliamentary GBV implementation tracker as the accountability mechanism.

CHAPTER 10
CONCLUSIONS AND RECOMMENDATIONS



Marching for gender justice in Lesotho. *Photo: GL Lesotho*

Key findings

- Of the 22 recommendations from 2013, only one was fully implemented (the CDV Act 2022) - though work to ensure its full operationalisation is underway; seven recommendations showed no evidence of action after eleven years.
- The 2025 study reveals GBV prevalence among LGBTQI+ populations but with no institutional reporting or referral pathway.
- Twelve cross-cutting findings show that GBV has declined but remains endemic, ACEs are the strongest predictor of adult violence, gender norms have shifted, and justice and support systems remain unable to serve survivors at scale.
- Twenty-six-tiered recommendations name lead institutions, specific timeframes, and measurable milestones, designed for accountability audit at the next follow-up study.
- Several new institutional instruments not present in 2013, the Legal Aid Clinics Guidelines, the Labour Act 2024, the NUL SGBV Policy, the Nokaneng app, and the WHO Country Strategy, create coordination and prevention frameworks that provide a stronger foundation for implementation than existed in 2013.
- Every major GBV service remains in Maseru; the highest-prevalence districts have the least access.
- The overarching lesson is that commitment without accountability produces laws that are not implemented and survivors who are not served.

Sixteen and sold, a story of abuse and survival



"The responsibility belongs entirely to the perpetrator. Being friendly is not consent. Walking with someone is not consent. Refusing a kiss is not an invitation for violence. Looking back has taught me to trust my instincts more, but it has also taught me that the blame never belongs to the survivor. The perpetrator does not deserve your future."

Lipuo, 34, Mafeteng

Lipuo concludes this report by highlighting the core purpose of the entire accountability audit. The perpetrator must be held responsible, and the system needs to ensure this accountability. Survivors deserve a future that the perpetrator cannot disrupt. The report includes twenty-six recommendations aimed at transforming this vision into reality, ensuring that accountability extends both upward to institutions and inward to the perpetrators themselves.

Overview

This chapter draws together the evidence from across the study to present twelve cross-cutting findings and a structured set of recommendations for the next phase of Lesotho's GBV response. It begins with an accountability audit of the 22 recommendations from the 2013 study, assessing what was implemented and what was not, before presenting the 2025 findings and a tiered recommendation framework organised by responsible institution and timeframe. The chapter is designed to ensure that recommendations are specific, measurable, and accountable so that the next follow-up study can assess what was delivered.

10.1 Introduction

The 2013 GL-Lesotho Gender-Based Violence Indicators Study produced recommendations across six thematic domains. Those recommendations were submitted to the government, civil society, and development partners. Some were acted on. Many were not. Eleven years later, this follow-up study finds that police reporting rates are unchanged at approximately 10%, shelter utilisation is unchanged at near-zero, no common referral protocol exists between GBV service sectors, and only 12.1% of the population has heard of Lesotho's most important recent GBV legislation, the Counter Domestic Violence Act 2022, three years after its enactment.

A conclusions chapter that generates a new list of recommendations without first accounting for the old ones would be complicit in the same accountability-free cycle that allowed these gaps to persist. This chapter, therefore, begins with an accountability audit, a systematic assessment of what happened to the 2013 recommendations. Only then does it turn to the 2025 recommendations framework, structured with named responsible institutions, specific timeframes, and measurable milestones so that the 2031 follow-up study can conduct the same audit and reach better verdicts.

The chapter also presents a government performance scorecard, a seven-domain evidence-based rating of what has been achieved since 2013. The scores reflect the data from Chapters 3 through 9. They are

intended to be fair, specific, and actionable. Each score below 4 identifies a domain where action is required.

10.2 The 2025 accountability audit

The following table assesses each of the 2013 study's recommendations against the 2025 evidence. Four verdicts are used:

1) Implemented - evidence of action that substantially meets the recommendation's intent.
2) Partial - meaningful action taken, but significant gaps remain.
3) Planned - political commitment exists; operational delivery has not followed.
4) Not implemented - no evidence of action twelve years later.

Table 10.1: 2013-2025 accountability audit

2013 recommendation	Verdict	2025 evidence
Domain 1 - Extent and underreporting		
Train health staff in VAW screening and referral	Partial	Health-sector GBV provisions exist in the National Reproductive Health Policy. However, 10.3% of injured women were not asked by the provider. WHO CCS 2024-27 identifies health-systems strengthening, but no standardised GBV screening tool is documented in routine PHC.
Address underreporting to police and hospitals	Not implemented	Police reporting: 9.9% women, 7.5% men, unchanged from 2013. DHS 2023-24 independently corroborates low help-seeking (45% women, 29% urban). Only 1.4% were satisfied with the police response.
Strengthen policies protecting women from harassment in workplaces and schools	Partial	The Labour Act 2024 establishes the Dispute Prevention Directorate and a workplace protection framework. NUL adopted the SGBV Policy (S.P. 2024-50) and SOPs (S.P. 2024-51). School harassment: 2.6% of all women; 12.3% of harassment in schools.
Domain 2 - Drivers and patterns		
Challenge cultural norms promoting IPV	Partial	Agreement that a woman should obey her husband: 97%-33.9% women/49.2% men. Kick4Life reports 93% improved attitudes among 6,000+ youth. However, rape myths and pluralistic ignorance persist; no ACE-informed prevention system.
Include children in abuse prevention; address the ACE cycle	Not implemented	80.3% of women and 77.7% of men carry ≥1 ACE. OR 6.68 women / OR 4.75 men for 4+ ACEs. No ACE screening in PHC. LANFOD documents 74% of persons with disabilities are most affected by GBV.
Further research into alcohol-related IPV	Partial	87% of male perpetrators ever drank; 30.6% cannabis use. DHS 2023-24 provides an independent attitudes baseline. No national alcohol-GBV policy framework.
Increase media coverage and political will	Partial	PWC state of emergency call March 2025. Nokaneng app launched. 93% of ministerial statements contained no budget specificity (2025 PDA).

2013 recommendation	Verdict	2025 evidence
Domain 3 - Effects		
Address GBV-HIV nexus	Partial	Reproductive coercion was documented at notable levels (condom refusal 3.6%; stealthing 2.2%). The WHO Country Cooperation Strategy 2024-2027 integrates GBV into Lesotho's health system priorities, and the Ministry of Health's existing clinical protocols, aligned with WHO guidance on indicator-based clinical inquiry (WHO, 2013; WHO/UNFPA/UNHCR, 2020), provide a foundation for strengthening the health sector response. Under these protocols, health care providers are guided to raise the topic of violence with patients presenting with injuries or conditions suggestive of GBV/IPV, rather than conducting routine universal screening. What remains absent is an integrated GBV-HIV clinical inquiry protocol at the PHC level that links these existing clinical management tools into a standardised pathway.
Prioritise mental health resources for GBV survivors	Not implemented	The mental health burden is substantial: 65.8% of women survivors met the CES-D threshold for clinically significant depression, 25.8% met the PCL-5 threshold for probable PTSD, and male perpetrators of IPV were twice as likely to screen positive for depression (OR 2.07). The mental health infrastructure remains severely constrained, with a psychiatrist-to-population ratio of 0.05 per 100,000. The Commonwealth Secretariat estimates that GBV costs the Lesotho economy between M462.9 million and M1,926 million annually. Survivors who do present at health facilities receive psychological support through existing service pathways, but the gap between the scale of need and the available mental health workforce remains wide.
Domain 4 - Response		
Train all stakeholders on GBV	Partial	CGPU has conducted sector-specific GBV training, and the Legal Aid Guidelines of December 2025 establish standardised protocols for 56 legal aid providers. The Ministry of Health has its own WHO-aligned GBV training manual for health service providers. What is absent is a harmonised national GBV training curriculum that bridges these sector-specific efforts across CGPU, health, justice, and civil society, ensuring consistent survivor-centred standards and shared referral protocols.
Address justice impediments	Partial	CDV Act 2022 enacted. Legal Aid Guidelines with SOGIE inclusion. FIDA: 72 paralegals, 4 attorneys, 11 districts. But the CDV Act is not operational; fewer than 2% of survivors see their case reach any court outcome (N=23).
Balance mediation; train mediators	Partial	The CDV Act addresses mediation concerns. No documented national standards for GBV mediation practice.

2013 recommendation	Verdict	2025 evidence
Rebuild forensic laboratory capacity	Not implemented	Lab fire-destroyed specimens sent to Pretoria with month-long delays. Adult convictions collapsed from 74 (2021) to single digits (2024). This is the single most impactful investment available to the justice sector.
Domain 5 - Support		
Establish one-stop centres; replicate Lapeng in all districts	Not implemented	Lapeng continues, but Thuso's assessment finds 4/12 criteria unmet. MPC launched in November 2025 (Maseru only). Shelter utilisation: 1.0-1.3%. No district replication confirmed. A Leribe shelter exists but is non-functional. A Global Fund shelter is nearing completion.
Train the CGPU continuously	Partial	WFP 2025 mapping documents 57 CGPU offices, 21 dedicated personnel, and 3 safe spaces. Training documented but not standardised. 1.4% survivor satisfaction.
Educate chiefs against violence-promoting attitudes	Partial	Ke Kabelo Ea Ka programme active. WFP mapping recommends engaging chiefs and local leaders. No national programme engaging all Principal Chiefs has been documented.
Domain 6 - Prevention		
Enact the Domestic Violence Bill	Implemented	CDV Act 2022 enacted, Lesotho's most significant legislative advance. ILO C190 was ratified in 2019. The Labour Act 2024 adds a workplace framework. However, the CDV Act's operational implementation is incomplete.
Upscale awareness campaigns in rural areas	Planned	Radio reaches 12.4%; community events 8.8%. CDV Act awareness 12.1%. Nokaneng app launched. Hope for Women Assembly targets 4 hotspot villages/districts. No documented rural scale-up.
Mandate politicians to publicise GBV; provide an explicit budget	Planned	PWC state of emergency call. EU M168.5m CSO commitment. But 93% of ministerial statements have no budget specificity. No statutory GBV budget line.
Understand village-level dynamics; employ evidence-based interventions	Partial	2025 norms gap, rape myths, and ACE dose-response provide the strongest evidence base to date. Kick4Life 93% attitude improvement demonstrates an evidence-based model. Not yet translated to village-level programmes.
Domain 7 - Integrated approaches / Coordination		
Establish an inter-agency working group	Partial	Anti-GBV Forum established (GIZ support), confirmed by 3 organisations. WFP mapping corroborates the referral pathway gap. Underfunded; no statutory mandate.
Operationalise Lapeng; upgrade before decentralising	Planned	Lapeng continues, but Thuso's assessment finds 4/12 criteria unmet. MPC launched in November 2025 in Maseru. No decentralisation documented.
Address the vague referral system	Partial	Legal Aid Guidelines Dec 2025: create the first standardised referral protocol (56 providers). Nokaneng app provides the first digital service directory. But there is no cross-sector referral form.
Establish common GBV data management	Not implemented	Different sectors still use different forms. No GBVIMS operational. DHS 2023-24 provides independent data but cannot substitute for continuous administrative monitoring.

Source: Gender Links analysis

The audit summary in Table 10.1 shows that of the 22 assessed 2013 recommendations, one was fully implemented (CDVA enacted); 8 were partially implemented (meaningful action taken, significant gaps remain); 6 were planned but not delivered (political commitment without operational follow-through); 7 were not implemented (no evidence of action). One critical new gap has emerged: the unfortunate closure of the national forensic laboratory. The 2025 assessment also documents several new instruments that were not present in 2013, the Legal Aid Clinics Guidelines, the Labour Act 2024, the NUL SGBV Policy, the Nokaneng app, and the WHO Country Strategy, which create coordination and prevention frameworks that the 2013 recommendations did not anticipate.

A notable omission from the 2013 recommendations is LGBTQI+ inclusion. The 2013 study did not measure GBV among LGBTQI+ populations, and the recommendations did not address SOGIE-inclusive service delivery. The 2025 study, drawing on the THUSO project evidence, fills this measurement gap and reveals a population experiencing GBV at rates far exceeding the general population, with no institutional pathway for reporting, referral, or support. The 2025 recommendations below address this gap directly.

10.3 Twelve cross-cutting findings

Finding 1: GBV has declined but remains endemic, and the decline is uneven: Lifetime IPV experience among ever-partnered women fell from 62% (2013) to 45.7% (2025), a real 16.3 percentage-point reduction. Past-year IPV fell from 28% to 14.8%. Progress has been faster for emotional and sexual violence than for economic violence. District-level variation is extreme. Mafeteng shows the highest men's perpetration acknowledgement alongside the lowest women's experience, consistent with suppressed female disclosure rather than genuine low prevalence. This decline is independently corroborated by the DHS 2023-24: a multilevel analysis by Nakie et al. (2025)[280] reports IPV prevalence of 41.68% among ever-married women aged 15-49, confirming that the post-2013 decline is a real population-level trend.

Finding 2: Adverse childhood experiences are the architecture of future violence: ACEs are the single strongest independent predictor of adult IPV across both genders. Women with 4+ ACEs face an OR of 6.68; men face an OR of 4.75. More than 80% of adults carry at least one ACE. Physical abuse in childhood affects 63.6% of women and 68.7% of men. No ACE-informed assessment operates in primary health care. No ACE-informed parenting programme operates at a national scale.

Finding 3: Gender norms have shifted dramatically, but the resistant minority is the priority: The shift in the belief that a woman should obey her husband from 97% to 33.9% (women) and from 96% to 49.2% (men) is the most striking normative finding. However, 7.2% of men still believe a husband has the right to discipline his wife. Men's rape myths score (1.34) is an independent predictor of perpetration (OR 1.72). The DHS 2023-2024 independently corroborates this pattern of declining but persistent violence-legitimating attitudes. Kick4Life's Programme Profile 2026 documents 93% of participants showing improved attitudes toward women's role in society, demonstrating that targeted programmes can shift the resistant minority.[281]

[280] Nakie, G., Tadesse, G., Fentahun, S., Rtbey, G., Andualem, F., Kibralew, G., Kelebie, M., Melkam, M., Kassa, M.A., Mengistie, B.A., Alemayehu, T.T., Yigezu, M., Segon, T., Wassie, Y.A. and Tinsae, T. (2025) 'Multilevel Analysis of Intimate Partner Violence and Associated Factors Among Reproductive-Age Women: Lesotho Demographic and Health Survey 2023 to 2024 Data', Journal of Interpersonal Violence, p. 08862605251368842. Available at: https://doi.org/10.1177/08862605251368842.

[281] Kick4Life, Programme Profile 2026; Lesotho DHS 2023-2024, Ministry of Health and ICF.

Finding 4: GBV generates a mental health crisis invisible to the health system: 65.8% of women IPV survivors and 60.2% of men meet the CES-D depression threshold. 25.8% of women have probable PTSD. Perpetrator depression: OR 2.07 for men. Lesotho's mental health infrastructure is unchanged from 2013: 0.05 psychiatrists per 100,000. The Commonwealth Secretariat 2020 estimates the economic cost of GBV in Lesotho at M462.9 million to M1,926 million annually.[282]

Finding 5: The justice system reaches fewer than 2% of survivors: The justice funnel narrows drastically at every stage. Of women who experienced IPV, only 9.9% reported to police. Of those who reported, 15.6% saw an arrest. Of the 23 cases in the survey sample that reached a court verdict, 16 resulted in a conviction, but this figure is too small to generalise as a system-wide conviction rate (95% CI: 50%-87%). What can be stated with confidence is that fewer than 2% of women IPV survivors in this study saw their case reach any court outcome at all, and the vast majority never entered the justice system.The infrastructure required to sustain even this narrow pipeline is deteriorating. The forensic laboratory has been destroyed. The CDV Act 2022's Family Court provisions have not been operationalised. The Legal Aid guidelines establish standardised referral protocols across 56 providers, the first cross-sector framework, but reach cannot yet compensate for the justice pipeline's structural failures.

Finding 6: The informal support system carries what the formal system cannot: 56.6% of women survivors receive support from family; 39.9% of men from friends. These informal networks are Lesotho's real GBV support system. By contrast, 0.3% disclose to an NGO worker; shelter utilisation is 1.0-1.3%; police satisfaction is 1.4%. The DHS 2023-2024 confirms this pattern: 45% of women who experienced violence sought help, 49% in rural areas, 29% in urban areas, overwhelmingly through informal channels. LNFOD documents that persons with disabilities face compounded barriers, with 74% identified as most affected by GBV.[283]

Finding 7: The CDV Act 2022 is a landmark, but its non-implementation is the most urgent concern: The CDV Act 2022 is Lesotho's most important legislative advance. Three years after enactment: 12.1% of the population has heard of it; the Family Court designation has not been operationalised, presiding officers have not been designated, and family court rules have not been promulgated; the protection order mechanism is not fully operational; and no comprehensive public awareness campaign has been conducted, partly due to ongoing technical discussions around a proposed amendment. The Labour Act 2024's establishment of the Dispute Prevention Directorate demonstrates that Lesotho can create operational institutional mechanisms. The same institutional design should be applied to CDV Act implementation.

Finding 8: Prevention campaigns reach less than 15% through any single channel: Radio reaches 12.4% with GBV campaign content; community events 8.8%; online 6.9%. The CDV Act reaches 5.5% through the radio. The WFP 2025 GBV Mapping documents 16+ providers implementing awareness campaigns but identifies persistent referral pathway gaps. Hope for Women Assembly's targeting of 4 hotspot villages per district represents a precision model that should be scaled.[284]

Finding 9: The Anti-GBV Forum exists and needs investment: Lesotho has a named multi-sectoral GBV coordination body. This is a real advance. It is also currently underfunded, irregularly convening, and without a statutory mandate. The Nokaneng app provides the first digital service directory. The Legal Aid Guidelines provide the first standardised referral protocol. The NUL SOPs provide an institutional coordination model. These new instruments must

[282] Commonwealth Secretariat (2020), Economic Cost of Violence Against Women and Girls: Lesotho.
[283] DHS 2023-2024; LANFOD, Disability-GBV evidence, cited in Chapters 5 and 7.
[284] WFP, GBV Mapping Report, 13 April 2025.

be connected through the Forum as the designated coordination body. The Section 6.7.2 qualitative analysis of TFGBV non-reporting reinforces the coordination imperative, with 81% of online abuse survivors never reporting and one in ten not knowing where to report, the Forum must ensure that TFGBV reporting pathways are integrated into its service directory and that Nokaneng explicitly includes online abuse as a reportable category.

Finding 10: Lesotho's GBV response is reactive and urban: Every major GBV service is in Maseru. The highest-prevalence districts, Mohale's Hoek, Quthing, Mokhotlong, and Mafeteng, have limited formal access. Care for Basotho operates in four districts (Maseru, Berea, Leribe, Butha-Buthe), targeting key populations, demonstrating that geographic extension is feasible. The system must become upstream (ACE-informed, school-based, community-level) and distributed (shelter and practitioners in every district).[285]

Finding 11: LGBTQI+ persons experience targeted violence that existing systems do not record, refer, or redress: The THUSO Project Baseline Study (2026) documents GBV prevalence among LGBTQI+ persons that substantially exceeds general population rates: 50% of transgender respondents experienced GBV in the twelve months preceding the survey, compared with 14.8% past-year IPV among the general population. Among transgender survivors, 93.8% of incidents were directly linked to gender identity or expression. The International Human Rights Lab reports that 69% of LGBTQI+ persons experienced GBV, with 62% experiencing physical violence and 22.5% sexual violence, including "corrective rape" and forced initiation practices. These forms of targeted violence have no parallel in the general population and require a distinct prevention and response architecture.

The institutional response system is structurally unable to receive these cases. None of the three CGPU offices assessed by the THUSO project (Maseru, Berea, Leribe) had standard operating procedures that included LGBTQI+ or transgender persons; intake forms and data systems recorded only binary male/female categories. Lapeng Care Centre, Lesotho's sole GBV shelter, failed four of twelve international safe accommodation criteria in the THUSO assessment, including the absence of staff trained in SOGIE-inclusive competencies. No referral pathway currently exists for LGBTQI+ GBV survivors within the formal system.

The Legal Aid Clinics Guidelines (December 2025) represent the first documented framework to explicitly name sexual orientation and gender identity as protected grounds for non-discriminatory service delivery. Operationalising these standards across CGPU, shelters, health facilities, and the judiciary is the immediate priority.

Finding 12: Persons with disabilities face compounding vulnerability that the response system is not equipped to address: Women with disabilities report higher lifetime GBV prevalence than women without disabilities (73.3% versus 65.1%), with the disparity most pronounced for economic IPV (28.1% versus 21.2%) and physical IPV (33.3% versus 26.2%). The LNFOD Gender Analysis (2024) documents that 74% of respondents identify women and girls with disabilities as the population most affected by GBV, with economic dependence on caregivers identified as a specific and distinct pathway to abuse. Sign language capacity is absent across all ten CGPU offices nationally. No disability intermediaries exist in any court to support witnesses with communication difficulties.The ICJ's September 2025 report, *From Exclusion to Equality*, confirms the systemic nature of this exclusion. Prior to the landmark 2019 *Koali Moshoeshoe* High Court judgment, Section 219 of the Criminal Procedure and Evidence Act categorically barred persons with intellectual disabilities from

[285] Care for Basotho Association, programme documentation; Kick4Life Programme Profile 2026.

giving testimony, a provision the court struck down as unconstitutional. The Persons with Disabilities Equity Act (2021), Section 32, mandates that the Chief Justice enact rules governing court accommodations, but these rules have not yet been promulgated. The gap between the legislative framework and operational reality mirrors the CDV Act pattern documented in Finding 7 and requires the same accountability mechanism to close.

10.4 Recommendations framework

The recommendations are organised by priority tier, naming the responsible institution, priority level (Immediate: within 6 months; Short-term: 6-18 months; Medium-term: 18 months-3 years; Long-term: beyond 3 years), and a measurable milestone. Recommendation A0 establishes the overarching National GBV Prevention and Response Plan within which all subsequent recommendations are situated. Indicative costing for each recommendation was not within the scope of this study; a dedicated costing exercise, building on the Commonwealth Secretariat (2020) economic cost model and the Chapter 5 cost estimates, is recommended as part of the Tier A implementation planning.

Table 10.2: Priority tiered recommendations

#	Recommendation	Lead institution	Milestone	Cost - to be determined
Priority Tier A - Immediate (within 6 months - no new legislation required)				
A0	Develop a National GBV Prevention and Response Plan (with 5-year targets, annual milestones, and a dedicated prevention budget line) as the overarching framework guiding all counter-GBV efforts, coordination, and resource allocation. The Plan should integrate the CDV Act implementation roadmap, the Anti-GBV Forum mandate, shelter expansion sequencing, and the recommendations of this study into a single costed accountability instrument.	Ministry of Gender / Anti-GBV Forum	Terms of reference and drafting committee established within 2 months. Draft Plan completed within 6 months. Final Plan adopted by Cabinet within 12 months.	
A1	Complete the CDV Act amendment process currently under technical review and promulgate family court rules enabling protection orders and the operationalisation of the Family Court system under Section 16.	Ministry of Justice	CDV Act amendment finalised by (Month+3). Family court rules gazetted by (Month+6). ≥1 trained GBV-designated magistrate[286] per district by (Month+12).	
A2	Establish a dedicated secretariat[287] for the Anti-GBV Forum comprising, at minimum, a full-time coordinator, an M&E officer, and administrative support, and secure a ring-fenced government budget line. If an existing budget line under the Social Empowerment Division can be repurposed or expanded, this should be the first option.	Ministry of Gender	Budget allocation confirmed (existing Social Empowerment Division line or new vote) by 2026/27. Secretariat coordinator appointed within 3 months. First quarterly meeting with published minutes within 4 months.	
A3	Digitalise and distribute the existing national GBV service directory, drawing on the MCA service mapping (288 providers) and WFP 2025 GBV	Anti-GBV Forum / Ministry of Gender	Digital directory consolidated and distributed to all 10 districts within 4 months. Nokaneng integration	

[286] The "GBV magistrate" designation refers to identifying at least one magistrate per district who receives specialised GBV training and is assigned to preside over domestic violence matters within the existing court structure, not the creation of new courts, but the allocation of dedicated judicial capacity within the current system.

[287] The secretariat's core functions are convening quarterly multi-sectoral meetings, maintaining the national GBV service directory, coordinating the common referral protocol (A4), compiling annual GBV statistics for Parliament (B6), and overseeing the National GBV Prevention and Response Plan (A0).

#	Recommendation	Lead institution	Milestone	Cost - to be determined
	Mapping, to all CGPU stations, health facilities, courts, and social welfare offices. Integrate the directory into the Nokaneng app (A7) as the publicly accessible digital platform.		completed concurrently with A7. Updated annually by the Anti-GBV Forum secretariat (A2).	
A4	Harmonise existing GBV referral instruments, including the medical referral form used between CGPU and health facilities and the Social Development comprehensive referral form, into a unified case registration and referral system across CGPU, health, courts, and civil society, designed for integration into the GBVIMS+ system currently under development by SIHHBDP-PIU under MCA-Lesotho (C5). Pilot in 2 districts. The harmonised instrument provides the immediate paper-based bridge, while GBVIMS+ provides the digital architecture into which it will be migrated.	Ministry of Health Planning and Statistics / LMPS / MoJ	Existing referral instruments harmonised in consultation with SIHHBDP-PIU and piloted in 2 districts within 6 months. National rollout plan aligned with GBVIMS+ deployment timeline (C5).	
A5	Begin emergency restoration of national forensic laboratory capacity, the single most impactful investment for improving GBV prosecution outcomes. Establish a Service Level Agreement (SLA) with Pretoria specifying maximum turnaround times pending restoration.	Ministry of Health / MoJ	SLA established within 3 months. Lab restoration feasibility study within 6 months.	
A6	Launch a structured CDV Act public awareness campaign using radio and community meetings, specifically naming the law and its protections. If the proposed amendment is finalised before the campaign launch, the campaign should incorporate the amended provisions. If the amendment process extends beyond 6 months, the campaign should proceed on the enacted Act, with a supplementary phase upon amendment - the 12.1% awareness figure cannot be allowed to persist while amendment discussions continue.	Ministry of Gender / CGPU	Campaign design completed within 2 months (incorporating amendment provisions if finalised). Campaign live within 4 months. Target: 25% CDV Act awareness within 12 months.	
A7	Integrate the Nokaneng app into the formal referral architecture: mandate its use as the standard service directory for CGPU officers and health workers making referrals.	Anti-GBV Forum / Vodacom-UNFPA	Integration protocol issued within 4 months. App data is verified and updated by the Forum secretariat quarterly.	
A8	Adopt SOGIE-inclusive standard operating procedures at all CGPU stations, informed by the Legal Aid Clinics Guidelines' non-discrimination framework. Update intake forms to record gender identity beyond the male/female binary. Issue a directive requiring officers to accept and process GBV complaints from LGBTQI+ persons without discrimination.	LMPS / CGPU National Coordinator	SOPs issued within 4 months. Intake forms updated within 6 months. Training of all CGPU officers is completed within 12 months.	
Priority Tier B - Short-Term (6-18 months, requiring budget allocation)				
B1	Establish GBV psychosocial support capacity at PHC level in all 10 districts by designating ≥1 existing health professional per district (clinical nurse or community health worker at PHC level, with referral to psychiatric nurses at hospital level) to receive specialised GBV psychosocial support training and a defined GBV caseload within their existing post. This builds on the existing PHC staffing	Ministry of Health	≥1 GBV-trained health professional designated per district within 12 months. GBV psychosocial support training curriculum developed within 6 months. Mental health clinical inquiry protocol piloted in 3 districts within 18 months.	

#	Recommendation	Lead institution	Milestone	Cost - to be determined
	structure rather than creating a new cadre and leverages the community health worker networks established through the HIV response. Referral pathway to specialist psychiatric services for complex cases.			
B2	Expand shelter[288] and one-stop centre capacity: ≥3 additional facilities in high-prevalence districts (Mohale's Hoek, Quthing, Mokhotlong).	Ministry of Gender	≥1 new facility operational outside Maseru within 18 months. 10-district coverage plan with a budget within 12 months.	
B3	Introduce ACE-informed clinical inquiry, not routine screening, in primary health care for adults presenting with injury, mental health concerns, or reproductive health services, consistent with WHO guidance on indicator-based inquiry.	Ministry of Health	Existing UNICEF-supported clinical inquiry module adapted for ACE-informed assessment within 9 months. Pilot in 3 districts within 18 months.	
B4	Operationalise the CDV Act 2022 Section 26 rehabilitation provisions by establishing a court-mandated perpetrator programme pilot in Maseru, with therapeutic intervention as a condition of non-custodial sentencing. Section 26 provides the statutory mandate for rehabilitation centres and programmes; this recommendation activates that mandate through a structured pilot, drawing on Chapter 5's finding that male perpetrators carry significant depression burdens (OR 2.07), creating a therapeutic opening for intervention alongside accountability.	Ministry of Justice / Judiciary	Programme design within 9 months. Pilot operational within 18 months. First cohort assessed within 24 months.	
B5	Develop a national GBV training curriculum for CGPU, magistrates, and prosecutors, aligned with the CDV Act and survivor-centred standards.[289] For health workers, adapt and contextualise the existing WHO GBV training manual to the Lesotho CDV Act framework rather than developing a parallel curriculum.	LMPS / Ministry of Justice	Curriculum developed within 9 months. 100% CGPU officers trained within 18 months.	
B6	Operationalise the CDV Act 2022 data collection and reporting obligations (Sections 11 and 14) by publishing an annual national GBV statistical report from CGPU, health, court, and civil society data, disaggregated by district, gender, age, and case type.	Ministry of Gender / Ministry Health Planning and Statistics / LBOS	First report within 12 months (2026-2027 data). Subsequent reports by the end of March annually.	
B7	Replicate the NUL SGBV Policy and SOPs model across all tertiary and secondary educational institutions, establishing institutional prevention frameworks with mandatory training and defined referral protocols.	Ministry of Gender / Ministry Health / Ministry of Education and Training / NUL	Model policy template developed within 9 months. Adopted by ≥5 tertiary institutions within 18 months.	
B8	Operationalise the Labour Act 2024 workplace GBV prevention provisions: develop sector-specific GBV prevention guidelines for high-risk sectors (public transport, mining, security).	Ministry of Labour / Dispute Prevention Directorate	Sector guidelines developed within 12 months. Pilot in the public transport sector (building on the GIZ model) within 18 months.	

[288] The 2025 survey data establish the national need: 45.7% of ever-partnered women experienced lifetime IPV, yet shelter utilisation stands at 1.0%, a figure structurally skewed by the fact that the only functioning shelter (Lapeng Care Centre, annual capacity approximately 120 survivors) is located in Maseru, meaning survivors in the remaining nine districts have no accessible shelter infrastructure. Six districts recorded no shelter utilisation whatsoever. The WFP 2025 GBV Mapping estimates a national deficit of nine additional shelters. The near-zero utilisation rate reflects the absence of accessible infrastructure, not the absence of need.

[289] Survivor-Centred Approach | Protection, Gender & Inclusion. Available at: https://pgi.ifrc.org/survivor-centred-approach (Accessed: 7 June 2026).

#	Recommendation	Lead institution	Milestone	Cost - to be determined
B9	Establish SOGIE-inclusive safe accommodation standards for all GBV shelters and one-stop centres, addressing the four criteria gaps identified in the THUSO Lapeng assessment: staff SOGIE-competency training, inclusive intake procedures, confidential reporting mechanisms, and referral protocols to LGBTQI+-affirming health and legal services.	Ministry of Gender / Thuso Project	Standards developed within 9 months. Lapeng achieves 12/12 criteria within 18 months. Standards adopted as a condition for any new shelter funding.	
Priority Tier C - Medium-Term (18 months-3 years, system-level investment)				
C1	Operationalise the National GBV Prevention and Response Plan (A0) through a dedicated prevention budget line, 5-year costed targets, and annual milestones. Prevention spending target: ≥30% of total GBV allocation. The first annual implementation report should be tabled in Parliament.	Ministry of Gender	Prevention budget line established within 18 months. First annual implementation report tabled in Parliament within 24 months.	
C2	Implement a national ACE-informed parenting support programme through the Department of Social Welfare and community health workers.	Ministry of Social Development	Programme design within 12 months. Pilot 3 districts within 24 months. National scale-up within 36 months.	
C3	Integrate GBV prevention into the national school curriculum (primary and secondary) with teacher training in GBV identification and referral.	Ministry of Education	GBV module drafted within 12 months. Piloted in 30 schools within 24 months. National rollout within 36 months.	
C4	Establish PWC GBV Implementation Tracker, a publicly accessible quarterly dashboard monitoring CDV Act implementation, budgets, shelter capacity, and CGPU performance.	Parliamentary Women's Caucus	Tracker designed within 6 months. First dashboard within 12 months. Annual briefing to the National Assembly.	
C5	Operationalise GBVIMS+ (currently under development by SIHHBDP-PIU) across all CGPU stations, Lapeng, and major civil society providers.	Anti-GBV Forum / LMPS	System piloted in Maseru within 18 months. National rollout within 36 months.	
C6	Update and institutionalise the MCA-commissioned GBV service mapping (FHI 360, 288 providers across 10 districts) and conduct minimum standards assessment by district.	Ministry of Gender / Anti-GBV Forum	Mapping completed within 18 months. District service plans within 24 months.	
Priority Tier D: Long-Term (beyond 3years, sustained normative and structural change)				
D1	Implement a national social norms campaign to close the pluralistic ignorance gap, revealing actual community attitudes. Priority target: differentiated by education - social norms revelation for highly educated women (norms gap _3.32); direct attitude programming for women with lower education.	Ministry of Gender / Anti-GBV Forum	Campaign in all 10 districts within 36 months. Norms gap re-measured at the 2031 GL study.	
D2	Develop a harmonisation framework between the CDV Act 2022 and the Laws of Lerotholi, clarifying customary court jurisdiction over domestic violence.	Ministry of Justice / Law Reform Commission	Framework submitted to Cabinet within 36 months. Traditional court GBV protocol within 48 months.	
D3	Scale male engagement programme nationally, targeting rape myths and ACE trauma, in all 10 districts. Government core funding.	Ministry of Gender	Programmes in all 10 districts within 36 months. Men's rape myths target: mean score <1.0 by 2031.	
D4	Establish a national GBV research agenda through NUL and BOS, annual administrative data, biennial estimates, and programme evaluation.	NUL / BOS	Research agenda within 18 months. First annual report within 24 months. Next prevalence study by 2031.	
D5	Develop a national key populations GBV strategy, addressing the specific prevention, support, and coordination needs of female sex workers,	Ministry of Gender / Care for Basotho / Thuso Project	Strategy developed within 24 months. Dedicated service pathways in ≥4 districts within 36 months. SOGIE-	

#	Recommendation	Lead institution	Milestone	Cost - to be determined
	LGBTQI+ individuals, persons with disabilities (including implementation of the Disability Equity Act's protections), and other marginalised groups. The strategy should include: (a) SOGIE-inclusive practice standards for all GBV service providers, adopting the Legal Aid Clinics Guidelines' non-discrimination framework as the sector-wide standard; (b) dedicated GBV prevention programming targeting the drivers of identity-based violence, including "corrective rape" and forced initiation; (c) disaggregated data collection enabling routine monitoring of GBV among key populations; and (d) meaningful participation of LGBTQI+ organisations (including the Thuso Project, Care for Basotho, and She-Hive) in strategy design and implementation oversight.		inclusive practice standard adopted by the Anti-GBV Forum. LGBTQI+ GBV prevalence re-measured in the 2031 study.	

Source: Lesotho GBV 2013 and 2025 survey instruments, Gender Links

10.5 Government performance scorecard



The study rates government performance across seven GBV domains on a five-point evidence-based scale (1 = No action; 2 = Minimal action; 3 = Partial progress; 4 = Substantial progress; 5 = Fully implemented). The full scorecard is presented in Appendix Table A13: Government performance scorecard (2013-2025).

LGBTQI+ inclusion is not scored as a separate domain because the 2013 study did not establish a baseline. However, the 2025 evidence warrants its inclusion in the 2031 scorecard. The baseline position is clear: zero CGPU offices with SOGIE-inclusive SOPs, zero shelters meeting LGBTQI+ safe accommodation criteria, and no GBV prevention programming targeting identity-based violence. The Legal Aid Clinics Guidelines (December 2025) provide the first formal non-discrimination framework that can serve as the benchmark for progress.

10.6 The next steps, making this chapter count!



This study recommends the following next steps between the publication of the study and the next full study.

Milestone review - 12 months (2026)

By December 2026, the Anti-GBV Forum should convene a structured review of Tier A recommendations. Gender Links and the PWC should jointly publish an implementation status report assessing family court rules (A1); Forum budget (A2); service directory (A3); referral form pilot (A4); forensic lab SLA (A5); CDV Act campaign (A6); and Nokaneng integration (A7).

Mid-term review - 24 months (2027)

By mid-2027, an independent review of Tier B recommendations should examine the psychosocial capacity (B1), shelter expansion (B2), ACE-informed assessment (B3), perpetrator programme (B4), training curriculum (B5), annual GBV report (B6), NUL model replication (B7), and workplace prevention operationalisation (B8). This review should include the survivor's voice.

Full study review - 2030

The next full GL-Lesotho GBV Indicators Study (albeit with full government funding) should be conducted in 2030. It should repeat the prevalence survey using the same methodology; conduct a full accountability audit of the 2025 recommendations; update the scorecard; and add a module on children's GBV exposure.

The implementation tracker

The PWC GBV Implementation Tracker (C4) should serve as the live accountability mechanism between study cycles. It should be publicly accessible, updated quarterly, and presented annually to the National Assembly. It should track CDV Act milestones, CGPU training rates, shelter capacity, Anti-GBV Forum meeting outputs, and the annual GBV report publication.

10.7 Final thoughts - Twelve years, one lesson

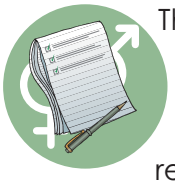
The 2025 GL-Lesotho Gender-Based Violence Indicators Follow-up Study finds a country in which real progress has been made, but fundamental gaps persist. The normative transformation is genuine. Fewer than half of Basotho adults now believe a wife must obey her husband, where once it was virtually everyone. The CDV Act 2022 is a genuine legislative achievement. The Parliamentary Women's Caucus has claimed an oversight mandate that did not exist in 2013. EU and GIZ investments have built a coordination infrastructure. The Labour Act 2024, the Legal Aid Clinics Guidelines, the NUL SGBV Policy, and the Nokaneng app represent new institutional instruments that create frameworks the 2013 study could not have anticipated.

But the survivor navigating the GBV system in 2025 faces the same fragmented journey as the survivor in 2013. The police reporting rate is unchanged. The shelter is still only in Maseru. The referral form does not exist. Persons with disabilities face compounding barriers to justice. The forensic laboratory has burned down. The mental health system cannot serve the 65.8% of survivors who need it. And only 12.1% of Basotho adults know the CDV Act exists. This is the accountability gap between what Lesotho's laws say and what Lesotho's survivors experience. LGBTQI+ and transgender survivors face these same barriers compounded by institutional exclusion: no CGPU station has SOGIE-inclusive procedures, no shelter meets international safe accommodation standards for gender-diverse persons, and no referral pathway exists for identity-based violence.

The recommendations in this chapter are more specific, more accountable, and more time-bound than their 2013 predecessors. They draw on the strongest evidence base ever assembled on GBV in Lesotho, including the 2025 prevalence survey, the DHS 2023-2024, the WFP GBV Mapping, the Thuso Project assessment, the NUL institutional framework,

and the Labour Act 2024. But they will produce the same outcome as the 2013 recommendations unless three things change.

- First, the Anti-GBV Forum, currently a voluntary coordination platform with no dedicated budget or secretariat, must be formalised with terms of reference, a secretariat housed within the Social Empowerment Division, and a recurrent budget line to sustain quarterly convening and progress monitoring.
- Second, the PWC must operationalise the implementation tracker.
- Third, development partners must require co-investment, not just co-branding.



The lesson of the 2013-2025 period is not that Lesotho lacks commitment. It is that commitment without accountability produces laws that are not implemented, recommendations that are not acted on, and survivors who are not served. Yet amid these systemic failures, survivors themselves articulate with striking clarity where responsibility lies.

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STATISTICAL APPENDIX

This appendix contains detailed statistical tables referenced in the main text. These tables provide comprehensive breakdowns that support the analytical narrative in their respective chapters.

Appendix Table A1: Sample characteristics by gender

Characteristic	Women (%)	N	Men (%)	N
Age group				
15-17	7.7	2563	6.7	1686
18-24	15.4	2563	18.2	1686
25-34	20.5	2563	21.5	1686
35-44	17.5	2563	20.9	1686
45-54	12.8	2563	12.4	1686
55+	26.1	2563	20.3	1686
Education				
High school completed	2.0	2565	11.6	1689
Primary completed	72.3	2565	67.9	1689
Some high school	5.2	2565	2.2	1689
Some primary	4.2	2565	2.4	1689
Some tertiary	7.5	2565	6.5	1689
Tertiary completed	3.5	2565	2.7	1689
Never attended	5.3	2565	6.7	1689
Marital status				
Divorced	3.9	2310	5.2	1435
Married	46.1	2310	46.1	1435
Never Married	23.8	2310	36.9	1435
Separated	5.3	2310	4.8	1435
Widowed	20.9	2310	7.0	1435
District				
Berea	14.2	2565	14.5	1689
Botha-Bothe	3.7	2565	3.6	1689
Leribe	11.4	2565	11.4	1689
Mafeteng	9.3	2565	9.4	1689
Maseru	29.2	2565	30.1	1689
Mohale's Hoek	9.7	2565	9.5	1689
Mokhotlong	7.2	2565	7.1	1689
Qacha's Nek	3.3	2565	3.4	1689
Quthing	5.8	2565	5.8	1689
Thaba-Tseka	6.3	2565	5.1	1689
Settlement type				
Peri-Urban	9.9	2565	9.6	1689
Rural	51.7	2565	50.7	1689
Urban	38.4	2565	39.7	1689

Characteristic	Women (%)	N	Men (%)	N
Ecological zone				
Foothills	11.3	2565	10.2	1678
Lowlands	58.7	2565	60.4	1678
Mountains	21.0	2565	20.7	1678
Senqu River Valley	9.0	2565	8.7	1678
Currently employed				
Yes	72.0	2565	60.9	1689
No	28.0	2565	39.1	1689
Any disability				
No	80.5	2565	89.3	1689
Yes	19.5	2565	10.7	1689
Multiple disabilities (2+)	7.3	2565	3.3	1689
Seeing	9.4	2565	4.6	1689
Hearing	2.4	2565	2.1	1689
Walking	7.2	2565	4.3	1689
Concentrating	9.9	2565	3.6	1689
Self-care	0.9	2565	1.5	1689
Communicating	0.8	2565	1.0	1689
Wealth quintile				
Poorest	19.4	2479	18.4	1639
Second	17.8	2479	18.5	1639
Middle	19.0	2479	18.8	1639
Fourth	23.0	2479	21.1	1639
Richest	20.8	2479	23.2	1639
Total N		**2565**		**1689**

Source: Lesotho GBV 2025 Prevalence Survey[290] Gender Links

[290] All estimates are survey-weighted; N is the unweighted subpopulation count. 2. 'Any Disability' is a composite indicator based on the Washington Group Short Set of Questions on Disability. It captures functional limitations in six domains: seeing, hearing, walking, cognition, self-care, and communication. A respondent is classified as having a disability if they report 'a lot of difficulty' or 'cannot do at all' in at least one domain.

Appendix Table A2: Lifetime prevalence of GBV

Violence Type	Women Exp %	N	Women Perp %	N	Men Exp %	N	Men Perp %	N
Any GBV (lifetime)	66.7	2565	20.7	2310	46.2	1689	27.6	1435
Any IPV	45.7	2310	20.7	2310	28.2	1435	27.6	1435
Emotional IPV	32.5	2310	14.8	2310	20.8	1435	19.2	1435
Physical IPV	27.6	2310	6.4	2310	7.4	1435	15.0	1435
Economic IPV	22.6	2310	6.2	2310	11.5	1435	6.2	1435
Severe Physical IPV	17.6	2310			3.8	1435		
Sexual IPV	11.3	2310	1.4	2310	3.0	1435	4.1	1435
IPV During Pregnancy (women only)	6.5	1990						
Any NPSV	9.4	2565	1.4	2310			17.6	1689
Forced sex	6.4	2308	1.0	2310			3.3	1402
Attempted rape	5.0	2293					13.1	1689
Forced sex through threats	3.0	2314					2.8	1499
Incapacitated assault	1.5	2297					4.9	1474
Gang rape	1.0	2312						
Any sexual harassment	21.3	2565			10.6	1689		
Public spaces	85.5	572			66.5	200		
School	12.3	572			16.4	200		
Work	6.4	572			13.3	200		
Any Technology-Facilitated GBV (TFGBV) - (Internet Users)	18.2	1232			21.0	681		
Online stalking	11.5	1232			10.6	681		
Online abuse/messages	9.2	1232			13.5	681		
Fake profile/identity theft	4.2	1232			5.9	681		
Online sextortion	1.8	1232			1.3	681		
Image sharing without consent	0.6	1232			0.7	681		
Any Reproductive Coercion (RC)	9.4	2310	5.3	2565	6.3	1689	5.9	1689
Pregnancy coercion								
Forced pregnancy	2.8	2310	0.6	2310	2.1	1463	1.9	1499
Threatened to leave if there was no child			0.2	2310			1.3	1499
Contraceptive Sabotage								
Told not to use birth control	5.4	2310			2.8	1463		
Damaged birth control	0.8	2310	0.3	2310	0.8	1463	1.0	1499
Condom removed during sex	2.2	2310	0.4	2310	3.3	1499		
Hidden/destroyed birth control							1.3	1499
Blocked partner from the clinic							1.1	1499
Refused to use a condom							3.6	1499
Lied about using birth control			2.3	2310				

Violence Type	Women Exp %	N	Women Perp %	N	Men Exp %	N	Men Perp %	N
Stopped birth control without telling			1.1	2310				
Control of pregnancy outcomes								
Forced abortion	1.3	2310						
Forced miscarriage	1.8	2310						
Continued pregnancy against the partner's wishes			2.4	2310				
Lied about paternity			0.3	2310				
Harmful Practices								
Child marriage	33.6	2057			28.2	1174		
Any child abuse/adversity	80.3	2565			77.7	1689		
Physical abuse	63.6	2565			68.7	1689		
Emotional abuse	32.9	2565			33.5	1689		
Neglect	31.6	2565			30.2	1689		
Household dysfunction	26.2	2565			24.0	1689		
Witnessed intimate partner violence	21.9	2565			14.1	1689		
Sexual abuse	14.4	2565			14.5	1689		

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

Appendix Table A3: Lifetime IPV prevalence by socio-demographic characteristics

Demographic Factor	Women Exp %	Men Perp %	N	Men Exp %	Women Perp %	N	p-value
Age group							
15-17	21.2	13.7	94	18.9	16.9	48	0,002
18-24	38.9	22.0	367	23.2	16.7	240	
25-34	48.8	23.3	491	26.4	26.2	316	
35-44	47.4	37.2	416	35.3	21.9	302	
45-54	50.5	29.4	301	32.8	23.0	199	
55+	47.5	27.4	640	25.1	17.2	329	
Education level							
Never attended	52.0	29.8	49	20.0	16.1	172	0,025
Some primary	47.8	26.9	1 636	27.7	21.6	955	
Primary completed	46.3	22.1	141	29.6	10.3	27	
Some high school	31.1	36.6	104	26.3	15.7	37	
High school completed	34.3	27.0	187	30.1	20.6	116	
Some tertiary	52.2	29.2	74	40.5	25.2	41	
Tertiary completed	39.6	29.9	119	37.8	23.9	87	
Marital status							
Divorced	57.5	38.9	81	44.2	24.6	66	0,000
Married	46.4	31.2	1 077	28.4	22.6	675	
Never married	31.6	21.6	508	24.3	15.1	515	
Separated	69.4	29.9	127	38.4	39.1	76	
Widowed	51.7	26.1	517	28.6	17.6	103	
Wealth quintile							
Poorest	41.6	24.5	475	25.0	15.6	261	0,022
Poorer	46.0	34.7	438	28.4	14.5	283	
Middle	54.8	30.0	418	25.3	28.2	282	
Richer	45.1	26.7	470	30.2	24.7	284	
Richest	40.4	24.1	434	30.8	19.4	285	
Employment status							
Not employed	43.3	24.2	1 673	23.8	19.1	842	0,018
Employed	51.3	32.3	637	34.1	24.6	593	
Disability status							
No disability	44.4	27.7	1 827	28.3	20.9	1 278	0,031
Any disability	50.8	27.0	483	27.3	20.1	157	
Settlement type							
Urban	45.3	30.7	292	29.1	19.4	186	0,709
Peri-urban	44.6	28.0	1 224	26.4	18.4	710	
Rural	47.2	26.5	794	29.9	24.2	539	

Denominator: Ever been in an intimate relationship.

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

Appendix Table A4: Alcohol and substance use by IPV experience and perpetration

Indicator	Women No IPV %	Women IPV %	p-value	Women No Perp %	Women Perp %	p-value	Men No IPV %	Men IPV %	p-value	Men No Perp %	Men Perp %	p-value	N
Alcohol use													
Ever drank alcohol	56.0	66.8	0.000	58.7	69.5	0.002	66.7	86.2	0.000	66.6	87.0	0.000	3745
Drank alcohol in the last 12 months	62.2	70.1	0.009	62.9	76.9	0.000	81.0	85.3	0.222	81.2	85.0	0.272	2418
Alcohol use frequency (AUDIT-C Q1 mean, 0-4)	1.50	1.67	0.032	1.55	1.69	0.148	1.92	1.91	0.917	1.92	1.92	0.972	1768
Typical quantity per session (AUDIT-C Q2 mean, 0-4)	0.86	0.88	0.830	0.86	0.90	0.727	1.07	1.31	0.005	1.04	1.37	0.000	1768
Binge drinking frequency (AUDIT-C Q3 mean, 0-4)	0.62	0.70	0.317	0.66	0.69	0.709	1.31	1.28	0.820	1.25	1.38	0.327	1768
Age started drinking (ordinal mean, 1-4)	3.63	3.71	0.121	3.68	3.64	0.642	3.39	3.39	0.984	3.35	3.45	0.170	1768
AUDIT-C total score (mean, 0-12, drinkers only)	2.99	3.25	0.192	3.07	3.27	0.332	4.30	4.50	0.335	4.21	4.68	0.051	1768
Drug use													
Ever used drugs	4.3	7.6	0.008	5.4	7.6	0.223	20.4	33.7	0.000	19.8	35.6	0.000	3745
Used drugs in the last 12 months	4.3	7.6	0.008	5.4	7.6	0.223	20.4	33.7	0.000	19.8	35.6	0.000	3745
Drug use frequency, last 12 months (mean)	2.12	2.28	0.589	2.25	2.12	0.674	2.40	2.47	0.669	2.37	2.51	0.466	506
Specific drugs used													
Used cannabis	1.0	1.5	0.466	1.0	1.9	0.270	15.7	29.2	0.000	15.3	30.6	0.000	3745
Used cocaine	0.0	0.2	0.339	0.1	0.0	0.655	0.1	0.5	0.114	0.1	0.5	0.105	3745
Used heroin	0.1	0.0	0.121	0.1	0.0	0.388	0.0	0.0		0.0	0.0		3745
Used mandrax	0.0	0.0		0.0	0.0		0.0	0.0		0.0	0.0		3745
Used methamphetamine	0.0	0.0		0.0	0.0		0.2	0.4	0.394	0.3	0.2	0.685	3745
Used prescription drugs (misuse)	1.4	2.5	0.014	1.9	1.8	0.871	1.2	2.3	0.196	0.9	3.2	0.013	3745
Used other drugs	1.9	3.7	0.095	2.3	4.4	0.090	4.5	4.4	0.911	4.6	4.3	0.850	3745
Injection drug use													
Ever injected drugs	0.6	0.0	0.081	0.3	0.4	0.864	0.3	1.1	0.405	0.3	1.0	0.426	2666
Injected drugs in the last 12 months	48.4			64.2	0.0	0.167	100.0	100.0		100.0	100.0		7

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

Appendix Table A5: IPV by relationship characteristics

Characteristic	Women No IPV %	Women IPV %	Men No IPV %	Men IPV %	N	p-value (Women)	p-value (Men)
Sexual history							
Age at first sex (mean)	17.16	17.14	16.85	16.65	2 405	0.835	0.280
Partner and household							
Currently has a partner	43.8	34.8	58.3	66.5	1 992	0.030	0.112
Currently lives with partner	11.0	13.5	6.7	6.6	944	0.554	0.979
Ever lived with a partner	21.2	26.6	36.7	50.2	3 745	0.017	0.003
Partner is employed	43.1	50.8	20.6	32.4	2 532	0.038	0.006
Partner age (mean)	40.95	42.88	34.18	34.33	2 696	0.074	0.888
Marriage							
Age at first marriage (mean)	20.41	24.29	25.66	25.79	2 715	0.425	0.812
Married before age 18 (child marriage)	33.8	39.0	26.0	38.4	2 722	0.130	0.014
In a polygamous relationship	6.7	5.8	6.1	3.5	1 749	0.678	0.231
Controlling behaviours (mean, 1-4 scale)							
Partner is jealous of clothes/appearance	2.86	2.71	2.86	2.81	2 696	0.013	0.562
Must know partner's whereabouts	2.40	2.28	2.32	2.07	2 696	0.016	0.002
Partner flaunts other relationships	3.01	2.99	3.10	2.93	2 696	0.751	0.007
Never tried to control the partner	2.66	2.61	2.59	2.43	2 696	0.270	0.036
Reproductive coercion							
The partner refused to use birth control	2.5	8.9	0.9	7.6	3 745	0.000	0.000
Had to hide birth control from partner			0.3	3.7	1 375		0.000
Partner damaged/destroyed birth control	0.2	1.4	0.1	2.5	3 745	0.001	0.000
The partner tried to stop the birth control	0.9	1.3			2 310	0.554	
The partner lied about birth control	1.3	3.5			2 310	0.024	
Lobola norms (mean, 1-4 scale)							
Believes lobola means the husband owns the wife	2.84	2.79	2.83	2.62	3 685	0.304	0.025
Believes lobola entitles husband to sex	2.98	2.93	3.02	2.80	3 686	0.277	0.007
Community norm: lobola means ownership	2.66	2.53	2.77	2.43	3 322	0.011	0.000
Community norm: lobola entitles sex	2.71	2.61	2.85	2.55	3 284	0.072	0.001

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

Appendix Table A6: Lifetime IPV experience and perpetration by council

Council	Women Exp %	95% CI	N	Men Perp %	95% CI	N	Men Exp %	95% CI	N	Women Perp %	95% CI	N
Berea	43.6	(40.3 - 46.8)	33	5.5	(-3.5 - 14.6)	23	5.4	(-7.3 - 18.0)	23	16.3	(12.3 - 20.2)	33
Bokong	44.6	-	20	27.0	-	15	23.8	-	15	9.5	-	20
Bolahla	50.0	(50.0 - 50.0)	10	16.7	-	6	16.7	-	6	30.0	(30.0 - 30.0)	10
Butha-Buthe	46.7	(34.4 - 58.9)	55	54.0	(33.9 - 74.1)	38	48.7	(13.4 - 84.0)	38	26.2	(2.7 - 49.8)	55
Hleoheng	14.3	(14.3 - 14.3)	14	40.0	(40.0 - 40.0)	5	40.0	(40.0 - 40.0)	5	0.0	-	14
Hlotse	51.6	(32.3 - 70.8)	35	21.8	(0.3 - 43.4)	24	36.5	(18.9 - 54.2)	24	22.5	(8.2 - 36.9)	35
Kanana	62.5	(62.5 - 62.5)	8	33.3	(33.3 - 33.3)	6	33.3	(33.3 - 33.3)	6	37.5	(37.5 - 37.5)	8
Khoelenya	61.2	(45.9 - 76.5)	22	0.0	-	10	26.9	(-18.3 - 72.1)	10	38.1	(-7.9 - 84.0)	22
Khutlo-se-Metsi	9.3	(-10.9 - 29.5)	11	80.1	(66.0 - 94.3)	5	40.4	(-2.0 - 82.9)	5	0.0	-	11
Kubake	33.8	(14.8 - 52.7)	18	32.0	(-25.1 - 89.1)	15	13.3	(11.0 - 15.6)	15	5.8	(-6.8 - 18.5)	18
Kueneng	85.7	(85.7 - 85.7)	7	50.0	(50.0 - 50.0)	6	33.3	(33.3 - 33.3)	6	14.3	(14.3 - 14.3)	7
Lehlakaneng	12.6	(2.2 - 23.1)	29	21.1	(9.9 - 32.4)	20	21.1	(9.9 - 32.4)	20	4.7	(-3.8 - 13.2)	29
Likila	42.7	(24.6 - 60.8)	32	57.1	(36.1 - 78.1)	21	39.1	(-0.5 - 78.6)	21	22.7	(5.3 - 40.1)	32
Likolobeng	45.7	(9.7 - 81.6)	28	11.3	(-7.5 - 30.0)	20	9.9	(-6.6 - 26.5)	20	13.0	(-3.7 - 29.6)	28
Lilala	33.3	(33.3 - 33.3)	12	42.9	(42.9 - 42.9)	7	28.6	-	7	0.0	-	12
Linakeng	39.7	(36.6 - 42.8)	30	49.5	(24.0 - 75.0)	15	16.7	(-4.2 - 37.7)	15	15.4	(8.7 - 22.1)	30
Lithipeng	63.6	(63.6 - 63.6)	11	16.7	(16.7 - 16.7)	6	33.3	(33.3 - 33.3)	6	45.5	(45.5 - 45.5)	11
Litsoetse	46.2	(20.7 - 71.7)	32	45.9	(40.3 - 51.4)	18	23.9	(10.1 - 37.7)	18	17.5	(7.1 - 27.9)	32
Mafeteng	44.1	(29.9 - 58.3)	74	39.7	(17.3 - 62.2)	48	54.1	(24.4 - 83.9)	48	22.8	(11.6 - 34.0)	74
Maisa-Phoka	36.4	(36.4 - 36.4)	11	0.0	-	7	0.0	-	7	9.1	(9.1 - 9.1)	11
Makeoane	46.1	(29.5 - 62.6)	53	6.1	(-3.9 - 16.1)	31	14.4	(-9.0 - 37.7)	31	21.7	(14.7 - 28.7)	53
Makhoalipana	53.1	(48.5 - 57.7)	29	43.2	(18.4 - 68.0)	19	28.7	(14.8 - 42.6)	19	26.4	(-11.7 - 64.5)	29
Makhoarane	47.3	(10.2 - 84.4)	21	9.6	(-0.6 - 19.9)	14	9.6	(-0.6 - 19.9)	14	15.7	(10.0 - 21.3)	21
Makoabating	26.4	(15.2 - 37.6)	31	64.7	(9.8 - 119.6)	16	41.6	(5.1 - 78.2)	16	8.0	(-11.2 - 27.2)	31
Mamafubelu	39.0	(36.6 - 41.3)	21	60.1	(33.4 - 86.8)	14	45.8	(19.1 - 72.5)	14	16.9	(9.8 - 24.0)	21
Mamant'so	38.5	(38.5 - 38.5)	13	42.9	(42.9 - 42.9)	7	28.6	-	7	15.4	(15.4 - 15.4)	13
Mamants'o	27.3	(27.3 - 27.3)	11	50.0	-	4	50.0	-	4	27.3	(27.3 - 27.3)	11
Manka	28.9	(7.0 - 50.8)	21	41.3	(17.1 - 65.6)	12	24.3	(-21.9 - 70.6)	12	14.2	(9.8 - 18.6)	21
Manonyane	42.9	(11.4 - 74.4)	16	27.3	(23.0 - 31.6)	15	45.4	(36.9 - 54.0)	15	35.8	(9.5 - 62.0)	16
Mapoteng	53.8	(38.1 - 69.6)	29	28.1	(2.3 - 54.0)	20	39.5	(6.8 - 72.1)	20	23.6	(1.5 - 45.8)	29
Maputsoe	56.5	(36.5 - 76.5)	87	45.1	(27.6 - 62.6)	56	47.9	(30.5 - 65.3)	56	17.1	(8.1 - 26.1)	87
Maseru	43.4	(37.7 - 49.1)	253	17.8	(10.5 - 25.1)	177	20.3	(11.7 - 28.8)	177	24.0	(18.1 - 29.9)	253
Matsoku	39.1	(26.5 - 51.7)	56	8.7	(-9.3 - 26.6)	35	3.7	(-6.6 - 14.1)	35	15.4	(2.9 - 27.9)	56
Mazenod	44.4	(-6.5 - 95.2)	22	40.8	(1.9 - 79.7)	15	27.1	(8.3 - 45.8)	15	17.8	(0.4 - 35.2)	22
Menkhoaneng	55.9	(50.4 - 61.4)	24	0.0	-	15	22.2	(15.5 - 28.8)	15	17.7	(1.1 - 34.2)	24
Menoaneng	50.3	(45.2 - 55.4)	32	25.3	(-10.4 - 61.0)	15	33.0	(8.4 - 57.6)	15	18.8	(17.6 - 19.9)	32
Metsi-Maholo	27.3	(27.3 - 27.3)	11	71.4	(71.4 - 71.4)	7	28.6	(28.6 - 28.6)	7	18.2	(18.2 - 18.2)	11
Mohale's Hoek	65.3	(50.3 - 80.3)	67	25.0	(9.5 - 40.5)	39	31.7	(11.6 - 51.8)	39	43.2	(33.5 - 52.8)	67
Mohlakeng	50.0	(50.0 - 50.0)	12	20.0	-	5	0.0	-	5	25.0	(25.0 - 25.0)	12
Mokhotlong	55.3	(41.3 - 69.4)	39	43.0	(12.7 - 73.3)	27	46.1	(18.0 - 74.2)	27	37.8	(13.7 - 61.9)	39

Council	Women Exp %	95% CI	N	Men Perp %	95% CI	N	Men Exp %	95% CI	N	Women Perp %	95% CI	N
Motanasela	40.5	(14.0 - 67.1)	35	9.2	(-4.0 - 22.4)	19	7.7	(-1.7 - 17.2)	19	9.1	(3.0 - 15.1)	35
Mphokojoane	47.4	(26.6 - 68.2)	46	45.4	(20.0 - 70.8)	24	26.4	(3.1 - 49.8)	24	10.9	(-8.4 - 30.2)	46
Mtjanyane	45.5	-	11	57.1	(57.1 - 57.1)	7	71.4	(71.4 - 71.4)	7	18.2	(18.2 - 18.2)	11
Ngoajane	51.3	(29.2 - 73.5)	24	78.6	(56.9 - 100.3)	15	27.5	(24.1 - 30.8)	15	32.3	(2.8 - 61.8)	24
Nqoe	32.7	(18.3 - 47.1)	69	41.8	(20.9 - 62.7)	38	35.7	(24.9 - 46.5)	38	9.0	(1.4 - 16.6)	69
Ntŝupe	40.4	(30.8 - 49.9)	44	19.2	(8.6 - 29.9)	27	8.6	(-6.3 - 23.6)	27	0.0	-	44
Phuthiatsana	30.8	(22.2 - 39.5)	18	30.1	(23.9 - 36.3)	14	30.1	(23.9 - 36.3)	14	16.8	(-2.0 - 35.6)	18
Qacha's Nek	36.6	(11.8 - 61.3)	46	24.9	(2.2 - 47.6)	30	38.2	(19.7 - 56.8)	30	11.4	(4.0 - 18.9)	46
Qanya	44.7	(32.6 - 56.7)	32	12.1	(-9.5 - 33.6)	22	27.3	(5.9 - 48.7)	22	2.1	(-3.2 - 7.5)	32
Qhoasing	65.7	(32.7 - 98.7)	42	23.0	(15.8 - 30.2)	17	27.8	(4.6 - 51.1)	17	30.2	(1.9 - 58.6)	42
Qibing	27.3	(27.3 - 27.3)	11	71.4	(71.4 - 71.4)	7	57.1	(57.1 - 57.1)	7	9.1	(9.1 - 9.1)	11
Qiloane	60.0	(60.0 - 60.0)	10	25.0	-	8	50.0	-	8	30.0	(30.0 - 30.0)	10
Qomoqomong	60.0	(60.0 - 60.0)	10	42.9	(42.9 - 42.9)	7	28.6	(28.6 - 28.6)	7	10.0	(10.0 - 10.0)	10
Quthing	50.4	(40.7 - 60.0)	60	46.8	(9.5 - 84.2)	45	42.2	(20.6 - 63.9)	45	25.7	(14.0 - 37.4)	60
Ramapepe	35.6	(-1.9 - 73.0)	17	27.4	(12.5 - 42.4)	10	32.6	(17.6 - 47.5)	10	12.3	(8.9 - 15.7)	17
Ramoetsana	20.8	(-3.0 - 44.5)	25	36.0	(11.3 - 60.8)	12	29.2	(12.5 - 45.9)	12	40.0	(40.0 - 40.0)	25
Ratau	59.7	(46.5 - 72.9)	21	37.0	(29.6 - 44.4)	13	26.8	(6.5 - 47.0)	13	29.3	(0.7 - 58.0)	21
Seate	50.8	(38.7 - 63.0)	33	38.5	(15.3 - 61.8)	20	52.1	(39.4 - 64.9)	20	38.6	(4.0 - 73.1)	33
Semena	28.9	(20.3 - 37.5)	23	30.3	(16.4 - 44.1)	12	35.0	(6.3 - 63.7)	12	11.7	(3.4 - 20.0)	23
Semonkong	58.3	(-5.1 - 121.7)	21	16.0	(10.2 - 21.9)	18	37.3	(-28.0 - 102.5)	18	22.9	(-10.6 - 56.3)	21
Senekane	30.0	(30.0 - 30.0)	10	28.6	(28.6 - 28.6)	7	42.9	(42.9 - 42.9)	7	30.0	(30.0 - 30.0)	10
Senqebethu	46.9	(42.4 - 51.4)	19	30.4	(22.6 - 38.1)	16	20.7	(4.1 - 37.2)	16	31.9	(29.2 - 34.6)	19
Senqunyane	82.9	(81.8 - 84.0)	23	11.5	(-1.4 - 24.5)	12	33.3	(33.3 - 33.3)	12	45.4	(35.8 - 55.1)	23
Sephokong	27.3	(27.3 - 27.3)	11	25.0	(25.0 - 25.0)	4	75.0	(75.0 - 75.0)	4	27.3	(27.3 - 27.3)	11
Siloe	46.5	(13.0 - 79.9)	22	7.3	(-27.2 - 41.8)	12	25.4	(10.7 - 40.2)	12	12.1	(-38.1 - 62.3)	22
Tebe-Tebe	66.7	(66.7 - 66.7)	12	0.0	-	8	62.5	-	8	25.0	(25.0 - 25.0)	12
Telle	37.6	(31.8 - 43.4)	41	38.5	(19.5 - 57.6)	27	35.4	(30.0 - 40.8)	27	16.5	(7.5 - 25.5)	41
Tenesolo	22.6	(-3.7 - 48.9)	21	0.0	-	7	0.0	-	7	4.4	(-4.1 - 12.9)	21
Thaba-Mokhele	67.6	(16.8 - 118.4)	32	1.6	(-17.2 - 20.4)	16	3.2	(-34.4 - 40.9)	16	23.5	(-45.8 - 92.8)	32
Thaba-Tseka	36.1	(3.8 - 68.4)	34	22.3	(-2.4 - 46.9)	14	12.7	(-10.4 - 35.8)	14	23.9	(-14.1 - 61.9)	34
Tosing	54.1	(21.2 - 86.9)	20	29.3	(5.4 - 53.1)	14	28.6	(28.6 - 28.6)	14	10.0	(8.4 - 11.7)	20
Ts'a-le-Moleka	55.8	(41.2 - 70.4)	23	18.1	(-10.9 - 47.2)	12	25.4	(16.7 - 34.2)	12	21.2	(9.8 - 32.5)	23
Ts'ana-Talana	11.1	(-5.1 - 27.3)	20	46.0	(37.1 - 55.0)	11	56.1	(32.3 - 79.9)	11	5.5	(-2.6 - 13.6)	20
Tsitsong	57.5	(45.7 - 69.3)	25	38.0	(22.9 - 53.2)	10	31.0	(23.4 - 38.6)	10	10.8	(1.6 - 20.0)	25
Tsoelikana	41.4	(25.3 - 57.5)	35	17.9	(2.8 - 33.0)	23	38.5	(19.8 - 57.2)	23	15.5	(-6.4 - 37.4)	35
Tsoili-Tsoili	66.7	(66.7 - 66.7)	6	33.3	(33.3 - 33.3)	6	0.0	-	6	16.7	(16.7 - 16.7)	6
Tsoilitsoili	0.0	-	8	20.0	(20.0 - 20.0)	5	20.0	(20.0 - 20.0)	5	0.0	-	8
Tŝitsong	70.0	(70.0 - 70.0)	10	37.5	(37.5 - 37.5)	8	25.0	(25.0 - 25.0)	8	20.0	(20.0 - 20.0)	10

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links & Lesotho Bureau of Statistics

Appendix Table A7: Lifetime emotional IPV experience and perpetration by council

Council	Women Exp %	95% CI	N	Men Perp %	95% CI	N	Men Exp %	95% CI	N	Women Perp %	95% CI	N
Berea	34.6	(28.5 - 40.7)	33	5.5	(-3.5 - 14.6)	23	5.4	(-7.3 - 18.0)	23	9.0	(3.2 - 14.7)	33
Bokong	24.3	-	20	27.0	-	15	23.8	-	15	0.0	-	20
Bolahla	30.0	(30.0 - 30.0)	10	16.7	(16.7 - 16.7)	6	16.7	(16.7 - 16.7)	6	30.0	(30.0 - 30.0)	10
Butha-Buthe	38.0	(17.7 - 58.2)	55	31.1	(-2.5 - 64.7)	38	33.3	(4.0 - 62.7)	38	19.6	(0.9 - 38.4)	55
Hleoheng	7.1	(7.1 - 7.1)	14	20.0	(20.0 - 20.0)	5	40.0	(40.0 - 40.0)	5	0.0	-	14
Hlotse	39.8	(33.9 - 45.6)	35	17.7	(4.5 - 30.8)	24	24.3	(1.2 - 47.4)	24	20.6	(8.3 - 32.9)	35
Kanana	50.0	-	8	16.7	(16.7 - 16.7)	6	16.7	(16.7 - 16.7)	6	37.5	(37.5 - 37.5)	8
Khoelenya	43.0	(27.7 - 58.3)	22	0.0	-	10	13.4	(-9.1 - 36.0)	10	19.0	(-3.9 - 42.0)	22
Khutlo-se-Metsi	9.3	(-10.9 - 29.5)	11	80.1	(66.0 - 94.3)	5	40.4	(-2.0 - 82.9)	5	0.0	-	11
Kubake	33.8	(14.8 - 52.7)	18	19.5	(-1.0 - 40.1)	15	7.0	(-9.0 - 23.0)	15	5.8	(-6.8 - 18.5)	18
Kueneng	85.7	-	7	50.0	(50.0 - 50.0)	6	33.3	(33.3 - 33.3)	6	0.0	-	7
Lehlakaneng	8.7	(3.7 - 13.7)	29	21.1	(9.9 - 32.4)	20	21.1	(9.9 - 32.4)	20	4.7	(-3.8 - 13.2)	29
Likila	34.2	(15.9 - 52.5)	32	25.3	(10.0 - 40.6)	21	32.7	(-6.9 - 72.2)	21	22.7	(5.3 - 40.1)	32
Likolobeng	27.1	(18.3 - 35.9)	28	11.3	(-7.5 - 30.0)	20	9.9	(-6.6 - 26.5)	20	9.2	(-1.0 - 19.4)	28
Lilala	25.0	(25.0 - 25.0)	12	42.9	(42.9 - 42.9)	7	14.3	-	7	0.0	-	12
Linakeng	24.3	(18.2 - 30.4)	30	25.1	(-7.7 - 57.9)	15	16.7	(-4.2 - 37.7)	15	0.0	-	30
Lithipeng	27.3	(27.3 - 27.3)	11	0.0	-	6	16.7	(16.7 - 16.7)	6	36.4	(36.4 - 36.4)	11
Litsoetse	36.3	(11.6 - 60.9)	32	33.7	(28.8 - 38.7)	18	23.9	(10.1 - 37.7)	18	7.8	(1.7 - 14.0)	32
Mafeteng	34.1	(21.8 - 46.3)	74	28.6	(10.2 - 47.0)	48	45.3	(24.5 - 66.1)	48	11.6	(-0.1 - 23.3)	74
Maisa-Phoka	36.4	(36.4 - 36.4)	11	0.0	-	7	0.0	-	7	9.1	(9.1 - 9.1)	11
Makeoane	28.7	(16.1 - 41.2)	53	1.1	(-0.0 - 2.2)	31	11.5	(-4.7 - 27.8)	31	17.8	(6.4 - 29.1)	53
Makhoalipana	43.4	(-5.0 - 91.8)	29	30.4	(8.6 - 52.1)	19	28.7	(14.8 - 42.6)	19	21.3	(1.3 - 41.2)	29
Makhoarane	22.0	(10.1 - 33.9)	21	9.6	(-0.6 - 19.9)	14	0.0	-	14	9.4	(8.7 - 10.0)	21
Makoabating	19.0	(4.8 - 33.2)	31	41.6	(5.1 - 78.2)	16	32.0	(-5.8 - 69.7)	16	2.7	(-3.7 - 9.1)	31
Mamafubelu	26.6	(19.0 - 34.3)	21	49.6	(31.8 - 67.4)	14	45.8	(19.1 - 72.5)	14	16.9	(9.8 - 24.0)	21
Mamant'so	23.1	(23.1 - 23.1)	13	28.6	-	7	28.6	(28.6 - 28.6)	7	7.7	(7.7 - 7.7)	13
Mamants'o	27.3	(27.3 - 27.3)	11	50.0	-	4	25.0	-	4	9.1	-	11
Manka	14.7	(-11.6 - 40.9)	21	32.8	(-2.4 - 68.1)	12	16.2	(-14.6 - 47.1)	12	4.9	(-3.9 - 13.6)	21
Manonyane	28.6	(7.6 - 49.6)	16	18.1	(5.3 - 31.0)	15	40.9	(34.5 - 47.3)	15	21.5	(5.7 - 37.2)	16
Mapoteng	43.8	(21.1 - 66.5)	29	28.1	(2.3 - 54.0)	20	31.1	(-15.4 - 77.6)	20	23.6	(1.5 - 45.8)	29
Maputsoe	30.9	(20.6 - 41.3)	87	24.6	(18.8 - 30.4)	56	25.8	(13.0 - 38.6)	56	15.3	(6.4 - 24.3)	87
Maseru	33.1	(27.0 - 39.1)	253	16.4	(9.5 - 23.3)	177	16.8	(8.6 - 25.0)	177	21.5	(16.0 - 27.1)	253
Matsoku	23.6	(7.7 - 39.6)	56	1.5	(-0.4 - 3.4)	35	3.2	(-6.5 - 12.8)	35	7.6	(-5.4 - 20.6)	56
Mazenod	31.2	(4.5 - 58.0)	22	27.1	(8.3 - 45.8)	15	20.2	(11.5 - 28.8)	15	13.4	(4.1 - 22.8)	22
Menkhoaneng	45.1	(34.1 - 56.2)	24	0.0	-	15	9.2	(1.4 - 17.0)	15	11.8	(0.8 - 22.8)	24
Menoaneng	28.8	(18.7 - 38.9)	32	12.2	(-6.0 - 30.4)	15	26.1	(9.9 - 42.3)	15	9.6	(-0.8 - 20.0)	32
Metsi-Maholo	18.2	(18.2 - 18.2)	11	28.6	(28.6 - 28.6)	7	0.0	-	7	0.0	-	11
Mohale's Hoek	50.3	(27.8 - 72.9)	67	17.7	(4.6 - 30.7)	39	28.1	(2.8 - 53.4)	39	27.4	(15.1 - 39.7)	67
Mohlakeng	33.3	(33.3 - 33.3)	12	20.0	-	5	0.0	-	5	8.3	(8.3 - 8.3)	12
Mokhotlong	48.0	(25.9 - 70.0)	39	16.9	(-6.5 - 40.3)	27	23.1	(0.6 - 45.6)	27	34.9	(2.1 - 67.6)	39

Council	Women Exp %	95% CI	N	Men Perp %	95% CI	N	Men Exp %	95% CI	N	Women Perp %	95% CI	N
Motanasela	32.2	(16.0 - 48.5)	35	0.0	-	19	4.0	(-4.1 - 12.0)	19	9.1	(3.0 - 15.1)	35
Mphokojoane	28.3	(-7.6 - 64.1)	46	13.9	(3.1 - 24.7)	24	12.5	(-0.2 - 25.2)	24	9.4	(-7.3 - 26.2)	46
Mtjanyane	36.4	(36.4 - 36.4)	11	57.1	(57.1 - 57.1)	7	57.1	(57.1 - 57.1)	7	18.2	(18.2 - 18.2)	11
Ngoajane	34.7	(12.6 - 56.8)	24	78.6	(56.9 - 100.3)	15	13.7	(12.1 - 15.4)	15	32.3	(2.8 - 61.8)	24
Nqoe	26.8	(11.1 - 42.6)	69	35.9	(22.4 - 49.4)	38	33.6	(24.1 - 43.0)	38	1.7	(-1.4 - 4.7)	69
Ntŝupe	24.3	(14.1 - 34.6)	44	4.6	(-4.1 - 13.4)	27	3.0	(-3.6 - 9.7)	27	0.0	-	44
Phuthiatsana	20.6	(14.8 - 26.4)	18	9.6	(-9.0 - 28.2)	14	9.6	(-9.0 - 28.2)	14	10.3	(7.4 - 13.2)	18
Qacha's Nek	24.4	(9.5 - 39.3)	46	14.4	(-4.5 - 33.3)	30	24.9	(5.4 - 44.5)	30	4.8	(-3.1 - 12.7)	46
Qanya	25.5	(16.8 - 34.2)	32	6.0	(-4.7 - 16.8)	22	24.2	(1.3 - 47.2)	22	0.0	-	32
Qhoasing	56.1	(24.3 - 87.9)	42	13.2	(-13.0 - 39.5)	17	14.6	(-24.6 - 53.8)	17	17.2	(7.3 - 27.2)	42
Qibing	18.2	(18.2 - 18.2)	11	42.9	(42.9 - 42.9)	7	28.6	(28.6 - 28.6)	7	0.0	-	11
Qiloane	30.0	(30.0 - 30.0)	10	25.0	-	8	37.5	-	8	20.0	-	10
Qomoqomong	30.0	(30.0 - 30.0)	10	42.9	(42.9 - 42.9)	7	14.3	(14.3 - 14.3)	7	10.0	(10.0 - 10.0)	10
Quthing	40.5	(27.9 - 53.2)	60	31.7	(4.9 - 58.5)	45	33.5	(17.1 - 49.9)	45	22.4	(10.3 - 34.5)	60
Ramapepe	20.1	(5.3 - 34.8)	17	20.0	(20.0 - 20.0)	10	20.0	(20.0 - 20.0)	10	0.0	-	17
Ramoetsana	15.2	(-16.9 - 47.3)	25	0.0	-	12	20.5	(-5.8 - 46.8)	12	12.7	(-18.3 - 43.7)	25
Ratau	46.3	(28.6 - 63.9)	21	26.8	(6.5 - 47.0)	13	26.8	(6.5 - 47.0)	13	22.9	(3.0 - 42.7)	21
Seate	20.4	(-10.2 - 51.1)	33	21.4	(-2.4 - 45.1)	20	36.0	(12.4 - 59.7)	20	19.3	(2.0 - 36.6)	33
Semena	11.3	(0.5 - 22.1)	23	30.3	(16.4 - 44.1)	12	35.0	(6.3 - 63.7)	12	0.0	-	23
Semonkong	31.7	(-48.9 - 112.3)	21	16.0	(10.2 - 21.9)	18	30.2	(-11.6 - 72.0)	18	16.5	(-9.4 - 42.4)	21
Senekane	20.0	(20.0 - 20.0)	10	0.0	-	7	14.3	(14.3 - 14.3)	7	10.0	(10.0 - 10.0)	10
Senqebethu	30.0	(15.5 - 44.5)	19	6.9	(1.4 - 12.4)	16	0.0	-	16	31.9	(29.2 - 34.6)	19
Senqunyane	54.0	(43.7 - 64.2)	23	0.0	-	12	33.3	(33.3 - 33.3)	12	36.9	(27.8 - 45.9)	23
Sephokong	27.3	(27.3 - 27.3)	11	25.0	(25.0 - 25.0)	4	75.0	(75.0 - 75.0)	4	18.2	(18.2 - 18.2)	11
Siloe	36.4	(36.4 - 36.4)	22	0.0	-	12	7.3	(-27.2 - 41.8)	12	8.1	(-25.4 - 41.6)	22
Tebe-Tebe	41.7	(41.7 - 41.7)	12	0.0	-	8	37.5	-	8	25.0	(25.0 - 25.0)	12
Telle	33.3	(30.7 - 35.9)	41	35.2	(24.1 - 46.3)	27	35.4	(30.0 - 40.8)	27	10.5	(1.6 - 19.3)	41
Tenesolo	13.9	(4.6 - 23.1)	21	0.0	-	7	0.0	-	7	0.0	-	21
Thaba-Mokhele	57.4	(-10.7 - 125.6)	32	0.0	-	16	0.0	-	16	20.2	(9.0 - 31.4)	32
Thaba-Tseka	27.9	(3.7 - 52.1)	34	15.9	(-20.6 - 52.4)	14	12.7	(-10.4 - 35.8)	14	7.9	(-6.6 - 22.4)	34
Tosing	34.4	(15.1 - 53.8)	20	21.8	(9.9 - 33.7)	14	21.8	(9.9 - 33.7)	14	5.3	(-4.0 - 14.5)	20
Ts'a-le-Moleka	42.3	(19.6 - 65.1)	23	18.1	(-10.9 - 47.2)	12	25.4	(16.7 - 34.2)	12	8.7	(7.8 - 9.5)	23
Ts'ana-Talana	11.1	(-5.1 - 27.3)	20	46.0	(37.1 - 55.0)	11	56.1	(32.3 - 79.9)	11	0.0	-	20
Tsitsong	26.7	(16.2 - 37.2)	25	31.0	(23.4 - 38.6)	10	31.0	(23.4 - 38.6)	10	5.9	(-11.2 - 22.9)	25
Tsoelikana	34.5	(22.8 - 46.2)	35	10.2	(-5.7 - 26.2)	23	25.7	(9.7 - 41.6)	23	8.6	(-2.4 - 19.6)	35
Tsoili-Tsoili	66.7	(66.7 - 66.7)	6	33.3	(33.3 - 33.3)	6	0.0	-	6	16.7	(16.7 - 16.7)	6
Tsoilitsoili	0.0	-	8	20.0	(20.0 - 20.0)	5	20.0	(20.0 - 20.0)	5	0.0	-	8
Tŝitsong	40.0	(40.0 - 40.0)	10	37.5	(37.5 - 37.5)	8	25.0	(25.0 - 25.0)	8	20.0	(20.0 - 20.0)	10

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

Appendix Table A8: Lifetime physical IPV experience and perpetration by council

Council	Women Exp %	95% CI	N	Men Perp %	95% CI	N	Men Exp %	95% CI	N	Women Perp %	95% CI	N
Berea	21.8	(11.3 - 32.2)	33	5.5	(-3.5 - 14.6)	23	0.0	-	23	1.9	(-2.8 - 6.6)	33
Bokong	28.5	-	20	12.7	-	15	0.0	-	15	9.5	-	20
Bolahla	20.0	(20.0 - 20.0)	10	0.0	-	6	0.0	-	6	10.0	(10.0 - 10.0)	10
Butha-Buthe	35.6	(20.4 - 50.7)	55	28.9	(9.9 - 47.8)	38	20.7	(2.2 - 39.2)	38	4.9	(-4.5 - 14.4)	55
Hleoheng	7.1	(7.1 - 7.1)	14	40.0	(40.0 - 40.0)	5	20.0	-	5	0.0	-	14
Hlotse	38.4	(18.9 - 57.9)	35	9.3	(1.1 - 17.6)	24	16.0	(0.4 - 31.6)	24	8.3	(2.7 - 13.9)	35
Kanana	37.5	(37.5 - 37.5)	8	33.3	(33.3 - 33.3)	6	0.0	-	6	25.0	(25.0 - 25.0)	8
Khoelenya	46.3	(23.3 - 69.3)	22	0.0	-	10	0.0	-	10	5.8	(-1.9 - 13.4)	22
Khutlo-se-Metsi	9.3	(-10.9 - 29.5)	11	40.4	(-2.0 - 82.9)	5	0.0	-	5	0.0	-	11
Kubake	22.7	(0.6 - 44.8)	18	25.0	(-48.1 - 98.1)	15	0.0	-	15	0.0	-	18
Kueneng	85.7	-	7	16.7	(16.7 - 16.7)	6	0.0	-	6	0.0	-	7
Lehlakaneng	0.0	-	29	5.5	(-5.6 - 16.5)	20	5.5	(-5.6 - 16.5)	20	0.0	-	29
Likila	19.7	(7.1 - 32.2)	32	31.7	(4.5 - 58.9)	21	3.2	(-3.6 - 10.0)	21	6.0	(-6.2 - 18.3)	32
Likolobeng	31.2	(-11.8 - 74.1)	28	0.0	-	20	0.0	-	20	7.6	(-9.5 - 24.7)	28
Lilala	8.3	(8.3 - 8.3)	12	14.3	-	7	0.0	-	7	0.0	-	12
Linakeng	8.1	(4.1 - 12.0)	30	45.3	(22.4 - 68.3)	15	0.0	-	15	9.9	(9.1 - 10.7)	30
Lithipeng	36.4	(36.4 - 36.4)	11	0.0	-	6	33.3	(33.3 - 33.3)	6	9.1	(9.1 - 9.1)	11
Litsoetse	21.1	(10.8 - 31.4)	32	25.1	(13.0 - 37.2)	18	0.0	-	18	4.8	(-0.9 - 10.6)	32
Mafeteng	27.4	(16.6 - 38.2)	74	16.6	(-3.3 - 36.6)	48	14.6	(2.3 - 27.0)	48	3.1	(-1.3 - 7.5)	74
Maisa-Phoka	27.3	-	11	0.0	-	7	0.0	-	7	0.0	-	11
Makeoane	30.3	(13.4 - 47.2)	53	2.2	(-0.0 - 4.4)	31	2.8	(-5.1 - 10.8)	31	10.8	(7.3 - 14.3)	53
Makhoalipana	39.0	(7.0 - 71.0)	29	30.4	(8.6 - 52.1)	19	12.9	(2.6 - 23.1)	19	5.1	(-13.9 - 24.2)	29
Makhoarane	34.6	(10.1 - 59.2)	21	0.0	-	14	0.0	-	14	6.3	(0.0 - 12.6)	21
Makoabating	21.9	(10.7 - 33.0)	31	37.5	(7.0 - 68.1)	16	13.8	(-1.4 - 28.9)	16	0.0	-	31
Mamafubelu	24.1	(10.5 - 37.7)	21	35.3	(17.5 - 53.1)	14	10.5	(1.6 - 19.4)	14	9.7	(9.2 - 10.3)	21
Mamant'so	15.4	(15.4 - 15.4)	13	14.3	(14.3 - 14.3)	7	14.3	(14.3 - 14.3)	7	7.7	(7.7 - 7.7)	13
Mamants'o	27.3	(27.3 - 27.3)	11	25.0	-	4	25.0	-	4	9.1	-	11
Manka	19.5	(-15.5 - 54.6)	21	16.2	(-14.6 - 47.1)	12	0.0	-	12	9.6	(7.4 - 11.7)	21
Manonyane	28.6	(7.6 - 49.6)	16	18.1	(5.3 - 31.0)	15	9.0	(-20.9 - 39.0)	15	7.2	(1.9 - 12.4)	16
Mapoteng	25.4	(6.8 - 44.1)	29	6.6	(-6.9 - 20.1)	20	16.0	(-3.9 - 36.0)	20	15.5	(1.7 - 29.3)	29
Maputsoe	23.5	(12.6 - 34.4)	87	18.2	(9.5 - 26.9)	56	1.4	(-1.8 - 4.5)	56	4.3	(-0.3 - 9.0)	87
Maseru	26.8	(21.6 - 32.0)	253	11.3	(5.3 - 17.3)	177	7.3	(1.7 - 12.8)	177	7.2	(3.4 - 11.1)	253
Matsoku	22.0	(13.0 - 30.9)	56	7.7	(-9.8 - 25.2)	35	0.5	(-1.1 - 2.0)	35	0.7	(-1.7 - 3.2)	56
Mazenod	35.6	(0.8 - 70.4)	22	33.9	(5.1 - 62.8)	15	6.4	(-5.1 - 17.9)	15	4.4	(-3.7 - 12.4)	22
Menkhoaneng	42.7	(26.1 - 59.2)	24	0.0	-	15	13.0	(11.9 - 14.1)	15	11.8	(0.8 - 22.8)	24
Menoaneng	21.5	(16.4 - 26.7)	32	18.7	(-7.3 - 44.8)	15	5.7	(-9.6 - 21.0)	15	6.0	(-0.4 - 12.4)	32
Metsi-Maholo	0.0	-	11	14.3	(14.3 - 14.3)	7	0.0	-	7	0.0	-	11
Mohale's Hoek	28.1	(18.3 - 37.8)	67	10.4	(-4.3 - 25.1)	39	11.8	(-3.6 - 27.2)	39	14.0	(2.1 - 25.8)	67
Mohlakeng	33.3	(33.3 - 33.3)	12	0.0	-	5	0.0	-	5	25.0	(25.0 - 25.0)	12
Mokhotlong	29.8	(16.2 - 43.4)	39	20.0	(-24.7 - 64.8)	27	11.6	(-0.8 - 23.9)	27	10.3	(-5.2 - 25.7)	39

Council	Women Exp %	95% CI	N	Men Perp %	95% CI	N	Men Exp %	95% CI	N	Women Perp %	95% CI	N
Motanasela	23.4	(4.0 - 42.9)	35	9.2	(-4.0 - 22.4)	19	0.0	-	19	4.9	(-1.7 - 11.5)	35
Mphokojoane	19.6	(0.3 - 39.0)	46	45.4	(20.0 - 70.8)	24	0.0	-	24	5.3	(-4.3 - 15.0)	46
Mtjanyane	45.5	-	11	42.9	(42.9 - 42.9)	7	14.3	(14.3 - 14.3)	7	0.0	-	11
Ngoajane	43.0	(20.9 - 65.1)	24	15.4	(-31.4 - 62.1)	15	0.0	-	15	12.0	(-2.7 - 26.7)	24
Nqoe	22.5	(12.4 - 32.6)	69	5.6	(-4.2 - 15.4)	38	2.1	(-2.9 - 7.1)	38	6.0	(1.8 - 10.1)	69
Ntŝupe	28.1	(23.3 - 32.8)	44	19.2	(8.6 - 29.9)	27	2.5	(-3.9 - 9.0)	27	0.0	-	44
Phuthiatsana	27.6	(26.8 - 28.3)	18	20.5	(-4.3 - 45.4)	14	4.8	(-4.5 - 14.1)	14	3.3	(-4.7 - 11.2)	18
Qacha's Nek	12.7	(-10.6 - 36.0)	46	11.7	(-9.2 - 32.5)	30	14.4	(-2.3 - 31.2)	30	2.0	(-4.5 - 8.6)	46
Qanya	34.0	(32.3 - 35.8)	32	12.1	(-9.5 - 33.6)	22	12.2	(1.7 - 22.7)	22	2.1	(-3.2 - 7.5)	32
Qhoasing	41.5	(22.0 - 61.0)	42	18.1	(0.8 - 35.4)	17	23.0	(7.2 - 38.8)	17	18.3	(-11.1 - 47.7)	42
Qibing	9.1	(9.1 - 9.1)	11	42.9	(42.9 - 42.9)	7	0.0	-	7	0.0	-	11
Qiloane	30.0	(30.0 - 30.0)	10	0.0	-	8	12.5	-	8	10.0	(10.0 - 10.0)	10
Qomoqomong	40.0	(40.0 - 40.0)	10	14.3	(14.3 - 14.3)	7	0.0	-	7	0.0	-	10
Quthing	30.7	(17.9 - 43.5)	60	34.7	(0.5 - 68.8)	45	10.4	(-2.3 - 23.2)	45	7.6	(-0.5 - 15.7)	60
Ramapepe	35.6	(-1.9 - 73.0)	17	0.0	-	10	0.0	-	10	4.6	(-3.4 - 12.5)	17
Ramoetsana	8.8	(6.6 - 11.0)	25	20.5	(-5.8 - 46.8)	12	6.8	(-1.9 - 15.6)	12	8.8	(6.6 - 11.0)	25
Ratau	43.3	(41.1 - 45.5)	21	26.8	(6.5 - 47.0)	13	15.7	(13.9 - 17.6)	13	0.0	-	21
Seate	26.6	(18.4 - 34.9)	33	19.6	(9.3 - 29.9)	20	27.8	(15.8 - 39.8)	20	5.5	(-5.0 - 16.1)	33
Semena	26.3	(11.4 - 41.2)	23	5.1	(-5.9 - 16.1)	12	0.0	-	12	8.7	(-3.9 - 21.3)	23
Semonkong	28.6	(-12.1 - 69.3)	21	7.1	(-16.4 - 30.5)	18	33.9	(-40.3 - 108.1)	18	0.0	-	21
Senekane	30.0	(30.0 - 30.0)	10	0.0	-	7	28.6	(28.6 - 28.6)	7	20.0	(20.0 - 20.0)	10
Senqebethu	25.6	(19.3 - 32.0)	19	18.6	(17.5 - 19.7)	16	13.8	(2.8 - 24.8)	16	10.6	(9.7 - 11.5)	19
Senqunyane	61.1	(25.3 - 96.9)	23	11.5	(-1.4 - 24.5)	12	28.2	(15.2 - 41.1)	12	5.3	(-8.3 - 18.9)	23
Sephokong	9.1	-	11	0.0	-	4	0.0	-	4	9.1	-	11
Siloe	8.1	(-25.4 - 41.6)	22	7.3	(-27.2 - 41.8)	12	16.4	(6.5 - 26.2)	12	0.0	-	22
Tebe-Tebe	58.3	(58.3 - 58.3)	12	0.0	-	8	0.0	-	8	16.7	(16.7 - 16.7)	12
Telle	31.1	(23.6 - 38.5)	41	29.6	(12.4 - 46.8)	27	5.7	(-3.4 - 14.8)	27	3.9	(0.3 - 7.5)	41
Tenesolo	13.1	(-12.4 - 38.6)	21	0.0	-	7	0.0	-	7	4.4	(-4.1 - 12.9)	21
Thaba-Mokhele	40.1	(36.3 - 43.8)	32	0.0	-	16	1.6	(-17.2 - 20.4)	16	2.0	(-42.5 - 46.6)	32
Thaba-Tseka	23.9	(-14.1 - 61.9)	34	15.9	(-5.8 - 37.6)	14	6.4	(-17.7 - 30.4)	14	10.8	(-9.9 - 31.6)	34
Tosing	34.0	(-2.3 - 70.2)	20	14.3	(14.3 - 14.3)	14	14.3	(14.3 - 14.3)	14	0.0	-	20
Ts'a-le-Moleka	33.7	(11.7 - 55.6)	23	18.1	(-10.9 - 47.2)	12	18.1	(-10.9 - 47.2)	12	0.0	-	23
Ts'ana-Talana	5.5	(-2.6 - 13.6)	20	10.1	(-4.8 - 25.0)	11	0.0	-	11	0.0	-	20
Tsitsong	39.6	(36.3 - 42.9)	25	7.0	(-15.7 - 29.8)	10	0.0	-	10	0.0	-	25
Tsoelikana	25.9	(11.2 - 40.6)	35	12.8	(10.3 - 15.3)	23	7.7	(-3.5 - 18.9)	23	3.5	(-2.2 - 9.1)	35
Tsoili-Tsoili	66.7	(66.7 - 66.7)	6	16.7	(16.7 - 16.7)	6	0.0	-	6	0.0	-	6
Tsoilitsoili	0.0	-	8	0.0	-	5	20.0	(20.0 - 20.0)	5	0.0	-	8
Tŝitsong	40.0	(40.0 - 40.0)	10	0.0	-	8	0.0	-	8	0.0	-	10

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

Appendix Table A9: Lifetime sexual IPV experience and perpetration by council

Council	Women Exp %	95% CI	N	Men Perp %	95% CI	N	Men Exp %	95% CI	N	Women Perp %	95% CI	N
Berea	3.9	(-5.6 - 13.3)	33	0.0	-	23	2.7	(-3.6 - 9.0)	23	0.0	-	33
Bokong	9.5	-	20	1.6	-	15	0.0	-	15	0.0	-	20
Bolahla	30.0	(30.0 - 30.0)	10	0.0	-	6	0.0	-	6	0.0	-	10
Butha-Buthe	16.0	(7.9 - 24.1)	55	14.2	(-3.8 - 32.3)	38	15.5	(-2.8 - 33.8)	38	0.0	-	55
Hleoheng	7.1	(7.1 - 7.1)	14	0.0	-	5	0.0	-	5	0.0	-	14
Hlotse	3.9	(-5.0 - 12.8)	35	7.6	(-3.1 - 18.3)	24	0.0	-	24	2.0	(-2.5 - 6.4)	35
Kanana	25.0	(25.0 - 25.0)	8	16.7	(16.7 - 16.7)	6	0.0	-	6	0.0	-	8
Khoelenya	28.1	(5.2 - 51.1)	22	0.0	-	10	0.0	-	10	0.0	-	22
Khutlo-se-Metsi	0.0	-	11	0.0	-	5	0.0	-	5	0.0	-	11
Kubake	11.7	(-13.6 - 36.9)	18	0.0	-	15	0.0	-	15	0.0	-	18
Kueneng	28.6	(28.6 - 28.6)	7	0.0	-	6	0.0	-	6	0.0	-	7
Lehlakaneng	0.0	-	29	5.5	(-5.6 - 16.5)	20	0.0	-	20	0.0	-	29
Likila	4.2	(-4.8 - 13.2)	32	9.7	(-0.2 - 19.6)	21	3.2	(-3.6 - 10.0)	21	2.1	(-2.4 - 6.6)	32
Likolobeng	7.1	(-3.3 - 17.5)	28	3.8	(-2.5 - 10.0)	20	0.0	-	20	3.8	(-4.7 - 12.3)	28
Lilala	0.0	-	12	0.0	-	7	0.0	-	7	0.0	-	12
Linakeng	10.7	(3.6 - 17.8)	30	12.5	(-7.9 - 33.0)	15	0.0	-	15	7.3	(1.2 - 13.5)	30
Lithipeng	9.1	(9.1 - 9.1)	11	16.7	(16.7 - 16.7)	6	0.0	-	6	0.0	-	11
Litsoetse	4.1	(-4.7 - 12.9)	32	0.0	-	18	4.7	(-5.9 - 15.4)	18	4.8	(-0.9 - 10.6)	32
Mafeteng	9.6	(1.8 - 17.5)	74	9.7	(-5.7 - 25.2)	48	3.6	(-2.3 - 9.4)	48	3.1	(-1.6 - 7.7)	74
Maisa-Phoka	18.2	(18.2 - 18.2)	11	0.0	-	7	0.0	-	7	0.0	-	11
Makeoane	12.1	(0.3 - 23.9)	53	3.9	(-6.0 - 13.8)	31	0.0	-	31	0.0	-	53
Makhoalipana	10.0	(5.7 - 14.2)	29	8.2	(-28.1 - 44.5)	19	8.2	(-28.1 - 44.5)	19	0.0	-	29
Makhoarane	25.3	(0.1 - 50.4)	21	0.0	-	14	0.0	-	14	0.0	-	21
Makoabating	7.0	(-0.9 - 15.0)	31	0.0	-	16	5.2	(-7.4 - 17.8)	16	0.0	-	31
Mamafubelu	2.6	(-3.3 - 8.5)	21	14.3	(14.3 - 14.3)	14	0.0	-	14	2.6	(-3.3 - 8.5)	21
Mamant'so	7.7	(7.7 - 7.7)	13	0.0	-	7	0.0	-	7	0.0	-	13
Mamants'o	9.1	-	11	25.0	-	4	0.0	-	4	0.0	-	11
Manka	9.8	(-7.7 - 27.3)	21	0.0	-	12	0.0	-	12	0.0	-	21
Manonyane	35.8	(9.5 - 62.0)	16	0.0	-	15	4.5	(-10.5 - 19.5)	15	14.3	(3.8 - 24.8)	16
Mapoteng	13.4	(9.4 - 17.4)	29	6.6	(-6.9 - 20.1)	20	10.2	(-0.9 - 21.4)	20	0.0	-	29
Maputsoe	15.9	(5.3 - 26.5)	87	6.1	(-1.1 - 13.2)	56	1.0	(-1.3 - 3.3)	56	0.0	-	87
Maseru	10.3	(5.2 - 15.5)	253	3.1	(0.4 - 5.8)	177	1.5	(-0.2 - 3.3)	177	1.3	(-0.2 - 2.8)	253
Matsoku	9.8	(-11.3 - 31.0)	56	4.5	(-10.3 - 19.3)	35	0.6	(-1.3 - 2.4)	35	4.1	(-7.2 - 15.3)	56
Mazenod	13.1	(-11.0 - 37.2)	22	0.0	-	15	0.0	-	15	4.4	(-3.7 - 12.4)	22
Menkhoaneng	0.0	-	24	0.0	-	15	0.0	-	15	0.0	-	24
Menoaneng	12.2	(6.8 - 17.5)	32	13.1	(-9.2 - 35.4)	15	6.9	(-4.3 - 18.1)	15	0.0	-	32
Metsi-Maholo	0.0	-	11	0.0	-	7	0.0	-	7	9.1	(9.1 - 9.1)	11
Mohale's Hoek	13.3	(-2.6 - 29.3)	67	5.2	(-2.9 - 13.4)	39	12.6	(-3.6 - 28.7)	39	4.3	(-0.7 - 9.3)	67
Mohlakeng	33.3	(33.3 - 33.3)	12	0.0	-	5	0.0	-	5	0.0	-	12
Mokhotlong	10.8	(-18.5 - 40.2)	39	6.1	(-8.3 - 20.6)	27	10.3	(-5.0 - 25.6)	27	0.0	-	39

Council	Women Exp %	95% CI	N	Men Perp %	95% CI	N	Men Exp %	95% CI	N	Women Perp %	95% CI	N
Motanasela	4.0	(-4.2 - 12.2)	35	0.0	-	19	0.0	-	19	0.0	-	35
Mphokojoane	9.2	(-8.6 - 27.0)	46	3.2	(-4.8 - 11.2)	24	1.4	(-2.1 - 4.8)	24	0.0	-	46
Mtjanyane	9.1	-	11	0.0	-	7	0.0	-	7	0.0	-	11
Ngoajane	14.3	(7.0 - 21.7)	24	13.7	(12.1 - 15.4)	15	9.9	(-3.5 - 23.2)	15	0.0	-	24
Nqoe	12.5	(5.1 - 19.9)	69	13.5	(-1.1 - 28.1)	38	3.5	(-3.1 - 10.2)	38	0.0	-	69
Ntŝupe	10.0	(5.2 - 14.8)	44	0.0	-	27	0.0	-	27	0.0	-	44
Phuthiatsana	0.0	-	18	0.0	-	14	0.0	-	14	0.0	-	18
Qacha's Nek	4.8	(-3.1 - 12.7)	46	3.1	(-7.7 - 13.9)	30	3.1	(-7.7 - 13.9)	30	1.8	(-4.3 - 7.9)	46
Qanya	2.1	(-3.2 - 7.5)	32	0.0	-	22	0.0	-	22	0.0	-	32
Qhoasing	9.3	(1.7 - 16.9)	42	0.0	-	17	23.0	(7.2 - 38.8)	17	0.0	-	42
Qibing	9.1	(9.1 - 9.1)	11	14.3	(14.3 - 14.3)	7	14.3	(14.3 - 14.3)	7	0.0	-	11
Qiloane	20.0	(20.0 - 20.0)	10	12.5	-	8	12.5	-	8	0.0	-	10
Qomoqomong	20.0	(20.0 - 20.0)	10	0.0	-	7	14.3	(14.3 - 14.3)	7	0.0	-	10
Quthing	12.1	(3.5 - 20.6)	60	7.5	(-0.0 - 14.9)	45	1.4	(-2.5 - 5.4)	45	1.2	(-2.1 - 4.5)	60
Ramapepe	12.3	(8.9 - 15.7)	17	0.0	-	10	0.0	-	10	0.0	-	17
Ramoetsana	0.0	-	25	8.7	(-5.4 - 22.9)	12	8.7	(-5.4 - 22.9)	12	0.0	-	25
Ratau	32.8	(10.8 - 54.9)	21	5.5	(-5.5 - 16.6)	13	11.0	(-11.1 - 33.1)	13	3.5	(-3.1 - 10.1)	21
Seate	7.4	(-15.0 - 29.7)	33	8.2	(-5.5 - 21.9)	20	2.5	(-2.3 - 7.3)	20	0.0	-	33
Semena	0.0	-	23	0.0	-	12	0.0	-	12	3.0	(-3.5 - 9.5)	23
Semonkong	14.5	(8.4 - 20.6)	21	0.0	-	18	7.1	(-16.4 - 30.5)	18	0.0	-	21
Senekane	20.0	(20.0 - 20.0)	10	14.3	(14.3 - 14.3)	7	0.0	-	7	0.0	-	10
Senqebethu	31.9	(29.2 - 34.6)	19	0.0	-	16	6.9	(1.4 - 12.4)	16	4.4	(-3.8 - 12.5)	19
Senqunyane	7.9	(-12.5 - 28.4)	23	0.0	-	12	16.7	(16.7 - 16.7)	12	0.0	-	23
Sephokong	0.0	-	11	0.0	-	4	0.0	-	4	0.0	-	11
Siloe	5.0	(-11.7 - 21.8)	22	0.0	-	12	7.3	(-27.2 - 41.8)	12	0.0	-	22
Tebe-Tebe	0.0	-	12	0.0	-	8	0.0	-	8	0.0	-	12
Telle	17.5	(13.6 - 21.3)	41	5.8	(0.6 - 11.1)	27	0.0	-	27	4.3	(-6.3 - 14.9)	41
Tenesolo	0.0	-	21	0.0	-	7	0.0	-	7	0.0	-	21
Thaba-Mokhele	13.9	(-111.4 - 139.2)	32	1.6	(-17.2 - 20.4)	16	1.6	(-17.2 - 20.4)	16	0.0	-	32
Thaba-Tseka	8.2	(-0.5 - 17.0)	34	0.0	-	14	6.3	(-8.9 - 21.6)	14	2.6	(-5.0 - 10.2)	34
Tosing	14.8	(8.9 - 20.7)	20	0.0	-	14	6.8	(-5.1 - 18.7)	14	0.0	-	20
Ts'a-le-Moleka	12.5	(2.0 - 23.1)	23	0.0	-	12	16.4	(10.6 - 22.2)	12	7.7	(-11.8 - 27.2)	23
Ts'ana-Talana	0.0	-	20	0.0	-	11	0.0	-	11	0.0	-	20
Tsitsong	20.8	(14.3 - 27.4)	25	0.0	-	10	0.0	-	10	5.0	(-2.9 - 12.9)	25
Tsoelikana	10.4	(2.5 - 18.2)	35	7.7	(-3.5 - 18.9)	23	5.1	(-4.3 - 14.5)	23	3.5	(-2.2 - 9.1)	35
Tsoili-Tsoili	0.0	-	6	0.0	-	6	0.0	-	6	0.0	-	6
Tsoilitsoili	0.0	-	8	0.0	-	5	0.0	-	5	0.0	-	8
Tŝitsong	40.0	(40.0 - 40.0)	10	12.5	(12.5 - 12.5)	8	0.0	-	8	10.0	(10.0 - 10.0)	10

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

Appendix Table A10: Lifetime economic IPV experience and perpetration by council

Council	Women Exp %	95% CI	N	Men Perp %	95% CI	N	Men Exp %	95% CI	N	Women Perp %	95% CI	N
Berea	12.8	(6.3 - 19.4)	33	2.9	(-3.8 - 9.5)	23	2.7	(-3.6 - 9.0)	23	5.4	(-1.1 - 11.8)	33
Bokong	23.0	-	20	0.0	-	15	0.0	-	15	9.5	-	20
Bolahla	30.0	(30.0 - 30.0)	10	0.0	-	6	0.0	-	6	10.0	(10.0 - 10.0)	10
Butha-Buthe	32.7	(23.6 - 41.9)	55	16.4	(5.2 - 27.5)	38	6.8	(-5.3 - 18.8)	38	8.2	(-6.8 - 23.2)	55
Hleoheng	14.3	(14.3 - 14.3)	14	0.0	-	5	0.0	-	5	0.0	-	14
Hlotse	30.7	(18.5 - 43.0)	35	0.0	-	24	10.5	(-1.1 - 22.1)	24	10.6	(1.8 - 19.4)	35
Kanana	37.5	(37.5 - 37.5)	8	16.7	(16.7 - 16.7)	6	33.3	(33.3 - 33.3)	6	37.5	(37.5 - 37.5)	8
Khoelenya	27.3	(27.3 - 27.3)	22	0.0	-	10	26.9	(-18.3 - 72.1)	10	28.1	(5.2 - 51.1)	22
Khutlo-se-Metsi	9.3	(-10.9 - 29.5)	11	20.6	(-36.0 - 77.2)	5	19.9	(5.7 - 34.0)	5	0.0	-	11
Kubake	22.7	(0.6 - 44.8)	18	0.0	-	15	6.2	(-12.0 - 24.5)	15	0.0	-	18
Kueneng	42.9	(42.9 - 42.9)	7	0.0	-	6	16.7	(16.7 - 16.7)	6	14.3	(14.3 - 14.3)	7
Lehlakaneng	4.0	(-4.2 - 12.1)	29	11.9	(6.8 - 17.1)	20	5.5	(-5.6 - 16.5)	20	0.0	-	29
Likila	27.2	(8.5 - 46.0)	32	14.2	(-6.8 - 35.2)	21	9.6	(-10.7 - 29.9)	21	8.5	(-1.0 - 17.9)	32
Likolobeng	8.0	(-5.1 - 21.1)	28	0.0	-	20	3.8	(-2.5 - 10.0)	20	0.0	-	28
Lilala	16.7	(16.7 - 16.7)	12	0.0	-	7	14.3	(14.3 - 14.3)	7	0.0	-	12
Linakeng	22.8	(10.5 - 35.0)	30	16.7	(-4.2 - 37.7)	15	0.0	-	15	5.5	(-0.9 - 11.9)	30
Lithipeng	18.2	(18.2 - 18.2)	11	0.0	-	6	33.3	(33.3 - 33.3)	6	18.2	(18.2 - 18.2)	11
Litsoetse	16.3	(3.0 - 29.6)	32	0.0	-	18	3.5	(-4.3 - 11.3)	18	5.1	(-1.9 - 12.1)	32
Mafeteng	32.5	(24.0 - 41.0)	74	14.4	(-0.4 - 29.2)	48	15.8	(2.1 - 29.5)	48	11.2	(4.0 - 18.4)	74
Maisa-Phoka	18.2	(18.2 - 18.2)	11	0.0	-	7	0.0	-	7	0.0	-	11
Makeoane	29.2	(6.8 - 51.6)	53	2.2	(-0.0 - 4.4)	31	3.9	(-4.4 - 12.2)	31	6.9	(1.1 - 12.6)	53
Makhoalipana	30.2	(0.5 - 59.9)	29	21.0	(-23.9 - 66.0)	19	25.7	(5.1 - 46.3)	19	11.0	(-11.0 - 33.0)	29
Makhoarane	12.6	(0.1 - 25.2)	21	9.6	(-0.6 - 19.9)	14	9.6	(-0.6 - 19.9)	14	0.0	-	21
Makoabating	7.4	(2.0 - 12.8)	31	13.8	(-1.4 - 28.9)	16	27.5	(-2.8 - 57.8)	16	5.3	(-7.4 - 18.1)	31
Mamafubelu	31.8	(27.7 - 35.9)	21	10.5	(1.6 - 19.4)	14	0.0	-	14	9.7	(9.2 - 10.3)	21
Mamant'so	30.8	(30.8 - 30.8)	13	28.6	(28.6 - 28.6)	7	28.6	(28.6 - 28.6)	7	7.7	(7.7 - 7.7)	13
Mamants'o	18.2	-	11	25.0	-	4	50.0	-	4	9.1	-	11
Manka	19.1	(14.7 - 23.5)	21	8.5	(-2.5 - 19.5)	12	8.1	(-7.3 - 23.5)	12	9.6	(7.4 - 11.7)	21
Manonyane	28.6	(7.6 - 49.6)	16	0.0	-	15	0.0	-	15	7.2	(1.9 - 12.4)	16
Mapoteng	36.3	(15.1 - 57.4)	29	0.0	-	20	3.6	(-6.8 - 14.1)	20	15.5	(1.7 - 29.3)	29
Maputsoe	38.1	(24.5 - 51.7)	87	21.8	(7.3 - 36.4)	56	31.6	(15.3 - 47.8)	56	3.8	(-1.2 - 8.7)	87
Maseru	23.0	(16.6 - 29.4)	253	1.6	(-0.9 - 4.1)	177	8.0	(3.0 - 13.0)	177	3.8	(1.0 - 6.6)	253
Matsoku	19.7	(-3.7 - 43.1)	56	0.0	-	35	2.7	(-6.7 - 12.1)	35	4.8	(-4.7 - 14.3)	56
Mazenod	35.3	(-14.2 - 84.8)	22	0.0	-	15	13.3	(11.9 - 14.7)	15	0.0	-	22
Menkhoaneng	25.0	(25.0 - 25.0)	24	0.0	-	15	0.0	-	15	0.0	-	24
Menoaneng	21.1	(7.2 - 35.1)	32	0.0	-	15	5.7	(-9.6 - 21.0)	15	3.2	(-3.0 - 9.4)	32
Metsi-Maholo	9.1	(9.1 - 9.1)	11	57.1	(57.1 - 57.1)	7	28.6	(28.6 - 28.6)	7	9.1	(9.1 - 9.1)	11
Mohale's Hoek	31.1	(11.4 - 50.8)	67	11.5	(-10.2 - 33.3)	39	20.6	(1.9 - 39.4)	39	19.8	(11.0 - 28.5)	67
Mohlakeng	25.0	(25.0 - 25.0)	12	0.0	-	5	0.0	-	5	8.3	(8.3 - 8.3)	12
Mokhotlong	22.6	(4.9 - 40.4)	39	4.2	(-8.6 - 17.0)	27	15.8	(-2.9 - 34.5)	27	2.1	(-5.0 - 9.2)	39

Council	Women Exp %	95% CI	N	Men Perp %	95% CI	N	Men Exp %	95% CI	N	Women Perp %	95% CI	N
Motanasela	14.4	(-4.4 - 33.2)	35	0.0	-	19	3.8	(-3.3 - 10.9)	19	4.9	(-1.7 - 11.5)	35
Mphokojoane	26.6	(11.6 - 41.6)	46	0.0	-	24	12.5	(-0.2 - 25.2)	24	3.7	(-4.3 - 11.6)	46
Mtjanyane	27.3	(27.3 - 27.3)	11	0.0	-	7	14.3	(14.3 - 14.3)	7	0.0	-	11
Ngoajane	21.3	(6.6 - 36.1)	24	3.8	(-7.8 - 15.5)	15	3.8	(-7.8 - 15.5)	15	0.0	-	24
Nqoe	16.9	(4.5 - 29.3)	69	2.8	(-3.9 - 9.6)	38	5.5	(-2.1 - 13.0)	38	3.1	(-1.5 - 7.6)	69
Ntŝupe	11.4	(1.6 - 21.2)	44	0.0	-	27	3.0	(-3.6 - 9.7)	27	0.0	-	44
Phuthiatsana	17.3	(15.1 - 19.5)	18	4.8	(-4.5 - 14.1)	14	25.3	(9.8 - 40.9)	14	3.3	(-4.7 - 11.2)	18
Qacha's Nek	21.8	(-7.1 - 50.7)	46	4.3	(-7.7 - 16.2)	30	11.8	(-14.1 - 37.6)	30	2.8	(-5.1 - 10.7)	46
Qanya	17.0	(-1.0 - 35.1)	32	0.0	-	22	3.1	(-4.8 - 11.0)	22	0.0	-	32
Qhoasing	25.3	(-8.9 - 59.5)	42	18.1	(-1.3 - 37.5)	17	23.0	(7.2 - 38.8)	17	0.3	(-0.2 - 0.9)	42
Qibing	18.2	(18.2 - 18.2)	11	42.9	(42.9 - 42.9)	7	28.6	(28.6 - 28.6)	7	9.1	(9.1 - 9.1)	11
Qiloane	20.0	(20.0 - 20.0)	10	0.0	-	8	12.5	-	8	0.0	-	10
Qomoqomong	40.0	(40.0 - 40.0)	10	14.3	(14.3 - 14.3)	7	14.3	(14.3 - 14.3)	7	0.0	-	10
Quthing	14.1	(0.3 - 27.8)	60	10.3	(3.7 - 16.9)	45	17.3	(-0.9 - 35.5)	45	3.0	(-2.8 - 8.9)	60
Ramapepe	20.1	(5.3 - 34.8)	17	7.4	(-7.5 - 22.4)	10	12.6	(-2.4 - 27.5)	10	7.7	(-3.6 - 19.1)	17
Ramoetsana	6.4	(-9.2 - 21.9)	25	13.7	(-3.9 - 31.2)	12	15.6	(7.0 - 24.1)	12	28.1	(20.4 - 35.8)	25
Ratau	23.9	(-0.4 - 48.1)	21	5.5	(-5.5 - 16.6)	13	0.0	-	13	12.9	(-4.7 - 30.6)	21
Seate	27.7	(12.5 - 43.0)	33	10.7	(-1.2 - 22.6)	20	26.8	(23.4 - 30.2)	20	15.3	(-10.6 - 41.2)	33
Semena	14.7	(6.7 - 22.6)	23	0.0	-	12	0.0	-	12	0.0	-	23
Semonkong	13.2	(-23.5 - 49.8)	21	0.0	-	18	19.8	(-9.6 - 49.2)	18	11.4	(-5.3 - 28.2)	21
Senekane	30.0	(30.0 - 30.0)	10	28.6	(28.6 - 28.6)	7	14.3	(14.3 - 14.3)	7	30.0	(30.0 - 30.0)	10
Senqebethu	8.8	(-7.5 - 25.0)	19	4.8	(-7.3 - 17.0)	16	6.9	(1.4 - 12.4)	16	0.0	-	19
Senqunyane	5.3	(-8.3 - 18.9)	23	0.0	-	12	28.2	(15.2 - 41.1)	12	11.2	(3.8 - 18.6)	23
Sephokong	0.0	-	11	0.0	-	4	25.0	(25.0 - 25.0)	4	0.0	-	11
Siloe	9.1	(9.1 - 9.1)	22	0.0	-	12	16.4	(6.5 - 26.2)	12	12.1	(-38.1 - 62.3)	22
Tebe-Tebe	33.3	(33.3 - 33.3)	12	0.0	-	8	25.0	-	8	16.7	(16.7 - 16.7)	12
Telle	19.0	(9.9 - 28.1)	41	12.5	(-4.7 - 29.7)	27	18.2	(9.0 - 27.4)	27	0.0	-	41
Tenesolo	13.9	(4.6 - 23.1)	21	0.0	-	7	0.0	-	7	0.0	-	21
Thaba-Mokhele	12.2	(-49.8 - 74.2)	32	0.0	-	16	1.6	(-17.2 - 20.4)	16	2.0	(-42.5 - 46.6)	32
Thaba-Tseka	16.4	(-2.8 - 35.6)	34	6.4	(-17.7 - 30.4)	14	12.7	(-10.4 - 35.8)	14	5.3	(-12.4 - 22.9)	34
Tosing	19.1	(-11.2 - 49.4)	20	7.5	(-4.4 - 19.4)	14	14.3	(14.3 - 14.3)	14	4.8	(-2.8 - 12.4)	20
Ts'a-le-Moleka	30.8	(24.3 - 37.3)	23	9.1	(-5.5 - 23.6)	12	0.0	-	12	9.6	(-8.3 - 27.5)	23
Ts'ana-Talana	5.5	(-2.6 - 13.6)	20	0.0	-	11	10.1	(-4.8 - 25.0)	11	5.5	(-2.6 - 13.6)	20
Tsitsong	31.7	(29.0 - 34.3)	25	0.0	-	10	0.0	-	10	0.0	-	25
Tsoelikana	13.8	(-2.8 - 30.4)	35	5.1	(-4.3 - 14.5)	23	17.9	(-10.6 - 46.5)	23	3.5	(-2.2 - 9.1)	35
Tsoili-Tsoili	33.3	(33.3 - 33.3)	6	16.7	(16.7 - 16.7)	6	0.0	-	6	0.0	-	6
Tsoilitsoili	0.0	-	8	0.0	-	5	0.0	-	5	0.0	-	8
Tŝitsong	60.0	(60.0 - 60.0)	10	0.0	-	8	12.5	-	8	0.0	-	10

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

Appendix Table A11: Lifetime NPSV experience by council

Council	Women Exp %	95% CI	N
Berea	1.8	(-2.5 - 6.0)	36
Bokong	0.0	-	24
Bolahla	20.0	(20.0 - 20.0)	10
Butha-Buthe	12.0	(-4.3 - 28.2)	60
Hleoheng	7.1	(7.1 - 7.1)	14
Hlotse	9.1	(-2.3 - 20.5)	39
Kanana	0.0	-	12
Khoelenya	12.0	(5.5 - 18.5)	23
Khutlo-se-Metsi	0.0	-	16
Kubake	4.3	(-8.4 - 17.0)	22
Kueneng	25.0	-	8
Lehlakaneng	0.0	-	35
Likila	8.3	(8.3 - 8.3)	36
Likolobeng	7.0	(-2.0 - 16.1)	36
Lilala	8.3	(8.3 - 8.3)	12
Linakeng	4.6	(-0.2 - 9.3)	35
Lithipeng	16.7	(16.7 - 16.7)	12
Litsoetse	8.8	(8.0 - 9.5)	35
Mafeteng	9.9	(0.1 - 19.7)	78
Maisa-Phoka	8.3	(8.3 - 8.3)	12
Makeoane	10.0	(1.2 - 18.7)	59
Makhoalipana	23.4	(-32.1 - 78.8)	33
Makhoarane	0.0	-	23
Makoabating	2.1	(-3.6 - 7.8)	34
Mamafubelu	2.2	(-3.0 - 7.4)	24
Mamant'so	0.0	-	13
Mamants'o	25.0	(25.0 - 25.0)	12
Manka	9.8	(-7.7 - 27.3)	21
Manonyane	3.2	(-10.7 - 17.1)	18
Mapoteng	18.1	(5.4 - 30.8)	32
Maputsoe	9.1	(4.8 - 13.4)	95
Maseru	13.4	(9.0 - 17.8)	291
Matsoku	13.8	(-8.3 - 35.9)	60
Mazenod	12.4	(5.6 - 19.1)	24
Menkhoaneng	4.9	(-6.2 - 15.9)	24
Menoaneng	9.1	(8.3 - 10.0)	33
Metsi-Maholo	9.1	-	11
Mohale's Hoek	3.8	(-1.8 - 9.5)	73
Mohlakeng	25.0	(25.0 - 25.0)	12
Mokhotlong	1.9	(-4.6 - 8.4)	44
Motanasela	10.6	(7.2 - 13.9)	36

Council	Women Exp %	95% CI	N
Mphokojoane	7.7	(-7.4 - 22.7)	50
Mtjanyane	9.1	-	11
Ngoajane	8.3	(8.3 - 8.3)	24
Nqoe	17.5	(8.1 - 26.8)	72
Ntŝupe	5.5	(0.6 - 10.4)	48
Phuthiatsana	0.0	-	18
Qacha's Nek	3.9	(-8.9 - 16.7)	48
Qanya	1.9	(-3.0 - 6.7)	36
Qhoasing	5.0	(-3.7 - 13.6)	46
Qibing	0.0	-	11
Qiloane	25.0	(25.0 - 25.0)	12
Qomoqomong	0.0	-	12
Quthing	16.9	(7.2 - 26.6)	66
Ramapepe	4.2	(-2.5 - 10.9)	19
Ramoetsana	2.5	(-3.6 - 8.7)	32
Ratau	8.3	(8.3 - 8.3)	24
Seate	11.2	(5.8 - 16.5)	36
Semena	13.1	(5.7 - 20.6)	27
Semonkong	8.3	(-23.3 - 39.9)	26
Senekane	0.0	-	12
Senqebethu	22.1	(-4.6 - 48.8)	24
Senqunyane	18.6	(-7.2 - 44.5)	24
Sephokong	8.3	(8.3 - 8.3)	12
Siloe	17.5	(14.7 - 20.3)	23
Tebe-Tebe	8.3	(8.3 - 8.3)	12
Telle	8.2	(1.2 - 15.2)	46
Tenesolo	8.7	(8.0 - 9.3)	23
Thaba-Mokhele	14.9	(-28.6 - 58.3)	36
Thaba-Tseka	0.0	-	49
Tosing	7.9	(-6.0 - 21.8)	24
Ts'a-le-Moleka	4.6	(-4.4 - 13.7)	24
Ts'ana-Talana	0.0	-	23
Tsitsong	0.0	-	25
Tsoelikana	3.2	(-2.0 - 8.5)	37
Tsoili-Tsoili	0.0	-	7
Tsoilitsoili	0.0	-	8
Tŝitsong	0.0	-	11

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

Appendix Table A12: Lifetime sexual harassment experience by council

Council	Women Exp %	95% CI	N	Men Exp %	95% CI	N
Berea	15.1	(2.2 - 27.9)	36	5.0	(-3.4 - 13.4)	25
Bokong	0.0	-	24	11.1	-	15
Bolahla	30.0	(30.0 - 30.0)	10	50.0	(50.0 - 50.0)	6
Butha-Buthe	44.9	(34.8 - 55.0)	60	17.8	(-2.9 - 38.5)	39
Hleoheng	21.4	(21.4 - 21.4)	14	0.0	-	8
Hlotse	25.4	(10.1 - 40.7)	39	24.3	(15.5 - 33.1)	26
Kanana	33.3	(33.3 - 33.3)	12	12.5	(12.5 - 12.5)	8
Khoelenya	32.8	(20.4 - 45.2)	23	0.0	-	16
Khutlo-se-Metsi	0.0	-	16	11.0	(2.3 - 19.7)	9
Kubake	31.9	(27.7 - 36.1)	22	0.0	-	16
Kueneng	37.5	-	8	0.0	-	6
Lehlakaneng	0.0	-	35	27.8	(-10.9 - 66.5)	22
Likila	27.7	(15.9 - 39.6)	36	11.3	(-0.0 - 22.6)	24
Likolobeng	20.9	(-14.1 - 56.0)	36	3.1	(-2.1 - 8.3)	24
Lilala	8.3	(8.3 - 8.3)	12	12.5	(12.5 - 12.5)	8
Linakeng	2.2	(-2.7 - 7.0)	35	21.6	(12.1 - 31.2)	22
Lithipeng	33.3	(33.3 - 33.3)	12	0.0	-	7
Litsoetse	15.3	(-0.4 - 30.9)	35	13.4	(2.4 - 24.3)	21
Mafeteng	23.2	(15.6 - 30.9)	78	31.6	(21.5 - 41.7)	57
Maisa-Phoka	33.3	(33.3 - 33.3)	12	25.0	(25.0 - 25.0)	8
Makeoane	11.2	(7.0 - 15.4)	59	7.5	(-2.5 - 17.5)	36
Makhoalipana	18.6	(-17.9 - 55.2)	33	17.9	(-29.1 - 64.8)	23
Makhoarane	6.0	(-0.7 - 12.7)	23	8.1	(-1.2 - 17.4)	17
Makoabating	15.3	(8.1 - 22.5)	34	32.3	(21.6 - 43.1)	23
Mamafubelu	11.0	(-14.9 - 37.0)	24	9.2	(1.4 - 17.0)	16
Mamant'so	23.1	(23.1 - 23.1)	13	12.5	(12.5 - 12.5)	8
Mamants'o	16.7	(16.7 - 16.7)	12	50.0	-	4
Manka	37.8	(15.9 - 59.7)	21	14.2	(11.0 - 17.5)	14
Manonyane	9.7	(1.1 - 18.2)	18	8.4	(-6.0 - 22.7)	16
Mapoteng	36.9	(15.2 - 58.7)	32	34.3	(5.7 - 63.0)	23
Maputsoe	29.5	(16.9 - 42.2)	95	6.6	(-2.6 - 15.8)	63
Maseru	21.1	(13.7 - 28.6)	291	8.9	(3.8 - 14.0)	196
Matsoku	16.3	(15.2 - 17.4)	60	2.0	(-4.6 - 8.7)	40
Mazenod	16.7	(16.7 - 16.7)	24	19.0	(8.8 - 29.1)	16
Menkhoaneng	42.7	(26.1 - 59.2)	24	30.2	(13.6 - 46.7)	16
Menoaneng	23.7	(14.6 - 32.7)	33	0.0	-	16
Metsi-Maholo	18.2	(18.2 - 18.2)	11	0.0	-	8
Mohale's Hoek	56.7	(44.8 - 68.5)	73	4.3	(-2.3 - 11.0)	47
Mohlakeng	16.7	(16.7 - 16.7)	12	25.0	(25.0 - 25.0)	8
Mokhotlong	21.3	(-18.6 - 61.1)	44	8.0	(-3.9 - 19.8)	29
Motanasela	17.0	(10.3 - 23.7)	36	23.0	(-11.3 - 57.2)	24

Council	Women Exp %	95% CI	N	Men Exp %	95% CI	N
Mphokojoane	15.4	(1.0 - 29.8)	50	1.0	(-1.7 - 3.7)	30
Mtjanyane	27.3	(27.3 - 27.3)	11	0.0	-	8
Ngoajane	31.0	(23.6 - 38.4)	24	0.0	-	16
Nqoe	27.8	(18.7 - 37.0)	72	4.0	(-0.8 - 8.9)	48
Ntŝupe	13.7	(2.4 - 25.0)	48	3.0	(-3.3 - 9.3)	28
Phuthiatsana	14.0	(3.9 - 24.1)	18	0.0	-	17
Qacha's Nek	27.5	(-2.9 - 57.9)	48	30.4	(-1.2 - 62.1)	32
Qanya	24.1	(18.0 - 30.2)	36	12.5	(-5.5 - 30.4)	24
Qhoasing	17.2	(-10.1 - 44.5)	46	5.2	(-10.0 - 20.3)	30
Qibing	9.1	(9.1 - 9.1)	11	33.3	(33.3 - 33.3)	9
Qiloane	0.0	-	12	11.1	-	9
Qomoqomong	25.0	(25.0 - 25.0)	12	0.0	-	7
Quthing	29.6	(15.2 - 44.0)	66	0.0	-	47
Ramapepe	18.4	(2.2 - 34.6)	19	20.6	(-11.4 - 52.5)	13
Ramoetsana	14.1	(1.5 - 26.6)	32	7.2	(-4.2 - 18.5)	21
Ratau	27.5	(15.1 - 39.9)	24	5.2	(-4.7 - 15.2)	14
Seate	13.0	(5.1 - 20.9)	36	1.8	(-1.9 - 5.4)	27
Semena	5.0	(-2.0 - 12.0)	27	4.1	(-5.0 - 13.2)	15
Semonkong	23.4	(-7.8 - 54.5)	26	5.8	(-14.7 - 26.4)	22
Senekane	25.0	(25.0 - 25.0)	12	0.0	-	8
Senqebethu	18.1	(4.8 - 31.5)	24	0.0	-	20
Senqunyane	33.3	(33.3 - 33.3)	24	0.0	-	14
Sephokong	16.7	(16.7 - 16.7)	12	0.0	-	8
Siloe	42.7	(17.4 - 68.0)	23	0.0	-	15
Tebe-Tebe	0.0	-	12	12.5	(12.5 - 12.5)	8
Telle	18.9	(11.7 - 26.0)	46	5.2	(0.6 - 9.9)	30
Tenesolo	8.7	(8.0 - 9.3)	23	12.0	(0.3 - 23.6)	8
Thaba-Mokhele	26.9	(9.1 - 44.8)	36	1.0	(-11.4 - 13.4)	23
Thaba-Tseka	3.5	(-8.8 - 15.9)	49	15.2	(-23.6 - 54.0)	17
Tosing	20.2	(-0.6 - 41.1)	24	0.0	-	15
Ts'a-le-Moleka	18.5	(-17.7 - 54.6)	24	16.7	(-23.9 - 57.4)	16
Ts'ana-Talana	4.8	(-2.7 - 12.4)	23	37.0	(28.6 - 45.3)	16
Tsitsong	13.8	(-4.0 - 31.5)	25	4.8	(-9.6 - 19.2)	15
Tsoelikana	30.6	(3.3 - 58.0)	37	26.9	(-8.9 - 62.7)	30
Tsoili-Tsoili	28.6	(28.6 - 28.6)	7	66.7	(66.7 - 66.7)	6
Tsoilitsoili	50.0	-	8	40.0	(40.0 - 40.0)	5
Tŝitsong	9.1	(9.1 - 9.1)	11	0.0	-	8

Source: Lesotho GBV 2025 Prevalence Survey, Gender Links

Appendix Table A13: Government performance scorecard (2013-2025)

Domain	Score	Key evidence	Priority action
Normative change and prevention	3	Agreement that a woman should obey her husband: 97%_33.9%/49.2%. Kick4Life 93% attitude improvement. Campaigns reach <15%. No ACE-informed prevention.	Social norms campaign (D1). Male engagement in all districts (D3). School GBV curriculum (C3).
Legal framework and CDV Act	3	CDV Act 2022 enacted. ILO C190 ratified. The Labour Act 2024 adds a workplace framework. But: Family Court provisions not operationalised; no family court rules; 12.1% awareness.	Promulgate family court rules (A1). Restore forensic lab (A5). CDV Act campaign (A6).
Police and Justice response	2	Reporting: 9.9% unchanged. Fewer than 2% of survivors reach a court verdict (N=23). Legal Aid Guidelines Dec 2025: create the first referral protocol for 56 providers.	National GBV training (B5). Forensic lab (A5). Referral form (A4). Perpetrator programme (B4).
Health sector and mental health	2	Depression: 65.8% women survivors. WHO CCS 2024-27 integrates GBV. Mental health infrastructure unchanged. Cost: M462.9m-M1,926m/year.	GBV psychosocial in all districts (B1). ACE-informed assessment (B3). GBV-HIV integration.
Support services and shelter	1	Shelter: 1.0-1.3%. Thuso assessment: 4/12 criteria unmet. NGO disclosure: 0.3%. Nokaneng app launched, but not yet integrated.	Expand shelter to 3 districts (B2). Activate Forum referral protocols (A2-A4). Service mapping (C6).
Multi-sectoral coordination	2	Anti-GBV Forum exists. Legal Aid Guidelines and the Nokaneng app are new instruments. But: underfunded, no referral protocol, no common data system.	Forum budget and mandate (A2). Service directory (A3). Referral form (A4). GBVIMS (C5).
Political accountability and data	2	93% of statements have no budget specificity. No annual GBV report. NUL adopted an institutional SGBV policy. The Labour Act creates the Dispute Prevention Directorate.	PWC Tracker (C4). Annual GBV report (B6). Budget transparency (C1).
OVERALL	2.4/5	Legislative progress (CDV Act, Labour Act, Legal Aid Guidelines) has not yet been translated into operational delivery or measurable survivor outcomes.	Immediate: A1 (regulations), A2 (Forum), A5 (lab), A7 (Nokaneng). Short-term: B1, B2, B5, B7, B8.

ANNEX 1

Field teams by district

Maseru
Supervisors: **Kautse Mphakalasi, Mamolibeli Ngakane, Maneo Phakisi**
Kananelo Stephen Phetho, Lepota Mafeka, Liakanyo Raphoka, Makarabo Nthako, Mamothe Mafeka, Motlatsi Alexis Bale, Nteboheleng Mabetha, Phoka Nyakane, Pulane Ramajoe, Refiloe Jeanett Khomohaka, Relebohile Mpeete, Thabang Lekhabunyane, Thabelo Mohapi, Davis Thapelo Mosala

Leribe
Supervisors: **Limpho Mathola, Mapuleng Shale**
Kalimo Mokobori, Lereko Sello, Likhapha Lehlabaphiri, Lineo Leshoele, Malillo Mofua, Matseliso Maome, Moreboli Chale, Nyeoe Ntene, Pulane Elizabeth Khasemeng, Tseliso Morris Makeki

Berea
Supervisors: **Lepelesane Moerane, Rannyaliseng Maanela**
Makione John Khabo, Mathabelo Theresia Khoete, Mofolisi Maduna, Mohapi Malise, Mokhantso Mohasoa, Moliehi Maphasa, Retselitsoe Senekane, Teboho Tau, Tiisetso Julliet Mankimane

Mafeteng
Supervisors: **Katiso Mefi, Mantsane Monaheng**
Khahliso Tema, Lekhutla Francis Ts'Oene, Mamohau Bokaako, Masabata Nyapholi, Masiu Masiu, Matlotliso Mary Tau, Palesa Khatli, Thapelo Moeketsi

Mohale's Hoek
Supervisors: **Nonkosi Mothala, Bahlakoana Mpoko**
Kefuoe Mahloko, Lerato Phonyane, Lieketseng Malesela, Masemere Elias Belemane, Mphonyane Ramarumo, Refiloe Mohejane

Butha-Buthe
Supervisor: **Ntaoleng Mafisa**
Malekhetho Khoto, Mamapalane Veronica Sekitla, Mantsebo Veronica Molumo, Rampine Molebatsi, Refiloe Masaoana, Rethabile Tau

Mokhotlong
Supervisor: **Palesa Mabea**
Bohang Tau, Bokang Andreas Palime, Malikete Chale, Mohapi Malefane, Ts'Ireletso Lekoetje

Quthing
Supervisor: **Matoka Setumo**
Lerato Mosola, Mafusi Elizabeth Ts'Enki, Maseakhoe Mpana, Moeketse Jeffrey Moeketse, Rapelang Semakale

Thaba-Tseka
Supervisor: **Teboho Setai**
Lebohang Mokhethi, Lithakong Moqhali, Makhema Phohleli Joseph, Maletsatsi Matjama, Nthati Lesala

Qacha's Nek
Supervisor: **Ntheka Matobo**
Matseliso Lepheana, Mohapi Ithabeleng, Motseki Nts'Ene, Realeboha Joel Selahla

ANNEX 2

Key differences between the 2013 and 2025 survey instruments

Dimension	2013 Study	2025 Study
Measurement approach	Unidirectional: women's questionnaire measured experience of violence only (Section 10); men's questionnaire measured perpetration of violence against women only (Section 10). No cross-measurement.	Bi-directional: both instruments measure experience AND perpetration of IPV. Women's questionnaire adds Section 13 (perpetration); men's questionnaire adds Section 11 (experience of IPV from a partner). Enables analysis of mutual violence and experience-perpetration linkages for both genders.
Household characteristics and wealth	Both instruments (Section 1): household composition, housing materials, assets, and food security. Used for wealth quintile construction.	Both instruments (Section 1): retained with updated asset list (added computer/laptop)- same DHS-aligned wealth proxy approach.
Demographics	Section 2 (both instruments): age, education level, marital status, employment status, personal income, religion, and ethnicity. Education is measured in broad categories (no schooling, primary, secondary, tertiary). Employment is binary (working/not working) within the sector.	Section 2 (both instruments): age, education level (expanded categories including vocational/technical training), marital status (added cohabiting option), employment status with detailed categories (formal, informal, self-employed, seasonal), personal and household income bands, religion, and ethnicity.
	Age range: 18+ years (with some items referencing 18-49 age band for comparability with DHS).	15+ years with no upper age limit, enabling measurement among adolescents (15-17) and older adults to capture elder abuse for the first time.
	Gender identity: Not measured-binary sex recorded by the enumerator observation only.	Self-reported gender identity added (Q2.3): Woman, Man, Gender Non-Conforming, prefer not to say, Don't Know, Refuse to Answer. Enables disaggregation beyond binary sex.
Disability measurement	Not measured. No disability screening or functioning questions.	Washington Group Short Set on Functioning (Section 3, Q3.1-3.6): six domains, seeing, hearing, walking, remembering, self-care, communicating, each on a four-point difficulty scale. Enables GBV disaggregation by disability status.
Adverse childhood experiences (ACEs)	Twelve-item childhood experiences checklist (Section 2, Q24-35 women / Q140-152 men) covering neglect, emotional abuse, physical abuse (home and school), sexual abuse, witnessing maternal IPV, household substance abuse, and household instability. Four-point frequency scale (never/sometimes/often/very often).	Revised and standardised six-domain ACE framework (Section 4) with binary (yes/no) response format. Domains: emotional abuse, physical abuse, sexual abuse, neglect, household substance abuse, witnessing domestic violence, and household member imprisonment. Enables direct computation of domain-level prevalence and mean ACE score.

Dimension	2013 Study	2025 Study
IPV experience	Women: full experience module covering emotional, controlling, economic, physical, and sexual IPV with lifetime and past-12-month recall, plus frequency (Section 10)-men: not measured.	Both instruments include Section 11 (Experience of IPV) covering emotional/psychological, controlling behaviours and economic, physical, and sexual violence. Lifetime and past-12-month recall with frequency. Men's experience module mirrors women's, item for item.
IPV perpetration	Men: full perpetration module covering emotional, controlling, economic, physical, and sexual IPV with lifetime and past-12-month recall (Section 10). Women: not measured. Not measured as a separate domain.	Both instruments include Section 13 (Perpetration of IPV) covering emotional/psychological, controlling behaviours and economic, physical, and sexual violence. Women's perpetration module mirrors men's item-for-item. Both include help-seeking after perpetration.
Reproductive coercion	No items on forced pregnancy, condom removal, or birth-control sabotage.	Dedicated sub-section (Part E/F within Section 11) in both instruments: forced use/non-use of birth control, forced pregnancy, condom removal during sex, birth-control sabotage. Measured as both experience and perpetration.
Abuse in pregnancy	Dedicated Section 12 (women only): economic abuse during pregnancy, physical violence, forced sex during pregnancy, premature labour, miscarriage. Seven items.	Integrated into the IPV experience module (Section 11, Part E) for women: physical violence during pregnancy, miscarriage due to violence. Streamlined to focus on physical and sexual violence during pregnancy.
Non-partner sexual violence (NPSV)	Women: experience of forced/ persuaded sex by a non-partner, with perpetrator, age, location, and 12-month recall (Section 11, Q184-190). Men: perpetration of forced/ persuaded sex, gang rape, with 12-month recall (Section 11, Q533-541).	Women: expanded experience module (Section 14, Q14.1-14.12), adding attempted rape, incapacitated assault, pressured sex, and gang rape as distinct items. Men: perpetration (Section 14, Q14.1-14.4) with new motivational probes on why attempted assaults stopped.
Sexual harassment	Women only (Section 13): focused on quid pro quo harassment at work (Q230-232) and school (Q233-236), plus verbal harassment by teachers-men: not measured.	Both instruments (Section 15): broadened to cover unwanted sexual comments, gestures, or physical advances in public spaces, on transport, in markets, on the street, at school, and at work. Both experience and location-specific prevalence.
Technology-facilitated GBV (TFGBV)	Not measured. No internet or social media items.	New Section 16 in both instruments: internet/social media usage frequency; six TFGBV types, online stalking, abusive messages, fake profiles/identity theft, sextortion, non-consensual image sharing; offline escalation; emotional impact; help-seeking and reporting.
Effects, help-seeking, and access to justice	Women only: injury, medical treatment, police reporting, protection orders, court experience, satisfaction with services, and reasons for non-reporting (within Section 10).	Both instruments (Section 12): injury severity, days in bed, days off work, medical attention, police reporting, court outcomes, satisfaction, and reasons for non-reporting. Men who experienced IPV now report effects and help-seeking, matching the women's module.

Dimension	2013 Study	2025 Study
Gender attitudes and norms	Both instruments: community ideas about gender relations/social norms (Section 3), attitudes about rape (Section 4), Gender Equitable Women/Men Scale (Section 5), Relationship Control Scale (Section 9).	Retained and updated: Gender and Relations (Section 5, with Part B on perceived community norms added to men's instrument), Attitudes about Rape (Section 6), GEM Scale (Section 7), Relationship Control Scale (Section 10). Updated items reflect legislative changes since 2013.
Witnessing domestic violence and bystander intervention	Both instruments: witnessing domestic violence in childhood and as an adult (Section 6). No bystander intervention items.	Section 8 retained the witnessing module and expanded with bystander intervention items (men's instrument Q8.9-8.13): whether the respondent intervened, the type of intervention (talked to the victim/perpetrator, called the police, connected to services), and the frequency of discussing domestic violence.
Fathering and caregiving	Men only (Section 7): number of biological children, financial support frequency, desired parental role, relationship with children. Basic module (~8 items).	Men only (Section 9): expanded module on involvement with children, caregiving activities, relationship quality, shared parenting, attitudes towards fathering role. Greater depth on active caregiving and equitable parenting.
Sex, pregnancy, and reproductive health	Women: Section 7 (sex and pregnancy) covering sexual debut, pregnancies, and contraception. Men: within Section 7 (fathering) covering sexual debut and contraception.	Section 9 (women: Sex and Pregnancy; men: Fathering and Relationships). Women's instrument retains pregnancy history, contraception, and sexual debut. Both instruments were standardised.
Sexual health and HIV	Both instruments: sexual behaviour (Section 14), transactional sex (men: Section 22), circumcision (men: Section 23), STI/HIV testing (Section 15).	Both instruments (Section 17): Parts A-D covering sexual activity and history, sexual health, transactional sex, and HIV prevention knowledge. Men's instrument adds Part E (circumcision). Consolidated into a single multi-part section.
Mental health and trauma	Both instruments: Experiences of Trauma (Section 16), CES-D depression scale (Section 17), PTSD checklist (Section 19) - three validated instruments already present.	Both instruments retain all three: Experiences of Trauma (Section 18), CES-D (Section 19), PCL-5 post-traumatic stress checklist (Section 21). PCL-5 replaces the earlier PTSD checklist with the updated DSM-5-aligned version.
Substance use	Both instruments (Section 18): alcohol and drug use items covering frequency, quantity, and types of substances.	Both instruments (Section 20): retained alcohol and drug use with AUDIT-style frequency and quantity items. Expanded response options and substance categories.
Prevention campaigns and legal awareness	Both instruments (Section 20): awareness of GBV prevention campaigns, recall of specific campaigns, and knowledge of relevant legislation.	Both instruments (Section 22): retained campaign awareness and expanded legal knowledge to include the Counter Domestic Violence Act (2022), Labour Act (2024), and ILO Convention C190. Updated to reflect post-2013 legislative landscape.
Sources of support	Women only (Section 21): accessing support during emotional difficulties.	Both instruments (Section 23): sources of support during periods of emotional difficulty. Extended to men.

Source: Lesotho GBV 2013 and 2025 survey instruments, Gender Links

ANNEX 3

Comparison of Sampling Designs, 2013 and 2025

Dimension	2013 Baseline	2025 Follow-up
Sampling design	Two-stage proportionate stratified design using probability proportional to size (PPS) systematic sampling.	Three-stage proportionate stratified cluster design using probability proportionate to size (PPS) sampling. Stage 1: EA selection; Stage 2: household selection; Stage 3: within-household respondent selection via the Kish Grid.
Sampling frame	The latest Lesotho Population Census available at the time. Measure of size (MOS): dwelling counts obtained from the Census.	2022 Lesotho Population and Housing Census, provided by the Bureau of Statistics (BOS). MOS: household counts from the Census frame.
Primary Sampling Units (PSUs)	Enumeration Areas (EAs). EA code structure: 9 digits encoding district, constituency, community council, ecological zone, and EA number.	Enumeration Areas (EAs). Same 9-digit EA code structure retained from the Census. Each EA has clearly delineated boundaries specified on a census base map.
Stratification	Two levels: (i) Urban and Rural (two categories); (ii) Ecological zones - Lowlands, Foothills, Mountains, and Senqu River Valley. Applied across all ten districts.	Three levels: (i) District (10 districts); (ii) Ecological zones - Lowlands, Foothills, Mountains, and Senqu River Valley; (iii) Settlement type - Urban, Peri-Urban, and Rural (three categories, compared to 2013's two).
Settlement classification	Two categories: Urban (89 EAs) and Rural (136 EAs).	Three categories: Urban (80 EAs), Peri-Urban (28 EAs), and Rural (117 EAs). The peri-urban category captures transitional settlement areas that were not distinguished in the 2013 design.
Number of EAs/clusters	225 EAs (89 urban, 136 rural), distributed across all ten districts by PPS.	225 EAs (80 urban, 28 peri-urban, 117 rural), distributed across all ten districts by PPS.
Ecological zone distribution	Stratified by the Lowlands, Foothills, Mountains, and the Senqu River Valley. Exact EA counts per zone are not reported in the published methodology.	Lowlands: 110 EAs; Mountains: 62 EAs; Peri-Urban/Foothills: 25 EAs; Senqu River Valley: 28 EAs. Distribution reflects PPS allocation within each district.
Sample size calculation	Based on achieving sufficient statistical power to estimate the prevalence of GBV experience (women) and perpetration (men) with ±5% absolute precision. Assumed 10% non-response rate and design effect (deff) of 1.8.	Target: 4,500 completed interviews (2,700 women; 1,800 men), a 3:2 ratio consistent with 2013. 225 clusters _ 20 households _ 1 respondent = up to 4 500 interviews.
Achieved sample	Self-weighting design; total achieved sample not reported in the published methodology section.	4,254 completed interviews: 2,565 women (95%) and 1,689 men (94%). Overall completion rate: 95%. All 225 clusters visited and completed.

Dimension	2013 Baseline	2025 Follow-up
Interviews per EA	20 interviews per EA: One eligible respondent per household. Fixed number per EA (implied by self-weighting PPS design). Gender is determined by EA allocation.	20 interviews per EA: 12 women and 8 men. Both genders were interviewed within the same EA but in separate households.
Gender allocation method	Gender segregated by EA: men and women were not interviewed from the same household or EA. EA allocation determined gender. Ensured respondent safety.	Both genders were interviewed within the same EA but in separate households to avoid contamination. No EA-level gender segregation. Permits within-cluster gender comparisons.
EA mapping and geo-informatics	EA boundaries defined from the Census. Satellite maps used as reference maps showing EA boundaries and principal physical features/landmarks (mountains, rivers, roads, electric poles).	EA boundaries specified on census base maps provided by BOS from the 2022 Census, with clear enumeration area boundary delineation. Digital geo-referenced maps are used for field navigation and cluster identification.
Household listing	Formal listing exercise: field teams visited each village in the selected EA, recorded every structure and the names of household heads. Produced a comprehensive list of residential households (occupied and vacant)-final sample selected from this listing form.	Supervisors and enumerators listed all households in each selected EA, verified the listing, and assigned a unique number to each household. The listing served as the sampling frame for household selection-systematic interval sampling from a random starting point. Up to 5 replacement households per cluster permitted.
Respondent selection within the household	One randomly selected eligible person per household (gender determined by EA allocation).	Kish Grid method: enumerators compiled a household roster of all eligible members (aged 15+), ranked by age from oldest to youngest. The last digit of the household ID and the number of eligible members were cross-referenced against the Kish Grid table to identify the selected respondent. This eliminated interviewer discretion in respondent selection.
Age eligibility	18 years or older.	15 years or older, with no upper age limit. Enables measurement among adolescents (15-17) and older adults (elder abuse).
Residency and household membership	Must have been sleeping in the selected household for at least four nights a week - mental competency required.	Must have slept in the sampled household for at least four nights per week. Domestic servants are included if they sleep 5+ nights and eat with the family. Visitors are included if they have slept in the household for the past 4 weeks. Students/persons living in a household for schooling or work purposes are included. Absent members in institutions are excluded.

Dimension	2013 Baseline	2025 Follow-up
Substitution policy	No substitution of non-respondents allowed. Researchers made three follow-up visits to contact potential participants.	No respondent substitution within a household (proxy response not permitted). Up to 5 replacement households per cluster where the originally selected dwelling was unavailable or ineligible. Up to 3 additional contact attempts per respondent.
Weighting	Self-weighting design via PPS: selection probabilities at each stage were set to be constant, reducing variance due to weight variation. All analyses accounted for the two-stage structure with PSUs as clusters.	Design weights calculated for each cluster to account for differential selection probabilities. Normalised household weights derived for nationally representative estimates.
Data collection mode	Personal Digital Assistants (PDAs). Participants chose their preferred language; interviewers read questions from the PDA screen. Skip button available. Data downloaded daily and merged.	Tablet-based KoBoCollect software with real-time server synchronisation. Real-time quality monitoring by supervisors via daily field reports covering household progress, respondent completion, quality spot-checks and back-checks, and incident reporting.
Data collection period	16 March to 15 April 2013 (approximately one month).	8 November to 23 November 2025 (16 days). All 225 clusters visited and completed.
Data analysis software	Stata Version 11. Taylor linearisation for 95% confidence intervals from complex multistage sample surveys. Pearson's chi-squared test for categorical associations, no replacement of missing data.	Stata/MP Version 19.5 (multiprocessor edition). Design weights applied for all estimates. Advanced analytical capabilities, including updated survey estimation commands.
Ethical protocol	Voluntary participation; information sheet (read aloud if necessary); signed consent; non-consecutive study IDs; trauma counselling training for interviewers; support material with counselling contacts distributed to all women interviewed; local police informed; project referred to in non-specific terms.	Consistent with the 2013 protocol. Informed consent; anonymity; referral pathways; community sensitisation through local authorities; project referred to as a "relationship study" to protect respondent safety. Supervisor daily field reports include incident and safety reporting.

Source: 2013 Lesotho GBV Indicators Study (Final Report, Chapter 2); 2025 Lesotho GBV Indicators Follow-up Study, Chapter 2; BOS Sampling Methodology Presentation (November 2025); BOS Selected EAs Sampling Frame

THE GBV ROADMAP

Three Frameworks for Measuring Progress

• SADC Protocol on Gender and Development (2016) • UN Sustainable Development Goals (2030) • AU Agenda 2063

ELIMINATION OF VIOLENCE

SADC Art. 20(1)(a): Enact and enforce legislation prohibiting all forms of gender-based violence.
SADC Art. 20(1)(b): Eliminate all harmful social and cultural practices, such as child marriage, forced marriage, and female genital mutilation.
SDG Target 5.2: Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation.
SDG Target 5.3: Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation.
AU 2063 Goal 17: Eliminate all forms of discrimination and violence against women and girls.
AU 2063 Target 6.3.8: End harmful social norms and customary practices against women and girls, such as child marriages and FGM.

RESPONSE, JUSTICE AND SUPPORT

SADC Art. 20(3): Review and strengthen laws applicable to sexual offences to ensure justice and fairness are accorded to survivors in a manner that ensures dignity, protection and respect.
SADC Art. 23(2): Ensure accessible, effective and responsive police, prosecutorial, health, social welfare and other services to redress cases of GBV.
SADC Art. 23(3): Provide accessible, affordable and specialised legal services, including legal aid, to survivors of GBV.
SDG Target 16.1: Significantly reduce all forms of violence and related death rates everywhere.
SDG Target 16.3: Promote the rule of law at the national and international levels and ensure equal access to justice for all.
AU 2063 Ind. 72: Percentage of reported cases of violence against women and girls that have been prosecuted.

PREVENTION AND SOCIAL CHANGE

SADC Art. 21(1): Take measures to discourage traditional norms and practices which legitimise and exacerbate the persistence and tolerance of GBV, with a view to eliminating them.
SADC Art. 22(1): Enact legislative provisions that define and prohibit sexual harassment in all spheres and provide deterrent sanctions for perpetrators.
SADC Art. 24(1): Provide gender education and training to service providers involved in GBV, including the police, the judiciary, health and social workers.
SDG Target 5.1: End all forms of discrimination against all women and girls everywhere.
SDG Target 5.c: Adopt and strengthen sound policies and enforceable legislation for the promotion of gender equality and the empowerment of all women and girls.

INTEGRATED APPROACHES AND MEASUREMENT

SADC Art. 25(1): Adopt integrated approaches, including institutional cross-sector structures, with the aim of eliminating GBV.
SADC Art. 35(3): Collect and analyse baseline data against which progress in achieving targets will be monitored.
SDG Ind. 5.2.1: Proportion of ever-partnered women and girls subjected to physical, sexual or psychological violence by a current or former intimate partner.
AU 2063 Asp. 6: An Africa whose development is people-driven, relying on the potential of African people, especially its women and youth, and caring for children.

THE ULTIMATE GOAL

All three frameworks converge on a single imperative: a world in which no woman, man, girl or boy experiences gender-based violence - backed by laws that protect, services that respond, institutions that prevent, and data that measures progress.

This study contributes to that measurement.

The 2025 Lesotho Gender-Based Violence (GBV) Indicators Follow-up Study is a nationally representative survey of GBV prevalence, effects, responses, support, and prevention across all ten districts of Lesotho. It is the second in a series of GBV Indicators Studies conducted by Gender Links Lesotho (GLL), building directly on the 2013 baseline study. GLL conducted the study in partnership with the Lesotho Bureau of Statistics (LBOS) and the Ministry of Gender, Youth and Social Development, funded by the European Union through a grant to GLL.

